HEDIS® MY 2026
Quick Reference Guide

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For a complete list of codes and the most recent HEDIS measurements, standards, and information about changes the NCQA made to the technical specifications, such as changing the terminology from “member” to “person,” please visit the NCQA website at **ncqa.org**, or see the HEDIS value sets. Only subsets of the NCQA-approved codes are listed in this document. This list is not exhaustive. This information is based on technical specification released in August 2025. An addendum document will be available after the final technical specifications are released in spring 2026.

HEDIS® MY 2026
Quick Reference Guide

Updated to reflect NCQA HEDIS MY 2026 Technical Specifications

Oklahoma Complete Health strives to provide quality healthcare to our membership as measured through HEDIS quality metrics. We created the HEDIS MY 2026 Quick Reference Guide to help you increase your practice's HEDIS rates and address care opportunities for your patients. Please always follow the state and/or Centers for Medicare and Medicaid Services (CMS) billing guidance and ensure the HEDIS codes are covered prior to submission. Measurement period 2026 is defined as Jan. 1, 2026 through Dec. 31, 2026.

What is HEDIS®?

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans. NCQA develops HEDIS measures through a committee represented by purchasers, consumers, health plans, healthcare providers, and policy makers.

What are the scores used for?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS rates to evaluate health insurance companies' efforts to improve preventive health outreach for persons.

Physician-specific scores are also used to measure your practice's preventive care efforts. Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increased premium — for example, Pay for Performance or Quality Bonus Funds.

How are rates calculated?

HEDIS rates are collected in various ways: administrative data, hybrid (medical record review data), and electronic clinical data systems (ECDS). *Administrative* data consists of claim or encounter data submitted to the health plan. *Hybrid* data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of person medical records to abstract data for services rendered but not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the need for medical record review. If services are not billed or billed inaccurately, they are not included in the calculation.

(continued)

Transition to ECDS-Only Reporting

Over the last several years, NCQA has added the option to report the ECDS reporting standard for several existing HEDIS measures alongside traditional HEDIS reporting. This allows health plans to assess their ECDS reporting capabilities and represents a step forward in adapting HEDIS to accommodate the expansive information available in electronic clinical datasets used for patient care and quality improvement. Based on these results, NCQA has announced the transition of several measures to ECDS-only. The major reporting change to be aware of is that the traditional hybrid measure (LSC) that transitions to ECDS-only will no longer use the annual chart retrieval process to demonstrate compliance. All compliance from medical records must be processed through prospective supplemental data. The data sources for ECDS are Electronic Health Records, Health Information Exchanges, Case Management Systems, and Administrative Claims. For more information on ECDS and the data allowed for compliance, please visit **ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/**.

ECDS Measures Effective for MY 2026	
Adult Immunization Status (AIS-E)	(MCR*/MCD*/MKT*)**
Blood Pressure Control for Patients With Diabetes (BPD-E)	(MCR/MCD/MKT)
Blood Pressure Control for Patients With Hypertension (BPC-E)	(MCR*/MCD*/MKT)
Breast Cancer Screening (BCS-E)	(MCR*/MCD*/MKT*)**
Cervical Cancer Screening (CCS-E)	(MCD*/MKT)** (Optional scoring MKT)
Childhood Immunization Status (CIS-E)	(MCD*/MKT)**
Colorectal Cancer Screening (COL-E)	(MCR*/MCD*)** (Optional scoring MKT)
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	(MCR*/MCD*/MKT)
Documented Assessment After Mammogram (DBM-E)	(MCR/MCD/MKT)
Follow-Up After Abnormal Mammogram Assessment (FMA-E)	(MCR/MCD/MKT)
Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)	(MCD)
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	(MCD*)**
Immunizations for Adolescents (IMA-E)	(MCD*/MKT*)**
Lead Screening in Children (LSC-E)	(MCD)
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	(MCD*)**
Postpartum Depression Screening and Follow-Up (PDS-E)	(MCD)
Prenatal Depression Screening and Follow-Up (PND-E)	(MCD)
Prenatal Immunization Status (PRS-E)	(MCD*)**
Statin Therapy for Patients With Cardiovascular Disease (SPC-E)	(MCR/MCD)
Statin Therapy for Patients With Diabetes (SPD-E)	(MCD)
Social Need Screening and Intervention (SNS-E)	(MCD/MKT)
Tobacco Use Screening and Cessation Intervention (TSC-E)	(MCR/MCD)
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)	(MCR/MCD)

**Impact to Health Plan Rating/MA Stars/QRS Stars information as of MY 2025. MY 2026 information is pending.*

***Required to be reported for Medicare and Medicaid plans with Accreditation. Information as of MY 2025. MY 2026 information is pending.*

(continued)

How can I improve my HEDIS® scores?

- ✓ Conduct preventive care visits annually and ensure your patients are up to date with their recommended screenings (i.e., mammograms, colonoscopies, etc.).
- ✓ Ensure that all claim/encounter data for each and every service rendered is submitted in an accurate and timely manner.
- ✓ Include Current Procedural Terminology (CPT) II codes to provide additional details and reduce medical record requests.
- ✓ Make sure that chart documentation reflects all services billed.
- ✓ Bill (or report by encounter submission) for all delivered services, regardless of contract status.
- ✓ Respond timely to medical records requests.
- ✓ Submit supplemental data throughout the measurement period.
- ✓ Early engagement with pharmacy adherence is key — once a person loses days on a prescription, those days cannot be recovered.
- ✓ Speak with the persons about any barriers to adherence.
- ✓ Consider utilizing RxEffect — a free online portal for our network providers that will prioritize your high-risk patients more efficiently. This will save on resources, as it lists your patients at highest risk for non-adherence.
- ✓ If you have any questions regarding pharmacy and person barriers, please reach out to your local Provider Relations Representative for assistance.
- ✓ Speak with your patients about the availability of a transportation benefit (if applicable) to assist with access to care.
- ✓ Ensure that patients are aware of the option for mail-order prescription refills.
- ✓ Remember that you are now able to prescribe 100 days' supply of medications for both retail and mail-order.

Updates to HEDIS® Measures

This guide has been updated with information from the release of the HEDIS 2026 Volume 2 Technical Specifications by NCQA and is subject to change.

New Measures MY 2026:

- Blood Pressure Control for Patients With Diabetes (BPD-E)
- Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)
- Tobacco Use Screening and Cessation Intervention (TSC-E)

(continued)

Retired Measures MY 2026:

- Asthma Medication Ratio (AMR)
- Lead Screening in Children (LSC)*
- Statin Therapy for Patients With Cardiovascular Disease (SPC)*
- Statin Therapy for Patients With Diabetes (SPD)*
- Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

**Only the LSC-E, SPD-E and SPC-E will be reported.*

Transitioned Measures MY 2026:

- Lead Screening in Children (LSC-E)
- Statin Therapy for Patients With Cardiovascular Disease (SPC-E)
- Statin Therapy for Patients With Diabetes (SPD-E)

Availity

Clinical Quality Validation (CQV) is a time-saving application within Availity® Essentials that allows providers to quickly address and submit documentation for open Quality Care gaps, and is a source of submission for Pay for Performance (P4P)/Partnership 4 Quality (P4Q) programs. With an integrated workflow, pre-populated forms, document upload, and status tracking, CQV is entirely digital from start to finish. Providers can electronically document their patient's care and assessments to close HEDIS quality care gaps for health plan persons using CQV.

- ✓ The provider's office must be registered with Availity (**availity.com**) to receive and respond to quality care gaps electronically.
- ✓ Availity administrators must ensure that the roles to access CQV are assigned to the proper users. **Tip:** Locate the administrator for the organization in the Essentials menu bar. Click *[Your Name's] Account | My Account | Organization(s) | Open My Administrators*.
- ✓ Trainings and step-by-step documentation on how to navigate Availity's CQV portal can be found within Availity Essentials under the Help & Training tab.

The Availity CQV portal can be used in place of mailing and faxing medical records, relieving the administrative burden on the provider's office.

CONTENTS

ADULT HEALTH

CONTENTS

PHARMACY MEASURES

WOMEN'S HEALTH

CONTENTS

PEDIATRIC HEALTH

GENERAL HEALTH

SOCIAL DETERMINANTS OF HEALTH

CONTENTS

BEHAVIORAL HEALTH

ADULT HEALTH

Call To Action: Please refer to the provider portal to find a complete list of person care gaps as applicable for the measures in this document.

(AAP) Adults' Access to Preventive/Ambulatory Health Services

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of persons 20 years of age and older who had an ambulatory or preventive care visit during the measurement period. Commercial persons who had an ambulatory or preventive care visit during the measurement period or the two years prior to the measurement. Services that count include outpatient evaluation and management (E&M) visits, consultations, assisted living/home care oversight, preventive medicine, and counseling.

Tips

- Synchronous telehealth visits, asynchronous telehealth visits (e-visits and virtual check-ins), or telephone visits are acceptable.
- Help or schedule person's appointments for preventive care visits.
- Document the date and the type of visit.
- Submit the applicable codes.

CPT*	HCPCS*	ICD-10*
98966–98972, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 92002, 92004, 92012, 92014, 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 99421–99423, 99441–99444, 99457, 99458, 99483	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2063, G2251, G2252, S0620, S0621, S2250, T1015	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

**Codes subject to change.*

(ACP) Advance Care Planning

Line of Business: Medicare

Measure evaluates the percentage of adults:

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

Tips

- Encourage persons to consider an Advance Directive, Medical Power of Attorney, Health Care Power of Attorney, or Physician Orders for Life Sustaining Treatment (POLST).
- Help persons in scheduling an Annual Preventive Visit.
- Telephone visits, e-visits, or virtual check-ins are acceptable.
- Submit the applicable codes.

CPT*	CPT II*	HCPCS*	ICD-10*
99483, 99497	1123F, 1124F, 1157F, 1158F	S0257	Z66

**Codes subject to change.*

(AIS-E) Adult Immunization Status

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, pneumococcal, hepatitis B, and coronavirus disease 2019 (COVID-19).

Tips

- Schedule appointments within immunization timeframes.
- Discuss the importance of vaccinations during person appointments.
- Include immunization history from all sources in the person's medical record.
- Use electronic medical record (EMR) system to set reminders flags.

Description	Codes*
Adult Hepatitis B Vaccine Procedure	**CPT:** 90697, 90723, 90739, 90740, 90743, 90744, 90746–90759
Adult Influenza Vaccine Procedure	**CPT:** 90653, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
Adult Pneumoccocal Vaccine Procedure	**CPT:** 90670, 90671, 90677, 90684, 90732 **HCPCS:** G0009
COVID-19 Vaccine Procedure	**CPT:** 91304, 91320, 91322
Td Vaccine Procedure	**CPT:** 90714
Tdap Vaccine Procedure	**CPT:** 90715
Herpes Zoster Vaccine Procedure	**CPT:** 90750

**Codes subject to change.*

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

Lines of Business: Medicaid, Medicare, Marketplace

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

The HTN diagnosis or HTN+ med can occur anytime between Jan. 1 of the prior year and Jun. 30 of the measurement period.

Note: For a person to be included in measure, the person must have had at least two medical visits on two different dates of service with a diagnosis of HTN, ***OR*** *one medical visit with a diagnosis of HTN and a dispensed antihypertension medication.*

Tips

- Collect BP reading via any telehealth visit (does not require a remote monitoring device to be the source).
- Retake BP readings if the reading is = or >140/90 mm Hg.
- Help persons schedule their hypertension follow-up appointments.
- Educate persons on what a controlled BP means.
- Talk with persons about taking their own BP via a digital device.
- If a person uses a digital device and reports the blood pressure reading(s), ensure the reading(s) are captured in the person's EMR.
- Submit applicable codes.

Description	Codes*
Diastolic Blood Pressure	**CPT II:** 3078F, 3079F, 3080F
Diastolic Less Than 90	**CPT II:** 3078F, 3079F
Systolic and Diastolic Result	**CPT:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F
Systolic Blood Pressure	**CPT:** 3074F, 3075F, 3077F
Systolic Less Than 140	**CPT:** 3074F, 3075F
Hypertension/Essential Hypertension	**ICD-10-CM:** I10
Exclusion: Encounter for Palliative Care	**ICD-10-CM:** Z51.5

**Codes subject to change.*

(BPD) Blood Pressure Control for Patients With Diabetes

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 18 to 75 years of age with diabetes (type 1 or 2) whose BP was adequately controlled (<140/90 mm Hg) during the measurement period.

Persons are identified by at least two diabetes diagnoses during measurement period or PY, or at least one diabetes diagnosis and at least one diabetes medication dispensing event.

Tips

- For self-reported BP readings, the person is required to utilize a digital device to record their BP measurement. Manual BP readings are not acceptable.
- Check BP on both arms and record the lowest systolic and diastolic readings.
- If the initial BP reading is >140 systolic or >90 diastolic on first measurement, retake BP readings after patient rests quietly for five minutes. Remember to record both the initial and second BP readings.
- Never round up BP readings.
- Use correct cuff size on bare arm.
- The most recent BP reading during the measurement period is used.
- Persons should rest quietly for at least five minutes before the first BP is taken.
- The last BP reading taken during the measurement period is used.
- Submit applicable codes.

Description	Codes*
Palliative Care	**HCPCS:** G9054
Systolic Greater Than/Equal to 140	**CPT II:** 3077F
Systolic 130–139	**CPT II:** 3075F
Systolic Less Than 130	**CPT II:** 3074F
Diastolic 80–89	**CPT II:** 3079F
Diastolic Greater Than/Equal to 90	**CPT II:** 3080F
Diastolic Less Than 80	**CPT II:** 3078F

**Codes subject to change.*

(BPD-E) Blood Pressure Control for Patients With Diabetes

This is a first-year measure.

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 18 to 75 years of age with diabetes (type 1 or 2) whose most recent BP was <140/90 mm Hg during the measurement period.

Persons are identified by a diabetes diagnosis.

Either of the following meets criteria:

- ✓ **Claim/encounter data.** At least two diagnoses of diabetes (Diabetes Value Set — Do not include laboratory claims [claims with POS code 81]) on different dates of service during the measurement period or the year prior to the measurement period.
- ✓ **Pharmacy data.** At least one diagnosis of diabetes (Diabetes Value Set — Do not include laboratory claims [claims with POS code 81]) and at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medications List) during the measurement period or the year prior to the measurement period.

