Guide to HEDIS® Measures MY 2025

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Quality Performance Management

HEDIS® Operations

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L.A. Care HEALTH PLAN®

For All of L.A.

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Welcome to Guide to HEDIS® Measures MY 2025

L.A. Care Health Plan (L.A. Care) is a National Committee for Quality Assurance (NCQA) accredited health plan. HEDIS® is the gold standard for measuring quality health care performance, and is part of the NCQA accreditation process. Guide to HEDIS® Measures is a reference guide designed to help your practice provide the best quality care, in alignment with the HEDIS® standards. This document is merely a tool and provides a general summary on some limited HEDIS® Program requirements. This document should not be used as legal advice or expert advice or comprehensive summary of the HEDIS® Program. Please refer to **ncqa.org** for HEDIS® Program measures and guidelines as well as relevant statutes.

The information provided in this document is for 2025 HEDIS® measurement period and is current at the time this document was created. NCQA HEDIS® Program requirements, applicable laws, and L.A. Care's policy change from time to time, and information and documents requested from you may also change to comply with these requirements

L.A. Care is not affiliated with NCQA or its HEDIS® Program and does not receive any financial remuneration from it.

Guide to HEDIS® Measures highlights priority HEDIS® measures that can potentially have significant impact on Auto-assignment and Minimum Performance Level (MPL), NCQA Accreditation, and Cal Medi-Connect (CMC) Quality Performance Withhold. Additionally, if you participate in and qualify for Physician P4P, the information contained in this reference guide may help you maximize the incentives you receive as part of L.A. Care's Physician Pay-for-Performance Program for Medi-Cal and L.A. Care Covered members.

L.A. Care Health Plan collects HEDIS® data throughout the measurement year and reports annually from January to May for the prior year. For example, 2025 claims, encounters, and other HEDIS® data are submitted throughout 2025. In January to May of 2026, data for 2025 continues to be submitted along with Medical Record review for Hybrid measures and final HEDIS® 2025 rates and results are reported.

For HEDIS® related inquiries, please contact **HEDIS_Ops@lacare.org**. *Note: All emails containing member PHI MUST be securely encrypted.*

Pay-for-Performance: Look for measures with Pay-for-Performance that are included in L.A. Care's Pay-for-Performance programs for Measurement Year 2025.

For more details contact **incentive_ops@lacare.org**. *Note: All emails containing member PHI MUST be securely encrypted.*

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis/Bronchiolitis (AAB)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid

Q: Which members are included in the sample?

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

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data with a date of service from any outpatient, telephonic, e-visit or virtual check-in, an observation or ED visit with an acute bronchitis diagnosis and no new or refill prescription for an antibiotic medication in 2024.

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazole	• Vancomycin
Natural penicillins	• Penicillin G benzathine- procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second-generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefixime	• Cefotaxime • Cefpodoxime	• Ceftazidime • Ceftriaxone
Urinari-anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis/Bronchiolitis (AAB)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claim/encounter data

SAMPLE CODES

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

ICD-10 Codes	
Acute Bronchitis	J20.0-J20.9

CPT Codes	
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99429, 99455, 99456

HCPCS Codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion(s)

Competing Diagnosis, Comorbid Conditions, Hospice Care and Pharyngitis.

*Exclude members who died during 2025.

Note: Do not include visits that result in inpatient stay.

Adult's Access to Preventative/ Ambulatory Health Services (AAP)

Q: Which members are included in the sample?

A: Members 20 years and older who had an ambulatory or preventative care visit.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of medical record is acceptable?

A: Evidence from a claim/encounter with a date of service.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data

Adult's Access to Preventative/ Ambulatory Health Services (AAP)

SAMPLE CODES

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

CPT Codes

98966-98968, 99212-99215, 99441-99444

HCPCS Codes

G0402, G0438-39, G0463, G2010, G2012, G2061-63, S0620-21, T1015

Exclusion(s)

Hospice Care

* Exclude members who died during 2025.

Advance Care Planning (ACP)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Members 66-80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claims/encounter data submission only using the appropriate codes. Including : Advanced Illness, Frailty, and Palliative Care codes and Dispensed dementia medication. (Do not include laboratory claims).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Q: What type of document is acceptable?

A: Evidence of claims/encounter for a discussion or documentation about preferences for resuscitation, life sustaining treatment and end of life care.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Exclusion: Hospice Care

Advance Care Planning (ACP)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

CPT II Codes	
Advance Care Planning	1123F, 1124F

CPT Codes	
Assessment of Advance Care Planning	99483

Exclusion(s)
Members in hospice or using hospice services anytime during 2025. *Exclude members who died during 2025.

Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

NCQA Accreditation Medicaid

Q: Which members are included in the sample?

A: Children 6-12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- ☑ Initiation Phase. The percentage of members 6-12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase
- ☑ Continuation and Maintenance (C&M) Phase. The percentage of members 6-12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

NCQA Accreditation Medicaid

Q: What type of document is acceptable?

A: Evidence from claim/encounter data:

1. Children in the specified age range who were dispensed an ADHD medication:

ADHD Medications

Drug Class	Prescription	Medication Lists
CNS stimulants	• Dexmethylphenidate • Dextroamphetamine • Lisdexamfetamine • Methylphenidate • Methamphetamine	• Dexmethylphenidate Medications List • Dextroamphetamine Medications List • Lisdexamfetamine Medications List • Methylphenidate Medications List • Methamphetamine Medications List
Alpha-2 receptor agonists	• Clonidine • Guanfacine	• Clonidine Medications List • Guanfacine Medications List
Miscellaneous ADHD medications	• Atomoxetine • Dexmethylphenidate Serdexmethylphenidate • Viloxazine	• Atomoxetine Medications List • Dexmethylphenidate Serdexmethylphenidate Medications List • Viloxazine Medications List

2. Member follow-up visit with a practitioner with prescribing authority, within 30 days of ADHD medication dispensing:
   - Of these members, in the following 9 months, who received at least 2 additional follow-up visits with any practitioner

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data for any of the following: outpatient visit, observation visit, Health and Behavior assessment or intervention visit, intensive outpatient encounter or partial hospitalization visit,Community Mental Health Center visit,telephone visit, E-Visit or Virtual Check-In.
- ☑ Schedule 30-day follow-up for all children who are dispensed ADHD medication to assess how medication is working

Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

NCQA Accreditation Medicaid

SAMPLE CODES

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

CPT Codes	
ADD Stand Alone Visits	96150-96154, 98960-98962, 99078, 99202-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99401-99404, 99411, 99412, 99510
ADD Visits Group 1	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
ADD Visits Group 2	99221-99223, 99231-99233, 99238, 99239, 99251-99255
Outpatient	99391-99394

HCPCS Codes	
ADD Stand Alone Visits	G0155, G0176, G0177, G0409- G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

Exclusion(s)
Hospice Care, Acute Inpatient Stay, Mental Disorder, Behavioral Disorder, Neurodevelopmental Disorder, Narcolepsy *Exclude members who died during 2025.

Asthma Medication Ratio (AMR)

Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claim/encounter data

Asthma Medication Ratio (AMR)

Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: What type of document is acceptable?

A: Evidence from claim/encounter data with documentation of all asthma medications for members identified as having persistent asthma during 2025.

Asthma Controller Medication

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	• Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Beta2 adrenergic agonist—corticosteroid combination	Albuterol-budesonide	Albuterol Budesonide Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Asthma Medication Ratio (AMR)

Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

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

ICD-10 Codes - Asthma	
Mild Intermittent Asthma	J45.20-J45.22
Mild Persistent Asthma	J45.30-J45.32
Moderate Persistent Asthma	J45.40-J45.42
Severe Persistent Asthma	J45.50-J45.52
Other and Unspecified Asthma	J45.901-J45.902, J45.909, J45.990, J45.991, J45.998

CPT Codes	
ED	99281-99285
Observation	99217-99220
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS Codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion(s)
Acute Respiratory Failure, Chronic respiratory Conditions Due to Fumes/Vapors, COPD, Cystic Fibrosis, Emphysema, Hospice Care, Obstructive Chronic Bronchitis, Other Emphysema. *Exclude members who died in 2025.

Breast Cancer Screening (BCS-E)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Women 50-74 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: *None. This measure requires claim/encounter data submission only using the appropriate value set codes.*

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/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: Palliative Care and Hospice Care
- ☑ Exclusions: for Breast Cancer Screening: (Use designated Value Set Code for each)

Any of the following meet criteria for bilateral mastectomy:

- Bilateral Mastectomy
- Unilateral Mastectomy with bilateral modifier must be from the same procedure.

Breast Cancer Screening (BCS-E)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS® measure?

- 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 MRIs are not appropriate methods for breast cancer screening.

SAMPLE CODES

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

CPT Codes	
Mammography	77055-77057, 77061-77063, 77065-77067

HCPCS Codes	
Mammography	G0202, G0204, G0206

Exclusion(s)

Absence of Left Breast, Absence of Right Breast, Acute Inpatient, Advanced Illness, Bilateral, Mastectomy, Frailty, History of Bilateral Mastectomy, Hospice Care, Observation, Outpatient, Unilateral Mastectomy, Palliative Care.

*Exclude members who died in 2025.

Blood Pressure Control for Patients with Diabetes (BPD)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars

Q: Which members are included in the sample?

A: Members 18-75 years of age with diabetes (Type 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90) in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Blood Pressure (BP) control (< 140/90 mmHG)

- The most recent BP reading during an outpatient visit, or in a non-acute inpatient/ER setting in 2022. (Note: ALWAYS recheck BP if initial reading is at or > 140/90 mm Hg)
- Member reported BP reading during Telehealth visit.
- BP readings documented as an "average BP" are eligible for use. DO NOT USE RANGES or THRESHOLDS.

DO NOT INCLUDE BP Reading:

- *Taken during an acute impatient stay or ED visit.*
- *Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope DOES NOT MEET CRITERIA.*

BP cuffs are now a RX benefit for Medi-Cal members. No authorization is needed, just a prescription with a diagnosis code that justifies medical necessity for cardiovascular monitoring for a chronic condition or on a regular basis.

Q: What type of document is acceptable?

A: All progress notes from office and Telehealth visits in 2025.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ During Telehealth visits, Blood pressure readings taken and reported by the member meet criteria if taken with a digital device.
- ☑ BP cuffs are now a RX benefit for Medi-Cal members. No authorization is needed, just a prescription with a diagnosis code that justifies medical necessity for cardiovascular monitoring for a chronic condition or on a regular basis. necessary.
- ☑ Exclusion: Polycystic Ovarian Syndrome (PCOS), Gestational diabetes or Steroid induced diabetes, Hospice setting/services, Palliative care, No Diagnosis on DM in any setting in 2024 and 2025, I-SNP, LTI, Frailty, Advanced Illness.

Blood Pressure Control for Patients with Diabetes (BPD)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars

SAMPLE CODES

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

CPTII Codes	
Systolic	3074F, 3075F, 3077F
Diastolic	3078F, 3079F, 3080F

Exclusion(s)

Polycystic Ovarian Syndrome (PCOS), Gestational diabetes or Steroid induced diabetes, Hospice setting/services, Palliative care, No Diagnosis on DM in any setting in 2024 and 2025, I-SNP, LTI, Frailty, Advanced Illness

*Exclude members who died during 2025

Blood Pressure Control for Patients with Hypertension (BPC-E)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars

Q: Which members are included in the sample?

A: 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 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of medical record is acceptable?

A: Evidence from a claim/encounter with a date of service.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data

Blood Pressure Control for Patients with Hypertension (BPC-E)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars

SAMPLE CODES

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

ICD-10 Codes

3074F, 3075F, 3077F, 3078F, 3079F, 3080F

Exclusion (s)

- Members who use hospice services or elect to use a hospice benefit in 2025.
- Members who die any time in 2025.
- Members receiving palliative care any time in 2025.
- Members who had an encounter for palliative care any time in 2025.
- Members with a nonacute inpatient admission in 2025.
- Members with a diagnosis that indicates end-stage renal disease any time during the member's history on or prior to the last day of 2025.

