HEDIS®/STAR Reference Guide 2024

MedPOINT MANAGEMENT

What's New for Measurement Year 2024

The future of HEDIS® is becoming clearer. As part of a quality improvement ecosystem that allows electronic data exchange among clinical care teams, payers, public health agencies and researchers, NCQA envisions that health plans will increasingly be able to exchange HEDIS® data with provider EHRs, health information exchanges, health registries, and other health plans. The technology that will enable these computer systems to talk to each other is called the FHIR API.

This transition will occur over many years. NCQA is trying to nudge the process forward by gradually converting HEDIS® measures to ECDS (Electronic Clinical Data System) measures or e-measures. Although the e-measures include technical specifications for how data will be exchanged within the ecosystem, what's important for provider offices to know now is that these measures cannot be reported with encounter data (CPT and ICD-10 codes) alone. Some of the first measures to become e-measures are cancer screenings because it has always been the case that historical and patient- reported cancer screenings cannot be reported through the regular encounter submission process. Provider offices must submit supplemental data (medical records or EHR extracts) to report that data. Provider offices that have the data in a structured format that can be easily extracted are at a significant advantage. Sometime in the future, health plans will query the EHRs for HEDIS® data using the FHIR API and supplemental data will be eliminated.

The need for provider offices to have their EHR data in a structured format has taken on new urgency as the Department of Health Care Services (DHCS) has announced its intention to hold two depression screening e-measures which cannot be reported without depression screening scores to the national Medicaid 50th percentile in 2024. Provider offices that can't produce an EHR extract of their patient's depression screening scores will have great difficulty meeting these measures. In this guide, we describe how to report the depression screening score as supplemental data using LOINC codes and we encourage provider offices to confirm that these scores are consistently being stored as structured data in their EHRs.

The increasing number of e-measures is just one of the ways that NCQA is challenging the healthcare system to improve. To improve health equity, some HEDIS® measures will now be reported with race and ethnicity stratification. There are several measures that require stratification by race and ethnicity. NCQA has also introduced the first HEDIS® measure for Social Determinants of Health Screening. Meanwhile, measure benchmarks continue to increase year after year. We hope this background and the information contained in this guide will help provider offices rise to the challenge. As always, please fully utilize the Cozeva platform which is intended to help provider offices be successful with HEDIS® and reach out to your HEDIS/Stars specialist for assistance at any time.

Thank you.

ADULTS

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Colorectal Cancer Screening (COL)	**45-75 years as of 12/31/2024**	**Commercial, Medicare, Medi-Cal (2025)**	**Members who had appropriate screening for colorectal cancer:** • Fecal occult blood test FOBT – annually (2024) • Fecal immunochemical test (FIT) – annually (2024) • Multitargeted stool DNA with Fit test (sDNA FIT) – 3 years (2022-2024) • CT colonography – 5 years (2020-2024) • Flexible sigmoidoscopy – 5 years (2020-2024) • Colonoscopy – 10 years (2015-2024) **Best Practices:** • Clearly document previous colonoscopy, including year. • Proof of service for point-of-care FOBT/FIT testing must specify "spontaneous bowel movement" or "not DRE." If screening was done by another provider or in another country, document what type of test was done, the date screening was completed (month/year) and the result to submit as supplemental data. • If creating a lab requisition online, check if your contracted lab requires that the sample be submitted to the lab within 14 days of the requisition date to avoid rejection of the specimens. • If giving a FOBT kit, do not create an online requisition.	**Description** / **Codes** **Guaiac-based fecal occult blood test (gFOBT)** — **CPT:** 82270 **HCPCS:** G0328 **Fecal immunochemical test (FIT)** — **CPT:** 82274 **Multitargeted stool DNA with FIT test (sDNA FIT)** ***(i.e., Cologuard)*** — **CPT:** 81528 **CT colonography** — **CPT:** 74261-74263 **Flexible sigmoidoscopy** — **CPT:** 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350 **Colonoscopy** — **CPT:** 44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398 **HCPCS:** G0105, G0121 **Exclusions:** Colorectal cancer (anytime during the member's history), total colectomy, members age 66+ in institutional SNP or long-term institution or with frailty and advanced illness or dementia. Other exclusions apply. **Note:** CPT II Code 3017F does not close the HEDIS® measure, but is useful for flagging documentation for chart retrieval.