Tips

- For self-reported BP readings, the person is required to utilize a digital device to record their BP measurement. Manual BP readings are not acceptable.
- Check BP on both arms and record the lowest systolic and diastolic readings.
- If the initial BP reading is >140 systolic or >90 diastolic on first measurement, retake BP readings after patient rests quietly for five minutes. Remember to record both the initial and second BP readings.
- Never round up BP readings.
- Use correct cuff size on bare arm.
- The most recent BP reading during the measurement period is used.
- Persons should rest quietly for at least five minutes before the first BP is taken.
- The last BP reading taken during the measurement period is used.
- If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

If the most recent BP was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set), use the following to determine compliance:

Description	Codes*
Systolic 130–139	**CPT II:** 3075F
Diastolic 80-89	**CPT II:** 3079F
Diastolic Less Than 80	**CPT II:** 3078F

**Codes subject to change.*

(CBP) Controlling High Blood Pressure

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement period.

Persons are identified by at least two visits with different dates of service with a diagnosis of hypertension on or between 1/1/PY–6/30/MY.

Tips

- For self-reported BP readings, the person is required to utilize a digital device to record their BP measurement. Manual BP readings are not acceptable.
- Check BP on both arms and record the lowest systolic and diastolic readings.
- If the initial BP reading is >140 systolic or >90 diastolic on first measurement, retake BP readings after patient rests quietly for five minutes. Remember to record both the initial and second BP readings.
- Never round up BP readings.
- Use correct cuff size on bare arm.
- The most recent BP reading during the measurement period is used.
- Persons should rest quietly for at least five minutes before the first BP is taken.
- The last BP reading taken during the measurement period is used.
- Submit applicable codes.

Note: When submitting CPT II codes, report both systolic and diastolic to complete blood pressure reading.

Description	Codes*
Systolic Greater Than/Equal to 140	**CPT II:** 3077F
Systolic Less than 140	**CPT II:** 3074F, 3075F
Diastolic Greater Than/Equal to 90	**CPT II:** 3080F
Diastolic 80–89	**CPT II:** 3079F
Diastolic Less Than 80	**CPT II:** 3078F

**Codes subject to change.*

(COA) Care for Older Adults

Line of Business: Medicare

Measure evaluates the percentage of adults 66 years of age and older who had each of the following during the measurement period:

✓ Medication review ✓ Functional status assessment

Tips

- A Functional Status Assessment does not require a specific setting. Services rendered during a telephone visit, e-visit, or virtual check-in meet criteria.
- Evidence of five Activities of Daily Living (ADLs) or four Instrumental Activities of Daily Living (iADLs) required for Functional Status Assessment.
- A complete medication list must be present if submitting a medical record for review (hybrid collection).
- Medication reviews must be completed, signed, and dated by the prescribing practitioner or clinical pharmacist. Reviews completed by registered nurses (RNs), licensed practical nurses (LPNs), etc., are not acceptable for this measure.
- Medication review may be performed without the person present.
- If the person is not taking any medications, there must be a signed and dated notation of this by the prescribing practitioner or clinical pharmacist.
- Complete the COA assessment form annually during an annual wellness exam.
- Submit applicable codes.

Description	Codes*
Medication Review (Requires both CPT II codes of 1159F [Medication List] and 1160F [Medication Review] to be billed simultaneously to get credit.)	**CPT:** 90863, 99483, 99605, 99606 **CPT II:** Both 1159F and 1160F **HCPCS:** G8427
Functional Status Assessment	**CPT:** 99483 **CPT II:** 1170F **HCPCS:** G0438, G0439

**Codes subject to change.*

(COL-E) Colorectal Cancer Screening

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 45 to 75 years of age who had an appropriate screening for colorectal cancer during the measurement period.

Tips

- Educate persons on proper sample collection when distributing fecal immunochemical test (FIT) or fecal occult blood test (FOBT) testing kits.
- Complete and document all screenings for patients.
- Educate persons on the importance of colorectal cancer screenings for early detection and the options available to complete their screening.
- Talk with persons about using the home screenings for their colorectal cancer screening.
- Help persons schedule their colonoscopy screening appointments.
- Submit applicable codes.

Description	Codes*
Colonoscopy (within past 10 years)	**CPT:** 44388–44392, 44394, 44401–44408, 45378–45382, 45384–45386, 45388–45393, 45398 **HCPCS:** G0105, G0121
CT Colonography (within past five years)	**CPT:** 74261–74263
sDNA FIT Lab Test (within past three years)	**CPT:** 0464U, 81528
Flexible Sigmoidoscopy (within past five years)	**CPT:** 45330–45335, 45337–45338, 45340–45342, 45346–45347, 45349, 45350 **HCPCS:** G0104
FOBT Lab Test (within measurement period)	**CPT:** 82270, 82274 **HCPCS:** G0328
Colorectal Cancer	**ICD-10:** C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Palliative Care	**HCPCS:** G9054
Total Colectomy	**CPT:** 44150–44153, 44155–44158, 44210–44212

**Codes subject to change.*

(EED) Eye Exam for Patients With Diabetes

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 18 to 75 years of age with diabetes (type 1 or 2) who had a retinal eye exam during the measurement period.

Persons are identified by at least two diabetes diagnoses during measurement period or PY, or at least one diabetes diagnosis and at least one diabetes medication dispensing event.

Include the diagnosis of uncomplicated diabetes diagnosis on all claims as applicable.

Tips

- Refer all diabetic persons to an acceptable eye care professional (optometrist or ophthalmologist) annually for a dilated or retinal diabetic eye exam.
- Educate persons on the eye damage that could be caused by their diabetes.
- Help persons to schedule their annual diabetic eye exam appointments.
- Evidence of a result (whether retinopathy is found or not) must be present.
- Submit applicable codes.

Description	Codes*
Retinal Eye Exam (Billed by an Eye Care Professional)	**CPT:** 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201–92205, 92230, 92235, 92250, 99213–99215, 99242–99245 **HCPCS:** S0620, S0621, S3000
Retinal Imaging	**CPT:** 92227, 92228
Autonomous Eye Exam	**CPT:** 92229 **LOINC:** 105914-6 with a result
Interactive Outpatient Encounter	**CPT:** 98970–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012
Unilateral Eye Enucleation With a Bilateral Modifier	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **CPT Modifier:** 50
Eye Exam With Retinopathy	**CPT II:** 2022F, 2024F, 2026F
Eye Exam Without Retinopathy	**CPT II:** 2023F, 2026F, 2033F
Diabetic Retinal Screening Negative in Prior Year	**CPT II:** 3072F

**Codes subject to change.*

(FMC) Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions

Line of Business: Medicare

Measure evaluates the percentage of Emergency Department (ED) visits for persons 18 years of age and older who have multiple high-risk chronic conditions and had a follow-up service within seven days of the ED visit during the measurement period.

Tips

- Establish admission/discharge/transfer (ADT) feeds with local health systems to ensure timely notification of ED visits.
- Each ED visit requires a separate seven-day follow-up. If a patient has more than one ED visit in an eight-day period, only the first eligible visit is included.
- Maintain reserved appointments so patients with an ED visit can be seen within seven days of their discharge.
- An in-person office visit is not required. The follow-up visit may be provided via telehealth, telephone, e-visit, or virtual check-in.
- Submit applicable codes.

Eligible chronic condition diagnoses:

- Chronic obstructive pulmonary disease (COPD), asthma, or unspecified bronchitis
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

Description	Codes*
Complex Care Management Services	**CPT:** 99439, 99487, 99489–99491 **HCPCS:** G0506
Outpatient and Telehealth	**CPT:** 98966–98968, 98970–98972, 98980, 98981, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99429, 99441–99443, 99455–99458, 99483 **HCPCS:** G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250–G2252, T1015
Case Management Encounter	**CPT:** 99366 **HCPCS:** T1016, T1017, T2022, T2023
Substance Use Disorder Services	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012

(continued)

(FMC) Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions *(continued)*

Line of Business: Medicare

Description	Codes*
Outpatient or Telehealth Behavioral Health (BH) Outpatient	**CPT:** 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176–G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036–H0037, H0039–H0040, H2000, H2010–H2011, H2013–H2020, T1015
Substance Abuse Counseling and Surveillance**	**ICD-10:** Z71.41, Z71.51 **Do not include lab claims with place of service (POS) code 81.
Transitional Care Management Services	**CPT:** 99495, 99496
Partial Hospitalization or Intensive Outpatient	**HCPCS:** G0410, G0411, G0035, G2001, G2012, S0201, S9480, S9484, S9485
Visit Setting Unspecified	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255
An Outpatient or Telehealth Behavioral Health Visit	**Visit Setting Unspecified with Outpatient POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72
An Intensive Outpatient Encounter or Partial Hospitalization	**Visit Setting Unspecified with POS:** 52
A Community Mental Health Center Visit	**Visit Setting Unspecified with POS:** 53
A Telehealth Visit	**Visit Setting Unspecified with Telehealth POS:** 02, 10
Electroconvulsive Therapy	**CPT:** 90870 **ICD-10:** GZB0ZZZ-GZB4ZZZ **With Outpatient POS:** 24, 52, 53

**Codes subject to change.*

(GSD) Glycemic Status Assessment for Patients With Diabetes

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 18 to 75 years of age with diabetes (type 1 or 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period:

- ✓ Glycemic Status <8.0%
- ✓ Glycemic Status >9.0%

Persons are identified by at least two diabetes diagnoses during measurement period or PY or at least one diabetes diagnosis and at least one diabetes medication dispensing event.

Tips

- If the glycemic status is >9.0%, re-test after implementing appropriate treatment.
- POC testing is acceptable with appropriate coding and documentation with date of service and value.
- Person-reported A1c/glucose results are acceptable if documented in chart with test date and value.
- Conduct a diabetic visit with diabetic patients at least once per year.
- Document all A1c lab values with dates for diabetic persons.
- Provide education to persons regarding the need to monitor and manage their blood sugars (HgA1c).
- Assist persons if needed to schedule lab visits for regular A1c testing to include transportation assistance.
- Submit applicable codes.

Note: A person who was previously compliant can become non-compliant with a more recent result.

Description	Codes*
HbA1c Lab Test	**CPT:** 83036, 83037
HbA1c Level Less Than 7	**CPT II:** 3044F
HbA1c Level Greater Than/Equal to 7 and Less than 8	**CPT II:** 3051F
HbA1c Level Greater Than/Equal to 8 and Less Than/Equal to 9	**CPT II:** 3052F
HbA1c Greater Than 9.0	**CPT II:** 3046F

**Codes subject to change.*

*Note: Do **not** include a modifier when using CPT II codes.*

(KED) Kidney Health Evaluation for Patients With Diabetes

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 18 to 85 years of age with diabetes (type 1 or 2) who received a kidney health evaluation, defined by **BOTH** an estimated glomerular filtration rate (eGFR) **AND** a urine albumin-creatinine ratio (uACR), on the same or different dates of service during the measurement period.

Persons are identified by at least two diabetes diagnoses during measurement period or PY or at least one diabetes diagnosis and at least one diabetes medication dispensing event.

Tips

- Conduct a diabetic visit with diabetic patients at least once per year.
- Educate persons on why good kidney function is important as they work to manage their health and diabetes.
- Help persons schedule their diabetes follow-up appointments and remind them of the care gaps that should be covered to include kidney function.
- Submit applicable codes.

Note the following gap closure criteria:

Persons who received **BOTH** an eGFR and a uACR during the measurement period on the same or different dates of service:

✓ **uACR** — a urine lab that may appear alone on lab report.

OR

✓ **Urine creatinine and quantitative urine albumin.** These two may appear on the lab report in addition to or without a uACR result.

To close the care gap with the urine creatinine and quantitative urine albumin, test **cannot** be completed more than four days apart.

Note: As a best practice, perform both urine tests on the same day.

Description	Codes*
eGFR**	**CPT:** 80047, 80048, 80050, 80053, 80069, 82565
AND	
Option 1: Quantitative Urine Albumin and Urine Creatinine**	**CPT:** 82043 and 82570
OR	
Option 2: Urine Albumin Creatinine Ration (uACR)**	**LOINC:** 13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

**Codes subject to change.*

***Must perform both options 1 and 2 if eGFR is not done.*

(PCE) Pharmacotherapy Management of COPD Exacerbation

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of COPD exacerbations for persons 40 years of age and older who had an acute inpatient discharge or ED visit on or between Jan. 1 to Nov. 30 of the measurement period and were dispensed appropriate medications.

Two rates are reported:

1. Dispensed a systemic **corticosteroid** (or there was evidence of an active prescription) **within 14 days of the event**.
2. Dispensed a **bronchodilator** (or there was evidence of an active prescription) **within 30 days of the event**.

A prescription is considered active if the "days' supply" indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant date.

- ✓ For acute inpatient stay, the relevant date is the date of admission.
- ✓ For an ED visit, the relevant date is the date of service.

The measure is based on episodes of acute inpatient discharges and ED visits. It is possible for there to be multiple events for the same person.

Tips

- Support early recognition of COPD exacerbations, emphasizing the importance of seeking care timely to prevent complications and slow disease progression.
- Reinforce the importance of adhering to prescribed medications, especially systemic corticosteroids and bronchodilators. Encourage use of pillboxes, reminder applications, and/or enrolling in automatic refill programs to support adherence.
- Prioritize early detection and management of COPD exacerbations with corticosteroids and bronchodilators to reduce the risk of acute episodes and support long-term disease control.
- Facilitate timely follow-up appointments to ensure medication access. Confirm prescriptions are filled, and address barriers such as cost or transportation.
- Reconcile medications carefully with discharge summaries to avoid errors and ensure continuity of care.
- Ensure vaccinations are up to date, including influenza, pneumonia, COVID-19, Respiratory Syncytial Virus (RSV), and others, as appropriate.

Systemic Corticosteroid Medications			
Description	**Prescription**		
Glucocorticoids	• cortisone • methylprednisolone	• dexamethasone • prednisolone	• hydrocortisone • prednisone

(continued)

(PCE) Pharmacotherapy Management of COPD Exacerbation *(continued)*

Lines of Business: Medicaid, Medicare, Marketplace

Bronchodilator Medications			
Description	**Prescription**		
Anticholinergic Agents	• aclidinium-bromide • ipratropium	• umeclidinium • tiotropium	
Beta 2-Agonists	• albuterol • metaproterenol • indacaterol	• levalbuterol • formoterol • oledaterol	• arformoterol • salmeterol
Bronchodilator Combinations	• albuterol-ipratropium • budesonide-formoterol • formoterol-mometasone • glycopyrrolate-indacaterol • Umeclidinium-vilanterol • Olodaterol-tiotropium	• formoterol-aclidinium • formoterol-glycopyrrolate • fluticasone-salmeterol • fluticasone-vilanterol • fluticasone furoate-umeclidinium-vilarterol	

(PCR) Plan All-Cause Readmissions

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates for persons 18 years of age and older, the number of acute inpatient and observation stays during the measurement period that were followed by an unplanned acute readmission for any diagnosis within 30 days, and the predicted probability of an acute readmission.