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 2025.

- Members with a diagnosis of pregnancy anytime in 2025.
- Medicare members 66 years of age and older as of the last day of 2025 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
- Members 66–80 years of age as of the last day of 2025 with frailty and advanced illness.
  1. Frailty. At least two indications of frailty with different dates of service during 2025.
  2. Advanced Illness. Either of the following during the 2025 or 2024:
  – Advanced illness on at least two different dates of service.
  – Dispensed dementia medication.
- Members 81 years of age and older as of the last day of 2025 with at least two indications of frailty with different dates of service during 2025.

Controlling High Blood Pressure (CBP)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 50th percentile or greater)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (DSNP) (CMC)
Pay-for-Performance (P4P)
Medicare STARS
Medi-Cal Accountability Set (MCAS)
LACC QTI (Quality Transformation Initiative)

Q: Which members are included in the sample?

A: Members 18-85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Notation of the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record in 2025. (*Note: ALWAYS recheck BP if initial reading is at or > 140/90 mm Hg*)
BP reading must occur on or after the date when the second diagnosis of hypertension occurred.
BP readings taken and reported by member using **any** digital device.
BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible to use.

Q: What type of medical record is acceptable?

A: All progress notes in 2025.

Controlling High Blood Pressure (CBP)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 50th percentile or greater)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (DSNP) (CMC)
Pay-for-Performance (P4P)
Medicare STARS
Medi-Cal Accountability Set (MCAS)
LACC QTI (Quality Transformation Initiative)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ During Telehealth visits, Blood pressure readings taken and reported by the member meet criteria if taken with a digital device
- ☑ Submit any documentation with ESRD, Pregnancy, Kidney transplant or dialysis - *documentation will assist in excluding members from the HEDIS® sample*
- ☑ BP cuffs are now a RX benefit for Medi-Cal members. No authorization is needed, just a prescription with a diagnosis code that justifies medical necessity for cardiovascular monitoring for a chronic condition or on a regular basis. necessary.
- ☑ Exclusion: Members with diagnosis of pregnancy in 2025. Total or partial Nephrectomy.
- ☑ Exclusion: Palliative Care and Hospice Care
- ☑ Exclusion: For Medicare - members 66 years and older living in long term in institutional settings

SAMPLE CODES

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

CPTII Codes	
Systolic	3074F, 3075F, 3077F
Diastolic	3078F, 3079F, 3080F

Exclusion(s)

Acute Inpatient, Palliative Care, Advanced Illness, ESRD, ESRD Obsolete, Frailty, Inpatient Stay, Kidney Transplant, Transplant, Non-acute Inpatient Stay, Pregnancy, Hospice Care.

*Exclude members who died during 2025.

Cervical Cancer Screening (CCS-E)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- ☑ Women 21-64 years of age who had cervical cytology performed within 2023, 2024, 2025.
- ☑ Women 30-64 years of age who had cervical high- risk human papillomavirus (hrHPV) testing performed within 2021, 2022, 2023, 2024 or 2025.
- ☑ Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) contesting within 2021, 2022, 2023, 2024 or 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

*This measure requires claim/encounter data submission using the appropriate Value Set Codes.

A: Documentation must include both of the following criteria:

- ☑ a note indicating the date test was performed, ***and***
- ☑ the result or finding

Q: What type of medical record is acceptable?

A: Acceptable document:

- ☑ Cervical cytology report/HPV report
- ☑ Chronic Problem List with documentation of Pap Smear with or without HPV, must include date and result
- ☑ Progress note or consultation- notation of date and result of Pap Smear/HPV testing.
- ☑ Documentation that members with history of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix meets exclusion (optional) criteria.
- ☑ Any of the following documentation meets criteria:
  1. "Complete", "Total", or "Radical" (abdominal, vaginal or unspecified)
  2. "vaginal hysterectomy"
  3. "vaginal pap smear" in conjunction with documentation of "hysterectomy"

Cervical Cancer Screening (CCS-E)

State Medicaid Auto-Assignment
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Request results of screenings be sent to you if done at OB/GYN visit
- ☑ Exclusion: Palliative Care, Hospice Care, Hysterectomy with no residual cervix, cervical agenesis, acquired absence of cervix, or vaginal hysterectomy

SAMPLE CODES

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

CPT Codes	
Cervical Cytology	88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
HPV Tests	87620-87622, 87624, 87625

HCPCS Codes	
Cervical Cytology	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
HPV Tests	G0476

Exclusion(s)

Absence of Cervix, Palliative Care, Hospice Care, Encounter for Palliative Care

*Exclude members who died during 2025.

Chlamydia Screening (CHL)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in 2024.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation in the medical record is acceptable?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

- One chlamydia test in 2025.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/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:
  - A pregnancy test in 2025 **and** a prescription for isotretinoin (Retinoid) on the date of pregnancy test or the 6 days after the pregnancy test
  - A pregnancy test in 2025 **and** an x-ray on the date of the pregnancy test or the 6 days after the pregnancy test

Chlamydia Screening (CHL)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

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

ICD-10 Codes
Refer to Pregnancy Value Set
Refer to Pregnancy Tests Value Set
Refer to Sexual Activity Value Set

CPT Codes	
Chlamydia Tests	87110, 87270, 87320, 87490-87492, 87810
Pregnancy Tests	81025, 84702, 84703
Sexual Activity	Refer to Sexual Activity Value Set

HCPCS Codes	
Sexual Activity	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0199, S4981, S8055

Exclusion(s)
Hospice Care, A pregnancy test in 2025 and a Rx for isotretinoin on the day of pregnancy test or 6 days after test OR A pregnancy test in 2025 and an x-ray on the date of the pregnancy test or 6 days after test.
*Exclude members who died during 2025. *Exclude members who were assigned MALE at birth.

Childhood Immunization Status (CIS-E)

State Medicaid Auto – Assignment (Combo 10)
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
LACC QTI (Quality Transformation Initiative)

Q: Which members are included in the sample?

A: 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 type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines **by their second birthday.** LAIV(Influenza) vaccination must occur on the child's second birthday.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

*This measure requires claim/encounter data submission using the appropriate Value Set Codes.

A: Documentation must include <u>any</u> of the following:

Specific for: ***MMR, HepB, VZV, and HepA***

☑ Evidence of the antigen or combination vaccine (include specific dates)

☑ Documented history of the illness

Specific for: ***DTaP, HiB, IPV, PCV, rotavirus, and influenza***

☑ Evidence of the antigen or combination vaccine (include specific dates)

<u>OR</u>

☑ Notation indicating contraindication for a specific vaccine:
(Use designated Value Set Codes for each)

Any Particular Vaccine	• Anaphylactic reaction to the vaccine or its components
DTaP	• Encephalopathy ***with*** a vaccine adverse-effect code
MMR, VZV, and Influenza	• Immunodeficiency • HIV • Anaphylactic reaction to neomycin • Lymphoreticular cancer, Multiple Myeloma, or Leukemia
Rotavirus	• Severe combined immunodeficiency • History of intussusception

Childhood Immunization Status (CIS-E)

State Medicaid Auto – Assignment (Combo 10)
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
LACC QTI (Quality Transformation Initiative)

Q: What documentation is needed in the medical record?

OR

☑ Notation indicating contraindication for a specific vaccine:
(Use designated Value Set for each)

IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin
Hepatitis B	Anaphylactic reaction to common baker's yeast

Q: What type of medical record is acceptable?

*Evidence from a claim/encounter with a date of service.

A: One or more of the following:

- ☑ Certificate of immunization including specific dates and types of vaccines
- ☑ Hospital record with notation of HepB
- ☑ Immunization Record and Health History Form
- ☑ Health Maintenance Form
- ☑ Lab report for seropositive test
- ☑ Print out of LINK/CAIR registry
- ☑ Progress/office notes with notations of vaccines given
- ☑ Medical History Form

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Upload immunizations on to California Immunizations Registry (**http://cairweb.org**)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (**http://www.lacare.org/sites/default/files/LA1401_0815.pdf**)
- ☑ Educate parents about the importance of timely vaccinations and share the immunization schedule
- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure proper documentation of dates and types of immunizations, test results, history of illness, or contraindication for a specific vaccine
- ☑ Exclude organ and bone marrow transplant members.

  Note: Exclude children who have immunocompromising conditions or contraindication for a specific vaccine.

Childhood Immunization Status (CIS-E)

State Medicaid Auto – Assignment (Combo 10)
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid
LACC QTI (Quality Transformation Initiative)

SAMPLE CODES

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

CPT Codes	
Dtap-IPV-Hib-HepB	90697
DTap Vaccine	90698, 90700, 90721, 90723
Haemophilus Influenzae Type B (HiB) Vaccine	90644-90648, 90698, 90721, 90748
Hepatitis A Vaccine	90633
Hepatitis B Vaccine	90723, 90740, 90744, 90747, 90748
Inactivated Polio Vaccine (IPV)	90698, 90713, 90723
Influenza Vaccine	90655, 90657, 90661, 90662, 90673, 90685-90688
Measles, Mumps and Rubella Vaccine	90707, 90710
Pneumococcal conjugate vaccine, 13 valent (PCV13)	90670
Pneumococcal conjugate vaccine, 20 valent (PCV20	90677
Rotavirus Vaccine (2 dose)	90681
Rotavirus Vaccine (3 dose)	90680
Varicella Zoster Vaccine	90710, 90716

HCPCS Codes	
Influenza	G0008
Pneumococcal	G0009
Hepatitis B Vaccine	G0010

Exclusion(s)

Anaphylaxis due to vaccine is numerator compliant for DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, Rotavirus, and FLU. Encephalitis due to vaccine is numerator compliant for DTap only, Disorders of Immune System, HIV, Intussusception, Malignant Neoplasm of Lymphatic Tissue, Severe Combined Immunodeficiency, Vaccine Causing Adverse Effect, Hospice Care.

*Exclude members who died during 2025.

Care for Older Adults (COA)

Q: Which members are included in the sample?

A: Adults 66 years and older who had **each** of the following in 2025:

- ☑ Medication review
- ☑ Functional status assessment

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A:

- ☑ **Evidence of Medication Review** – must include medication list in the medical record, and evidence of a medication review and the date when it was performed ***or*** notation that the member is not taking any medication and the date when it was noted
- ☑ **Evidence of Functional Status Assessment** – documentation must include evidence of functional status assessment ***and*** the date when it was performed

Q: What type of medical record is acceptable?

A:

Medication Review:

- ☑ Current medication list in 2025
- ☑ Notation of medication review in 2025
- ☑ Date and notation that the member is not taking any medication in 2025

Note: Medication Review does not require member to be present. The medication list may include medication names only or may include names, dosages and frequency, over-the-counter (OTC) medications and herbal or suplemental therapies.

Functional Status Assessment:

- ☑ Progress notes, IHSS forms, HRA forms, AWE form
- ☑ Notation that Activities of Daily Living (ADL) were assessed or that at least 5 of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking
- ☑ Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least 4 of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
- ☑ Result of assessment using a standardized functional status assessment tool

Care for Older Adults (COA)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Submission of services rendered during a telephone visit, e-visit, or virtual check-in meet criteria.
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Timely submission of complete and accurate AWE Forms
- ☑ Exclude services provided in an acute inpatient setting

SAMPLE CODES

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

CPT II Codes	
Medication List	1159F
Medication Review	1160F
Functional Status Assessment	1170F

HCPCS Codes	
Medication List	G0439, G0438

Exclusion(s)

Hospice Care

*Exclude members who died during 2025.

Colorectal Cancer Screening (COL-E)

NCQA Accreditation – Medicare
NCQA Accreditation – Medicaid
LACC QTI (Quality Transformation Initiative)

Q: Which members are included in the sample?