ADULTS

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Controlling High Blood Pressure (CBP)	18-85 years & Hypertensive as of 12/31/2024	Commercial, Medi-Cal, Medicare	Members with ≥2 diagnoses of hypertension between 01/01/2023 - 06/30/2024 whose last blood pressure of 2024 was **<140/90**. **Best Practices:** • Most recent BP value counts. • If there are multiple readings on the same date, the lowest values from both notations can be used. • Use CPT II outcome codes on encounters and consider automating codes in your EHR. • Retake BP at end of appointment if initial reading is high. • BP from non-medical providers can be used if they are using the medical provider's EHR (i.e., dentists and optometrists). **Telehealth:** • BP readings from patient's digital BP monitoring devices during telehealth visits are acceptable.	**CPT II Codes:** • 3074F – Systolic (< 129 mm Hg) • 3075F – Systolic (= 130 – 139 mm Hg) • 3077F – Systolic (> 140 mm Hg) (non-compliant) • 3078F – Diastolic (< 79 mm Hg) • 3079F – Diastolic (= 80 – 89 mm Hg) • 3080F – Diastolic (> 90 mm Hg) (non-compliant) **Exclusions:** Members in hospice, with evident ESRD; kidney transplant, diagnosis of pregnancy; had a non-acute inpatient admission, all in 2024. Age 66+ in institutional SNP or long-term institution or with frailty and advanced illness or dementia. Other exclusions apply.

ADULTS

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Transitions of Care (TRC) Includes MRP - Medication Reconciliation Post- Discharge - 1111F	Documentation for members aged 18 and above with inpatient admission that includes notification of inpatient admission, discharge, patient engagement, and medication reconciliation in 2024	Medicare	Documentation of the following four rates: **1. Notification of Inpatient Admission** Documentation of receipt of notification with date of inpatient admission on the day of admission through 2 days after the admission (3 total days). • Medical record examples include phone call, email or fax, ER notification, electronic exchange, ADT alert system, shared EHR, health plan, PCP or care provider, specialist, orders for tests and treatments or planned inpatient admission. • This component is determined by health plan medical record sample. **2. Receipt of Discharge Information** Documentation of receipt of discharge information with date on the day of discharge through 2 days after the discharge (3 total days) via phone call, email or fax. • Medical record must include discharge summary or in EHR in structured fields, practitioner responsible during stay, procedures and treatments, diagnoses at discharge, current medication list, testing documentation and results, and post-care instructions. • This component is determined by health plan medical record sample. **3. Patient Engagement After Inpatient Discharge** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. • Document either outpatient visit with office or home visit, telephone, real-time audio and video telehealth visit or e-visit, or virtual check-in (not real-time). • This component is determined by encounter data. **4. Medication Reconciliation Post-Discharge** Documentation of medication reconciliation by PCP, registered nurse, or pharmacist on the date of discharge through 30 days after discharge (31 total days). Use CPT II code 1111F. • Document either that medications were reconciled, no changes, same, discontinued reviewed or member was seen post-discharge with reconciliation or review. • This component is determined by encounter data.	**CPT Codes for #3 and #4:** 99495 / 99496 - Transitions of care management for moderate/high complexity. **CPT II** Code for MRP (#4): 1111F - Discharge medications reconciled with the current medication list in outpatient medical record. **Best Practices:** • Add internal workflows to document notification of inpatient admission (#1) and discharge (#2) in the medical record as these components are validated through medical record review. • The use of 99495 or 99496 for patient engagement (#3) and medication post discharge (#4) are compliant for both components without additional codes. • Each sub measure is rated separately so meet as many components as possible.