Note: Marketplace and Medicaid: Patients 18 to 64 years of age. Medicare: Patients 18 years of age and older.

Tips

- Maintain reserved appointment availability for patients to follow up within seven days after discharge to help avoid readmissions.
- Educate patients on the importance of following discharge instructions, receiving adequate follow-up care, medication adherence, and improving health literacy.
- Address Social Determinants of Health (SDoH) to ensure patients can afford their medications, have sustainable housing, their nutrition and transportation needs are met, etc.
- Submit applicable codes.

Description	Codes*
Inpatient Stay	**UBREV:** 0100, 0101, 0110–0114, 0116–0124, 0126–0134, 0136–0144, 0146–0154, 0156–0160, 0164, 0167, 0169–0174, 0179, 0190–0194, 0199–0204, 0206–0214, 0219, 1000–1002
Observation Stay	**UBREV:** 0760, 0762, 0769

**Codes subject to change.*

(SPC-E) Statin Therapy for Patients With Cardiovascular Disease

Lines of Business: Medicaid, Medicare

The Statin Therapy for Patients With Cardiovascular Disease measure has transitioned to exclusive use of the Electronic Clinical Data Systems.

Measure evaluates the percentage of persons 21 to 75 years of age during the measurement period who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the criteria listed below.

The following rates are reported:

1. **Received Statin Therapy.** Persons who were dispensed at least one high-intensity or moderate-intensity statin medication during the asurement period.

2. **Statin Adherence 80%.** Persons who remained on a high-intensity or moderate intensity statin medication for at least 80% of the treatment period.

Note: Document patient muscular reactions to statins.

Tips

- Encourage patients to enroll in an auto-refill program at their pharmacy.
- Avoid giving samples. Any samples given will negatively impact adherence measurements and/or impact the "received statin therapy" rate.
- Offer tips to patients such as:
  - Take the medication at the same time each day.
  - Use a pill box.
  - Discuss potential side effects; encourage the person to contact the provider and not to stop using the medication.
- Review medication list during each visit with the patient.
- Discuss the importance of medication adherence with the patient.
- Retry with a different statin medication if person could not tolerate statin in the past.
- When appropriate, recommend providers prescribe extended days' supply.

	High-Intensity Statin Medications	
Description	**Prescription**	**Medication Lists**
High-intensity Statin Therapy	Atorvastatin 40–80 mg	Atorvastatin High Intensity Medications List
High-intensity Statin Therapy	Amlodipine-atorvastatin 40–80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity Statin Therapy	Rosuvastatin 20–40 mg	Rosuvastatin High Intensity Medications List
High-intensity Statin Therapy	Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity Statin Therapy	Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List

(continued)

(SPC-E) Statin Therapy for Patients With Cardiovascular Disease *(continued)*

Lines of Business: Medicaid, Medicare

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

(TRC) Transitions of Care

Line of Business: Medicare

Measure evaluates the percentage of discharges for persons 18 years of age and older who had **each** of the four reported rates listed below during the measurement period.

Four rates are reported:

1. **Notification of Inpatient Admission.**
   Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).

2. **Receipt of Discharge Information.**
   Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days).

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.

4. **Medication Reconciliation Post-Discharge.**
   Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Tips

- A medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse.
- A medication reconciliation performed without the person present meets criteria.
- Ensure follow-up appointments are scheduled within 30 days after discharge.
- Ensure the admission notification is documented in the patient's medical record and accessible to the primary care provider (PCP).
- A comprehensive medication list must be included.
- Document medication reconciliation including a reference to the patient's hospitalization, admission or inpatient stay.
- Services may be performed during a telephone visit, e-visit, or virtual check-in.
- Submit applicable codes.

(continued)

(TRC) Transitions of Care *(continued)*

Line of Business: Medicare

Best Documentation Practices

✓ Document evidence of receipt of **notification of inpatient admission** in the outpatient medical record.

Any of the examples meet criteria:

- Communication between inpatient providers or staff and the patient's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission between ED and the patient's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission to the patient's PCP or ongoing care provider through a health information exchange; an automated ADT alert system.
- Communication about admission with the patient's PCP or ongoing care provider through a shared EMR system. Evidence that the information was integrated into the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through two days after the discharge (three total days) meets criteria.
- Communication about admission to the patient's PCP or ongoing care provider from the patient's health plan.
- Indication that the patient's PCP or ongoing care provider admitted the patient to the hospital.
- Indication that a specialist admitted the patient to the hospital and notified the patient's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the patient's inpatient stay.
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission.

Note: When an ED visit results in an inpatient admission, notification that a provider sent the patient to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.

✓ Document evidence of **receipt of notification of discharge information** in the outpatient medical record. At a minimum, the discharge information must include **all** of the following:

- The practitioner responsible for the person's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, documentation of pending tests, or no tests pending. Instructions for post-discharge patient care.

Note: If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through two days after the discharge (three total days).

✓ Document evidence of **patient engagement after inpatient discharge** (e.g., office visits, home visits, telehealth that does not include the date of discharge).

Any of the following meet criteria:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the patient and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the patient and provider).

Note: If the patient is unable to communicate with the provider, interaction between the patient's caregiver and the provider meets criteria.

(continued)

(TRC) Transitions of Care *(continued)*

Line of Business: Medicare

Best Documentation Practices

✓ Document evidence of **post-discharge medication reconciliation** and the date it was performed in the outpatient medical record. Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. This reconciliation must be stored in the patient's medical record.

Any of the following meet criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the patient's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow up with evidence of medication reconciliation or review. Evidence that the patient was seen for post-discharge hospital follow up requires documentation that indicates the provider was aware of the patient's hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Note: A medication reconciliation performed without the person present meets criteria.

Description	Codes*
Medication Reconciliation Intervention	**CPT II:** 1111F
Medication Reconciliation	**CPT:** 99483, 99495–99496
Outpatient and Telehealth	**CPT:** 98966–98968, 98970–98972, 98980–98981, 99202–99205, 99211–99215, 99242–99245, 99341–99342, 99344–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411–99412, 99421–99423, 99429, 99441–99443, 99455–99458, 99483 **HCPCS:** G0071, G0402, G0438–G0439, G0463, G2010, G2012, G2250–G2252, T1015 **UBREV:** 0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Telehealth	**CPT:** 98000–98016
Transitional Care Management Services	**CPT:** 99495, 99496

**Codes subject to change.*

PHARMACY MEASURES

(AMO) Annual Monitoring for Persons on Long-Term Opioid Therapy

Line of Business: Marketplace

Measure evaluates the percentage of persons 18 years of age and older who are prescribed long-term opioid therapy and have not received a drug test at least once during the measurement period.

Measure looks for any paid, non-reversed prescription claims for 90 days' cumulative supply of any combination of opioid analgesics and drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids during the measurement period.

- ✓ A lower rate indicates better performance.
- ✓ Includes opioid medications indicated for pain and combination products.
- ✓ Cumulative days' supply does not have to be consecutive and excludes days' supply extending beyond the measurement period.
- ✓ The prescription claims can be for same or different opioids.
- ✓ Excludes medications prescribed or provided as part of medication-assisted treatment for opioid use disorder and formulations delivered by intravenous (IV) or epidural (EP) routes.
- ✓ Persons meeting any of the following criteria are also **not** included: hospice services, cancer diagnosis, cancer-related pain treatment, and palliative care.

Tips

- Evaluate risks for opioid misuse and abuse, including dependency and/or adverse effects.
- Review opioids and other medications to determine appropriate type, dosage, and overall effectiveness.
- Order urine drug screens (UDS) at least annually to confirm adherence to prescribed medications and to detect any non-prescribed substances that may increase the risk of adverse events.
- Complete routine pain and functional assessments, adjusting opioid analgesic dosages and seeking alternative treatments when clinically indicated.
- Assess for underlying mental health conditions such as anxiety or depression, as these may impact treatment outcomes and indicate a need for additional support.
- Educate on safe opioid use and proper storage to reduce risk of misuse or diversion.

Opioid Analgesics				
• benzhydrocodone	• dihydrocodeine	• levorphanol	• oxycodone	• tapentadol
• buprenorphine	• fentanyl	• meperidine	• oxymorphone	• tramadol
• butorphanol	• hydrocodone	• methadone	• pentazocine	
• codeine	• hydromorphone	• morphine		

(continued)

(AMO) Annual Monitoring for Persons on Long-Term Opioid Therapy *(continued)*

Line of Business: Marketplace

Description	Codes*
Drug Test	**CPT:** 80184, 80305–80307, 80324–80326, 80345–80354, 80356, 80358, 80359, 80361–80365, 80372, 80373, 80375–80377, 82542 **HCPCS:** G0480-G0483, G0659

**Codes subject to change.*

(INR) International Normalized Ratio Monitoring for Individuals on Warfarin

Line of Business: Marketplace

Measure evaluates the percentage of persons 18 years of age and older who had at least one 56-day interval of warfarin therapy and who received at least one INR monitoring test during each 56-day interval with active warfarin therapy.

Time frame for measure: The index prescription start date (IPSD) is the earliest date of service for warfarin during the measurement period. The treatment period begins with the IPSD and ends with the last day of supply for warfarin (date of service plus the day's supply for the last prescription claim for warfarin minus one) during the measurement period.

- ✓ Looks at persons who received at least one INR monitoring test or were hospitalized during each 56-day interval during the treatment period.
- ✓ Excludes those identified with a lab or medical claim for *INR home monitoring* during the measurement period.
- ✓ A higher rate indicates better performance.

*Note: Pharmacy claims for warfarin determine eligibility. Compliance is met by evidence of at least one INR lab test or an inpatient stay of **at least 3 consecutive days** during the measurement period.*

Tips

- Regular monitoring is crucial to ensure INR levels stay within the therapeutic range.
- Adjust medication doses based on INR results to avoid risks of bleeding or clotting.
- Review common signs and symptoms of bleeding, blood clots, and thrombotic events with the person during relevant visits.
- Encourage evening warfarin dosing and morning INR testing to allow for timely same-day dose adjustments when necessary.
- Provide education on dietary and supplement restrictions, emphasizing the importance of avoiding significant changes in vitamin K intake due to its effects on INR levels.

Meds: Warfarin

Description	Codes*
INR Test — prothrombin time	**CPT:** 85610
INR — measurement performed	**CPT:** 3555F

**Codes subject to change.*

(PDC) Proportion of Days Covered

Lines of Business: Medicare, Marketplace

Measure evaluates the percentage of persons 18 years of age and older who met the PDC threshold of 80% during the measurement period.

Tips

- Discuss the importance of medications and their role in managing chronic conditions with the patient.
- Consider generic, free to person, or low-cost medications.
- When appropriate, prescribe an extended day supply.
- Encourage auto-refill enrollment at their pharmacy.
- Consider offering mail order services, especially for patients with transportation barriers.
- Assess for potential side effects regularly and consider other strategies prior to therapy discontinuation (e.g., switching to other agents, every other day dosing with accurate prescription [quantity/days' supply]).
- Review medication list during each visit with the patient.
- Use motivational interviewing to identify true barriers to medication adherence.
- Define your process for following up with persons for medication adherence.
- Offer tips to patients such as taking the medication at the same time each day.
- Recommend medication reminder apps, pillboxes, or alarms.

Three rates are reported:

- ✓ Renin Angiotensin System Antagonists (PDC-RASA).
- ✓ Diabetes All Class (PDC-DR).
- ✓ Statins (PDC-STA).

1 (RASA) Adherence to Hypertensive Medications — Measure Overview

Measure evaluates the percentage of persons 18 years of age and older with a RASA medication with a PDC ≥ 80% during the measurement period.

- Higher rate indicates better performance.
- Two fills needed to index into the measure.
- Targeted early in the year.

Gap Closure Requirements

PDC ≥ 80% per person.

- **PDC calculated utilizing:** total days supplied of RASA pharmacy claims/date of first RASA fill to the end of the reporting interval.
- Each medication claim must be submitted through the health plan insurance. Cash payment, samples, or medications filled at out-of-network pharmacies do not count towards the measure.
- Final plan star score based upon the percentage of persons with a PDC ≥ 80%.

(continued)

Other Criteria

- **Medication Inclusions:** RASA medications — i.e., lisinopril, losartan, enalapril, valsartan.
- **Exclusions:** Persons with a sacubutril/valsartan claim, hospice enrollees, end-stage renal disease (ESRD).

2 (DIAB) Adherence to Diabetes Medications — Measure Overview

Measure evaluates the percentage of persons 18 years of age and older with a diabetes medication with a PDC ≥ 80%.

- Higher rate indicates better performance.
- Two fills needed to index into the measure.
- Targeted early in the year.

Gap Closure Requirements

PDC ≥ 80% per person.

- **PDC calculated utilizing:** total days supplied of diabetes pharmacy claims/date of first diabetes fill to the end of the reporting interval.
- Each medication claim must be submitted through the health plan insurance. Cash payment, samples or medications filled at out-of-network pharmacies do not count towards the measure.
- Final plan star score based upon the percentage of persons with a PDC ≥ 80%.

Other Criteria

- **Medication Inclusions:** Diabetes medications — i.e., metformin, glipizide, glimepiride, Januvia.
- **Exclusions:** Persons with an insulin claim, hospice enrollees, ESRD.

3 (STAT) Adherence to Cholesterol Medications — Measure Overview

Measure evaluates the percentage of persons 18 years of age and older with a cholesterol medication with a PDC ≥ 80%.

- Higher rate indicates better performance.
- Two fills needed to index into the measure.
- Targeted early in the year.

Gap Closure Requirements

PDC ≥ 80% per person.

- **PDC calculated utilizing:** total days supplied of STAT pharmacy claims/date of first STAT fill to the end of the reporting interval.
- Each medication claim must be submitted through the health plan insurance. Cash payment, samples or medications filled at out-of-network pharmacies do not count towards the measure.
- Final plan star score based upon the percentage of persons with a PDC ≥ 80%.

Other Criteria

- **Medication Inclusions:** STAT medications — i.e., atorvastatin, simvastatin, rosuvastatin, pravastatin.
- **Exclusions:** Hospice enrollees, ESRD.

(SPD-E) Statin Therapy for Patients With Diabetes

Line of Business: Medicaid

The Statin Therapy for Patients with Diabetes measure has transitioned to exclusive use of the Electronic Clinical Data Systems.