A: Members 45-75 years of age who had appropriate screenings for colorectal cancer.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** the colorectal cancer screening was performed. Appropriate screenings are defined by **any** of the following:

- ☑ Fecal Occult Blood Test in **2025**; guaiac (gFOBT) or immunochemical (FIT)
- ☑ Flexible sigmoidoscopy performed in **2021, 2022, 2023, 2024** or **2025**
- ☑ Colonoscopy in **2025** *or* **within 9 years prior to 2025**
- ☑ CT colonography performed in **2020, 2021, 2022, 2023,** or **2024**
- ☑ Stool DNA (Cologuard) with FIT test report in **2023, 2024,** or **2025**

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Health Maintenance Form
- ☑ Progress notes/Office visits notes
- ☑ Problem List
- ☑ Laboratory/Pathology Reports
- ☑ Pathology report that indicates the type of screening (e.g., colonoscopy or flexible sigmoidoscopy)
- ☑ Pathology report without indicating the type of screening but has evidence that the scope advanced beyond the splenic flexure or sigmoid colon
- ☑ Medical History Forms
- ☑ GI Consults/ Reports/ Flowcharts
- ☑ Complete Physical Examination Form

Note: Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

Colorectal Cancer Screening (COL-E)

NCQA Accreditation – Medicare
NCQA Accreditation – Medicaid
LACC QTI (Quality Transformation Initiative)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Prior to each visit for members 45 years and older, review chart to determine if COL screening has been completed, if not, discuss options with member, as colonoscopy every 10 years and stool testing done yearly are shown to have similar effectiveness in identifying colon cancer
- ☑ Request a supply of stool screening test kits from your contracted lab(s) to have on hand to share with members when at office visits
- ☑ If a member had a colonoscopy, the provider's office should ask the member for a copy of the report or the rendering provider's contact information to request the report and save a copy in the member's medical record
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Exclusions: Members with diagnosis of colorectal cancer or total colectomy.

Colorectal Cancer Screening (COL-E)

NCQA Accreditation – Medicare
NCQA Accreditation – Medicaid
LACC QTI (Quality Transformation Initiative)

SAMPLE CODES

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

CPT Codes	
FOBT	82270, 82274
Flexible Sigmoidoscopy	45330-45335, 45337-45342, 45345-45347, 45349, 45350
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
CT Colonography	74261-74263
Stool DNA (sDNA) with FIT test	81528

HCPCS Codes	
FOBT	G0328
Flexible Sigmoidoscopy	G0104
Colonoscopy	G0105, G0121
Colorectal Cancer (PET scan)	G0213-G0215, G0231
Stool DNA (sDNA) with FIT test	G0464

Exclusion(s)
Advanced Illness, Palliative Care, Colorectal Cancer, Frailty, Hospice Care, Total Colectomy *Exclude member who died during 2025.

Cardiac Rehabilitation (CRE)

Q: Which members are included in the sample?

A: 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. Four rates are reported:

- *Initiation.* The percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- *Engagement 1.* The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
- *Engagement 2.* The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
- *Achievement.* The percentage of member who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Cardiac Rehabilitation (CRE)

SAMPLE CODES

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

CPT Codes	
Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	93797
with continuous ECG monitoring (per session)	93798

HCPCS Codes	
Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session	G0422
Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session	G0423
Cardiac rehabilitation program, non-physician provider, per diem	S9472

Exclusion(s)

MI, CABG, Heart or heart/lung transplant, Heart valve repair or transplant, PCI, Hospice setting/services, Palliative care, I-SNP, LTI, Frailty and Advance Illness.

*Exclude member who died during 2025.

Appropriate Testing for Children with Pharyngitis (CWP)

Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 3 years and older, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode (**7/1/2024- 6/30/2025**) during any outpatient, telephone, observation or ED visit, and e-visit or virtual check-in.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence of claim/encounter data:

- ☑ Date of service for an outpatient or ED visit with a diagnosis of pharyngitis
- ☑ Throat culture lab report
- ☑ Date and result of strep test with a diagnosis of pharyngitis
- ☑ Antibiotic prescription for the episode

Appropriate Testing for Children with Pharyngitis (CWP)

Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Antibiotic Medications:

Description	Prescription		
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta lactamase inhibitors	• Amoxicillin-clavulanate		
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin	
Folate antagonist	• Trimethoprim		
Lincomycin derivatives	• Clindamycin		
Macrolides	• Azithromycin • Clarithromycin • Erythromycin		
Natural penicillins	• Penicillin G Benzathine • Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin	
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime	
Sulfonamides	• Sulfamethoxazole-trimethopin		
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline	
Third generation cephalosporins	• Cefdinir • Cefixime	• Cefpodoxime	• Ceftriaxone

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation

Appropriate Testing for Children with Pharyngitis (CWP)

Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

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

CPT Codes	
Group A Strep Tests	87070, 87071, 87081, 87430, 87650-87652, 87880
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS Codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion(s)
Hospice Care *Exclude members who died during 2025.

Use of High-Risk Medications in Older Adults (DAE)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: The percentage of Medicare members 67 years of age and older who had at least two dispensing events for the same high-risk medication to avoid from the same drug class, except for appropriate diagnoses.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of documentation is acceptable?

A: Evidence from a claim/encounter data:

☑ Two dispensing event(s) for a high-risk medication in 2025.

Use of High-Risk Medications in Older Adults (DAE)

NCQA Accreditation – Medicare (CMC)

High-Risk Medications

Drug Class	Prescription	Medication Lists
Anticholinergics, first-generation antihistamines	• Brompheniramine • Chlorpheniramine • Cyproheptadine • Dimenhydrinate	Potentially Harmful Antihistamines for Older Adults Medications List
	• Diphenhydramine (oral) • Doxylamine • Hydroxyzine • Meclizine • Promethazine • Tripolidine	
Anticholinergics, anti-Parkinson agents	• Benztropine (oral) • Trihexyphenidyl	Potentially Harmful Antiparkinsonian Agents for Older Adults Medications List
Antispasmodics	• Atropine (exclude ophthalmic) • Chlordiazepoxide-clidinium • Dicyclomine • Hyoscyamine • Scopolamine	Potentially Harmful Gastrointestinal Antispasmodics for Older Adults Medications List
Antithrombotic	• Dipyridamole (oral, excluding extended release)	Dipyridamole Medications List
Cardiovascular, alpha agonists, central	• Guanfacine	Guanfacine Medications List
Cardiovascular, other	• Nifedipine (excluding extended release)	Nifedipine Medications List
Central nervous system, antidepressants	• Amitriptyline • Amoxapine • Clomipramine • Desipramine • Imipramine • Nortriptyline • Paroxetine	Potentially Harmful Antidepressants for Older Adults Medication List
Central nervous system, barbiturates	• Butalbital • Phenobarbital • Primidone	Potentially Harmful Barbiturates for Older Adults Medications List
Central nervous system, vasodilators	• Ergoloid mesylates	Ergoloid Mesylates Medications List
Central nervous system, other	• Meprobamate	Meprobamate Medications List
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen • Estradiol • Estropipate	Potentially Harmful Estrogens for Older Adults Medications List

Use of High-Risk Medications in Older Adults (DAE)

NCQA Accreditation – Medicare (CMC)

High-Risk Medications

High-Risk Medications Based on Prescription and Diagnosis Data

Drug Class	Prescription	Medication Lists
Antipsychotics, first (conventional) and second (atypical) generation	• Aripiprazole • Aripiprazole lauroxil • Asenapine • Brexpiprazole • Cariprazine • Chlorpromazine • Clozapine • Fluphenazine • Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone • Perphenazine • Pimavanserin • Pimozide • Quetiapine • Risperidone • Thioridazine • Thiothixene • Trifluoperazine • Ziprasidone	• DAE Antipsychotic Medications List
Benzodiazepines, long, short and intermediate acting	• Alprazolam • Chlordiazepoxide • Clonazepam • Clorazepate • Diazepam • Estazolam • Flurazepam • Lorazepam • Midazolam • Oxazepam • Quazepam • Temazepam • Triazolam	• Benzodiazepine Medications List

High-Risk Medications with Days Supply Criteria

Description	Prescription	Average Daily Dose Criteria	Medication Lists
Anti-Infectives, other	• Nitrofurantoin • Nitrofurantoin macrocrystals-monohydrate	>90 days	• Potentially Harmful Antiinfectives for Older Adults Medicaation List

High-Risk Medications with Daily Average Dose Criteria

Description	Prescription	Average Daily Dose Criteria	Medication Lists
Cardiovascular, other	• Digoxin	>0.125 mg/day	• Digoxin .05 mg per mL Medications List • Digoxin .0625 mg Medications List • Digoxin .1 mg per mL Medications List • Digoxin .125 mg Medications List • Digoxin .25 mg Medications List • Digoxin .25 mg per mL Medications List
Tertiary TCAs (as single agent or as part of combination products)	• Doxepin	>6 mg/day	• Doxepin 3 mg Medications List • Doxepin 6 mg Medications List • Doxepin 10 mg Medications List • Doxepin 10 mg per mL Medications List • Doxepin 25 mg Medications List • Doxepin 50 mg Medications List • Doxepin 75 mg Medications List • Doxepin 100 mg Medications List • Doxepin 150 mg Medications List

Use of High-Risk Medications in Older Adults (DAE)

NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

SAMPLE CODES

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

CPT Codes	
Outpatient services:	
Office/other outpatient services:	99202-99205, 99211-99215
Consultations	99241-99245
Preventive medicine services	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429

HCPCS Codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion(s)
Hospice Care, Palliative Care, Encounter for Palliative Care
*Exclude members who died during 2025.

Documented Assessment After Mammogram (DBM-E)

Q: Which members are included in the sample?

A: Members 40–74 years of age with mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of medical record is acceptable?

A: Evidence from a claim/encounter with a date of service.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data

Documented Assessment After Mammogram (DBM-E)

SAMPLE CODES

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

CPT Codes

77061, 77062, 77063, 77065, 77066, 77067

LOINC Codes

86463-7, 72139-9, 91519-9, 91522-3, 72142-3, 72138-1, 91518-1, 91521-5, 72141-5, 72137-3, 91517-3, 91520-7, 72140-7

Exclusion(s)

- Members who die any time during 2025.
- Members who use hospice services or elect to use a hospice benefit any time during 2025.

Deprescribing of Benzodiazepines in Older Adults (DBO)

Q: Which members are included in the sample?

A: Members 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater in benzodiazepine dose (diazepam milligram equivalent [DMR] dose in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence of claim/encounter data:

Step 1 - Identify members with two or more benzodiazepine dispensing events on different dates of services (refer to the Oral Benzodiazepine Medications table below for medication list for identifying benzodiazepine dispensing events) during 2025.

Step 2 - Of the members identified in Step 1, identify those with qualifying Index treatment episode (ITE).

Step 3 - Of the members identified in Step 2, identify those with PDC > or = 50% during the treatment period.