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Follow UP After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	18 years & older as of the ED Visit, 18-64 years, 65 years & older	Medicare	**Step 1 -** An ED visit on or between January 1st & December 24th of the measurement year, where the member was 18 years or older on date of visit. • Denominator based on ED visits & not on members. **Step 2 -** Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or non-acute inpatient care setting. **Step 3 -** Identify ED visits where the member had a chronic condition prior to the ED Visits. Chronic Conditions Consist of: • COPD and asthma. • Alzheimer's disease and related disorders. • Chronic kidney disease • Depression. • Heart failure. • Acute myocardial infarction. • Atrial fibrillation. • Stroke and transient ischemic attack • Remove any visit with a principal diagnosis of encounter for other specified aftercare. • Remove any visit with any diagnosis of concussion with loss of consciousness or fracture of vault of skull, initial encounter. **Step 4 -** Identify ED visits where the member had two or more different chronic conditions prior to the ED visits, that meet the criteria included in Step 3 above. **Step 5 -** Multiple Visits in 8-day period. If a member has more than one ED visit in an 8-day period, include only the first eligible ED visit. A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. • An outpatient visit. • A telephone visit. ***Continued on next page***	

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Follow UP After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) ***Continued***			• Transitional care management services. • Case management visits. • Complex Care Management Services. • An outpatient or telehealth behavioral health visit. • An outpatient or telehealth behavioral health visit. • An intensive outpatient encounter or partial hospitalization. • An intensive outpatient encounter or partial hospitalization. • A community mental health center visit. • Electroconvulsive therapy. • A telehealth visit. • An observation visit. • A substance use disorder service. • An e-visit or virtual check-in. • A domiciliary or rest home visit. **Best Practices:** • Having notification process to be alerted of members that were seen in an ER 1-2 days after being seen. • Understanding what chronic conditions are eligible. • Identifying members with multiple chronic conditions.	

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION
Child and Adolescent Well-Care Visits (WCV)	3-21 years as of 12/31/2024 Age stratifications: 3-11 years 12-17 years 18-21 years	Commercial, Medi-Cal	The documentation must match the CPT or ICD-10 code definition. If the visit matches the code definition for CPT 99382-99395 ("Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures" - equivalent to a CHDP health assessment), submit that CPT code to receive HEDIS® credit. If the visit includes a significant component of well-care but does not meet the full definition for CPT 99382-99395, submit office visit CPT 99202-99215 together with a matching well-care ICD-10 Z-code to receive HEDIS® credit. The preferred documentation has the ICD10 Z-code plus the code definition printed in the assessment/plan where it can be easily seen by reviewers. A key phrase like "preventive care," "wellness visit," "well care," "well-child," or "routine health examination" should be included, along with a notation if there are abnormal findings. **Best Practices:** • If no labs or diagnostic procedures are required, indicate "no labs/procedures required" to make clear this was intentional. • Proper coding is essential so make sure age-specific CPT code is billed. Refer to http://www.aap.org or http://www.Brightfutures.org for age-appropriate guidance. • Well care can be done during sick visits by adding a well-care ICD-10 Z-code. **Telehealth:** • All components except physical exam can be completed by telehealth. • Use the wellness visit procedure code for the telehealth visit and include documentation in the record stating "in-person visit with physical exam planned by 12/31/2024." The preventive visit procedure code should not be submitted again for the in-person physical exam. • Physical exams can be completed during sick visits.

SAMPLE CODES / EXCLUSIONS

Description	CPT	ICD-10
New / Established patient-Early childhood (age 1–4 years)	99382 / 99392	Z00.121, Z00.129
New / Established patient-Early childhood (age 5-11 years)	99383 / 99393	Z00.121, Z00.129
New / Established patient-Adolescent (age 12-17 years)	99384 / 99394	Z00.121, Z00.129
New / Established patient-Adolescent (18+ years)	99385 / 99395	Z00.00, Z00.01
Sports Physical		Z02.5

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Childhood Immunization Status (CIS) (Combo 10)	Children aged 2 years in 2024 who had all immunizations by their 2nd birthday	Commercial, Medi-Cal	Children 2 years of age in 2024 who received these vaccines on or before their second birthday: 4 DTaP (diphtheria, tetanus, and acellular pertussis) 3 IPV (polio) 1 MMR (measles, mumps, rubella) 3 HiB (H influenza type B) 3 Hep B (hepatitis B) 1 VZV (chicken pox) 4 PCV (pneumococcal conjugate) 1 Hep A (hepatitis A) 2 or 3 RV (rotavirus) 2 Flu (influenza) **Best Practices:** • Always use CAIR2 -California Immunization Registry - cairweb.org. • Make sure 1-year olds are current with vaccines to avoid noncompliance next year. • Keep in mind flu vaccines are not available year-round. • Proper coding of Rota. Rota (NOS) defaults to 3 doses.	**Exclusions:** Please refer to the HEDIS® Value Set Directory (VSD) for specific exclusion codes for contradictions including Anaphylactic reaction, Encephalopathy, Adverse Effects for DTaP, Disorders of the Immune System, HIV, Malignant Neoplasm of Lymphatic Tissue, Severe 3.