Measure evaluates the percentage of persons 40 to 75 years of age during the measurement period with diabetes who did not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the criteria listed below.

Two rates are reported:

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

Note: Document patient muscular reactions to statins.

(SUPD) Statin Use in Persons With Diabetes

Line of Business: Medicare

Measure evaluates the percentage of persons 40 to 75 years of age with diabetes who have a single fill of a statin during the measurement period.

- ✓ Higher rate indicates better performance.
- ✓ Only one fill needed to index in the measure.
- ✓ Targeted later in the year vs. other measures (starting in late Jul. or Aug.).

Gap Closure Requirements

Person received a statin therapy:

- The number of persons who had at least one dispensing event for a statin medication during the measurement period.

Other Criteria

- **Medication inclusions:** Statin medications — i.e., atorvastatin, simvastatin, rosuvastatin, pravastatin.
- **Exclusions:** Include documentation for ERSD, rhabdomyolysis, pregnancy, cirrhosis, pre-diabetes, polycystic ovary syndrome.

(continued)

(SUPD) Statin Use in Persons With Diabetes *(continued)*

Line of Business: Medicare

Tips

- Encourage patients to enroll in an auto-refill program at their pharmacy.
- Avoid giving samples. Any samples given will negatively impact adherence measurements and/or impact the "received statin therapy" rate.
- Offer tips to patients such as:
  - Take the medication at the same time each day.
  - Use a pill box.
  - Discuss potential side effects; encourage the person to contact the provider and not to stop using the medication.
- Review medication list during each visit with the patient.
- Discuss the importance of medication adherence with the patient.
- Retry with a different statin medication if person could not tolerate statin in the past.
- When appropriate, recommend providers prescribe extended days' supply.

WOMEN'S HEALTH

(BCS-E) Breast Cancer Screening

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of person 40 to 74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer during the measurement period. One or more mammograms any time on or between Oct. 1 two years prior to the measurement period and the end of the measurement period.

Tips

- Schedule person's mammogram screening annually.
- Document the date and the specific procedure completed when reviewing the patient's history.
- Submit the appropriate ICD-10 diagnosis code for a person's history of bilateral mastectomy annually, Z90.13.
- Submit applicable codes.

Description	Codes*
Mammogram	**CPT:** 77061–77063, 77065–77067 **ICD-10 (bilateral mastectomy):** Z90.13
Palliative Care	**HCPCS:** G9054

**Codes subject to change.*

(CCS-E) Cervical Cancer Screening

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of persons 21 to 64 years of age who were screened for cervical cancer during the measurement period using **any** of the following criteria:

- ✓ Persons 21 to 64 years of age who had cervical cytology performed within last three years.
- ✓ Persons 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.
- ✓ Persons 30 to 64 years of age who had cervical cytology/high risk human papillomavirus (hrHPV) co-testing within the last five years.

Tips

- Document and code if person has had a hysterectomy with no residual cervix or absence of cervix. Document the type of hysterectomy (e.g., full, partial, vaginal, laparoscopic).
- Help persons schedule their routine cervical cancer screening.

(continued)

(CCS-E) Cervical Cancer Screening *(continued)*

Lines of Business: Medicaid, Marketplace

- Document the date and the specific procedure completed when reviewing the patient's history with result, or evidence of result.
- Submit the applicable codes.

Description	Codes*
Cervical Cytology Lab Test (Age 21 to 64)	**CPT:** 88141–88143, 88147, 88148, 88150, 88152, 88153, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143–G0145, G0147, G0148, P3000, P3001, Q0091
hrHPV Test (Age 30 to 64, every five years)	**CPT:** 87624–87626 **HCPCS:** G0476
Palliative Care	**HCPCS:** G9054

**Codes subject to change.*

(CHL) Chlamydia Screening

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of persons 16 to 24 years of age who were recommended for routine chlamydia screening, were identified as sexually active, and had at least one test for chlamydia during the measurement period.

Tips

- Providers should order an annual chlamydia screening for patients who will turn 16 years old by Dec. 31 of the measurement period.
- Perform chlamydia screening every year.
- Inform patient that chlamydia screening can be performed through a urine test. Offer this as an option for patients.
- Incorporate chlamydia screening as a standard laboratory test for patients aged 16 to 24, to be included during routine well-child and well-woman examinations.
- Place chlamydia swab next to Pap test or pregnancy detection materials.
- Advise persons during wellness visits or when they are seen for birth control to get screened for chlamydia.
- Submit applicable codes.

CPT*
87110, 87270, 87320, 87490–87492, 87810

**Codes subject to change.*

(DBM-E) Documented Assessment After Mammogram

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of episodes of mammograms during the measurement period documented in the form of a Breast Imaging Reporting and Data System (BI-RADS) assessment within 14 days of the mammogram for persons 40 to 74 years of age.

A higher rate indicates better performance.

Definitions:

- ✓ **BI-RADS assessment**
  - Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for imaging of mammography, ultrasound, and magnetic resonance imaging (MRI) of the breast.
- ✓ **Episode date**
  - The date of service for an eligible encounter during the intake period with a mammogram procedure.
- ✓ **Intake period**
  - Dec. 18 of the prior measurement period to Dec. 17 of the measurement period. The intake period is used to capture the episode date.

BI-RADS Scoring Categories:

- ✓ **Category 0: Incomplete** — Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison, advises additional imaging.
- ✓ **Category 1: Negative** or **Category 2: Benign**, advises resuming routine screening.
- ✓ **Category 3: Probably Benign**, recommends diagnostic mammograms at 6 months, followed by repeat screenings every 6–12 months for 1–2 years, if appropriate.
- ✓ **Category 4: Suspicious** and **Category 5: Highly Suggestive of Malignancy**, the recommendation is for tissue diagnosis using core needle biopsy (preferred) or needle localization excisional biopsy with specimen radiograph. When a needle biopsy (aspiration or core needle biopsy) is performed, obtaining concordance between the pathology report and the imaging finding is crucial.
- ✓ For **Category 6: Known Biopsy-Proven Malignancy**, the recommendation depends on the primary tumor, size of the invasive component, estimated disease volume, histological grade, and other relevant characteristics.

Tips

- Document the BI-RADS score in the health record on or within 14 days after the mammogram (15 days total).
- Ensure all required elements of the mammogram report are documented, especially if not included in the original interpretation.
- After mammography, ensure clear communication of the BI-RADS assessment, including its implications for cancer risk and recommended screening follow-up.
- Educate persons with an inconclusive or high-risk BI-RADS assessment about the need for additional screening, such as ultrasound or MRI, as recommended by clinical guidelines.

(continued)

(DBM-E) Documented Assessment After Mammogram *(continued)*

Lines of Business: Medicaid, Medicare, Marketplace

- Engage radiologists, PCPs, and specialists to ensure appropriate care based on the mammogram results. Support smooth transitions between departments for timely diagnostic follow up.
- Submit applicable codes.

Description	Codes*	
BI-RADS Assessment	**RadLex:** RID36028–RID36036, RID36041	
	SNOMED: 397138000	Mammography assessment **(Category 0)** Need additional imaging evaluation
	SNOMED: 397140005	Mammography assessment **(Category 1)** Negative
	SNOMED: 397141009	Mammography assessment **(Category 2)** Benign finding
	SNOMED: 397143007	Mammography assessment **(Category 3)** Probably benign finding, short interval follow-up
	SNOMED: 397144001	Mammography assessment **(Category 4)** Suspicious abnormality, biopsy should be considered
	SNOMED: 397145000	Mammography assessment **(Category 5)** Highly suggestive of malignancy
	SNOMED: 6111000179101	Mammography assessment **(Category 6)** Known biopsy, proven malignancy
	SNOMED: 6121000179106	Mammography assessment **(Category 4A)** Suspicious abnormality, biopsy should be considered, low suspicion of malignancy
	SNOMED: 6131000179108	Mammography assessment **(Category 4B)** Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy
	SNOMED: 6141000179100	Mammography assessment **(Category 4C)** Suspicious abnormality, biopsy should be considered, high suspicion of malignancy

**Codes subject to change.*

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

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of episodes during the measurement period for persons 40 to 74 years of age with inconclusive or high-risk BI-RADS assessments who received appropriate follow-up within 90 days of the assessment.

A higher rate indicates better performance.

✓ **BI-RADS assessment**

- Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for the imaging of mammography, ultrasound, and MRI of the breast.

✓ **Episode date**

- The dates of service during the intake period when a high-risk or inconclusive BI-RADS score was documented.

✓ **Intake period**

- Oct. 3 of the year prior to the measurement period to Oct. 2 of the measurement period. The intake period is used to capture the episode date.

Tips

- Document the BI-RADS score and appropriate follow-up within 90 days of assessment in the health record.
- Document inconclusive or high-risk BI-RADS assessment if it is missing from the mammogram report.
- To meet follow-up guidelines, ensure that one of the following appropriate actions occurs:
  - A **breast biopsy** at or within 90 days (91 days total) for a Category 4 (Suspicious) or Category 5 (Highly Suggestive of Malignancy) BI-RADS score.
  - A **mammogram** or **ultrasound** at or within 90 days (91 days total) for a BI-RADS score of 0 (Incomplete – Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison).
- Foster coordination between radiology, primary care, and oncology to ensure BI-RADS assessment is included in the follow-up plans for persons with higher risk factors.
- Submit applicable codes.

(continued)

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

Lines of Business: Medicaid, Medicare, Marketplace

Description	Codes*	
Breast Biopsy	**CPT:** 19081, 19083, 19085, 19100, 19101 **SNOMED:** 10940003, 28768007, 42125001, 44578009, 116219004, 116220005, 116334007, 172086006, 237372000, 237375003, 237376002, 237377006, 237378001, 237379009, 265253005, 274331003, 287553003, 303689004, 307298009, 387736007, 432109009, 432157003, 432337008, 432550005, 433008009, 433685008, 433805008, 442963006, 445171002, 445437001, 448336005, 448689003, 709628007, 711508007, 723990008, 725936002, 736615002, 770568001, 770569009, 770570005, 771086002, 771625002, 785800009, 786883001, 866232001, 1179705005, 1179707002, 1179708007, 1220570007, 1220571006, 1220572004, 1264555004, 1264556003, 1268323005, 1268996004, 1332066007, 1332067003, 1333891002, 1333892009, 1333893004, 1333894005, 1333895006, 1333896007, 1333897003, 1333898008, 1333899000, 1333900005, 1333901009, 1333902002, 1333903007, 1333904001, 1333905000, 1333906004, 1334078005, 1334079002, 1334080004, 1356791009, 2131000087106, 2141000087100, 2841000087108, 4541000087104, 4551000087101, 5181000087103, 12131000087109, 305011000000108, 305051000000107, 305071000000103, 306371000000109, 306381000000106, 306641000000107, 306651000000105, 306671000000101, 307971000000105, 307981000000107, 308041000000102, 872731000000104	
Breast Ultrasound	**CPT:** 76641, 76642 **LOINC:** 105420-4, 105421-2, 24599-3, 24601-7, 26215-4, 26216-2, 26288-1, 26290-7, 42132-1	
High-Risk BI-RADS Assessment	**RadLex:** RID36030-RID36034	
	SNOMED: 397144001	Mammography assessment **(Category 4)** — Suspicious abnormality, biopsy should be considered
	SNOMED: 397145000	Mammography assessment **(Category 5)** — Highly suggestive of malignancy
	SNOMED: 6121000179106	Mammography assessment **(Category 4A)** — Suspicious abnormality, biopsy should be considered, low suspicion of malignancy
	SNOMED: 6131000179108	Mammography assessment **(Category 4B)** — Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy
	SNOMED: 6141000179100	Mammography assessment **(Category 4C)** — Suspicious abnormality, biopsy should be considered, high suspicion of malignancy
Inconclusive BI-RADS	**RadLex:** RID36036	
	SNOMED: 397138000	Mammography assessment **(Category 0)** — Need additional imaging evaluation
Mammography	**CPT:** 77061–77063, 77065–77067 **LOINC:** 103885-0, 103886-8, 103892-6, 103893-4, 103894-2, 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3	

**Codes subject to change.*

(OMW) Osteoporosis Management in Women Who Had a Fracture

Line of Business: Medicare

Measure evaluates the percentage of women 65 to 85 years of age during the measurement period who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Note: Fractures of fingers, toes, face, and skull are not included in this measure.

Tips

- Provide persons who had a fracture with a referral for BMD test and encourage them to obtain the screening.
- When appropriate, prescribe medication to treat osteoporosis (bisphosphates).
- Check that fracture codes are used appropriately.
- Consider offering onsite BMD test for persons at risk.
- Women at risk for osteoporosis should receive a BMD test every two years.
- Submit applicable codes.

Description	Codes*
Palliative Care	**HCPCS:** G9054
Bone Mineral Density Tests	**CPT:** 76977, 77080, 77081, 77085, 77086
Osteoporosis Medications	**HCPCS:** J0897, J1740, J3110, J3111, J3489, Q5136
Long-Acting Osteoporosis Medications during Inpatient Stay	**HCPCS:** J0897, J1740, J3489, Q5136

**Codes subject to change.*

Osteoporosis Medications			
Description	**Prescription**		
Bisphosphonates	• Alendronate • Ibandronate	• Alendronate-cholecalciferol • Risedronate	• Zoledronic acid
Other agents	• Abaloparatide • Teriparatide	• Romosozumab • Raloxifene	• Denosumab

(OSW) Osteoporosis Screening in Older Women

Line of Business: Medicare

Measure evaluates the percentage of women 65 to 75 years of age who received an osteoporosis screening on or between the person's 65th birthday and Dec. 31 of the measurement period.

Tips

- Provide a BMD test for persons without a diagnosis who have not previously been treated for osteoporosis.
- Educate persons on bone health and how to adopt healthy practices.

Description	Codes*
Osteoporosis Screening Tests	**CPT:** 76977, 77078, 77080, 77081, 77085

**Codes subject to change.*

(PPC) Prenatal and Postpartum Care

Lines of Business: Medicaid, Marketplace

Measure evaluates percentage of live birth deliveries on or between Oct. 8 of the year prior to the measurement period and Oct. 7 of the measurement period. For these persons, the measure assesses the following facets of prenatal and postpartum care.