Oral Benzodiazpine Medications

Type of Benzodiazepine	Medication Lists	Strength	DME Conversion Factor
Alprazolam (oral)	Alprazolam 0.25 MG Medications List Alprazolam 0.5 MG Medications List Alprazolam 1 MG Medications List Alprazolam 1 MGPML Medications List Alprazolam 2 MG Medications List Alprazolam 3 MG Medications List	0.25 mg 0.5 mg 1 mg 1 mg 2 mg 3 mg	0.1
Chlordiazepoxide (oral)	Chlordiazepoxide 5 MG Medications List Chlordiazepoxide 10 MG Medications List Chlordiazepoxide 25 MG Medications List	5 mg 10 mg 25 mg	2.5
Clonazepam (oral)	Clonazepam 0.125 MG Medications List Clonazepam 0.25 MG Medications List Clonazepam 0.5 MG Medications List Clonazepam 1 MG Medications List Clonazepam 2 MG Medications List	0.125 mg 0.25 mg 0.5 mg 1 mg 2 mg	0.1
Clorazepate (oral)	Clorazepate 3.75 MG Medications List Clorazepate 7.5 MG Medications List Clorazepate 15 MG Medications List	3.75 mg 7.5 mg 15 mg	1.5
Diazepam (oral)	Diazepam 1 MGPML Medications List Diazepam 2 MG Medications List Diazepam 5 MG Medications List Diazepam 5 MGPML Medications List Diazepam 10 MG Medications List	1 mg 2mg 5mg 5mg 10 mg	1
Estazolam (oral)	Estazolam 1 MG Medications List Estazolam 2 MG Medications List	1 mg 2 mg	0.3
Flurazepam (oral)	Flurazepam 15 MG Medications List Flurazepam 30 MG Medications List	15 mg 30 mg	3
Lorazepam (oral)	Lorazepam 1 MG Medications List Lorazepam 2 MGPML Medications List	1 mg 2 mg	0.2
Midazolam (oral)	Midazolam 2 MGPML Medications List	2 mg	1.5
Oxazepam (oral)	Oxazepam 10 MG Medications List Oxazepam 30 MG Medications List	10 mg 30 mg	3
Quazepam (oral)	Quazepam 15 MG Medications List	15 mg	2
Temazepam (oral)	Temazepam 7.5 MG Medications List Temazepam 15 MG Medications List Temazepam 22.5 MG Medications List Temazepam 30 MG Medications List	7.5 mg 15 mg 22.5 mg 30 mg	2
Triazolam (oral)	Triazolam 0.125 MG Medications List Triazolam 0.25 MG Medications List	0.125 mg 0.25 mg	0.025

Deprescribing of Benzodiazepines in Older Adults (DBO)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data.

SAMPLE CODES

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

Exclusion(s)

Palliative Care, Hospice Care, Seizure disorders, REM sleep behavior disorder, Benzodiazepine Withdrawal or Ethanol Withdrawal on or between Jan 1 of the prior year to Dec 31, 2025

* Exclude members who died in 2025.

Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: 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 between January 1, 2024 - December 1, 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

NCQA Accreditation – Medicare (CMC)

Q: What type of documentation is acceptable?

A: Evidence from claim/encounter data for:

1. Rate 1: Drug-Disease Interactions - History of Falls and Antipileptics, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics or Antidepressants (SSRIs, Tricyclic Antidepressants and SNRIs)

Potentially Harmful Drugs for Older Adults With a History of Dementia Medications

Description	Prescription		
Anticholinergic agents, antiemetics	• Prochlorperazine	• Promethazine	
Anticholinergic agents, antihistamines	• Brompheniramine • Chlorpheniramine • Cyproheptadine	• Dimenhydrinate • Diphenhydramine • Doxylamine	• Hydroxyzine • Triprolidine • Meclizine
Anticholinergic agents, antimuscarinics (oral)	• Darifenacin • Fesoterodine • Flavoxate	• Oxybutynin • Solifenacin • Tolterodine	• Trospium
Anticholinergic agents, anti-Parkinson agents	• Benztropine	• Trihexyphenidyl	
Anticholinergic agents, skeletal muscle relaxants	• Cyclobenzaprine	• Orphenadrine	
Anticholinergic agents, antispasmodics	• Atropine • Chlordiazepoxide-clidinium	• Dicyclomine • Homatropine • Hyoscyamine	• Scopolamine
Anticholinergic agents, SSRIs	• Paroxetine		
Antipsychotics	• Aripiprazole • Aripiprazole lauroxil • Asenapine • Brexpiprazole • Cariprazine • Chlorpromazine • Clozapine • Fluphenazine	• Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone • Perphenazine	• Pimozide • Quetiapine • Risperidone • Thioridazine • Thiothixene • Trifluoperazine • Ziprasidone
Benzodiazepines	• Alprazolam • Chlordiazepoxide • Clonazepam • Clorazepate • Diazepam	• Estazolam • Flurazepam • Lorazepam • Midazolam • Oxazepam	• Quazepam • Temazepam • Triazolam
Nonbenzodiazepine hypnotics	• Eszopiclone	• Zaleplon	• Zolpidem
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

NCQA Accreditation – Medicare (CMC)

Q: What type of documentation is acceptable?

2. Drug-Disease Interactions- Dementia and Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics, Tricyclic Antidepressants or Anticholinergic Agents

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

3. Rate 3: Drug- Disease Interactions- Chronic Kidney Disease and Cox-2 Selective NSAIDS or Nonaspirin NSAIDs

Potentially Harmful Drugs for Older Adults With a History Chronic Kidney Disease Medications

Description	Prescription
Cox-2 Selective NSAIDs	• Celecoxib
Nonaspirin NSAIDs	• Diclofenac • Etodolac • Fenoprofen • Flurbiprofen • Ibuprofen • Indomethacin • Ketoprofen • Ketorolac • Meclofenamate • Mefenamic acid • Meloxicam • Nabumetone • Naproxen • Oxaprozin • Piroxicam • Sulindac • Tolmetin

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Exclusions: Palliative Care, Hospice Care

Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

CPT Codes	
Outpatient	
E&M, office/other outpatient services	99202-99205, 99211-99215
E&M, hospital observation services	99217-99220
E&M, consultations	99241-99245
E&M, preventive medicine services	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429
	Palliative Care code

Exclusion(s)

Palliative Care, Bipolar Disorder, Hospice Care, Psychosis, Other Bipolar Disorder Psychosis, Schizoaffective Disorder, Schizophrenia, or Seizure Disorder on or between January 1, 2024 and December 1, 2025.

* Exclude members who died in 2025.

Depression Remission or Response for Adolescents and Adults (DRR-E)

Q: Which members are included in the sample?

A: 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. Members who have follow-up PHQ-9 score documented within 4-8 months after the initial elevated PHQ-9 score.
- *Depression Remission.* Members who achieved remission within 4-8 months after the initial elevated PHQ-9 score.
- *Depression Response.* Members who achieved remission within 4-8 months after the initial elevated PHQ-9 score.
- * PHQ-9 assessment does not need to occur during a face to face encounter; it may be completed over the telephone or a web-based portal.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data including pharmacy data.

Q: What type of document is acceptable?

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claim/encounter data.

SAMPLE CODES

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

LOINC Codes	
PHQ-9	44261-6, 89204-2

Exclusion(s)

Members in hospice or using hospice services any time during 2024. Members with Bipolar disorder, Personality disorder, Psychotic disorder, Pervasive development disorder.

*Exclude members who died in 2025.

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

State Medicaid MPL (must achieve 50th percentile or greater)
Medi-Cal Accountability Set (MCAS)
* Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS)

Q: Which members are included in the sample?

A: 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- Members who were screened for clinical depression using a standardized instrument.
- Follow-Up on Positive Screening- Members who received follow-up care within 30 days of positive depression screen finding.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

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

State Medicaid MPL (must achieve 50th percentile or greater)
Medi-Cal Accountability Set (MCAS)
* Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS)

Q: What type of documentation is acceptable?

A: Evidence from a claim/encounter data:

- Documentation of standardized age appropriate tool for screening clinical depression.
- Documentation of a follow-up care on or 30 days after the date of the first positive screen (31 days total) from any one of the following.
  - a follow-up behavioral health encounter with or without a telehealth modifier including assessment, therapy, collaborative care, medication management, acute care and health encounters
  - a follow up outpatient visit with a diagnosis of depression or other behavioral health

condition, with or without telehealth modifier

  - a telephone visit with diagnosis of depression or other behavioral health condition
  - a follow-up with a case manager with documented assessment of depression symptoms
  - dispensed an antidepressant medication

Depression Screening Instrument	A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:	
	Instruments for Adolescents (12–17 years)	**Positive Finding**
	Patient Health Questionnaire (PHQ-9)[§]	Total Score >10
	Patient Health Questionnaire Modified for Teens (PHQ-9M)[§]	Total Score ≥10
	Patient Health Questionnaire-2 (PHQ-2)[§,‡]	Total Score ≥3
	Beck Depression Inventory-Fast Screen (BDI-FS)[§,‡]	Total Score ≥8
	Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥17
	Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥10
	PROMIS Depression	Total Score (T Score) ≥60
	Instruments for Adults (18+ years)	**Positive Finding**
	Patient Health Questionnaire (PHQ-9)[§]	Total Score ≥10
	Patient Health Questionnaire-2 (PHQ-2)[§,‡]	Total Score ≥3
	Beck Depression Inventory-Fast Screen (BDI-FS)[§,‡]	Total Score ≥8
	Beck Depression Inventory (BDI-II)	Total Score ≥20
	Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥17
	Duke Anxiety-Depression Scale (DADS)[§,†]	Total Score ≥30
	Geriatric Depression Scale Short Form (GDS)[‡]	Total Score ≥5
	Geriatric Depression Scale Long Form (GDS)	Total Score ≥10
	Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥10
	My Mood Monitor (M-3)[§]	Total Score ≥5
	PROMIS Depression	Total Score (T Score) ≥60
	Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥31
	[†]Proprietary; may be cost or licensing requirement associated with use. [‡]Brief screening instrument. All other instruments are full-length.	

Q: How to improve score for this HEDIS® measure?

- Use of complete and accurate Value Set Codes
- Timely submission of claim/encounter data

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

State Medicaid MPL (must achieve 50th percentile or greater)
Medi-Cal Accountability Set (MCAS)
* Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS)

SAMPLE CODES

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

LOINC Codes	
Patient Health Questionnaire 9 item (PHQ-9) total score [Reported] (Screening)	44261-6
Patient Health Questionnaire item 2 (PHQ-2) total score [Reported] (Screening)	55758-7

Exclusion(s)
Bipolar Disorder, Hospice Care *Exclude members who died in 2025.

Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH)

Q: Which members are included in the sample?

A: Members 67 years of age and older with diabetes (types 1 and 2), the risk-adjusted ratio of observed to expected (O/E) emergency department (ED) visits for hypoglycemia during 2024. Two rates are reported.

- For all members 67 years of age and older with diabetes (types 1 and 2), the risk-adjusted ratio of O/E ED visits for hypoglycemia during the measurement year, stratified by dual eligibility.
- For a subset of members 67 years of age and older with diabetes (types 1 and 2) who had at least one dispensing event of insulin with each 6-month treatment period from July1 of the year prior to the measurement year through December 31, 2025, the risk-adjusted ratio of O/E ED visits for hypoglycemia, stratified by dual eligibility.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data including pharmacy data.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ *Use of complete and accurate Value Set Codes.
- ☑ *Timely submission of claim/encounter data.

Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH)

CPT Codes	
Outpatient	98966-98968, 99441-99443, 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412

HCPS Codes

G0402, G0438, G0439, G0463, T1015

Exclusion(s)

Hospice Care

*Exclude members who died in 2025.

Eye Exam for Patients with Diabetes (EED)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars

Q: Which members are included in the sample?

A: Members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

*This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

A:

- ☑ A retinal or dilated eye exam by an eye care professional in 2025, OR
- ☑ A negative retinal or dilated eye exam by an eye care professional in 2024.
- ☑ Request a copy of retinal eye exam, if not received, from members eye specialist .

Q: What type of document is acceptable?

*Evidence from a claim/encounter with a date of service.

A:

- ☑ Retinal eye exam in 2024 or/and 2025 from eye specialist.
- ☑ Evidence/notation of bilateral eye enucleation any time prior to December 31, 2025.
- ☑ Eye exam result documentation with "unknown" does not meet criteria.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation

Eye Exam for Patients with Diabetes (EED)

Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars

SAMPLE CODES

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

ICD 10 Codes	
Measure Year (Current Year)	2022F, 2023F
Year Prior	3072F

Exclusion(s)
Hospice Care, Palliative Care, I-SNP, LTI, Frailty, Bilateral Eye Enucleation, and Advanced Illness. *Exclude members who died during 2025.

Follow-Up After Abnormal Mammogram Assessment (FMA-E)

Q: Which members are included in the sample?

A: 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter with a date of service.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data

Follow-Up After Abnormal Mammogram Assessment (FMA-E)

SAMPLE CODES

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

CPT Codes

19081, 19083, 19085, 19100, 19101, 76641-76642, 77062-77063, 77065-77067

LOINC Codes

103892-6, 26175-0, 72142-3, 72139-9, 91519-9, 72139-9, 72142-3, 26346-7, 48475-8, 48492-3

Exclusion(s)

- Members who die any time during 2025.
- Members who use hospice services or elect to use a hospice benefit any time during 2025.

