HEDIS® MY2024

Hybrid Measure Quick Guide

For All of L.A.

LA3096 07/24

Updates on HEDIS Measures MY2024

Specification Changes

- **Glycemic Status Assessment for Patients with Diabetes (GSD)**
  - Previously titled "Hemoglobin A1c Control for Patients with Diabetes (HBD)" .
  - Added glucose management indicator (GMI) as an option to meet numerator criteria.
  - Clarified that "Unknown" is not considered a result/finding for medical record reporting.
  - Removed the required exclusion for members who do not have diagnosis of diabetes.
- **Cervical Cancer Screening (CCS)**
  - A required exclusion for members who were assigned male at birth.
  - Clarified that "Unknown" is not considered a result/finding for medical record reporting.
- **Colorectal Cancer Screening (COL)**
  - Colorectal Cancer Screening (COL) will be reported using Electronic Clinical Data Systems (ECDS).
- **Lead Screening in Children (LSC)**
  - Clarified that documentation of "unknown" is not considered a result/finding for medical record reporting.
- **Eye Exam for Patients With Diabetes (EED)**
  - Clarified that if one eye is not accessible, leading to an indeterminate result, this is not considered a result/finding.
  - Removed the required exclusion for members who do not have diagnosis of diabetes.
- **Blood Pressure Control for Patients With Diabetes (BPD)**
  - Removed the required exclusion for members who do not have diagnosis of diabetes.
  - Clarified that documentation of "unknown" is not considered a result/finding for medical record reporting.

NCQA Alert

NCQA is now allowing Telehealth (Telephone visit, E-visit, or Virtual Check-in) for several measures including:

- **Care for Older Adults (COA)**
- **Prenatal and Postpartum Care (PPC)**
- **Transitions of Care (TRC)**
- **Blood Pressure Control for Patients with Diabetes (BPD)**
- **Controlling High Blood Pressure (CBP)**
- **Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)**

Providers should use the same codes as the in-person visits and to also include appropriate Telehealth visit codes with modifier. By having both codes, this can be captured administratively and will eliminate the need for medical record pursuit during HEDIS.

Click here to view **Codes for Telehealth/Telephonic.**

HEDIS MY2024 Hybrid Measure Quick Guide

L.A. Care HEALTH PLAN® For All of L.A.

Child/Adolescent Health 1

Women's Health 4

Adult/Elderly Health 6

Codes for Telehealth/Telephonic 10

Childhood Immunization Status (CIS) 14

Immunizations For Adolescents (IMA) 15

Lead Screening in Children (LSC) 16

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) 17

Cervical Cancer Screening (CCS) 19

Prenatal and Postpartum Care (PPC) 21

Controlling High Blood Pressure (CBP) 24

Eye Exam for Patients With Diabetes (EED) 25

Glycemic Status Assessment for Patients With Diabetes (GSD) 25

Hemoglobin A1c Control for Patients With Diabetes (HBD) 25

Blood Pressure Control for Patients with Diabetes (BPD) 26

Care for Older Adults (COA) 27

Colorectal Cancer Screening (COL) 28

Transitions of Care (TRC) 29

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Child/Adolescent Health		
Childhood Immunization Status (CIS)	Children 2 years of age who had the following **by their second birthday**: • Four (4) DTaP (Diphtheria, Tetanus and acellular pertussis) • Three (3) IPV (Inactivated Polio) • One (1) MMR (Measles, Mumps and Rubella) • Three (3) HiB (Haemophilus Influenza Type B) • Three (3) Hepatitis B • One (1) VZV (Varicella Zoster) • Four (4) PCV (Pneumococcal Conjugate) • One (1) Hepatitis A • Two (2) or three (3) RV (Rotavirus) • Two (2) Influenza	• Use of Complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. • Seropositive test results do not meet criteria for any of the numerators. • Documentation that the member received the immunization "at delivery" or "in the hospital" meet criteria (e.g. Hep B). • Anaphylaxis due to vaccine is numerator compliant for DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and Influenza. Encephalitis due to vaccine is numerator compliant for DTaP only. • Exclude members with immunocompromising conditions or contraindications to a specific vaccine on or before their second birthday, members using hospice services, and members who died during the measurement year • Participate in CAIR registry