- ✓ **Timeliness of Prenatal Care:** 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 in the organization.
- ✓ **Postpartum Care:** Percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

Tips

- Schedule an initial prenatal visit within the first 12 weeks of pregnancy with an obstetrician/gynecologist (OB/GYN), PCP, or nurse midwife.
- Educate persons on the importance of prenatal care throughout their pregnancy to include the postpartum visit.
- Ensure prenatal flow sheets and/or American College of Obstetricians and Gynecologists (ACOGs) person forms are fully completed, with dates of services and provider initials (if applicable).
- Schedule postpartum visits prior to discharge after delivery.
- Submit applicable codes.

(continued)

(PPC) Prenatal and Postpartum Care *(continued)*

Lines of Business: Medicaid, Marketplace

Description	Codes*
Online Assessments	**CPT:** 98970–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012
Prenatal Visits	**CPT:** 98980, 98981, 99202–99205, 99211–99215, 99242–99245, 99458, 99483 **HCPCS:** G0463, G2250–G2252, T1015
Stand-Alone Prenatal Visits	**CPT:** 99500 **CPT II:** 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004
Cervical Cytology Lab Test	**CPT:** 88141–88143, 88147, 88148, 88150, 88152–88153, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001
Postpartum Visits	**CPT:** 57170, 58300, 59430, 99501 **CPT II:** 0503F **HCPCS:** G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Telehealth Visits	**CPT:** 98000–98016, 98966–98968, 99441–99443

**Codes subject to change.*

Note: When using the Online Assessment, Telephone Visit, or Prenatal Visit codes, remember to also include a Pregnancy Diagnosis code.

(PRS-E) Prenatal Immunization Status

Line of Business: Medicaid

Measure evaluates the percentage of deliveries in the measurement period in which persons had received influenza and Tdap vaccinations during the measurement period.

Measurement Period:

- ✓ **Flu** — on or between Jul. 1 of the year prior to the measurement period and the delivery date.
- ✓ **Tdap** — vaccine received during the pregnancy (including the delivery date).

Tips

- Identify persons with open care gaps and flag in EHR system if possible.
- Offer needed vaccines during prenatal visits and check-ups, or when person is admitted for delivery.
- Educate person on the importance of vaccinations and how they protect both person and baby, and address any fear or anxiety associated with vaccinations during pregnancy.
- Document all vaccinations in the person EMR.
- Submit applicable codes.

Description	Codes*
Adult Influenza Immunization	**CVX:** 88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205, 320
Adult Influenza Vaccine Procedure	**CPT:** 90653, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
Tdap Immunization	**CVX:** 115
Tdap Vaccine Procedure	**CPT:** 90715
Encephalitis	**SNOMED:** 192710009, 192711008, 192712001
Anaphylaxis	**SNOMED:** 428291000124105, 428281000124107

**Codes subject to change.*

(CIS-E) Childhood Immunization Status

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of children two years of age during the measurement period who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

Tips

- Document both the name of the vaccine and the date it was administered in the medical record.
- Submit applicable codes.

Description	Codes*
DTaP (4 doses)**	**CPT:** 90697, 90698, 90700, 90723 **CVX:** 20, 50, 106, 107, 110, 120, 146, 198
HiB (3 doses)**	**CPT:** 90644, 90647, 90648, 90697, 90698, 90748 **CVX:** 17, 46, 47, 48, 49, 50, 51, 120, 146, 148, 198
Hep B (3 doses) May include a newborn vaccination.	**CPT:** 90697, 90723, 90740, 90744, 90747, 90748 **CVX:** 08, 44, 45, 51, 110, 146, 198 **HCPCS:** G0010 **ICD-10:** B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
IPV (3 doses)**	**CPT:** 90697, 90698, 90713, 90723 **CVX:** 10, 89, 110, 120, 146
MMR (1 dose) If using history of illness to close MMR gap, there must be evidence of illness with all three measles, mumps, and rubella.	**CPT:** 90707, 90710 **CVX:** 03, 94 **ICD-10:** B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9, B26.0, B26.1, B26.2, B26.3, B26.81, B26.82. B26.83, B26.84, B26.85, B26.89, B26.9, B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Pneumococcal Conjugate PCV (4 doses)**	**CPT:** 90670, 90671, 90677 **CVX:** 109, 133, 152, 215, 216 **HCPCS:** G0009
Varicella VZV (1 dose)	**CPT:** 90710, 90716 **CVX:** 21, 94 **ICD-10:** B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9

(continued)

(CIS-E) Childhood Immunization Status *(continued)*

Lines of Business: Medicaid, Marketplace

Description	Codes*
Hep A (1 dose)	**CPT:** 90633 **CVX:** 31, 83, 85 **ICD-10:** B15.0, B15.9
Influenza (2 doses)*** LAIV meets criteria for one of the two required vaccinations if administered on the 2nd birthday.	**CPT:** 90655–90658, 90660, 90661, 90672–90674, 90685–90689, 90756 **CVX:** 88, 111, 140, 141, 149, 150, 153, 155, 158, 161, 171, 186, 320
Rotavirus (2 doses)**	**CPT:** 90681
Rotavirus (3 doses)**	**CPT:** 90680 **CVX:** 116, 122
Anaphylaxis	Please refer to the HEDIS Value Set Directory for applicable SNOMED codes for anaphylaxis and encephalitis.

**Codes subject to change.*

***Do not count a vaccination administered prior to 42 days after birth.*

****Do not count a vaccination administered prior to 180 days after birth.*

*Note: Rotavirus is either 2 dose **OR** 3 dose for compliancy.*

(IMA-E) Immunizations for Adolescents

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of adolescents 13 years of age during the measurement period who had one dose of meningococcal vaccine, one 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 combination rates.

Tips

- Document both the name of the vaccine and the date it was administered in the medical record.
- Submit applicable codes.

Description	Codes*
Meningococcal (serogroups A, C, W, Y or A, C, W, Y, B) (1 dose) — must be administered between 10th and 13th birthday	**CPT:** 90619, 90623, 90624, 90733, 90734 **CVX:** 32, 108, 114, 136, 147, 167, 203, 316, 328
Tdap (1 dose) — must be administered between the 10th and 13th birthday	**CPT:** 90715
HPV (2 or 3 dose series) — must be administered between 9th and 13th birthday	**CPT:** 90649–90651 **CVX:** 62, 118, 137, 165
Anaphylaxis	Please refer to the HEDIS Value Set Directory for applicable SNOMED codes for anaphylaxis and encephalitis.

**Codes subject to change.*

(LSC-E) Lead Screening in Children

Line of Business: Medicaid

The Lead Screening in Children measure has transitioned to exclusive use of the Electronic Clinical Data Systems.

Measure evaluates the percentage of children two years of age during the measurement period who had one or more capillary or venous lead blood tests for lead poisoning on or prior to their second birthday.

Only one test is required.

Tips

- Lead screening must be performed on or prior to child's second birthday.
- Document both the date and results of the lead screening.
- Results of 'unknown' are not acceptable.
- Submit applicable codes.

CPT*
83655

**Codes subject to change.*

(OED) Oral Evaluation, Dental Services

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of persons under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement period.

Tips

- Remind persons or their responsible party about dental benefits.
- Encourage regular check-up visits with a dentist for routine exams, cleanings, and oral x-rays.
- Help persons schedule an appointment to see a dentist.
- Federally Qualified Health Centers and Rural Health Clinics/ Centers can serve as a Primary Care Dental Home provider.

Description	Codes*
Dental Provider	**Provider Taxonomy:** 122300000X, 1223D0001X, 1223D0004X, 1223E0200X, 1223G0001X, 1223P0106X, 1223P0221X, 1223P0300X, 1223P0700X, 1223S0112X, 1223X0008X, 1223X0400X, 1223X2210X, 122400000X, 124Q00000X, 125J00000X, 125K00000X, 125Q00000X, 126800000X, 204E00000X, 261QD0000X, 261QF0400X, 261QR1300X, 261QS0112X
Oral Evaluation	**CDT:** D0120, D0145, D0150

**Codes subject to change.*

(TFC) Topical Fluoride for Children

Line of Business: Medicaid

Measure evaluates the percentage of persons one to four years of age who received at least two fluoride varnish applications during the measurement period.

Tips

- Children must receive two fluoride varnish applications on different dates of services.
- During visits, educate parents about the importance of having children receive fluoride varnish applications.
- PCP can start applying fluoride varnish with the first tooth eruption and apply it every three to six months.
- Perform an Oral Health Risk Assessment to determine any risk factors.
- TFC treatment can be completed by a pediatrician or other qualified health care professional.

Description	Codes*
Topical Application of Fluoride Varnish	**CPT:** 99188 **CDT:** D1206
Application of Dental Fluoride Varnish (Procedure)	**SNOMED CT US Edition:** 313042009

**Codes subject to change.*

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

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of children who had the following number of well-child visits with PCP during the measurement period.

The following rates are reported:

1. **Well-Child Visits in the First 15 Months.** Children who turned 15 months old during the measurement period: Six or more well-child visits.
2. **Well-Child Visits for Age 15 Months to 30 Months.** Children who turned 30 months old during the measurement period: Two or more well-child visits.

Tips

- Remind caregivers of appointments by texts or phone calls.
- Educate caregivers about the importance of preventive care visits.
- Consider using templates with checkboxes to ensure required information is documented.
- Submit applicable codes.

Note: Telehealth well visits are no longer acceptable.

CPT*	HCPCS*	ICD-10*
99381, 99382, 99391, 99392, 99461	S0302	Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z02.84, Z76.1, Z76.2

**Codes subject to change.*

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

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of persons 3 to 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 period:

- ✓ Body Mass Index (BMI) percentile.
- ✓ Counseling for nutrition.
- ✓ Counseling for physical activity.

Tips

- Be sure to document all components of the WCC measure on every visit.
- Nutrition pertains to eating habits and behaviors (not appetite).
- BMI values are not acceptable, only percentiles. Ranges are not acceptable. If plotted on a chart, a BMI chart must be used (not age-growth chart).
- Call persons/caregivers to reschedule cancelled appointments.
- Include documentation if child/adolescent is counseled for weight or obesity.
- Submit applicable codes.

Description	Codes*
BMI Percentile	**ICD-10:** Z68.51, Z68.52, Z68.53, Z68.54, Z68.55, Z68.6 **LOINC:** 59574-4, 59575-1, 59576-9
Nutrition Counseling	**CPT:** 97802–97804 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470 **ICD-10:** Z71.3
Physical Activity	**HCPCS:** G0447, S9451 **ICD-10:** Z02.5, Z71.82

**Codes subject to change.*

(WCV) Child and Adolescent Well-Care Visits

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of persons 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN within the measurement period.

Tips

- Remind caregivers of appointments by texts or phone calls.
- Educate caregivers about the importance of preventive care visits to assess growth and development and to provide immunizations and anticipatory guidance on nutrition, physical activity, and safety.
- Components of a WCV should include a health history, physical development history, and mental development history along with:
  - A physical exam (including height, weight, and BMI percentile).
  - Health education and anticipatory guidance.

Note: Telehealth well visits are no longer acceptable.

CPT*	HCPCS*	ICD-10*
99382–99385, 99391–99395	G0438, G0439, S0302, S0610, S0612, S0613	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.2

**Codes subject to change.*

(AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of episodes for persons three months of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event on or three days after the episode.

Looks at eligible outpatient, telephone, ED visits, e-visits, or virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis during the intake period from Jul. 1 of the year prior to the measurement period to Jun. 30 of the measurement period that did not result in an inpatient stay.

A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).

Tips

- When clinically appropriate, suggest alternate symptom management options, such as over-the-counter medications, humidifiers, adequate fluids and rest, and other non-pharmacologic therapies.
- Avoid prescribing antibiotics for acute bronchitis or bronchiolitis in uncomplicated cases, as these conditions are typically viral and self-limiting.
- If clinical indications warrant antibiotic therapy, document the appropriate diagnosis to support the prescribed treatment.
- Ensure persons receive recommended respiratory vaccinations (e.g., influenza, pneumococcal, COVID-19, RSV) based on clinical guidelines and personal risk factors to help reduce the risk of infections that may mimic or contribute to acute bronchitis.
- Submit applicable codes.

Description	Codes*
Acute Bronchitis	**ICD-10:** J20.3-J20.9, J21.0, J21.1, J21.8, J21.9

**Codes subject to change.*

(AAF-E) Follow-Up After Acute and Urgent Care Visits for Asthma

Line of Business: Medicaid

The percentage of persons 5 to 64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge, or ED visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.

✓ **An asthma episode is defined as an encounter between Jan. 1 and Dec. 1 with a diagnosis of asthma.**

- For urgent care visits that result in an ED visit, the ED visit is the episode.
- For urgent care or ED visits that result in a nonacute inpatient stay, the urgent care or ED visit is the episode.
- For acute inpatient or observation stays that result in a nonacute inpatient stay, the acute inpatient or observation stay discharge is the episode.

✓ **The asthma episode date is the date of service for the asthma episode.**

- For acute inpatient or observation stay discharges, the episode date is the date of discharge.
- For direct transfers, the episode date is the discharge date from the last transfer admission.
- For ED or urgent care visits, the episode date is the date of service.

Note: Do not include persons with a diagnosis of cystic fibrosis in the measure. Do not include laboratory claims with POS 81.

Description	Codes*
Outpatient and Telehealth	**CPT:** 98000–98016, 98966–98968, 98970–98972, 98980, 98981, 99202–99205, 99211,99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99429, 99441–99443, 99455–99458, 99483
Asthma	**ICD-10:** J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50. J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

**Codes subject to change.*

(CWP) Appropriate Testing for Pharyngitis

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of episodes for persons three years of age and older where the person was **diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test** in the seven-day period: from three days *prior* to the episode date through three days after the episode.

Measure looks at eligible outpatient, telephone, ED visits, e-visits, or virtual check-ins with a diagnosis of acute pharyngitis during the intake period from Jul. 1 of the year prior to the measurement period to Jun. 30 of the measurement period that did not result in an inpatient stay.

Tips

- Perform a group A strep test (rapid antigen or throat culture) in persons who present with symptoms suggestive of strep throat before prescribing antibiotics.
- For persons with viral pharyngitis, offer guidance on supportive care, including over-the-counter analgesics, throat lozenges, oral rinses, hydration, and rest as clinically appropriate to effectively manage symptoms.
- Review and clearly document the group A strep test in the health record. Prescribe antibiotics for pharyngitis only when the test is positive.
- Submit applicable codes.