Follow-Up After Emergency Department Visit for Substance Use (FUA)

Q: Which members are included in the sample?

A: Members age 13 years and older who visited an emergency department (ED) with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow-up. Two rates are reported:

1. Members with ED visits who received follow-up within 30 days of the ED visit (31 total days).
2. Members with ED visits who received follow-up within 7 days of the ED visit (8 total days).

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data including pharmacy data.

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Follow-Up After Emergency Department Visit for Substance Use (FUA)

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	• Naltrexone (oral)	• Naltrexone Oral Medications List
Antagonist	• Naltrexone (injectable)	• Naltrexone Injection Medications List
Partial agonist	• Buprenorphine (sublingual tablet)	• Buprenorphine Oral Medications List
Partial agonist	• Buprenorphine (injection)	• Buprenorphine Injection Medications List
Partial agonist	• Buprenorphine (implant)	• Buprenorphine Implant Medications List
Partial agonist	• Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine Naloxone Medications List

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

SAMPLE CODES

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

CPT Codes	
Outpatient	90832-90834, 90836-90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99233, 99238-99239, 99251-99255

Exclusion(s)

Members in hospice or using hospice services any time during 2025.

* Exclude members who died in 2025.

Follow-Up After Hospitalization for Mental Illness (FUH)

State Medicaid MPL (must achieve 50th percentile or greater)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of documentation is acceptable?

A: Evidence from a claim/encounter data:

- Documentation of a follow-up visit in 2025 with a mental health provider within 7-30 days of discharge from hospitalization for treatment of mental illness
- Documentaion of a follow-up:
  - Visits in behavioral health settings.
  - Telephone Visits
- Include all discharges on or between January 1, 2025 and December 1, 2025.
  *Follow-up visits that occur on the date of discharge do not count.

Follow-Up After Hospitalization for Mental Illness (FUH)

State Medicaid MPL (must achieve 50th percentile or greater)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS® measure?

A:

- Use of complete and accurate Value Set Codes
- Timely submission of claim/encounter data
- Document hospice care readmission/direct transfer to acute setting for exclusion from the eligible population
- Mental Health Provider: A practitioner who provides mental health services and meets any of the following criteria:
    - An MD or (DO) who is certified or who successfully completed an accredited program in psychiatry or child psychiatry.
    - A licensed psychologist in his/her state of practice
    - A licensed or certified social worker with master's degree and is listed on the National Association of Social Worker's Clinical Register
    - A registered nurse (RN) certified as a psychiatric nurse or mental health clinical nurse specialist and has a master's degree in psychiatric/mental health
    - An individual 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
    - An individual 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 licensed on the National Board for Certified Counselors (NBCC)

Follow-Up After Hospitalization for Mental Illness (FUH)

State Medicaid MPL (must achieve 50th percentile or greater)
NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

CPT Codes	
FUH Stand Alone Visits:	98960-98962, 99078, 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99397, 99401-99404, 99408, 99411, 99412, 99483, 99510
FUH Visits Group 1:	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
FUH Visits Group 2:	99221-99223, 99231-99233, 99238, 99239, 99251-99255
TCM 14 Day:	99495
TCM 7 Day:	99496

HCPCS Codes	
FUH Stand Alone Visits:	G0155, G0176, G0177, G0409, G0410, G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, S0201, S9480, S9484, S9485, T1015

Exclusion(s)
Hospice Care, Nonacute Inpatient Stay *Exclude members who died during 2025.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Q: Which members are included in the sample?

A: Members age 6 years and older who visited an emergency department (ED) with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. Members with ED visits who received follow-up within 30 days of the ED visit (31 total days).
2. Members with ED visits who received follow-up within 7 days of the ED visit (8 total days).

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of documentation is acceptable?

A: Evidence from claim/encounter data.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

SAMPLE CODES

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

CPT Codes	
Outpatient	99217-99219, 9920
FUH Visits Group 1:	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
FUH Visits Group 2:	99221-99223, 99231-99233, 99238, 99239, 99251-99255
TCM 14 Day:	99495
TCM 7 Day:	99496

HCPCS Codes	
Outpatient	G2010, G2012, G2061-G2063

Exclusion(s)
Members in hospice or using hospice services any time during 2025. *Exclude members who died in 2025.

Glycemic Status Assessment for Patients With Diabetes (GSD)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars
LACC Quality Transformation Initiative (QTI)

Q: Which members are included in the sample?

A: Members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c]) or glucose management indicator [GMI]) was at either of the following levels during 2025:

- Glycemic status <8.0%.
- Glycemic status >9.0%.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A:

☑ Date of the most recent HbA1c test and the result

Q: What type of documentation is acceptable?

A:

☑ All progress notes with notation of HbA1c testing with results in 2025.
☑ Health Maintenance Log
☑ Lab Reports in 2025

Q: How to improve score for this HEDIS® measure?

A:

☑ Use of complete and accurate Value Set Codes
☑ Timely submission of claim/encounter data
☑ Ensure presence of all components in the medical record documentation
☑ Schedule regular follow-up with patients to monitor changes and adjust therapies as needed
☑ Exclusion:
Hospice setting/services, Palliative care, I-SNP, LTI, Frailty, Advanced Illness and members who died any time during 2025.

Glycemic Status Assessment for Patients With Diabetes (GSD)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation Medicaid
NCQA Accreditation Medicare (CMC)
Medicare Stars
LACC Quality Transformation Initiative (QTI)

SAMPLE CODES

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

CPT II Codes	
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

LOINC code	
The glucose management indicator (GMI) approximates the laboratory A1C level expected based on average glucose measured using continuous glucose monitoring (CGM) values	97506-0

Exclusion(s)
Hospice setting/services, Palliative care, No Diagnosis on DM in any setting in 2022 and 2023, I-SNP, LTI, Frailty, Advanced Illness, Members who died anytime in 2025 after Advanced Illness.

Initiation and Engagement of Substance Use Disorder Treatment (IET)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement in 2025 (13 yrs and older) who received the following:

- ☑ *Initiation of SUD Treatment.* The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
- ☑ *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter data

- ☑ Inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalizations, telehealth visit, or medication treatment within 14 days.
- ☑ Claims/encounter for new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

  Note: SUD Episode Date - date of service for encounter during the Intake period with a diagnosis of SUD.

  (Intake Period) - November 15, 2024 to November 14, 2025.

Initiation and Engagement of Substance Use Disorder Treatment (IET)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Consider screening all members at office and/or telehealth visits using a substance abuse screening tool
- ☑ Once a member is identified with SUD 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
- ☑ Exclude members from both Initiation of SUD Treatment and Engagement of SUD Treatment if the initiation of treatment event is an inpatient stay with a discharge date of November 14, 2025. Members in hospice or using hospice services any time during 2025. Members who died any time during 2025.

SAMPLE CODES

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

CPT Codes	
IET Stand Alone Visits	98960-98962, 99078, 99202-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99483, 99492-99494, 99510
IET Visits Group 1	90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
IET Visits Group 2	99221-99223, 99231-99233, 99238, 99239, 99251-99255

HCPCS Codes	
IET Stand Alone Visits	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, S0201, S9480, S9484, S9485, T1006, T1012, T1015
Detoxification	H0008-H0014

Exclusion(s)
SUD Abuse and Dependence, SUD Medication Treatment, Hospice Care

Immunizations for Adolescents (IMA-E)*

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P) (Combo 2)
NCQA Accreditation – Medicaid
*Adapted with financial support from the Centers for Disease Control & Prevention (CDC)

Q: Which members are included in the sample?

A: Adolescents who had one dose of meningococcal conjugate vaccine (MCV), one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) and 2 or 3 doses of the human papillomavirus (HPV) vaccines **by their 13th birthday**.

- ☑ Combo 1 - (Meningococcal, Tdap)
- ☑ Combo 2 - (Meningococcal, Tdap, HPV)

Note: The minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

*This measure requires claim/encounter data submission using the appropriate Value Set Codes.

A: Must include any of the following:

- ☑ A note indicating the name of specific antigen and the date of the immunization
- ☑ A certificate of immunization that includes specific dates and types of immunizations administered
- ☑ Anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday
- ☑ Encephalopathy with a vaccine adverse-effect anytime on or before the member's 13th birthday. (Tdap)

Pentavalent Meningococcal Vaccine – given between member's 10th and 13th birthday

Tdap vaccine – given between member's 10th and 13th birthday

HPV vaccine – 2-doses (given 146 days apart) or 3 doses given between member's 9th and 13th birthday

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Certificate of immunization including specific dates and types of vaccines
- ☑ Immunization Record and health History Form
- ☑ Health Maintenance Form/Report
- ☑ Print out of CAIR registry
- ☑ Progress note/Office visit – with notations of vaccines given
- ☑ Notation of anaphylactic reaction to serum or vaccination

Immunizations for Adolescents (IMA-E)*

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P) (Combo 2)
NCQA Accreditation – Medicaid
*Adapted with financial support from the Centers for Disease Control & Prevention (CDC)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Upload immunizations on to California Immunizations Registry (**http://cairweb.org**)
- ☑ Use the Childhood and Adolescent Wellness Flyers for Providers as a guideline of recommended health services for certain age groups (**https://www.lacare.org/sites/default/files/provider-wellness-flyers.pdf**)
- ☑ Use every office visit (including sick visits) to provide immunizations and well-care visits
- ☑ Educate parents about the importance of timely vaccinations and share the immunization schedule
- ☑ Use EHR alerts to notify parents about needed immunizations
- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation of dates and types of immunizations, or contraindication for a specific vaccine
- ☑ Exclusion: Members in hospice or using hospice services any time during 2025.
- ☑ Members who died any time during 2025.

SAMPLE CODES

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

CPT Codes	
Meningococcal Vaccine	90734
Meningococcal Polysaccharide Vaccine (MPSV4)	90733
Tdap Vaccine	90715
HPV Vaccine	90649-90651

Exclusion(s)

Anaphylactic Reaction Due To Serum, Anaphylactic Reaction Due To Vaccination, Encephalopathy Due To Vaccination, Hospice Care, Vaccine Causing Adverse Effect

Kidney Health Evaluation for Patients With Diabetes (KED)

Q: Which members are included in the sample?

A: Members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter of members who received **both** of the following during 2025 on the same or different dates of service:

- At least one eGFR.
- At least one uACR identified by ***both*** a quantitative urine albumin test ***and*** a urine creatinine test ***with*** service dates four or less days apart. For example, if the service date for the quantitative urine albumin test was December 1, 2025, then the urine creatinine test must have a service date on or between November 27, 2025 and December 5, 2025

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Use of accurate Exclusion Codes
- ☑ Perform kidney health evaluation (eGFR) and (uACR) for members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during 2025.

Required Exclusions

- Members with evidence of ESRD or dialysis any time during the member's history on or prior to December 31, 2025.
- Members receiving palliative care in 2025
- Members Enrolled in an Institutional SNP (I-SNP) or living long-term in an institution any time in 2025.
- Members with frailty and advanced illness during 2025
- Members in hospice or using hospice services anytime in 2025.
- Members who died any time during 2025.

Kidney Health Evaluation for Patients With Diabetes (KED)

SAMPLE CODES

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

CPT Codes

99202-99205, 99211-99215, 99241-99244

HCPCS Codes

G0402, G0438, G0439, G0463, T1015

Exclusion(s)

Chronic kidney disease stage 5, End stage renal disease, Dependence on renal dialysis, Hospice Care,Palliative Care.