Description	Codes
DTAP	90697 90698, 90700, 90723
IPV	90697, 90698, 90713, 90723
MMR	90707, 90710
HiB	90644, 90647, 90648, 90697,90698, 90748
Hepatitis A	90633
Hepatitis B	90697, 90723, 90740, 90744, 90747, 90748
VZV	90710, 90716
Pneumococcal Conjugate	90670, 90671
Rotavirus (2 dose) Rotavirus (3 dose)	90681 90680
Influenza	90655, 90657, 90660, 90661, 90672-90674, 90685-90689, 90756

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Immunizations for Adolescents (IMA) (Combo 2)	Adolescents aged 13 in 2024 who had immunizations before 13th birthday	Commercial, Medi-Cal	**The percentage of adolescents 13 years of age who had the following vaccines:** • **1 (MCV)** meningococcal conjugate. Must be completed on or between the *11th and 13th birthday*. • **1 (Tdap)** tetanus, diphtheria toxoids and acellular pertussis. Must be completed on or between the *10th and 13th birthday*. • **2 or 3 (HPV)** human papillomaviruses completed on or between the *9th and 13th birthday*. There must be **146 days** between the first and second doses of HPV vaccines.	**Exclusions:** Please refer to the HEDIS® Value Set Directory (VSD) for specific exclusion codes for contradictions including: Anaphylactic reaction, Encephalopathy and Adverse Effect of Tdap. The exclusion must have occurred on or before the member's 13th birthday. **Description** / **Codes** Meningococcal: 90619, 90733, 90734 Tdap: 90715 Human Papillomavirus (HPV): 901649, 90650, 90651 **Best Practices:** • Always use CAIR2 - California Immunization Registry - cairweb.org. • Note child's age and group vaccines against meningitis, HPV cancers, and whooping cough accordingly. Allow 146 days between HPV 1 and HPV 2 (give on or between member's 9th and 13th birthdays). • Start recommending HPV vaccination at age 9 to increase the success of completing the series by 13.
Lead Screening in Children (LSC)	2 years of age as of 12/31/2024	Medi-Cal	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. **Best Practices:** • Implement a standing order for lead screening. • Provide in office testing (capillary).	**CPT codes:** 83655 – Capillary or venous lead blood test

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Well-Child Visits in the First 30 Months of Life (W30)	**Part I** W30-A 0-15 months old in 2024 **Part II** W30-B 15-30 months old in 2024	Commercial, Medi-Cal	**Part I:** Completion of 6 or more well child visits with a primary care physician (PCP) prior to turning 15 months. **Part II:** Completion of 2 or more well child visits with a primary care physician (PCP) during 15 – 30 months old. A key phrase like “newborn visit,” “preventive care,” “wellness visit,” “well care,” “well-child,” or “routine health examination” should be included, along with a notation if there are abnormal findings. Visits must be with a PCP but does not need to be the practitioner assigned to the child. Well child visits must be at least 14 days apart to count.	**Description** / **CPT** / **ICD-10** New / Established patient - Early childhood (<8 days) — 99381 / 99391 — Z00.110 New / Established patient - Early childhood (age 8-28 days) — 99381 / 99391 — Z00.111 New / Established patient - Early childhood (age 1–4 years) — 99382 / 99392 — Z00.121, Z00.129
Developmental Screening in the First Three Years of Life (DEV)	1-3 years of age as of 12/31/2024	Medi-Cal	The percentage of children screened for risk of developmental, behavioral, and social delays using standardized screening tool in the 12 months preceding or on their first, second, or third birthday. The preferred documentation must include all of the following: • Date of service when screening test was completed and • The standardized tool used and • Evidence of screening result or screening score. The following domains must be included in the standardized development screening tool: • Motor • Language • Cognitive • Social-emotional	Developmental Screening in the first three (3) years of life **CPT:** 96110 **Examples of Screening Tools** Ages and Stages Questionnaire 3rd Edition (ASQ-3) — 1 – 5 1/2 years of age Parents’ Evaluation of Developmental Status (PEDS) — Birth to 8 years of age Parents Evaluation of Developmental Status – Developmental Milestones (PEDS-DM) — Birth to 8 years of age Survey of wellbeing in young children — Birth to 8 years of age **Note:** The following tools do not meet criteria: • Child’s social-emotional development (ASQ-SE) • Autism Screening (M-CHAT)

	HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
CHILDREN & ADOLESCENTS	**Topical Fluoride for Children (TFC)**	1-20 years as of 12/31/2024	Medi-Cal	The percentage of children 1-20 years old who receive at least two (2) fluoride varnish applications on different dates of service during 2024.	**Description** / **Codes** Topical Fluoride Administered by **Primary Care Physician** — **CPT:** 99188 Topical Fluoride Administered by **Dental Provider** — **CDT:** D1206, D1208
DIABETES CARE	**Hemoglobin A1c (HbA1c) or Glucose Management Indicator (GMI) (GSD)**	18-75 years as of 12/31/2024 (Type I or Type II Diabetics)	Commercial, Medi-Cal, Medicare	Documentation of a hemoglobin A1c (HbA1c) blood test in 2024 with date and result. **Includes:** **1.** Control <8% - higher rate is better **2.** Poor Control >9% - lower rate is better **Notes** • Most recent A1c result completed during the measurement year determines if the member is compliant or non-compliant. • If no A1c is completed during the measurement year, the member will be non-compliant.	**HbA1c Tests CPT:** 83036, 83037 **A1c Results CPT II:** 3044F - HbA1c Level <7.0% 3051F – HbA1c Level = 7.0% - 7.9% 3052F – HbA1c Level = 8.0% - 9.0% 3046F – HbA1c Level >9.0% (non-compliant) **Exclusions for all diabetic components:** Members in hospice, gestational diabetes, steroid induced diabetes, members age 66+ in institutional SNP or long-term institution or with frailty and advanced illness or dementia.
	Kidney Health Evaluation for Patients with Diabetes (KED)	18-85 years as of 12/31/2024	Commercial, Medi-Cal, Medicare	Members with diabetes (type 1 and type 2) who received both of the following: • At least one **eGFR** (estimated glomerular filtration rate) blood test **and** • At least one **uACR** (urine albumin-creatinine ratio) urine test.	**Lab CPT Codes:** • 82043 – Albumin; urine (e.g., microalbumin), quantitative • 82570 – Creatinine; urine • 82565 – Creatinine; serum **Exclusions:** Evidence of ESRD, member in palliative care, enrolled in an institutional SNP or long-term institution, have frailty and advanced illness.

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Eye Exam for Patients with Diabetes (EED)	18-75 years as of 12/31/2024 (Type I or Type II Diabetics)	Commercial, Medi-Cal, Medicare	Diabetics who had one of the following with an eye care professional (optometrist or ophthalmologist): • A retinal or dilated eye exam by an eye care professional during 2024. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2023. **Best Practices:** • Use CPT II codes in current measurement year to indicate "without retinopathy" for compliance in current and following year. • For retinal photos, the most common code for Eye Care Professionals to use is 92250 (not to be coded by PCP). • Other codes for eye professionals are available on the Retinal Eye Coding Guide.	**Diabetic Retinal Screening CPT:** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 99202, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 (Limited to eye care professionals) **Diabetic Retinal Screening done by Eye Care Professional and coded by any Provider type CPT II:** **2022F –** Face to face dilated exam with interpretation documented & reviewed, **with evidence** of retinopathy. **2023F –** Face to face dilated exam; without evidence of retinopathy. **2024F –** 7 standard photos with interpretation documented & reviewed: with evidence of retinopathy. 2025F – 7 standard photos; without evidence of retinopathy. **2025F –** 7 standard photos; without evidence of retinopathy. **2026F –** Retinal telemedicine (e.g., EyePACS) eye imaging validated to match diagnosis from 7 standard field stereoscopic photos: with evidence of retinopathy. **2033F –** Retinal telemedicine (e.g., EyePACS) eye imaging validated to match diagnosis from 7 standard field stereoscopic photos: without evidence of retinopathy.

	HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
DIABETES CARE	**Blood Pressure Control for Patients with Diabetes (BPD)**	18-75 years as of 12/31/2024 (Type I or Type II Diabetics)	Commercial, Medi-Cal, Medicare	Members with diagnosis of diabetes whose blood pressure was <140/90 by the end of 2024. **Best Practices:** • Most recent BP value counts. • Use CPT II outcome codes to avoid medical record requests. • Retake BP at end of appointment if initial reading is high– lowest values count. • Electronically submitted BP readings from patient monitoring devices are acceptable. **Telehealth:** • BP readings from patient digital BP monitoring device during telehealth visits are acceptable. • For Medicare, video should be used but still document reading if audio only.	**CPT II Codes:** • 3074F – Systolic < 129 mm Hg • 3075F – Systolic = 130-139 mm Hg • 3077F – Systolic > 140 mm Hg (non-compliant) • 3078F – Diastolic < 79 mm Hg • 3079F – Diastolic = 80-89 mm Hg • 3080F – Systolic > 90 mm Hg (non-compliant)
SENIORS	**Advance Care Planning (ACP)**	66-80 years with advanced illness, an indication of frailty, or who are receiving palliative care, and those 81 years and older as of 12/31/2024	Medicare	Documentation for an Advance Care Plan must include the date that a discussion occurred, that an Advance Care Plan was executed, or a note that a plan is in the medical record.	**Document Present CPT II:** 1157F **Discussion Documented CPT II:** 1158F

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Care for Older Adults (COA)	66 years and older as of 12/31/2024	Medicare SNP (Special Needs Plan) and MMP (Medicare-Medicaid Plan)	Members who had each of the following during 2024. • Medication review **and** reconciliation • Functional status assessment • Pain Assessment **Best Practice:** • Code for all **3 components** above as there is a separate rate for each. • Documentation for Medication Review must include medication list and date it was reviewed or note of no medications. • Complete Annual Wellness Exam (AWE) for all eligible patients and code for COA. • Functional Status documentation must specify • "ADLs were assessed" or "IADLs were assessed" or reference the standardized tool used or display the questions with the answers. • Documentation for Advance Care Plan must include note of discussion and date, or note that advance care plan was executed or note that plan is in the medical record. **Telehealth:** • The COA measure can be completed during any medically necessary visit including telephone visits. • The functional status and pain assessments can be conducted by phone by any care provider type, including registered nurses and medical assistants. • Medication review can be done by a prescribing clinician or clinical pharmacist, or a nurse practitioner signed by the clinician or pharmacist to document the list was reviewed (code CPT II codes). • Take advantage of every phone call or visit to complete this measure. • More details are available on the **Coding and Documentation Guide.**	**Part 1** **Medication Review:** CPT II: 1160F **&** **Medication List:** CPT II: 1159F Both codes must be used. **Part II** **Functional Status Assessment:** CPT II: 1170F **Part III** **Pain Assessment:** CPT II: 1125F (Pain Present) CPT II: 1126F (No Pain Present)
Osteoporosis Screening and Management after Fracture (OMW)	Women 67-85 years as of 12/31/2024	Medicare	Women with a fracture date between 07/01/2023 – 06/3/2024 and who had either a bone mineral density (BMD) test or dispensed prescription for a drug to treat osteoporosis **in the 6 months (180 days) after the fracture.** • Does not include fractures to the fingers, toe, face, or skull.	**Medications:** Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid. Abaloparatide, Denosumab, Raloxifene, Romosozumab, Teriparatide **Exclusions:** Members age 66+ in institutional SNP or long-term institution or with frailty and advanced illness or dementia or in palliative care (can be through telehealth encounters). Other exclusions apply.