Description	Codes*
Group A Strep Test	**CPT:** 87070, 87071, 87081, 87430, 87650-87652, 87880
Pharyngitis	**ICD-10:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

**Codes subject to change.*

Antibiotic Medications	
Description	**Prescriptions**
Aminopenicillins	• amoxicillin • ampicillin
Beta-Lactamase Inhibitors	• amoxicillin-clavulanate
First-Generation Cephalosporins	• cefadroxil • cefazolin • cephalexin
Folate Antagonist	• trimethoprim
Lincomycin Derivatives	• clindamycin
Macrolides	• azithromycin • clarithromycin • erythromycin
Natural Penicillins	• penicillin G benzathine • penicillin G potassium • penicillin G sodium • penicillin V potassium
Quinolones	• ciprofloxacin • levofloxacin • moxifloxacin • ofloxacin
Second-Generation Cephalosporins	• cefaclor • cefprozil • cefuroxime
Sulfonamides	• sulfamethoxazole-trimethoprim
Tetracyclines	• doxycycline • minocycline • tetracycline
Third-Generation Cephalosporins	• cefdinir • cefixime • cefpodoxime • ceftriaxone

(LBP) Use of Imaging Studies for Low Back Pain

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 18 to 75 years of age with a principal diagnosis of low back pain who did not have an imaging study (i.e., plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

The Index Episode Start Date (IESD) is the earliest eligible date of service during the Intake Period (Jan. 1 through Dec. 3 of the measurement period) when a person presents with a principal diagnosis of low back pain and has no claims or encounters for low back pain in the 180 days prior to that date.

A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies **did not** occur).

Excludes persons who meet any of the following criteria:

- ✓ Inpatient stays or visits resulting in an inpatient stay.
- ✓ Deceased, or receiving hospice or palliative care during the measurement period.
- ✓ Age 66+ with both frailty and advanced illness (including use of dementia medications).
- ✓ Medical history that may justify imaging within specified timeframes, such as:
  - Cancer, HIV, history of organ transplant, osteoporosis, or spondylopathy.
  - Lumbar surgery or medication treatment for osteoporosis.
  - IV drug use, neurologic impairment, or spinal infection.
  - Trauma or fragility fractures.
  - Prolonged corticosteroid use (≥90 consecutive days).

Tips

- If not medically required, avoid ordering diagnostic studies (i.e., plain X-ray, MRI, CT scan) for the diagnosis of uncomplicated low back pain in the absence of red flags (e.g., cancer, recent trauma, neurologic impairment, or IV drug abuse).
- When clinically indicated, provide person with education on cautious pain relief measures such as over-the-counter analgesics, activity modifications, and the use of ice and/or heat.
- If medically appropriate, consider physical therapy or other interventions such as massage, stretching, strengthening exercises, and manipulation.
- Assess for other contributing factors to low back pain (e.g., depression, anxiety, narcotic dependence, psychosocial stressors) and address them as clinically appropriate.
- Ensure timely and accurate submission of claims and encounter data to reflect care provided.
- Submit applicable codes.

(continued)

(LBP) Use of Imaging Studies for Low Back Pain *(continued)*

Lines of Business: Medicaid, Marketplace

Description	Codes*
Imaging Study	**CPT:** 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080–72084, 72100, 72110, 72114, 72120, 72125–72133, 72141, 72142, 72146–72149, 72156–72158, 72200, 72202, 72220
Uncomplicated Low Back Pain	**ICD-10:** M47.26–M47.28, M47.816–M47.818, M47.896–M47.898, M48.061, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.360, M51.362, M51.369, M51.37, M51.370, M51.372, M51.379, M51.86,M51.87, M53.2X6–M53.2X8, M53.3, M53.86–M53.88, M54.16–M54.18, M54.30–M54.32, M54.40–M54.42, M54.5, M54.50, M54.51, M54.59, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS

**Codes subject to change.*

(SNS-E) Social Needs Screening and Intervention

Lines of Business: Medicaid, Marketplace

Measure evaluates the percentage of persons (all ages) who were screened using prespecified instruments at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive during the measurement period.

Six rates are reported:

- ✓ **Food Screening.** The percentage of persons who were screened for food insecurity.
- ✓ **Food Intervention.** The percentage of persons who received a corresponding intervention within 30 days (one month) of screening positive for food insecurity.
- ✓ **Housing Screening.** The percentage of persons who were screened for housing instability, homelessness, or housing inadequacy.
- ✓ **Housing Intervention.** The percentage of persons who received a corresponding intervention within 30 days (one month) of screening positive for housing instability, homelessness, or housing inadequacy.
- ✓ **Transportation Screening.** The percentage of persons who were screened for transportation insecurity.
- ✓ **Transportation Intervention.** The percentage of persons who received a corresponding intervention within 30 days (one month) of screening positive for transportation insecurity.

The SNS-E screening numerator counts only screenings that use instruments in the measure specification as identified by the associated LOINC® code(s).

The SNS-E measure specification does not prohibit cultural adaptations or linguistic translations from being counted toward the measure's screening numerators.

Only screenings documented using the LOINC codes specified in the SNS-E measure count toward the measure's screening numerators. Some screening tools are proprietary and may require licensing agreements or costs.

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Marketplace

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool — Short Form	88122-7 88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Persons' Assets, Risks and Experiences (PRAPARE)®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8 95399-2	LA33-6
U.S. Household Food Security Survey (U.S. FSS)	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey (U.S. FSS)	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey (U.S. FSS)	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey — Six-Item Short Form (U.S. FSS)	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6
Housing Instability and Homelessness Instruments	**Screening Item LOINC Codes**	**Positive Finding LOINC Codes**
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool — Short Form	71802-3	LA31994-9 LA31995-6
Children's Health Watch Housing Stability Vital Signs™	98976-4 98977-2 98978-0	LA33-6 ≥2
Health Leads Screening Panel®[1]	99550-6	LA33-6
Protocol for Responding to and Assessing Persons' Assets, Risks and Experiences (PRAPARE)®[1]	93033-9 71802-3	LA33-6 LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

[1]*Proprietary; cost or licensing requirement may be associated with use.*

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Marketplace

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool — Short Form	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
Norwalk Community Health Center Screening Tool (NCHC)	99134-9 99135-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
Transportation Insecurity Instruments	**Screening Item LOINC Codes**	**Positive Finding LOINC Codes**
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool — Short Form	99594-4	LA33093-8 LA30134-3
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®[1]	99553-0	LA33-6

[1]*Proprietary; cost or licensing requirement may be associated with use.*

(continued)

(SNS-E) Social Needs Screening and Intervention *(continued)*

Lines of Business: Medicaid, Marketplace

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Inpatient Rehabilitation Facility — Patient Assessment Instrument (IRF-PAI) — version 4.0 (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Outcome and Assessment Information Set (OASIS) Form — version E — Discharge from Agency (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Outcome and Assessment Information Set (OASIS) Form — version E — Resumption of Care (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Outcome and Assessment Information Set (OASIS) Form — version E — Start of Care (CMS Assessment)	101351-5	LA30133-5 LA30134-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®[1]	93030-5	LA30133-5 LA30134-3
PROMIS®[1]	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

✓ Identify persons with positive screening and conduct an intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period.

Tips

- Interventions may include any of the following categories: adjustment, assistance, coordination, counseling, education, evaluation of eligibility, evaluation/assessment, provision, or referral.

Description	Codes*
Food Insecurity Procedures	**CPT:** 97802–97804 **HCPCS:** S5170 (Home delivered meals, including preparation; per meal) **HCPCS:** S9470 (Nutritional counseling, dietitian visit)
Food Insecurity (must be associated with Food Interventions)	**ICD-10:** Z59.41 and Z59.48
Administration of a Standardized, Evidence-Based Social Determinants of Health Risk Assessment Tool, 5–15 Minutes	**HCPCS**: G0136
Homelessness Diagnosis	**ICD-10:** Z59.00–Z59.02
Housing Inadequacy	**ICD-10:** Z59.10–Z59.12; Z59.19

**Codes subject to change.*

[1]*Proprietary; cost or licensing requirement may be associated with use.*

(TSC-E) Tobacco Use Screening and Cessation Intervention

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period, and who received tobacco cessation intervention if identified as a tobacco user.

Two rates are reported:

1. **Tobacco Use Screening.** The percentage of persons who were screened for tobacco use.
2. **Cessation Intervention.** The percentage of persons who were identified as a tobacco user and who received tobacco cessation intervention.

✓ A positive tobacco user is a person who was screened for tobacco use and had a documented positive result. Any of the following meet criteria:

- Tobacco Use Screening Value Set with Yes Value Set.
- LOINC code 72166-2 with Positive Tobacco Use Status Value Set.

✓ A negative tobacco user is a person who was screened for tobacco use and had a documented negative result. Any of the following meet criteria:

- Tobacco Use Screening Value Set with No Value Set.
- LOINC code 72166-2 with Negative Tobacco Use Status Value Set.

Description	Codes*
Positive Tobacco Use Status Note: Do not include laboratory claims (claims with POS code 81).	**LOINC:** LA18976-3, LA18977-1, LA18981-3, LA18982-1
Tobacco Use Cessation Counseling	**CPT:** 99406, 99407

**Codes subject to change.*

(URI) Appropriate Treatment for Upper Respiratory Infection

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of episodes for persons three months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event on or three days after the episode.

Measure looks at eligible outpatient, telephone, ED visits, e-visits, or virtual check-ins with a diagnosis of URI during the intake period from Jul. 1 of the year prior to the measurement period to Jun. 30 of the measurement period that did not result in an inpatient stay.

A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that **did not** result in an antibiotic dispensing event).

Tips

- Unless clinically indicated, discourage antibiotics for routine treatment of uncomplicated viral infections, such as common colds, which are usually self-limiting and do not require antibiotic therapy.
- Provide clear instructions on supportive care and symptom management.
- When antibiotics are not indicated, recommend symptom management strategies such as fluids, rest, over-the-counter medications, and nasal saline to support recovery and minimize unnecessary antibiotic prescribing.
- Submit applicable codes.

Description	Codes*
Acute Nasopharyngitis (common cold)	**ICD-10:** J00
Acute Laryngopharyngitis	**ICD-10:** J06.0
Acute Upper Respiratory Infection, Unspecified	**ICD-10:** J06.9

**Codes subject to change.*

SOCIAL DETERMINANTS OF HEALTH

(SDOH) Social Determinants of Health

Description	Codes*
Occupational Exposure to Risk Factors	**ICD-10:** Z57.0–Z57.9
Problems Related to Education and Literacy	**ICD-10:** Z55.0–Z55.9
Problems Related to Employment and Unemployment	**ICD-10:** Z56.0–Z56.9
Problems Related to Physical Environment	**ICD-10:** Z58.0–Z58.9
Problems Related to Housing and Economic Circumstances	**ICD-10:** Z59.0–Z59.9
Problems Related to Social Environment	**ICD-10:** Z60.0–Z60.9
Problems Related to Upbringing	**ICD-10:** Z62.0–Z62.9
Problems Related to Primary Support Group, Including Family Circumstances	**ICD-10:** Z63.0–Z63.9
Problems Related to Certain Psychosocial Circumstances	**ICD-10:** Z64.0–Z64.4
Problems Related to Other Psychosocial Circumstances	**ICD-10:** Z65.0–Z65.9
CPT/HCPCS Screening Codes Applicable to SDOH	**CPT:** 96156–96161, 97802–97804, 99377–99378 **HCPCS:** S5170, S9470, G0182, G9473–G9479, Q5003–Q5008, Q5010, S9126, T2042–T2046
Other Risk Factors	**ICD-10:** Z91.89

**Codes subject to change.*

Best Practices:

Include supplemental codes in the diagnosis section of a person's claim form. Assign as many SDOH codes necessary to describe all the social problems, conditions, or risk factors documented during the current episode of care.

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

Line of Business: Medicaid

Time frame is measurement period.

Measure evaluates the percentage of children newly prescribed attention deficit hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10-month) period, one of which was within 30 days of when the first ADHD medication was dispensed.

Two rates are reported:

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

Tips

- Complete a comprehensive medical and psychiatric exam, including rating scales from parents and teachers, before diagnosing and prescribing.
- Limit the first prescription of ADHD medication to a 28- to 30-day supply and schedule follow-up before the family leaves the office.
- Re-evaluate medication effectiveness no more than 30 days after initiation via telehealth when available, and regularly monitor medication effects thereafter.
- Periodically review the ongoing need for continued medication therapy.
- Reschedule any canceled appointments right away.
- Schedule telehealth visits if office visits are not acceptable.
- Submit applicable codes.

(continued)

(ADD-E) Follow-up Care for Children Prescribed ADHD Medication *(continued)*

Line of Business: Medicaid

Description	Codes*
Visit Setting Unspecified	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 71, 72
BH Outpatient Visit	**CPT:** 98000–98006, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, G0560, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
Health and Behavior Assessment/Intervention	**CPT:** 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
Partial Hospitalization/ Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Telehealth Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876,99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Telephone Visits	**CPT:** 98966–98968, 99441–99443
E-visit/Virtual Check-in	**CPT:** 98970–98972, 98980, 98981, 99421–99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252
Visit Setting Unspecified Value Set with Community Mental Health Center POS	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53

**Codes subject to change.*

(APM-E) Metabolic Monitoring for Children and Adolescents on Antipsychotics

Applicable Foster Care Measure

Line of Business: Medicaid

Measure evaluates the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during the measurement period.

Three rates reported:

1. Percentage of children and adolescents on antipsychotics who **received blood glucose testing**.
2. Percentage of children and adolescents on antipsychotics who **received cholesterol testing**.
3. Percentage of children and adolescents on antipsychotics who **received blood glucose and cholesterol testing**.

Tips

- Provide persons/caregivers with lab orders for HbA1c or glucose and cholesterol or LDL-C to be completed yearly.
- Coordinate care between behavioral and physical health providers.
- Educate the person and caregiver about the risks associated with taking antipsychotic medications and the importance of regular follow-up care.
- Submit applicable codes.

Description (Need either A1c or Glucose and LCL-C or Cholesterol)	Codes*
HbA1c Lab Tests	**CPT:** 83036, 83037 **CPT II:** 3044F, 3046F, 3051F, 3052F
Glucose Lab Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LDL-C Lab Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT II:** 3048F, 3049F, 3050F
Cholesterol Lab Tests	**CPT:** 82465, 83718, 83722, 84478

**Codes subject to change.*

*Note: Do **not** include a modifier when using CPT II codes.*

(APP) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Line of Business: Medicaid

Measure evaluates the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Identify persons eligible for antipsychotic medications and provide psychosocial care from 90 days prior to 30 days after beginning a medication.

Tips

- Before prescribing antipsychotic medication, complete or refer for a trial of first-line psychosocial care.
- Antipsychotic medications should be part of a comprehensive, multi-modal plan for coordinated treatment that includes psychosocial care.
- The need for continued therapy with antipsychotic medications should be reviewed periodically.