Use of Imaging Studies for Low Back Pain (LBP)

NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

- Imaging study with uncomplicated diagnosis of low back pain on the IESD or in the 28 days following the IESD. **Index Episode Start Date (IESD):** The earliest date of service for an outpatient or ED encounter during the Intake Period (January 1, 2025 – December 3, 2025) with a principal diagnosis of low back pain.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/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.*

Required Exclusions:

Any of the following meet criteria:

- Cancer
- Recent Trauma
- Intravenous drug abuse
- Neurologic impairment
- HIV
- Spinal infection
- Major organ transplant or History of major organ transplant
- Prolonged use of corticosteroids
- Osteoporosis
- Lumbar surgery
- Spondylopathy
- Fragility Fractures
- Palliative Care
- Hospice/Hospice services anytime during 2025
- Members who died any time during 2025
- Frailty in 2025 and advanced illness in 2024 or 2025 or Member who was dispensed dementia medication in 2025

Use of Imaging Studies for Low Back Pain (LBP)

NCQA Accreditation – Medicaid

SAMPLE CODES

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

CPT Codes	
Imaging Study	72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220
Observation	99217-99220
Osteopathic and Chiropractic Manipulative Treatment	98925-98929, 98940-98942
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456

HCPCS Codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion(s)
History of Malignant Neoplasm, HIV, Hospice Care, Intravenous Drug Abuse, Major Organ Transplant, Malignant Neoplasms, Neurologic Impairment, Other Malignant Neoplasm of Skin, Other Neoplasms, Prolonged Use of Corticosteroids, Recent Trauma, Spinal Infection, Palliative Care, Osteoporosis.

Lead Screening in Children (LSC)

State Medicaid MPL (must achieve 50th percentile or greater)

Q: Which members are included in the sample?

A: Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include both of the following:

- A note indicating the date the test was performed.
- The result or finding.

Q: What type of document is acceptable?

A: Evidence of claims/encounter/medical record of at least one lead capillary or venous blood test on or before the child's second birthday and the result or finding.

Q: How to improve score for this HEDIS® measure?

A: Documentation in the medical record must include both of the following:

- Use of comlete and accurate Value set Codes
- Timeline submission of claim/encounter data
- Exclusion:

☑ Members in hospice or using hospice services in 2025

☑ Members who died any time in 2025

SAMPLE CODES

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

CPT Code

83655

Exclusion(s)

Hospice care

Oral Evaluation, Dental Services (OED)

Q: Which members are included in the sample?

A: Members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data:

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set codes
- ☑ Timely submission of claim/encounter data.

Exclusion(s)

- ☑ Members in hospice or using hospice services in 2025
- ☑ Members who died any time in 2025

SAMPLE CODES

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

CPT Code	
Oral Evaluation	D0120, D0145, D0150

Exclusion(s)

Hospice care

Osteoporosis Management in Women Who Had a Fracture (OMW)

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Women 67-85 years of age who suffered a fracture, 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence of claim/encounter data:

- ☑ Bone Mineral Density (BMD) test, in any setting, on the Index Episode Start Date (IESD) or in the 180-day (6 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 (6 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 (6 month) period after IESD
- ☑ A dispensed prescription to treat osteoporosis
- ☑ Fracture
- ☑ Visit type

Osteoporosis Medications

Description	Prescription	
Biphosphonates	• Alendronate • Alendronate-cholecaliferol • Ibandronate	• Risedronate • Zoledronic Acid
Other agents	• Abaloparatide • Romosozumab • Denosumab	• Raloxifene • Teriparatide

Osteoporosis Management in Women Who Had a Fracture (OMW)

NCQA Accreditation – Medicare (CMC)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ ***Required Exclusions:***
  - Members who had a BMD test during the 730 days (24 months) prior to IESD*
  - Members who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to IESD*
  - Member who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to IESD*
  - Members who received palliative care during the intake period through the end of 2025.
  - Members in hospice or using hospice services anytime during 2025.
  - Members who are enrolled in an Institutional SNP (I-SNP) any time in 2025.
  - Members living long-term in an institution any time in 2025.
  - Members who died any time during 2025.
  - Frailty in 2025 and advanced illness during 2024 or 2025 or Member who was dispensed dementia medication in 2025

Note: ***Fractures of finger, toe, face and skull are not included.***

*IESD: Index Episode Start Date [The earliest date of service for any encounter during the Intake Period (07/01/2024-06/30/2025) with a diagnosis of fracture]

Osteoporosis Management in Women Who Had a Fracture (OMW)

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

CPT Codes	
Bone Mineral Density Tests	76977, 77078, 77080, 77081, 77082, 77085, 77086
Fractures	Refer to Fractures Value Set
Observation	99217-99220
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS Codes	
Fractures	S2360
Long-Acting Osteoporosis Medications	J0897, J1740, J3489
Osteoporosis Medications	J0630, J0897, J1740, J3110, J3489,
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion(s)
Advanced Illness, Bone Mineral Density Tests, Frailty, Hospice, Osteoporosis Medications, Palliative Care Assessment Value Set, Palliative Care Encounter Value Set, Palliative Care Intervention Value Set.

Osteoporosis Screening in Older Women (OSW)

Q: Which members are included in the sample?

A: Women 65–75 years of age who received osteoporosis screening in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from a claim/encounter with a date of service for one or more osteoporosis screening tests on or between the member's 65th birthday and December 31, 2025.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Use of accurate Exclusion Codes

Exclusions:

- Members who had a claim/encounter for osteoporosis therapy any time in the member's history through December 31, 2025.
- Members who had a dispensed prescription to treat osteoporosis anytime on or between January 1, 2022 through December 31, 2025.
- Members receiving palliative care in 2025.
- Members in hospice or using hospice services anytime during 2025
- Members who died any time during 2025.
- Frailty in 2025 and advanced illness during 2024 or 2025 or Member who was dispensed dementia medication in 2025

Dementia Medication List

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		
Dementia combinations	• Donepezil-memantine		

Osteoporosis Screening in Older Women (OSW)

SAMPLE CODES

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

CPT Codes

76977, 77078, 77080, 77081, 77085

Exclusion(s)

Terminal cancer, end-of-life care planning, Palliative care, Treatment due to osteoporosis or bone loss. Hospice setting, Comprehensive management and care coordination for advanced illness, Direct skilled nursing services of a registered nurse.

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

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: Members 18 years of age and older who were hospitalized and discharged from July 1, 2024 to June 30, 2025 with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data of an acute inpatient discharge with any diagnosis of AMI from July 1, 2024 to June 30, 2025 and at least 135 days of treatment with beta-blockers during the 180-day measurement interval.

Beta-Blocker Medications

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

Q: How to improve score for this HEDIS® measure?

A: Use of complete and accurate Value Set Codes. Timely submission of claim/encounter data. Exclude members identified as having intolerance or allergy to beta blocker therapy. Any of the following meet criteria:

- ☑ Asthma
- ☑ COPD
- ☑ Obstructive chronic bronchitis
- ☑ Chronic respiratory conditions due to fumes and vapors
- ☑ Hypotension, heart block >1 degree or sinus bradycardia
- ☑ A medication dispensing event indicative of a history or asthma
- ☑ Intolerance or allergy to beta-blocker therapy

Required Exclusions:

- Members in hospice or using hospice services anytime during 2025
- Members enrolled in an Institutional SNP (I-SNP) any time on or between July 1, 2024 to December 31, 2025.
- Members living long-term in an institution any time on or between July 1, 2024 to December 31, 2025.
- Frailty in 2025 and advanced illness during 2024 or 2025 or Member who was dispensed dementia medication in 2025
- Members 81 years of age and older with frailty diagnosis any time on or between July 1 2024 to December 31, 2025.
- Members who died any time during 2025

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

NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

ICD-10 Codes	
AMI	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4

Exclusion(s)
Advanced Illness, Adverse Effects of Beta-Adrenoreceptor Antagonists, Asthma, Beta-Blockers Contraindications, Chronic Respiratory Conditions Due to Fumes/Vapors, COPD, Frailty, Obstructive Chronic Bronchitis

Pharmacotherapy Management of COPD Exacerbation (PCE)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

1. Dispensed prescription for systemic corticosteroid on or 14 days after the Episode Date.

Systemic Corticosteroid Medications

Description	Prescription		
Glucocorticoids	• Cortisone-acetate	• Hydrocortisone	• Prednisolone
	• Dexamethsone	• Methylprednisolone	• Prednisone

Pharmacotherapy Management of COPD Exacerbation (PCE)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: What type of document is acceptable?

A:

2. Dispensed prescription for a bronchodilator on or 30 days after the Episode Date.

Bronchodilator Medications

Description	Prescription		
Anticholinergic agents	• Aclidinium-Bromide • Tiotropium	• Ipratropium • Umeclidinium	
Beta 2-agonists	• Albuterol • Arformoterol • Formoterol	• Indacaterol • Levalbuterol	• Metaproterenol • Salmeterol • Olodaterol
Bronchodilator combinations	• Albuterol-ipratropium • Budesonide-formoterol • Fluticasone-vilanterol • Fluticasone furoate-umeclidinium-vilanterol • Fluticasone-salmeterol	• Formoterol-aclidinium • Formoterol-glycopyrrolate • Formoterol-mometasone	• Olodaterol-tiotropium • Umeclidinium-vilanterol

Q: How to improve score for this HEDIS® measure?

A:

☑ Use of complete and accurate Value Set Codes

☑ Timely submission of claim/encounter data

Required Exclusions

- Members in hospice or using hospice services anytime during 2025
- Members who died any time during 2025.

Pharmacotherapy Management of COPD Exacerbation (PCE)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

ICD-10 Codes	
Chronic Bronchitis	J41.0, J41.1, J41.8, J42
Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9
COPD	J44.0, J44.1, J44.9

CPT Codes	
ED	99281-99285

HCPCS Codes
N/A

Exclusion(s)
Inpatient Stay, Nonacute Inpatient Stay

Plan All-Cause Readmissions (PCR) Star Measure

NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the sample?

A: For members 18 years of age and older, the number of acute inpatient and observation stays in 2025 that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

- Count of Index Hospital Stays (IHS) (denominator)
- Count of Observed 30-Day Readmissions (numerator)
- Count of Expected 30-Day Readmissions

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data of at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date (on or between January 1 and December 1, 2025).

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Review discharges and verify that they are for acute IP stays. Some maybe sub-acute, transitional care, rehab, etc.
- ☑ Schedule a follow-up once member has been discharged from the hospital to assess how the member doing to avoid possible readmission
- ☑ Capture all diagnoses as this is a case mix adjusted rate. *The sicker the member, the higher probability of a readmission*

Required Exclusions

- Members in hospice or using hospice services anytime during 2025

Postpartum Depression Screening and Follow-Up (PDS-E)

State Medicaid MPL (must achieve 50th percentile or greater)

Q: Which members are included in the sample?

A:

☑ Members who delivered that were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

- *Depression Screening*. Members who delivered that were screened for clinical depression using a standardized instrument during the postpartum period.
- *Follow-Up on Positive Screen.* Members that delivered who received follow-up care within 30 days of a positive depression screen finding.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Postpartum Depression Screening and Follow-Up (PDS-E)

State Medicaid MPL (must achieve 50th percentile or greater)

Q: What type of document is acceptable?

A:

- Evidence from claim/encounter data including pharmacy data
- A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
PROMIS Depression	Total score (T Score) ≥60

Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory—Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	90853-3	Total score ≥30

Postpartum Depression Screening and Follow-Up (PDS-E)

State Medicaid MPL (must achieve 50th percentile or greater)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data.
- ☑ Documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the date of delivery.
- ☑ **Depression Screening**
  - Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. *For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated*
- ☑ **Follow-Up on Positive Screen**
  - Documentation of members received follow-up care on or up to 30 days afterthe date of the first positive screen (31 total days).

  Any of the following on or up to 30 days after the first positive screen
  - An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
  - A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
  - A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
  - A dispensed antidepressant medication

  OR
  - Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Postpartum Depression Screening and Follow-Up (PDS-E)

State Medicaid MPL (must achieve 50th percentile or greater)

SAMPLE CODES

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

LOINC Codes	
Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]	44261-6
Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]	55758-7

CPT Codes	
Follow-Up Visit if the screening is positive for depression	98960-98962, 99078, 99202-99205, 99211 – 99215, 99217-99220, 99241 – 99245, 99341 – 99345, 99347 -99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412

Exclusion(s)
Deliveries in which members were in hospice or using hospice services any time during the measurement period.