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Immunizations for Adolescents (IMA)	Adolescents 13 years of age who had the following **by their thirteenth birthday:** • One (1) MCV (Meningococcal) between 11th – 13th birthday. • One (1) Tdap (Tetanus, Diptheria, Acellular Pertussis) between 10th – 13th birthday. • Three (3) HPV (Human papillomavirus) between 9th – 13th birthday or two (2) HPV with at least 146 days between 1st and 2nd dose.	• Use of Complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered • Participate in CAIR 2 registry • Anaphylaxis due to vaccine is numerator compliant for any of the antigens. • Encephalitis due to the vaccine is numerator compliant for Tdap only. • Exclude members using hospice services and members who died during the measurement year.

Lead Screening in Children (LSC)	Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning **by their second birthday.**	• Use of complete and accurate Value Set Codes **(Click to View)**
		• Timely submission of claims and encounter data
		• Documentation in the medical record must include a note indicating the date the test was performed and the result or finding.
		• Documentation of "unknown" is not considered a result/finding for medical record reporting.
		• Identify children at greatest risk by utilizing standardized lead screening questionnaires to determine if a child is at risk. Children at lower risk for lead exposure may be tested at 12–15 months of age.
		• Conduct necessary follow-up and explain to parents why follow-up is or isn't needed.
		• Avoid missed opportunities by taking advantage of every office visit (including sick visits) to perform lead testing.
		  ◦ Consider a standing order for in-office lead testing.
		  ◦ Educate parents about the dangers of lead poisoning and the importance of testing.
		  ◦ Provide in-office testing (capillary).
		• Educate parents about the major sources of lead and poisoning prevention such as:
		  ◦ Interventions to reduce exposure to dust
		  ◦ Attention to nutrition: plenty of iron, calcium and regular meals. Lead is absorbed more on an empty stomach.
		  ◦ Children and pregnant women should not be present in housing built before 1978 that is undergoing renovation.
		  ◦ Children should not have access to peeling paint or chewable surfaces that have been painted with lead based paint. Create barriers between living/play areas and lead sources.
		• Exclude members using hospice services and members who died during the measurement year.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Children & adolescents 3 – 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following in 2024: • BMI Percentile documentation • Counseling for nutrition • Counseling for physical activity	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • BMI Percentile can be documented as a value (e.g., 85th percentile) or plotted on a BMI-growth chart. Ranges and thresholds are not acceptable. A distinct BMI value or percentile is required. Documentation of >99% or <1% meets criteria. • Counseling for nutrition. Any one of the following meet criteria: discussion of current nutrition behaviors, checklist indicating nutrition was addressed, counseling or referral for nutrition education, member received educational materials on nutrition during a face-to-face visit, anticipatory guidance for nutrition, weight or obesity counseling. • Counseling for physical activity. Any one of the following meet criteria: discussion of current physical activity behaviors, checklist indicating physical activity was addressed, counseling or referral for physical activity, member received educational materials on physical activity during a face-to-face visit, anticipatory guidance specific to the child's physical activity, weight or obesity counseling. • Member-collected biometric values (height, weight, BMI percentile) meet criteria for the BMI Percentile numerator. • Services rendered during a telephonic visit, e-visit or virtual check-in meet criteria for the BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity indicators. • Exclude pregnant members, members using hospice services, and members who died during the measurement year.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Women's Health		
Cervical Cancer Screening (CCS)	Women 21 – 64 years of age who were screened for cervical cancer using either of the following: • Women 21-64 years of age who had cervical cytology performed between 2022-2024. • Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed between 2020-2024. • Women 30-64 years of age who had cervical cytology/high risk human papillomavirus (hrHPV) cotesting between 2020-2024.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Documentation in the medical record must include a note indicating the date when the cervical cytology was performed and the result. • Biopsies and samples that indicate "no cervical cells were present" do not meet criteria. • Exclude members with history of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix. Any of the following documentation meets criteria for exclusion: a. "complete", "total", or "radical" hysterectomy (abdominal, vaginal, or unspecified) b. "vaginal hysterectomy" c. "vaginal pap smear" in conjunction with documentation of "hysterectomy" d. "hysterectomy" in combination with documentation that the patient no longer needs pap testing/cervical cancer screening. Exclude members using hospice services or receiving palliative care, members who died during the measurement year, and members who were assigned male at birth.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Prenatal and Postpartum Care (PPC)	Women who delivered live births on or between 10/08/2023 - 10/07/2024 with the following facets of prenatal and postpartum care: • *Timeliness of Prenatal Care.* Women that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care*. Women that received a postpartum visit on or between 7 and 84 days after delivery.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Services provided during a telephone visit, e-visit or virtual check-in meet criteria for both Timeliness of Prenatal Care and Postpartum Care. • Prenatal care visit must include one of the following: i. Documentation indicating the woman 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. • Postpartum visit must include one of the following: 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. • Exclude members using hospice services and members who died during the measurement year.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Adult/Elderly Health		