WOMEN ONLY

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Breast Cancer Screening (BCS-E)	Women ages 50-74 by 12/31/2024	Commercial, Medi-Cal, Medicare	Women who had a mammogram to screen for breast cancer between 10/01/2022 and 12/31/2024. **Best Practices:** • MRIs, breast ultrasounds or biopsies DO NOT meet standards for this measure. Breast tomosynthesis does count. • Screen every other year.	**Mammogram CPT:** 77061-77063, 77065-77067 **Exclusions:** Bilateral Mastectomy: Z90.13. **Best Practice:** • Code exclusions every year during any outpatient encounter submission, especially if the member changed health plans.
Cervical Cancer Screening (CCS)	Women 21-64 years as of 12/31/2024	Commercial, Medi-Cal	**Members 21-64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using either of the following criteria:** • Members 21-64 years of age who had cervical cytology performed during the measurement year or two years prior (every 3 years). • Members 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed during the measurement year or four years prior (every 5 years) and who were 30 years or older on the date of the test. • Members 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed during the measurement year or four years prior (every 5 years) and who were 30 years or older on the date of the test. **Best Practices for Over Age 30:** • HPV test alone will count for this measure. If testing cytology and HPV, it is important to order • Co-testing (cytology and HPV). • Do not order Reflex testing where HPV is only tested if the cytology result is positive - a HPV test is required for compliance. • Self-reported screening from other provider or other countries that documents date (or month/year) and result in the medical record is acceptable.	**Cervical Cytology CPT:** 88141-88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174, 88175 **HPV Test CPT:** 87624, 87625 **Exclusions:** Documentation of total hysterectomy with absence of cervix, cervical agenesis or acquired absence of cervix. • Document exclusions every year. • Documentation of hysterectomy alone will not count. • Document “TAH,” “total (or complete or radical) hysterectomy” or “no cervix” or “vaginal hysterectomy” or exclusion will not count. **Z90.710** - Acquired absence of cervix and uterus **Z90.712** - Acquired absence of cervix with remaining uterus (rare) **Q51.5** - Agenesis and aplasia of cervix (including transgender male)

WOMEN ONLY

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Chlamydia Screening in Women (CHL)	16-24 years as of 12/31/2024	Commercial, Medi-Cal	Women identified as sexually active who had at least one test for chlamydia during 2024. Members identified as sexually active: **1.** Pregnancy **2.** Sexually Transmitted Infections (STI) Screenings **3.** Contraceptive prescribed **4.** Pregnancy test completed	**Chlamydia Screening CPT:** 87110, 87270, 87320, 87490-87492, 87810, 0353U **Best Practice:** • Implement universal screening for all patients 16 years or older by 12/31/2024. • Chlamydia can be tested by urine or gynecological exam.
Prenatal Care, Timeliness of (PPC-Pre)	Live births between 10/08/2023 - 10/07/2024 Prenatal care visit in the first trimester or within 42 days of enrollment First trimester is defined as 280-176 days prior to delivery (or EDD).	Commercial, Medi-Cal, Medicare	After a pregnancy test is confirmed, the PCP should code the visit as a Prenatal Visit and include the following: • Diagnosis of pregnancy • Last menstrual period (LMP) or estimated date of delivery (EDD) or gestational age • Date of service **Best Practice:** • Documenting the prenatal care visit on the same day of the positive pregnancy test helps meet the timing requirements of this measure. • Ensure that pregnant and recently delivered patients get priority for OB appointments. • Services may be provided by a PCP, OBGYN, other family care practitioner or Midwife. • Physical requirements such as a basic physical or OB exam or pelvic exam or fundus height, OB panel, TORCH panel, blood typing test or ultrasound of pregnant uterus can also be done in person to close this measure. **Telehealth:** • Prenatal visits can be completed by telehealth by documenting the items above.	**Prenatal visit during first trimester** **CPT:** 98966-98968, 98970-98972, 98980, 98981, 99202-99205, 99211-99215, 99241-99245, 99421-99423, 99441-99443, 99457, 99458, 99483 **CPT II:** 0500F **OB Panel:** 80055 **Note:** • CPSP (Comprehensive Perinatal Services Program) codes will be cross walked to appropriate CPT code and all notes need to be co-signed by MD, NP or PA.

	HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
WOMEN ONLY	**Postpartum Care (PPC-Post)**	Live births between 10/08/2023 - 10/07/2024 Postpartum visit between **7 and 84 days** after delivery.	Commercial, Medi-Cal	Documentation of a postpartum visit on or between 7 to 84 days after delivery and must include one of the following acceptable notations: • Postpartum care • PP care • PP check • 6-week check. (Other notations may apply). **Best Practices:** • Schedule both early (2nd week) and late (4-8 weeks) postpartum visits before mother and baby leave the hospital. • Offer home visit for postpartum. • Incision check for post C-section does constitute a postpartum visit. • A pap exam/cervical cancer screening will also count towards compliance. **Telehealth:** • Postpartum visit can be completed by telehealth with notations above.	**Postpartum Visit:** **CPT:** 57170, 58300, 59430, 99501 **CPT II:** 0503F **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 **NOTE:** • CPSP (Comprehensive Perinatal Services Program) codes will be cross walked to appropriate CPT code and all notes need to be co-signed by MD, NP or PA. • Global CPT codes may not reflect when postpartum care was rendered. • Z39.2 is the preferred ICD10 code that can be attached to any E&M code. Other Prenatal/Postpartum measures include: 1. Prenatal Depression Screening and Follow-Up (PND) 2. Postpartum Depression Screening and Follow-Up (PDS) 3. Prenatal Immunization Status (PRS)
PHARMACY MEASURES	**Asthma Medication Ratio (AMR)**	5-64 years as of 12/31/2024	Commercial, Medi-Cal	Members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	**Pharmacy data determines compliance in this measure.** **ICD10CM:** J45.21, J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.991, J45.998 **Exclusions:** Members with any the following conditions during their medical history through the measurement year. • Emphysema • Chronic obstructive pulmonary disease (COPD) • Chronic Respiratory Conditions due to fumes or vapors • Cystic Fibrosis • Acute respiratory failure

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	6 years and older (with a diagnosis on or between January 1 and December 1 2024)	Commercial, Medicare, Medi-Cal	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit with any practitioner for mental illness had a follow-up visit with any practitioner with a principal diagnosis of a mental health disorder. Two rates are reported: **1.** The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). **2.** The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). **Telehealth:** Follow-up visit after ED visit for mental illness can be completed by telehealth.	**Mental Illness Diagnosis Codes ICD-10:** F03, F20-F25, F28-F29, F30-F34, F39-F45, F48, F50-F53, F59, F60, F63-F66, F68, F69, F80-F82, F84, F88-F91, F93-F95, F98-F99, T14, T36-T65, T71 **Best practice:** • Use a diagnosis code for mental illness at each follow-up (a non-mental illness diagnosis code will not fulfill this measure).
Follow-up After Emergency Department Visit for Substance Use (FUA)	13 years and older (with a diagnosis on or between January 1 and December 1 2024)	Commercial, Medicare, Medi-Cal	The percentage of emergency department (ED) visits among members ages 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of a drug overdose, for which there was the follow-up visit or pharmacotherapy dispensing event. Two rates are reported: **1.** The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). **2.** The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). **Telehealth:** Follow-up visit after ED visit for mental illness can be completed by telehealth.	**Substance Use Disorder Diagnosis ICD-10:** F-10-F16, F18, F19, T40-T43, T51 **Best Practice:** • Use a diagnosis code for substance use at each follow-up visit (a non-substance diagnosis code will not fulfill this measure).

HEDIS® MEASURE	AGE	LOB	REQUIREMENT AND DOCUMENTATION	SAMPLE CODES / EXCLUSIONS
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	12 years and older	Commercial, Medicare, Medi-Cal	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days. **1.** Depression Screening. The percentage of members who were screened for clinical depression using an age-appropriate standardized tool. **2.** Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of the first positive depression screen finding. Additional information for coding available on DSF Tip Sheet.	LOINC Code: (PHQ-2): 55758-7 (PHQ-9): 44261-6 (PHQ-9 Teen): 89204-2 **Note:** Supplemental Data MUST be submitted to MedPOINT to receive compliance for this metric. **Best Practice**: • An outpatient, telephone, e-visit, or virtual check-in- a 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 conditions. • A dispensed antidepressant medication.

MedPOINT Information

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PLEASE NOTE

Information above is subject to change.

This list is not a complete list of all HEDIS® measures. The codes listed above are SAMPLE CODES.

Please refer to HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans and NCQA's HEDIS® Value Set Directory for a complete list.

Member Satisfaction Surveys (CAHPS) are part of HEDIS® and some P4P Programs.

MedPOINT MANAGEMENT