Prenatal Depression Screening and Follow-Up (PND-E)

State Medicaid MPL (must achieve 50th percentile or greater)

Q: Which members are included in the sample?

A: Members who delivered that were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

- *Depression Screening.* Members who delivered and were screened for clinical depression during pregnancy using a standardized instrument.
- *Follow-Up on Positive Screen.* Members who delivered and received follow-up care within 30 days of a positive depression screen finding.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A:

- Evidence from claim/encounter data including pharmacy data
- A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
PROMIS Depression	Total score (T Score) ≥60

Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory—Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	90853-3	Total score ≥30

Prenatal Depression Screening and Follow-Up (PND-E)

State Medicaid MPL (must achieve 50th percentile or greater)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data.
- ☑ Documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the date of delivery.
- ☑ **Depression Screening**
  - Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. *For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated*
- ☑ **Follow-Up on Positive Screen**
  - Documentation of members received follow-up care on or up to 30 days afterthe date of the first positive screen (31 total days).

Any of the following on or up to 30 days after the first positive screen

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication

OR

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Exclusion(s)

- Deliveries that occurred at less than 37 weeks gestation
- Deliveries in which members were in hospice or using hospice services any time during the measurement period.

Prenatal Depression Screening and Follow-Up (PND-E)

State Medicaid MPL (must achieve 50th percentile or greater)

SAMPLE CODES

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

LOINC Codes	
Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]	44261-6
Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]	55758-7

CPT Codes	
Follow-Up Visit if the screening is positive for depression	98960-98962, 99078, 99202-99205, 99211 – 99215, 99217-99220, 99241 – 99245, 99341 – 99345, 99347 -99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412

Prenatal and Postpartum Care (PPC)

State Medicaid Auto-Assignment (Timeliness of Prenatal Care)
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A:

- ☑ Members who delivered (EDD) between October 8, 2024 to October 7, 2025, **and**
- ☑ Had a prenatal care visits in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization, **and**
- ☑ Had a postpartum visit on or between 7 and 84 days after delivery

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is acceptable?

Prenatal Care Visit (First Trimester, on date of enrollment, or within 42 days of enrollment)

I. Documentation indicating the member is pregnant or references to the pregnancy; for example:

a. Documentation in a standardized prenatal flow sheet, or

b. Documentation of LMP, EDD or gestational age, or
– A positive pregnancy test result, or

c. Documentation of gravidity and parity, or

d. Documentation of complete obstetrical history, or

e. Documentation of prenatal risk assessment and counseling/education.

ii. A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).

iii. Evidence that a prenatal care procedure was performed, such as:

a. Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or

b. TORCH antibody panel alone, or

c. A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or

d. Ultrasound of a pregnant uterus.

Post-partum Visit (7 and 84 days after delivery)

Progress note with documentation of:

i. Pelvic exam

ii. Evaluation of weight, BP, breasts and abdomen.

– Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.

iii. Notation of postpartum care, including, but not limited to: – Notation of "postpartum care," "PP care," "PP check," "6-week check."

– A preprinted "Postpartum Care" form in which information was documented during the visit.

iv. Perineal or cesarean incision/wound check.

v. Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.

vi. Glucose screening for women with gestational diabetes.

vii. Documentation of any of the following topics:

a. Infant care or breastfeeding.

b. Resumption of intercourse, birth spacing or family planning.

c. Sleep/fatigue.

d. Resumption of physical activity.

e. Attainment of healthy weight.

Prenatal and Postpartum Care (PPC)

State Medicaid Auto-Assignment (Timeliness of Prenatal Care)
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claims/encounter data
- ☑ Services provided during a telephone visit, e-visit or virtual check-in meet criteria for both Timeliness of Prenatal Care and Postpartum Care
- ☑ Ensure presence of all components in the medical record documentation
- ☑ May use EDD to identify the first trimester for Timeliness of Prenatal Care and use the date of delivery for the Postpartum rate
- ☑ Documentation of deliveries **NOT** resulting in a Live Birth – *proper coding or documentation will assist in excluding members from the HEDIS® sample*

Required Exclusion:

- Members in hospice or using hospice services anytime during 2025
- Members who died any time during 2025.

SAMPLE CODES

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

CPT Delivery Codes

59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622

PRENATAL CARE

CPT Prenatal Ultrasound Codes

76801, 76805, 76811, 76813, 76815-76821, 76825-76828

Prenatal and Postpartum Care (PPC)

State Medicaid Auto-Assignment (Timeliness of Prenatal Care)
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

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

CPT Stand Alone Prenatal Visit Code

99500

CPT Prenatal Visit Codes

99202-99205, 99211-99215, 99241-99245, 99483

CPT II Stand Alone Prenatal Visit Codes

0500F, 0501F, 0502F

CPT Prenatal Bundled Service Codes

59400, 59425, 59426, 59510, 59610, 59618

HCPCS Prenatal Codes

Prenatal Visits	G0463, T1015
Stand Alone Prenatal Visits	H1000-H1004
Prenatal Bundled Services	H1005

POSTPARTUM CARE

ICD-10 Postpartum Visit Codes

Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Prenatal and Postpartum Care (PPC)

State Medicaid Auto-Assignment (Timeliness of Prenatal Care)
State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

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

CPT Postpartum Visit Codes

57170, 58300, 59430, 99501

CPT II Postpartum Visit Code

0503F

CPT Postpartum Bundled Service Codes

59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

HCPCS Postpartum Codes

Postpartum Visits	G0101
Cervical Cytology	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091

Exclusion(s)

Non-Live Births

Prenatal Immunization Status (PRS-E)

Q: Which members are included in the sample?

A: Members who delivered in the measurement period and had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claims/encounter data
- ☑ **Immunization Status: Influenza**
  - Documentation where members received an adult influenza vaccine on or between July 1, 2024 to 2025 and the delivery date, **or**
  - Documentation where members had anaphylaxis due to the influenza vaccine on or before the delivery date.
- ☑ **Immunization Status: Tdap**
  - Documentation where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), **or**
  - Documentation where members had any of the following:
    - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.
    - Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.

Required Exclusions

- Deliveries that occurred at less than 37 weeks gestation.
- Deliveries in which members were in hospice or using hospice services any time during the measurement period.

SAMPLE CODES

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

CPT Codes	
Outpatient	90630, 90653-90654, 90656, 90658, 90661-90662, 90673-90674, 90682, 90686, 90688-90689, 90694, 90715, 90756

Statin Therapy for Patients With Cardiovascular Disease (SPC)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the SAMPLE?

A: Males 21 – 75 years of age and members 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data:

1. *Received Statin Therapy.* Dispensed prescription for a high or moderate-intensity statin medication in 2025

High- and Moderate-Intensity Statin Medications:

Description	Prescription	Medication Lists
High-intensity statin therapy	• Atorvastatin 40-80 mg	• Atorvastatin High Intensity Medications List
	• Amlodipine-atorvastatin 40-80 mg	• Amlodipine Atorvastatin High Intensity Medications List
	• Rosuvastatin 20-40 mg	• Rosuvastatin High Intensity Medications List
	• Simvastatin 80 mg	• Simvastatin High Intensity Medications List
	• Ezetimibe-simvastatin 80 mg	• Ezetimibe Simvastatin High Intensity Medications List

Statin Therapy for Patients With Cardiovascular Disease (SPC)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Description	Prescription	Medication Lists
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	• Atorvastatin Moderate Intensity Medications List
	• Amlodipine-atorvastatin 10-20 mg	• Amlodipine Atorvastatin Moderate Intensity • Medications List
	• Rosuvastatin 5-10 mg	• Rosuvastatin Moderate Intensity Medications List
	• Simvastatin 20-40 mg	• Simvastatin Moderate Intensity Medications List
	• Ezetimibe-simvastatin 20-40 mg	• Ezetimibe Simvastatin Moderate Intensity Medications List
	• Pravastatin 40-80 mg	• Pravastatin Moderate Intensity Medications List
	• Lovastatin 40 mg	• Lovastatin Moderate Intensity Medications List
	• Fluvastatin 40-80 mg	• Fluvastatin Moderate Intensity Medications List
	• Pitavastatin 2–4 mg	• Pitavastatin Moderate Intensity Medications List

EXCLUSIONS:

Estrogen Agonist Medications:

Description	Prescription
Estrogen agonists	• Clomiphene

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Statin Therapy for Patients With Cardiovascular Disease (SPC)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: What type of documentation is acceptable?

2. *Statin Adherence 80%.* Proportion of days covered (PDC) by prescription medication for at least 80% of the treatment period based on pharmacy claims from earliest dispensing event in 2025.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Services provided during a telephone visit, e-visit or virtual check-in meet criteria for advanced illness exclusion.

Required Exclusions

- Members with a diagnosis of pregnancy during 2024-2025.
- In vitro fertilization during 2024-2025.
- Dispensed at least one prescription for clomiphene during 2024-2025.
- ESRD diagnosis during 2024-2025.
- Cirrhosis diagnosis during 2024-2025.
- Myalgia, myositis, myopathy or rhabdomyolysis during 2025.
- Members in hospice or using hospice services anytime during 2025.
- Members receiving palliative care during 2025.
- Members who died any time during 2025.
- Member with Muscular Reactions to Statins

Statin Therapy for Patients With Cardiovascular Disease (SPC)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

CPT Codes	
Acute Inpatient	99221 – 99223, 99231 – 99233, 99238, 99239, 99251-99255, 99291
CABG	33510 – 33514, 33516 – 33519, 33521 – 33523, 33533 – 33536
Other Revascularization	37220, 37221, 37224 – 37231
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
PCI	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982

HCPCS Codes	
CABG	S2205 – S2209
PCI	C9600, C9602, C9604, C9606, C9607

Exclusion(s)
Advanced Illness, Cirrhosis, ESRD, Frailty, IVF, Muscular Pain and Disease, Pregnancy, Encounter for Palliative Care

Statin Therapy for Patients With Diabetes (SPD)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: Which members are included in the SAMPLE?

A: 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None*. This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data

1. *Received Statin Therapy.* Dispensed prescription for a high, moderate, or low-intensity statin medication in 2025

High- and Moderate-Intensity Statin Medications:

Description	Prescription	Medication Lists
High-intensity statin therapy	• Atorvastatin 40-80 mg	• Atorvastatin High Intensity Medications List
	• Amlodipine-atorvastatin 40-80 mg	• Amlodipine Atorvastatin High Intensity Medications List
	• Rosuvastatin 20-40 mg	• Rosuvastatin High Intensity Medications List
	• Simvastatin 80 mg	• Simvastatin High Intensity Medications List
	• Ezetimibe-simvastatin 80 mg	• Ezetimibe Simvastatin High Intensity Medications List

Statin Therapy for Patients With Diabetes (SPD)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Description	Prescription	Medication Lists
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	• Atorvastatin Moderate Intensity Medications List
	• Amlodipine-atorvastatin 10-20 mg	• Amlodipine Atorvastatin Moderate Intensity Medications List
	• Rosuvastatin 5-10 mg	• Rosuvastatin Moderate Intensity Medications List
	• Simvastatin 20-40 mg	• Simvastatin Moderate Intensity Medications List
	• Ezetimibe-simvastatin 20-40 mg	• Ezetimibe Simvastatin Moderate Intensity Medications List
	• Pravastatin 40-80 mg	• Pravastatin Moderate Intensity Medications List
	• Lovastatin 40 mg	• Lovastatin Moderate Intensity Medications List
	• Fluvastatin 40-80 mg	• Fluvastatin Moderate Intensity Medications List
	• Pitavastatin 1–4 mg	• Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg	• Ezetimibe Simvastatin Low Intensity Medications List
	• Fluvastatin 20 mg	• Fluvastatin Low Intensity Medications List
	• Lovastatin 10-20 mg	• Lovastatin Low Intensity Medications List
	• Pitavastatin 1 mg	• Pitavastatin Low Intensity Medications List
	• Pravastatin 10–20 mg	• Pravastatin Low Intensity Medications List
	• Simvastatin 5-10 mg	• Simvastatin Low Intensity Medications List

Statin Therapy for Patients With Diabetes (SPD)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

Q: What type of document is acceptable?