Controlling High Blood Pressure (CBP)	Members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) in 2024.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Include BP readings taken and reported by member using any digital device. • BP readings documented as an "average BP" are eligible for use (e.g., "average BP 139/70"). Ranges or thresholds are not acceptable. • The following BP readings do not meet criteria: BP readings taken during an acute inpatient stay, ED visit, on same day as a diagnostic test or procedure that requires a change in diet or medication on or one day before the day of the test or procedure (with the exception of fasting blood tests), and those taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope. • Always recheck blood pressure if initial reading is 140/90 or greater. • Uncontrolled BP should be followed up later in the year. • Exclude members who meet any of the following criteria in the measurement year: a. Members who died. b. Members in hospice or using hospice services. c. Members receiving palliative care. d. Members with evidence of end-stage renal disease. e. Members with a diagnosis of pregnancy.
Blood Pressure Control for Patients with Diabetes (BPD)	Members 18 – 75 years of age with diabetes whose blood pressure (BP) was adequately controlled (<140/90) in 2024.	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Include BP readings taken and reported by member using any digital device. • BP readings documented as an "average BP" are eligible for use. Do not use ranges or thresholds. • Documentation of "unknown" is not considered a result/finding for medical record reporting. • The following BP readings **do not** meet criteria: BP readings taken during an acute inpatient stay, ED visit, on same day as a diagnostic test or procedure that requires a change in diet or medication on or one day before the day of the test or procedure (with the exception of fasting blood tests), and those taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope. • Always recheck blood pressure if initial reading is 140/90 or greater. • Uncontrolled BP should be followed up later in the year. • Exclude members using hospice services or receiving palliative care, and members who died during the measurement year.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Glycemic Status Assessment for Patients With Diabetes (GSD)	Members 18-75 years of age with diabetes whose most recent hemoglobin A1c or glucose management indicator (GMI) was at the following levels in 2024: • Glycemic Status <8.0% • Glycemic Status >9.0%	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Documentation in the medical record must include a note indicating the date when the HbA1c test or GMI was done and the result. • Documentation in the medical record must include a note indicating the date when the HbA1c test or GMI was done and the result. • A distinct numeric result is required for compliance. The indicator is not compliant if ranges or thresholds were used, or if result was missing, documented as "unknown", or if test was not performed in the measurement year. • Aim for HbA1c or glucose management indicator (GMI) of <8%. Monitor and document glucose level data in the progress notes. Include GMI results collected by member in the medical record. • Re-check HbA1c later in the year if it is high. • Exclude members using hospice services or receiving palliative care, and members who died during the measurement year.
Eye Exam for Patients With Diabetes (EED)	Members 18-75 years of age with diabetes who had a retinal eye exam.	• Use of complete and accurate Value Set Codes (Click to View) • Timely submission of claims and encounter data • Documentation in the medical record must include one of the following: - A retinal or dilated eye exam by an eye care professional in 2024, Or - A negative retinal or dilated eye exam by an eye care professional in 2023. • Request a copy of retinal eye exam from eye care specialist. • An eye exam result documented as "unknown" does not meet criteria. If one eye is not accessible, leading to an indeterminate result, this is not considered a result/finding. • Exclude members using hospice services or receiving palliative care, and members who died during the measurement year.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Care for Older Adults (COA)	Members 66 years and older who had each of the following in 2024: • Medication review • Functional status assessment • Pain assessment	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • Functional status assessment must include one of the following: notation of ADLs, IADLs, result of assessment of a standardized functional status assessment tool. • Medication Review to be done by prescribing provider and clinical pharmacist only. • Note: Medication Review does not require member to be present. • Pain assessment may be completed by using numerical pain scale, facial pain scale, or documentation of "no pain" upon assessment. • Services provided during a telephone visit, e-visit or virtual check-in meet criteria for all numerators. • Exclude members using hospice services and members who died during the measurement year.
Colorectal Cancer Screening (COL)	Members 45 – 75 years of age who had appropriate screening for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test in 2024 • Flexible sigmoidoscopy between 2020 – 2024 • Colonoscopy between 2015 – 2024 • CT Colonography between 2020 – 2024 • Stool DNA (sDNA) with FIT test between 2022 – 2024	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • FOBT test performed in an office setting or performed on a sample collected via a digital rectal exam (DRE) does not meet criteria. • Exclude members with history of colectomy or colorectal cancer, and members who died during the measurement year. • For colonoscopy procedures, if the scope advanced to the cecum, it meets criteria for the numerator.