Description	Codes*
Psychosocial Care or Residential Behavioral Health Treatment	**CPT:** 90832–90834, 90836–90840, 90845–90849, 90853, 90875, 90876, 90880 **HCPCS:** G0176, G0177, G0409–G0411, H0004, H0035–H0039, H0040, H2000, H2001, H2011–H2014, H2017–H2020, S0201, S9480, S9484, S9485
Residential Behavioral Health Treatment	**HCPCS:** H0017–H0019, T2048

**Codes subject to change.*

(ASF-E) Unhealthy Alcohol Use Screening and Follow-Up

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of persons 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument between Jan. 1 and Nov. 1 of the measurement period and, if screened positive, received appropriate follow-up care.

Two rates are reported:

1. **Unhealthy Alcohol Use Screening.** The percentage of persons who had a systematic screening for unhealthy alcohol use.
2. **Follow-Up Care on Positive Screen.** The percentage of persons receiving brief counseling or other follow-up care within 60 days (2 months) of screening positive for unhealthy alcohol use.

Note: A LOINC code submission via flat file is required to be adherent for the screening numerator.

(continued)

(ASF-E) Unhealthy Alcohol Use Screening and Follow-Up *(continued)*

Lines of Business: Medicaid, Medicare

Tips

- Train staff on the importance of screenings and recognizing the risk factors for unhealthy alcohol use.
- Develop a workflow that includes utilizing a standardized instrument for unhealthy alcohol screenings at least annually.
- Ask your provider relations representative about ways to submit data to the health plan directly from your EHR/EMR.
- Document follow up on positive screen on or up to 60 days after the first positive screen.

Unhealthy Alcohol Screening instrument: A standard assessment instrument that has been normalized and validated for the adult patient population. Eligible screening instruments with thresholds for positive findings for numerator 1 include:

Screening Instruments	Total Score LOINC Codes	Positive Finding
Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument	75624-7	Total score ≥8
Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument	75626-2	Total score ≥4 for men Total score ≥3 for women
Single-Question Screen (for men): "How many times in the past year have you had 5 or more drinks in a day?"	88037-7	Response ≥1
Single-Question Screen (for women and all adults older than 65 years): "How many times in the past year have you had 4 or more drinks in a day?"	75889-6	Response ≥1

✓ If the unhealthy alcohol screening is positive, the person must receive alcohol counseling or other follow-up care within 60 days of the first positive screen.

Description	Codes*
Alcohol Counseling or Other Follow Up Care	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, G2011, H0005, H0007, H0015, H0016, H0022, H00050, H2035, H2036, T1006, T1012
A Diagnosis of Encounter for Alcohol Counseling and Surveillance	**ICD-10:** Z71.41

**Codes subject to change.*

(COU) Risk of Continued Opioid Use

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of persons 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use.

Two rates are reported:

1. The percentage of persons with **at least 15 days of prescription opioids in a 30-day period**.
2. The percentage of persons with **at least 31 days of prescription opioids in a 62-day period**.

Decreased numerator score indicates improvement.

Tips

- Educate on opioid safety and risk associated with long-term use and use of multiple opioids from different providers.
- Involve person in decisions to initiate or continue opioid use, only prescribe opioids when medically necessary, in the lowest effective dose, for the shortest duration necessary.

Use all the medication lists below to identify opioid medication dispensing events

- Acetaminophen Benzhydrocodone Medications List
- Buprenorphine Medications List
- Butorphanol Medications List
- Acetaminophen Butalbital Caffeine Codeine Medications List
- Acetaminophen Codeine Medications List
- Aspirin Butalbital Caffeine Codeine Medications List
- Aspirin Carisoprodol Codeine Medications List
- Codeine Sulfate Medications List
- Acetaminophen Caffeine Dihydrocodeine Medications List
- Fentanyl Medications List
- Acetaminophen Hydrocodone Medications List
- Hydrocodone Medications List
- Hydrocodone Ibuprofen Medications List
- Hydromorphone Medications List
- Levorphanol Medications List
- Meperidine Medications List
- Methadone Medications List
- Morphine Medications List
- Belladonna Opium Medications List
- Opium Medications List
- Acetaminophen Oxycodone Medications List
- Aspirin Oxycodone Medications List
- Ibuprofen Oxycodone Medications List
- Oxycodone Medications List
- Oxymorphone Medications List
- Naloxone Pentazocine Medications List
- Tapentadol Medications List
- Acetaminophen Tramadol Medications List
- Tramadol Medications List

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

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of persons 12 years of age and older who were screened for clinical depression during the measurement period using a standardized instrument and, if screened positive, received follow-up care.

Two rates are reported:

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

Depression screening instrument: A standard assessment instrument that has been normalized and validated for the appropriate person population.

The following table includes eligible screening instruments with thresholds for positive findings.

Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score ≥60
Instruments for Adults (18+ years)	**Total Score LOINC Codes**	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety — Depression Scale (DUKE-AD)®	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3)®	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score ≥60
PROMIS Emotional Distress — Depression — Short Form	77861-3	Total score ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

(continued)

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

Lines of Business: Medicaid, Medicare, Marketplace

Tips

- Use age-appropriate screening instruments.
- Train staff on the importance of depression screenings and recognizing the risk factors for depression.
- Work with a care team to coordinate follow-up care for persons with a positive screening.
- Ensure all services conducted during the visit are coded appropriately, including the depression screening LOINC codes.
- Coordinate file submissions to the health plan that include EHR data.

Description	Codes*
Behavioral Health Encounter	**CPT:** 90791, 90792, 90832–90839, 90845–90849, 90853, 90865–90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
Depression Case Management Encounter That Documents Assessment for Symptoms of Depression or a Diagnosis of Depression or Other Behavioral Health	**CPT:** 99366, 99492–99494 **HCPCS:** G0512, T1016, T1017, T2022, T2023
Follow Up Visit With a Diagnosis of Depression or Other Behavioral Health Condition	**CPT:** 98000–98016, 98960–98962, 98966–98968, 98970–98972, 98980, 98981, 99078, 99202–99205, 99211–99215, 99242–99245, 99341–99342, 99344–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99441–99443, 99457, 99458,99483 **HCPCS:** G0071, G0463, G2010, G2012, G2250–G2252, T1015 **ICD-10:** F01.511, F01.518, F06.4, F10.180, F10.280, F10.980, F11.188, F11.288, F11.988, F12.180, F12.280, F12.980, F13.180, F13.280, F13.980, F13.180, F13.280, F13.980, F14.180, F14.280, F14.980, F15.180, F15.280, F15.980, F16.180, F16.280, F16.980, F18.180, F18.280, F18.980, F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F21-F24, F25.0, F25.1, F25.8, F25.9, F28-F29, F30.10-F30.13, F30.2-F30.4, F30.8, F30.9, F31.0, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78, F31.81, F31.89, F32.0-F32.5, F32.81, F32.89, F32.9, F32.A, F33.0-F33.3, F33.40-F33.42, F33.8, F33.9, F34.0, F34.1, F34.81, F34.89, F34.9, F39, F40.00-F40.02, F40.10. F40.11, F40.210, F40.218, F40.220, F40.228, F40.230-F40.233, F40.240-F40.243, F40.248, F40.290, F20.291, F40.298, F40.8-F41.1, F41.3, F41.8, F41.9, F42.2-F42.4, F42.8, F42.9, F43.0, F43.10-F43.12, F43.20-F43.25, F43.29, F43.81, F43.89, F43.9, F44.89, F45.21, F51.5, F53.0, F53.1, F60.0-F60.7, F60.81, F60.89, F60.9, F63.0-F63.3, F63.81, F63.89, F63.9, F69.10-F68.13, F68.8, F68.A, F84.0, F8.2, F84.3, F84.5, F84.8, F84.9, F90.0-F90.2, F90.8, F90.9, F91.0-F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0-F94.2, F94.8, F94.9, O90.6, O99.340-O99.345

(continued)

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

Lines of Business: Medicaid, Medicare, Marketplace

Description	Codes*
Hospice Encounter With a Diagnosis of Depression or Other Behavioral Health Condition	**ICD-10:** F01.511, F01.518, F06.4, F10.180, F10.280, F10.980, F11.188, F11.288, F11.988, F12.180, F12.280, F12.980, F13.180, F13.280, F13.980, F13.180, F13.280, F13.980, F14.180, F14.280, F14.980, F15.180, F15.280, F15.980, F16.180, F16.280, F16.980, F18.180, F18.280, F18.980, F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F21-F24, F25.0, F25.1, F25.8, F25.9, F28-F29, F30.10-F30.13, F30.2-F30.4, F30.8, F30.9, F31.0, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78, F31.81, F31.89, F32.0-F32.5, F32.81, F32.89, F32.9, F32.A, F33.0-F33.3, F33.40-F33.42, F33.8, F33.9, F34.0, F34.1, F34.81, F34.89, F34.9, F39, F40.00-F40.02, F40.10. F40.11, F40.210, F40.218, F40.220, F40.228, F40.230-F40.233, F40.240--F40.243, F40.248, F40.290, F20.291, F40.298, F40.8-F41..1, F41.3, F41.8, F41.9, F42.2-F42.4, F42.8, F42.9, F43.0, F43.10-F43.12, F43.20-F43.25, F43.29, F43.81, F43.89, F43.9, F44.89, F45.21, F51.5, F53.0, F53.1, F60.0-F60.7, F60.81, F60.89, F60.9, F63.0-F63.3, F63.81, F63.89, F63.9, F69.10-F68.13, F68.8, F68.A, F84.0, F8.2, F84.3, F84.5, F84.8, F84.9, F90.0-F90.2, F90.8, F90.9, F91.0-F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0-F94.2, F94.8, F94.9, O90.6, O99.340-O99.345
Exercise Counseling	**ICD-10:** Z71.82
Dispensed Antidepressant Medication	

**Codes subject to change.*

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

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of ED visits among persons 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose for which there was a follow-up.

Measure is based on ED visits; persons may appear in a measure sample more than once. Each ED visit requires a separate follow-up.

Two rates are reported:

1. **Discharges for which the person received follow-up within 30 days of discharge.**
   A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

2. **Discharges for which the person received follow-up within seven days of discharge.**
   A follow-up visit or a pharmacotherapy dispensing event within seven days after the ED visit (eight total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

(continued)

(FUA) Follow-Up After Emergency Department Visit for Substance Use Disorder (SUD) *(continued)*

Lines of Business: Medicaid, Medicare

Tips

- Offer virtual, telehealth, and phone visits.
- Maintain appointment availability in your practice for persons, and schedule follow-up appointments before the person leaves the office.
- Discuss the benefits of seeing a primary or specialty provider.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), or other community support groups.
- Reach out proactively within 24 hours if the person does not keep scheduled appointment to schedule another.

The visit can be with any practitioner if the claim includes a diagnosis of SUD (e.g., F10.xx–F19.xx) or drug overdose (e.g., T40–T43, T51). If the visit occurs with a mental health provider, the claim does not have to include the SUD or drug overdose diagnosis.

Description	Codes*
Outpatient Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2013, H2015, H2013–H2020, T1015 **POS:** 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71–72
Intensive Outpatient Encounter or Partial Hospitalization with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Non-residential Substance Abuse Treatment Facility with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 57, 58
Community Mental Health Center Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53

(continued)

(FUA) Follow-Up After Emergency Department Visit for Substance Use Disorder (SUD) *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Peer Support Service with any Diagnosis of SUD or Drug Overdose	**HCPCS:** G0140, G0177, H0024, H0025, H0038–H0040, H0046, H2014, H2023, S9445, T1012, T1016
Opioid Treatment Service That Bills Monthly or Weekly with any Diagnosis of SUD or Drug Overdose	**HCPCS:** G2086, G2087, G2071, G8074–G2077, G2080
Telehealth Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Telephone Visit with any Diagnosis of SUD or Drug Overdose	**CPT:** 98966–98968, 99441–99443
E-Visit or Virtual Check In with any Diagnosis of SUD or Drug Overdose	**CPT:** 98970–98972, 98980, 98981, 99422–99444, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252
Substance Use Disorder Services	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, H0001, H0005, H0015, H0016, H0022, H0047, H0050, H2035, H2036, H0006, H0028, T1006, T1012
Behavioral Health Screening or Assessment for SUD or Mental Health Disorders	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
Pharmacotherapy Dispensing Event or Medication Treatment Event	**Medications:** Disulfiram (oral), Naltrexone (oral and injectable), acamprosate (oral; delayed-release tablet), buprenorphine (implant, injection, or sublingual tablet), buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) **HCPCS:** G2069, G2070, G2072, G2073, H0020, H0033, J0570–J0575, J0577, J0578, J2315, Q9991, Q9992, S0109

**Codes subject to change.*

(FUH) Follow-Up After Hospitalization for Mental Illness

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare, Marketplace

Measure evaluates the percentage of discharges for persons six years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service.

Two rates are reported:

1. Discharges for which the person received **follow-up within 30 days after discharge**.
2. Discharges for which the mperson received **follow-up within seven days after discharge**.

Tips

- Schedule follow-up appointments prior to discharge and include the date and time on discharge instructions.
- Offer telehealth, and phone visits.
- Reach out proactively to assist in scheduling/rescheduling appointments within the required timeframes.
- Partner with the health plan to address social determinants, health equity, and quality care.
- Address comorbidities and integrate care with peer support and psychiatric collaborative care models.
- Submit applicable codes.

Description	Codes*
Outpatient Visit with a Mental Health Provider or With Any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015
Visit Setting Unspecified for Intensive Outpatient Encounter or Partial Hospitalization	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 52
Partial Hospitalization/ Intensive Outpatient	**HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485

(continued)

(FUH) Follow-Up After Hospitalization for Mental Illness *(continued)*

Lines of Business: Medicaid, Medicare, Marketplace

Description	Codes*
Community Mental Health Center Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 98960–98962, 99078, 99202–99205, 99211–99215, 99221–99223, 99231–99233, 99238, 99239, 99242–99245, 99252–99255, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015 **POS:** 53
Electroconvulsive Therapy	**CPT:** 90870 **POS:** 24, 52, 53
Peer Support Services or With Any Diagnosis of a Mental Health Disorder	**HCPCS:** G0140, G0177, H0024, H0025, H0038–H0040, H0046, H2014, H2023, S9445, T1012, T1013
Psychiatric Residential	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 56
Telehealth Visit With a Mental Health Provider or Any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Transitional Care Management	**CPT:** 99495, 99496
Telephone Visit With a Mental Health Provider or Any Diagnosis of a Mental Health Disorder	**CPT:** 98966–98968, 99441–99443
Psychiatric Collaborative Care Management With a Mental Health Provider or Any Diagnosis of a Mental Health Disorder	**CPT:** 99492–99494 **HCPCS:** G0512

**Codes subject to change.*

(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder among persons 13 years of age and older that result in a follow-up visit or service for substance use disorder during the measurement period.