EXCLUSIONS:

Estrogen Agonist Medications:

Description	Prescription
Estrogen agonists	• Clomiphene

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

2. *Statin Adherence 80%.* **Proportion of days covered (PDC) by prescription medication for at least 80% of the treatment period based on pharmacy claims from earliest dispensing event in 2025.**

Q: How to improve score for this HEDIS® measure?

A:

☑ Use of complete and accurate Value Set Codes
☑ Timely submission of claim/encounter data
☑ Services provided during a telephone visit, e-visit or virtual check-in meet criteria for advanced illness exclusion.

Required Exclusions

- Members with a diagnosis of pregnancy during 2024-2025.
- In vitro fertilization during 2024-2025.
- Dispensed at least one prescription for clomiphene during 2024-2025.
- ESRD diagnosis during 2024-2025.
- Cirrhosis diagnosis during 2024-2025.
- Myalgia, myositis, myopathy or rhabdomyolysis during 2025.
- Members in hospice or using hospice services anytime during 2025.
- Members receiving palliative care during 2025.
- Members who did not have a diagnosis of diabetes and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in 2024 or 2025.
- Members who died any time during 2025
- Member with Muscular Reactions to Statins

Statin Therapy for Patients With Diabetes (SPD)

NCQA Accreditation – Medicaid
NCQA Accreditation – Medicare (CMC)

SAMPLE CODES

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

CPT Codes	
Acute Inpatient	99221 – 99223, 99231 – 99233, 99238, 99239, 99251 – 99255, 99291
Outpatient	99202 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412, 99429, 99455, 99456, 99483
Nonacute Inpatient	99304 – 99310, 99315, 99316, 99318, 99324 – 99328, 99334 – 99337

Exclusion(s)
Advanced Illness, CABG, Cirrhosis, Diabetes, Diabetes Exclusions, ESRD, Frailty, IVD, IVF, MI Value Set; Old Myocardial Infarction Value, Muscular Pain and Disease, Other Revascularization, PCI, Pregnancy

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Adults 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.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes and pharmacy data.

Q: What type of document is acceptable?

A: Evidence from claim/encounter or lab data:

- Glucose test in 2025
- HbA1c test in 2025

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Services provided during a telephone visit, e-visit or virtual check-in meet criteria for eligible population.

Required Exclusions

A:

- Members with diabetes identified by claim/encounter and pharmacy data in 2024 or 2025
- Members who were dispensed insulin or oral hypogycemics/antihyperglycemics in 2024 or 2025
- Members who had no antipsychotic medications dispensed in 2025
- Members in hospice or using hospice services anytime during 2025
- Members who died any time during 2025

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

NCQA Accreditation – Medicaid

Antipsychotic Medications

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metfor min • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine-lixisenatide	• Insulin glargine • Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular	• Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Liraglutide (excluding Saxenda®)	• Semaglutide	• Albiglutide • Exenatide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Empagliflozin	• Ertugliflozin • Dapagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Tolazamide • Glipizide	• Glyburide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

NCQA Accreditation – Medicaid

Antipsychotic Medications

SSD Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Lumateperone	• Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone	• Olanzapine • Paliperidone • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine	• Perphenazine • Prochlorperazine	• Thioridazine • Trifluoperazine
Psychotherapeuticcombinations	• Amitriptyline-perphenazine		
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate	• Haloperidol decanoate • Olanzapine	• Paliperidone palmitate • Risperidone

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

NCQA Accreditation – Medicaid

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes

CPT Codes	
Non Acute Inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
Acute Inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

HCPCS Codes	
Annual wellness visit; includes a personalized prevention plan of service, initial visit	G0438
Behavioral health counseling and therapy, per 15 minutes	H0004
Mental health assessment, by non-physician	H0031
Comprehensive medication services, per 15 minutes	H2010
Skills training and development, per 15 minutes	H2014
Therapeutic behavioral services, per 15 minutes	H2019

Exclusion(s)
Diabetes, Long-Acting Injections, SSD Antipsychotic Medications List

Topical Fluoride for Children (TFC)

Q: Which members are included in the sample?

A: Members 1-4 years of age who received at least 2 fluoride varnish applications in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter or lab data:

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Required Exclusions

- ☑ Members in hospice or using hospice services in 2025
- ☑ Members who died any time in 2025

SAMPLE CODES

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

CPT Codes	
Application of topical fluoride	99188

CDT Codes	
Application of topical fluoride	D1206

Exclusion(s)
Hospice encounter

Topical Fluoride for Children (TFL-CH)

State Medicaid MPL (must achieve 50th percentile or greater)

Q: Which members are included in the sample?

A: Members 1-20 years of age who received at least 2 fluoride applications as (a) dental or oral health services, (b) dental services, and (c) oral health services in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter or lab data:

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data

Exclusions:

- ☑ Members in hospice or using hospice services in 2025
- ☑ Members who died any time in 2025

SAMPLE CODES

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

CPT Codes	
Application of topical fluoride	99188

CDT Codes	
Application of topical fluoride	D1206

Exclusion(s)
Hospice encounter

Transitions of Care (TRC)

Q: Which members are included in the sample?

A: Member 18 years and older who were discharged from acute or in acute setting from January 1, 2025 and December 1, 2025:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation Post-Discharge

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include evidence of the following:

- Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- Documentation of receipt of discharge information on the day of discharge through 2 days after the admission (3 total days).
- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Q: What type of document is acceptable?

A: All of the following documentation in 2025:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation with medication list
- All progress notes
- Current medication list
- All correspondence (phone call, email, fax) between inpatient provider and member's PCP
- All Hospital/SNF/Rehab discharge summaries

Medication Reconciliation does not require the member to be present

Transitions of Care (TRC)

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Services provided during a telephone visit, e-visit or virtual check-in within 30 days after discharge meet criteria.
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Evidence that the member was seen for post discharge; hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.

Required Exclusions

- Members in hospice or using hospice services anytime during 2025
- Members who died any time during 2025

SAMPLE CODES

The codes listed below are not inclusive and do not represent a complete list of codes

CPT Codes	
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456
Telephone Visits	98966, 98967, 98968, 99441, 99442, 99443
Transitional Care Management Services	99495, 99496
Medication Reconciliation	99483, 99495, 99496

CPTII	
Medication Reconciliation	1111F

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Children 3 months and older who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription in **2024 or 2025**.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What type of document is acceptable?

A: Evidence from claim/encounter data with a date of service for any outpatient or ED visit with **only** a URI diagnosis and no new or refill prescription for an antibiotic on or three days after the Index Episode Start Date (IESD).
Index Episode Start Date (IESD): The earliest date of service for an eligible visit (outpatient, observation, or ED) during Intake Period (July 1, 2024 - June 30, 2025).

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Ensure presence of all components in the medical record documentation
- ☑ Exclude claim/encounter data with more than one diagnosis code and ED visits or observation visits that result in an inpatient stay

Required Exclusions

- ☑ Exclude members in hospice or using hospice services anytime during 2025.
- ☑ Members who died any time during 2025.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

NCQA Accreditation – Medicaid

SAMPLE CODES

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

CPT Codes	
ED	99281-99285
Observation	99217-99220
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
Telephone Visit	98966 -98968, 99441- 99443
Online Assessment	98969, 99444

HCPCS Codes	
Outpatient	G0402, G0438, G0439, G0463, T1015

Required Exclusions	
Competing Diagnosis, Inpatient Stay, Phayngitis 1. HIV Value Set. 2. HIV Type 2 Value Set. 3. Malignant Neoplasms Value Set. 4. Other Malignant Neoplasm of Skin Value Set. 5. Emphysema Value Set.	6. COPD Value Set. 7. Comorbid Conditions Value Set. 8. Disorders of the Immune System Value Set. 9. Pharyngitis Value Set. 10. Competing Diagnosis Value Set.

Well-Child Visits in the First 30 Months of Life (W30)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Children who had the following number of well-child visits with a PCP during the last 15 months.

1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.
2. 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 between 15 and 30 months of age.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: None. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What type of medical record is acceptable?

A:

1. Evidence from a claim/encounter with a date of service for any six or more well-child visits on different dates of service on or before the 15-month birthday.
2. Evidence from a claim/encounter with a date of service for any two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Use every visit (including sick visit) to provide a well-child visit and immunizations

Required Exclusions

- ☑ Members in hospice or using hospice services any time during 2025.
- ☑ Members who died any time during 2025

Well-Child Visits in the First 30 Months of Life (W30)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

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

ICD-10 Codes

Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

CPT Codes

99381-99385, 99391-99395, 99461

HCPCS Codes

G0438, G0439, S0302

Exclusion(s)

Hospice setting or Hospice care.

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

NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile with height and weight documentation, counseling for nutrition, and counseling for physical activity in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: Documentation in the medical record must include a note indicating the **date** of the office visit and evidence of the following:

- ☑ BMI percentile ***or*** BMI percentile plotted on age-growth chart
- ☑ Height and weight
- ☑ Counseling for nutrition or referral for nutrition education
- ☑ Counseling for physical activity or referral for physical activity

Q: What type of medical record is acceptable?

A: One or more of the following:

- ☑ Progress notes/Office visits notes
- ☑ Anticipatory Guidance Form
- ☑ Staying Healthy Assessment Form
- ☑ Member-collected biometric values (height, weight, BMI percentile) meet criteria for the BMI Percentile numerator.
- ☑ Complete Physical Examination Form
- ☑ Dated growth chart/log
- ☑ Nutrition and Physical Activity Assessment Form
- ☑ What Does Your Child Eat Form

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

NCQA Accreditation – Medicaid

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Services rendered during a telephonic visit, e-visit or virtual check-in meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators.
- ☑ Ensure presence of all components in the medical record documentation

Required Exclusions

- Members in hospice or using hospice services anytime during 2025
- A diagnosis of pregnancy in 2025
- Members who died any time during 2025

Note: *Services specific to the assessment or treatment of an acute or chronic condition do not count toward the "Counseling for nutrition" and "Counseling for physical activity" indicators.*

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

NCQA Accreditation – Medicaid

SAMPLE CODES

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

ICD-10 Codes	
BMI Percentile	Z68.51-Z68.54
Nutrition Counseling	Z71.3
Physical Activity Counseling	Z02.5, Z71.82

CPT Codes	
Outpatient	99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
Nutrition Counseling	97802-97804

CPT Telephonic and Telehealth codes
99441-99443, 98966-98968, 99444, 99212-99215, 99201-99205

HCPCS Codes	
Outpatient	G0402, G0438, G0439, G0463, T1015
Nutrition Counseling	G0270, G0271, G0447, S9449, S9452, S9470
Physical Activity Counseling	G0447, S9451

Exclusion(s)
Pregnancy

Child and Adolescent Well-Care Visits (WCV)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

Q: Which members are included in the sample?

A: Members 3-21 years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner in 2025.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes.

Q: What documentation is needed in the medical record?

A: *None.* This measure requires claim/encounter data submission only using the appropriate Value Set Codes.

Q: How to improve score for this HEDIS® measure?

A:

- ☑ Use every visit (including sick visits) to provide a well-child visit (Ambulatory visits, Telephone visits, Online assessments)
- ☑ Use standardized templates for WCV in Electronic Health Records (EHR)
- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claim/encounter data
- ☑ Submission of telehealth claim/encounter

Required Exclusions

- Members in hospice or using hospice services anytime during 2025
- Members who died any time during 2025.

Child and Adolescent Well-Care Visits (WCV)

State Medicaid MPL (must achieve 50th percentile or greater)
Pay-for-Performance (P4P)
NCQA Accreditation – Medicaid

SAMPLE CODES

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

ICD-10 Codes

Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

CPT Codes

99381-99384, 99391-99395

HCPCS Codes

G0438, G0439, S0302

Exclusion(s)

Hospice setting or Hospice care.