Priority Measure	Measure Specification	How to Improve HEDIS Scores
Transitions of Care (TRC)	Members 18 years of age and older who had each of the following in 2024: • *Notification of Inpatient Admission*. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). • *Receipt of Discharge Information*. Documentation of receipt of discharge information on the day of discharge through 2 days after the admission (3 total days). • *Patient Engagement After Inpatient Discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. • *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	• Use of complete and accurate Value Set Codes **(Click to View)** • Timely submission of claims and encounter data • For Notification of Inpatient Admission and Receipt of Discharge Information, information must come from the hospital, health information exchange, or member's health plan. • For Patient Engagement After Inpatient Discharge, arrange for an outpatient visit (including office visits and home visits), telehealth visits (via telephone or videoconferencing), and e-visits or virtual check-ins within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. • For Medication Reconciliation Post-Discharge, documentation must include evidence of medication review or reconciliation of current medications with discharge medications. • Visit must have documentation indicating that the member was admitted, discharged, and/or hospitalized. • Note: Medication reconciliation does not require the member to be present. • Exclude members using hospice services and members who died during the measurement year.

TELEPHONIC **Codes that refer to phone conversations with your doctor are billed in time increments from five minutes to a half an hour.**	**CPT**
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 10 – 5 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 20 – 11 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 30 – 21 minutes of medical discussion	99443

TELEPHONIC **Codes for phone consultations with physician extenders, who are usually nurses, NPs, or PAs, usually correspond with a bill that is less than the bill for phone conversations with your doctor.**	**CPT**
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 10 – 5 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 20 – 11 minutes of medical discussion	98967
Telephone assessment andmanagement service providedby a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment andmanagement service or procedure within the next 24 hours or soonest available appointment; 30 – 21 minutes of medical discussion	98968
Email or some other online service to discuss a medical problem with a physician.	99444

Telehealth - Established Patients Add the Modifiers to specify the type of face-to-face visit.	CPT
Requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	99212
Requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	99213
Requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	99214
Requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	99215

Telehealth - New Patient **Add the Modifiers below to specify the type of face-to-face visit.**	**CPT**
Office or **other** outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. Billing Instructions: Bill 1 unit per visit.	99201
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. Billing Instructions: Bill 1 unit per visit.	99202
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family. Billing Instructions: Bill 1 unit per visit.	99203
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	99204
Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family. Billing Instructions: Bill 1 unit per visit.	99205

Modifiers	CPT
Synchronous telemedicine service rendered via a **real-time interactive audio and video** telecommunications system. Append this modifier to an appropriate CPT code (listed in Appendix P in the 2020/13/4 CPT manual) for a real time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider. The totality of the communication of information exchanged between the reporting provider and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Codes must be listed in Appendix P or have the symbol « next to the code.	95
Via **interactive audio and video telecommunication systems**. Use only when directed by your payer in lieu of modifier 95 *NOTE: Medicare stopped the use of modifier GT in 2017 when the place of service code 02 (telehealth) was introduced. If your payers reject a telemedicine claim and the 95 modifier is not appropriate, ask about modifier GT.*	GT (Telehealth)
The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)	02 (Telehealth)

CHILDHOOD IMMUNIZATION STATUS (CIS)

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

CIS

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

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

VACCINE (Combination)	CPT
DTaP-IPV/Hib combo	90698
DTaP-HepB-IPV	90723
DTaP- IPV-Hib-HepB	90697
MMRV (Measles, Mumps, Rubella, Varicella)	90710
HIB/HEP B	90748

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

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

IMMUNIZATIONS FOR ADOLESCENTS (IMA)

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

IMA

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

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

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

Lead Screening in Children (LSC)

Children who turn 2 years old during the measurement year. The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Lead Screening	CPT
Lead Screening	83655
EXCLUSIONS (Hospice)	**CPT**
Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	99377
99377: Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month **99378:** Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month	99378

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

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

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

WCC

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

CPT	
Medical Nutrition Therapy; initial assessment and intervention, individual, face-to-face with patient, each 15 minutes	97802
Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	97803
Group (two (2) or more individual(s)), each 30 minutes	97804
HCPCS	
Medical Nutrition Therapy; re-assessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with patient, each **15 minutes**	G0270
Medical Nutrition Therapy; re-assessment and subsequent intervention(s) following second referral in same year for change of diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), group (two (2) or more individuals), each **30 minutes**	G0271
Face-to-face behavioral counseling for obesity, **15 minutes**	G0447
Weight management classes, non-physician provider, per session	S9449
Nutrition classes, non-physician provider, per session	S9452
Nutritional counseling, dietician visit	S9470
Exercise classes, non-physician provider, per session	S9451

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

ICD-10	
BMI, pediatric, **less than 5th percentile** for age	Z68.51
BMI, pediatric, **5th percentile to 85th percentile** for age	Z68.52
BMI, pediatric, **85th percentile to 95th percentile** for age	Z68.53
BMI, pediatric, **greater than or equal to 95th percentile** for age	Z68.54
Counseling for nutrition	Z71.3
Exercise counseling/Physical activity	Z71.82
Encounter for examination for participation in sport	Z02.5
Exercise counseling	Z71.85

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

CERVICAL CANCER SCREENING (CCS)

Percentage of women 21–64 years of age as of December 31 of the measurement year who had cervical cytology **during the measurement year or the two (2) years prior (three (3) years total)** to the measurement year, or for women 30-64 years of age who had a cervical cytology and High Risk Human Papillomavirus (hrHPV) testing during the measurement year or the four (4) years prior (five (5) years total).

CCS

CCS	CPT
Cytopathology, cervical, or vaginal	88142
High-risk HPV Co-testing	87624
EXCLUSIONS	**ICD-10**
Acquired absence of both cervix and uterus	Z90.710
Acquired absence of cervix with remaining uterus	Z90.712

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

EXCLUSIONS

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

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

PRENATAL AND POSTPARTUM CARE (PPC)

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

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

PRENATAL CARE

CPT	
Prenatal Visit Stand Alone Code: Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring	99500
New Patient: Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three (3) key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, **10 minutes** are spent face-to-face with the patient and/or family.	99201
New Patient: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three (3) key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **20 minutes** are spent face-to-face with the patient and/or family.	99202
Established Patient: Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least (two) 2 of these (three) 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, **10 minutes** are spent face-to-face with the patient and/or family.	99212
Established Patient: Office or other outpatient visit for the evaluation and management of an **established patient,** which requires at least two (2) of these three (3) key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	99213
Established Patient: Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two (2) of these three (3) key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, **25 minutes** are spent face-to-face with the patient and/or family.	99214
Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	59400
Antepartum care only; 4-6 visits	59425
Antepartum care only; seven (7) or more visits	59426

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

PRENATAL AND POSTPARTUM CARE (PPC)

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

HCPCS	
Hospital outpatient clinic visit for assessment and management of a patient	G0463
Clinic visit/encounter, all-inclusive	T1015
Prenatal care, at-risk assessment	H1000
Prenatal care, at risk enhanced service; care coordination	H1002
Prenatal care, at-risk enhanced service; education	H1003
Prenatal care, at-risk enhanced service; follow-up home visit	H1004
Prenatal care, at-risk enhanced service package (includes h1001-h1004)	H1005

POSTPARTUM CARE

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

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

HCPCS

Description	Code
Cervical or vaginal cancer screening; pelvic and clinical breast examination	G0101
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	G0123
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	G0124
Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	G0141
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	G0143
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	G0144
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	G0145
Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	G0147
Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	G0148
Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision	P3000
Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician	P3001
Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	Q0091

ICD-10

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

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

CONTROLLING HIGH BLOOD PRESSURE (CBP)

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

CBP

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

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

DIABETES CARE

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

- **Eye Exam**
  - Eye Exam for Patients with Diabetes (EED)
- **Glycemic Status**
  - Glycemic Status Assessment for Patients With Diabetes (GSD))
- **BP Control (<140/90)**
  - Blood Pressure Control for Patients with Diabetes (BPD)

Eye Exam for Patients with Diabetes (EED)	CPT
Measure Year (Current year): Dilated eye exam with interpretation by an ophthalmologist or optometrist documented or reviewed; with evidence of retinopathy.	2022F
Measure Year (Current year): Dilated eye exam with interpretation by an ophthalmologist or optometrist documented or reviewed; without evidence of retinopathy.	2023F
Year Prior: **Must be a Negative result to be compliant**. Low risk for retinopathy (No evidence of retinopathy in the prior year) (DM). ***Reported date should be the date the provider reviewed the patient's eye exam from the prior year.***	3072F
Seven (7) standard stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.	2024F
Seven (7) standard stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.	2025F
Eye imaging validated to match diagnosis from seven (7) standard field stereoscopic photos results documented and reviewed	2026F
Glycemic Status Assessment for Patients With Diabetes (GSD)	**CPT**
7.0%: Most recent hemoglobin A1c (HbA1c) **level less than 7.0%** (DM)2,4	3044F
9.0%: Most recent hemoglobin A1c level **greater than 9.0%** (DM)2,4	3046F
Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than or equal to 8.0%	3051F
Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	3052F
Hemoglobin A1c Control for Patients With Diabetes (HBD)	**LOINC**
Hemoglobin A1c/Hemoglobin.total in Blood by Electrophoresis	4549-2
Hemoglobin A1c/Hemoglobin.total in Blood	4548-4
Hemoglobin A1c/Hemoglobin.total in blood by HPLC	17856-6
Glucose management indicator	97506-0

Blood Pressure Control for Patients with Diabetes (BPD)	CPT
Systolic Blood Pressure less than 130 mm Hg	3074F
Systolic Blood Pressure 130 - 139 mm Hg	3075F
Systolic Blood Pressure Greater than or Equal to 140 mm Hg	3077F
Diastolic Blood Pressure less than 80 mm Hg	3078F
Diastolic Blood Pressure 80 - 89 mm Hg	3079F
Diastolic Blood Pressure Greater than or Equal to 90 mm Hg	3080F

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

CARE FOR OLDER ADULTS (COA)

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

- Medication review.
- Functional status assessment.
- Pain assessment.

COA

COA	CPT II
Medication List	1159F
Medication Review	1160F
Pain present	1125F
No Pain present	1126F
Functional Status assessment ADL: five (5) Activities of Daily Living IADL: four (4) Instrumental Activities of Daily Living	1170F

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

COLORECTAL CANCER SCREENING (COL)

The percentage of members 45 –75 years of age who had appropriate screening for colorectal cancer. One (1) or more screenings for colorectal cancer. Any of the following meet criteria:

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

COL

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

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

TRANSITIONS OF CARE (TRC)

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

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

TRC

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

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

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

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

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