- ✓ For an acute inpatient discharge or residential treatment discharge, or for withdrawal management that occurred during an acute inpatient stay or residential treatment stay, the episode date is the date of discharge.
- ✓ For direct transfers, the episode date is the discharge date from the transfer admission.
- ✓ For withdrawal management (other than withdrawal management that occurred during an acute inpatient stay or residential treatment stay), the episode date is the date of service.

Two rates are reported:

1. The percentage of visits or discharges for which the person received follow-up for substance use disorder **within the 30 days after the visit or discharge.**
2. The percentage of visits or discharges for which the person received follow-up for substance use disorder **within the seven days after the visit or discharge.**

Note: Follow up does not include withdrawal management.

Tips

- Offer virtual, telehealth, and phone visits.
- Maintain appointment availability in your practice for persons and schedule follow-up appointments before the person leaves the office.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), or other community support groups.
- Reach out proactively within 24 hours if the person does not keep scheduled appointment to schedule another.

The claim should include a principal diagnosis of substance use disorder (e.g., applicable code F10.10–F19.29)

(continued)

(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder (SUD) *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
Outpatient Visit with a Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 98000–98007, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962,99078, 99202–99205, 99211–99215, 99242–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, G0560, H0002, H0004, H0031, H0034, H0036, H0037, H2000, H2010, H2011, H2013–H2020, H0039, H0040, T1015 **POS:** 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71–72
Intensive Outpatient Encounter or Partial Hospitalization with a Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 **POS:** 52
Non-residential Substance Abuse Treatment Facility with a Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 57, 58
Community Mental Health Center Visit with a Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53
Telehealth Visit with a Diagnosis of SUD	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Substance Use Disorder Services with a Diagnosis of SUD	**CPT:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
Opioid Treatment Service that Bills Monthly or Weekly with a Diagnosis of SUD	**HCPCS:** G2071, G2074–G2077, G2080, G2086, G2087
Residential Behavioral Health Treatment with a Diagnosis of SUD	**HCPCS:** H0017, H0018, H0019, T2048
Substance Use Disorder Counseling and Surveillance	**ICD-10:** Z71.41, Z71.51
Telephone Visit with a Diagnosis of SUD	**CPT:** 98966–98968, 99441–99443

(continued)

(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder (SUD) *(continued)*

Lines of Business: Medicaid, Medicare

Description	Codes*
E-Visit or Virtual Check in with a Diagnosis of SUD	**CPT:** 98970–98972, 98980, 98981, 99421–99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252
Pharmacotherapy Dispensing Event or Medication Treatment Event	**Medications:** Disulfiram (oral), Naltrexone (oral and injectable), acamprosate (oral; delayed-release tablet), buprenorphine (implant, injection, or sublingual tablet), buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) **HCPCS:** G2069, G2070, G2072, G2073, H0020, H0033, J0570–J0575, J0577, J0578, J2315, Q9991, Q9992, S0109
Peer Support Services with a Diagnosis of SUD	**HCPCS:** G0140, G0177, H0024, H0025, H0038–H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017

**Codes subject to change.*

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

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of ED visits for persons six years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service during the measurement period.

Two rates are reported:

1. The percentage of ED visits for which the person received follow-up **within 30 days of the ED visit (31 total days)**.
2. The percentage of ED visits for which the person received follow-up **within seven days of the ED visit (eight total days)**.

Tips

- Offer virtual, telehealth, and phone visits.
- Maintain appointment availability in your practice for persons and schedule follow-up appointments before the person leaves the office.
- Discuss the benefits of seeing a primary or specialty provider and appropriate ED utilization.
- Partner with the health plan to address social determinants, health equity, and quality care.

The claim should include a diagnosis of mental health disorder.

(continued)

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

Lines of Business: Medicaid, Medicare

Description	Codes*
Outpatient Visit with any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 98000–98007, 99221–99223, 99231–99233, 99238, 99239, 99252–99255, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, G0560, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015 **POS:** 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71–72
Intensive Outpatient Encounter or Partial Hospitalization with any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **HCPCS:** G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485 **POS:** 52
Community Mental Health Center Visit	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 53
Electroconvulsive Therapy	**CPT:** 90780 **POS:** 24, 52, 53
Telehealth Visit with any Diagnosis of a Mental Health Disorder	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 02, 10
Telephone Visit with any Diagnosis of a Mental Health Disorder	**CPT:** 98966–98968, 99441–99443
E-Visit or Virtual Check in with any Diagnosis of a Mental Health Disorder	**CPT:** 98970–98972, 98980, 98981, 99421–99423, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2250–G2252
Peer Support Services with any Diagnosis of a Mental Health Disorder	**HCPCS:** G0140, G0177, H0024, H0025, H0038–H0040, H0046, H2014, H2023, S9445, T1012, T1016
Psychiatric Collaborative Care Management	**CPT:** 99492–99494 **HCPCS:** G0140, T1017
Psychiatric Residential Treatment	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 **POS:** 56

**Codes subject to change.*

(HDO) Use of Opioids at High Dosage

Lines of Business: Medicaid, Medicare

Measures the percentage of persons 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement period.

Decreased score indicates improvement.

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Benzhydrocodone	• Acetaminophen Benzhydrocodone 4.08 mg Medications List • Acetaminophen Benzhydrocodone 6.12 mg Medications List • Acetaminophen Benzhydrocodone 8.16 mg Medications List	4.08 mg 6.12 mg 8.16 mg	1.2
Butorphanol	• Butorphanol 10 MGPML Medications List	10 mg	7
Codeine	• Codeine Sulfate 15 mg Medications List • Codeine Sulfate 30 mg Medications List • Codeine Sulfate 60 mg Medications List	15 mg 30 mg 60 mg	0.15
Codeine	• Acetaminophen Codeine 2.4 MGPML Medications List • Acetaminophen Codeine 15 mg Medications List • Acetaminophen Codeine 30 mg Medications List • Acetaminophen Codeine 60 mg Medications List	2.4 mg 15 mg 30 mg 60 mg	0.15
Codeine	• Acetaminophen Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	• Aspirin Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	• Aspirin Carisoprodol Codeine 16 mg Medications List	16 mg	0.15
Dihydrocodeine	• Acetaminophen Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Fentanyl Buccal or Sublingual Tablet, Transmucosal Lozenge (mcg)[1]	• Fentanyl 100 mcg Medications List • Fentanyl 200 mcg Medications List • Fentanyl 300 mcg Medications List • Fentanyl 400 mcg Medications List • Fentanyl 600 mcg Medications List • Fentanyl 800 mcg Medications List • Fentanyl 1200 mcg Medications List • Fentanyl 1600 mcg Medications List	100 mcg 200 mcg 300 mcg 400 mcg 600 mcg 800 mcg 1200 mcg 1600 mcg	0.13
Fentanyl Oral Spray (mcg)[2]	• Fentanyl 100 MCGPS Oral Medications List • Fentanyl 200 MCGPS Oral Medications List • Fentanyl 400 MCGPS Oral Medications List • Fentanyl 600 MCGPS Oral Medications List • Fentanyl 800 MCGPS Oral Medications List	100 mcg 200 mcg 400 mcg 600 mcg 800 mcg	0.18

(continued)

(HDO) Use of Opioids at High Dosage *(continued)*

Lines of Business: Medicaid, Medicare

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Fentanyl Nasal Spray (mcg)[3]	• Fentanyl 100 MCGPS Nasal Medications List • Fentanyl 300 MCGPS Nasal Medications List • Fentanyl 400 MCGPS Nasal Medications List	100 mcg 300 mcg 400 mcg	0.16
Fentanyl Transdermal Film/Patch (mcg/hr)[4]	• Fentanyl 12 MCGPH Medications List • Fentanyl 25 MCGPH Medications List • Fentanyl 37.5 MCGPH Medications List • Fentanyl 50 MCGPH Medications List • Fentanyl 62.5 MCGPH Medications List • Fentanyl 75 MCGPH Medications List • Fentanyl 87.5 MCGPH Medications List • Fentanyl 100 MCGPH Medications List	12 mcg 25 mcg 37.5 mcg 50 mcg 62.5 mcg 75 mcg 87.5 mcg 100 mcg	7.2
Hydrocodone	• Hydrocodone 10 mg Medications List • Hydrocodone 15 mg Medications List • Hydrocodone 20 mg Medications List • Hydrocodone 30 mg Medications List • Hydrocodone 40 mg Medications List • Hydrocodone 50 mg Medications List • Hydrocodone 60 mg Medications List • Hydrocodone 80 mg Medications List • Hydrocodone 100 mg Medications List • Hydrocodone 120 mg Medications List	10 mg 15 mg 20 mg 30 mg 40 mg 50 mg 60 mg 80 mg 100 mg 120 mg	1
Hydrocodone	• Acetaminophen Hydrocodone .5 MGPML Medications List • Acetaminophen Hydrocodone .67 MGPML Medications List • Acetaminophen Hydrocodone 2.5 mg Medications List • Acetaminophen Hydrocodone 5 mg Medications List • Acetaminophen Hydrocodone 7.5 mg Medications List • Acetaminophen Hydrocodone 10 mg Medications List	.5 mg .67 mg 2.5 mg 5 mg 7.5 mg 10 mg	1
Hydrocodone	• Hydrocodone Ibuprofen 2.5 mg Medications List • Hydrocodone Ibuprofen 5 mg Medications List • Hydrocodone Ibuprofen 7.5 mg Medications List • Hydrocodone Ibuprofen 10 mg Medications List	2.5 mg 5 mg 7.5 mg 10 mg	1
Hydromorphone	• Hydromorphone 1 MGPML Medications List Hydromorphone 2 mg Medications List • Hydromorphone 3 mg Medications List • Hydromorphone 4 mg Medications List • Hydromorphone 8 mg Medications List • Hydromorphone 12 mg Medications List • Hydromorphone 16 mg Medications List • Hydromorphone 32 mg Medications List	1 mg 2 mg 3 mg 4 mg 8 mg 12 mg 16 mg 32 mg	4

(continued)

(HDO) Use of Opioids at High Dosage *(continued)*

Lines of Business: Medicaid, Medicare

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Levorphanol	• Levorphanol 2 mg Medications List • Levorphanol 3 mg Medications List	2 mg 3 mg	11
Meperidine	• Meperidine 10 MGPML Medications List • Meperidine 50 mg Medications List • Meperidine 100 mg Medications List	10 mg 50 mg 100 mg	0.1
Methadone[5]	• Methadone 1 MGPML Medications List • Methadone 2 MGPML Medications List • Methadone 5 mg Medications List • Methadone 10 mg Medications List • Methadone 10 MGPML Medications List • Methadone 40 mg Medications List	1 mg 2 mg 5 mg 10 mg 10 mg 40 mg	3
Morphine	• Morphine 2 MGPML Medications List • Morphine 4 MGPML Medications List • Morphine 5 mg Medications List • Morphine 10 mg Medications List • Morphine 15 mg Medications List • Morphine 20 MGPML Medications List • Morphine 20 mg Medications List • Morphine 30 mg Medications List • Morphine 40 mg Medications List • Morphine 45 mg Medications List • Morphine 50 mg Medications List • Morphine 60 mg Medications List • Morphine 75 mg Medications List • Morphine 80 mg Medications List • Morphine 90 mg Medications List • Morphine 100 mg Medications List • Morphine 120 mg Medications List • Morphine 200 mg Medications List	2 mg 4 mg 5 mg 10 mg 15 mg 20 mg 20 mg 30 mg 40 mg 45 mg 50 mg 60 mg 75 mg 80 mg 90 mg 100 mg 120 mg 200 mg	1
Opium	• Belladonna Opium 30 mg Medications List • Belladonna Opium 60 mg Medications List	30 mg 60 mg	1
Oxycodone	• Oxycodone 1 MGPML Medications List • Oxycodone 5 mg Medications List • Oxycodone 7.5 mg Medications List • Oxycodone 9 mg Medications List • Oxycodone 10 mg Medications List • Oxycodone 13.5 mg Medications List • Oxycodone 15 mg Medications List • Oxycodone 18 mg Medications List	1 mg 5 mg 7.5 mg 9 mg 10 mg 13.5 mg 15 mg 18 mg	1.5

(continued)

(HDO) Use of Opioids at High Dosage *(continued)*

Lines of Business: Medicaid, Medicare

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Oxycodone	• Oxycodone 20 mg Medications List • Oxycodone 20 MGPML Medications List • Oxycodone 27 mg Medications List • Oxycodone 30 mg Medications List • Oxycodone 36 mg Medications List • Oxycodone 40 mg Medications List • Oxycodone 60 mg Medications List • Oxycodone 80 mg Medications List	20 mg 20 mg 27 mg 30 mg 36 mg 40 mg 60 mg 80 mg	1.5
Oxycodone	• Acetaminophen Oxycodone 1 MGPML Medications List • Acetaminophen Oxycodone 2 MGPML Medications List • Acetaminophen Oxycodone 2.5 mg Medications List • Acetaminophen Oxycodone 5 mg Medications List • Acetaminophen Oxycodone 7.5 mg Medications List • Acetaminophen Oxycodone 10 mg Medications List	1 mg 2 mg 2.5 mg 5 mg 7.5 mg 10 mg	1.5
Oxycodone	• Aspirin Oxycodone 4.84 mg Medications List	4.84 mg	1.5
Oxycodone	• Ibuprofen Oxycodone 5 mg Medications List	5 mg	1.5
Oxymorphone	• Oxymorphone 5 mg Medications List • Oxymorphone 7.5 mg Medications List • Oxymorphone 10 mg Medications List • Oxymorphone 15 mg Medications List • Oxymorphone 20 mg Medications List • Oxymorphone 30 mg Medications List • Oxymorphone 40 mg Medications List	5 mg 7.5 mg 10 mg 15 mg 20 mg 30 mg 40 mg	3
Pentazocine	• Naloxone Pentazocine 50 mg Medications List	50 mg	0.37
Tapentadol	• Tapentadol 50 mg Medications List • Tapentadol 75 mg Medications List • Tapentadol 100 mg Medications List • Tapentadol 150 mg Medications List • Tapentadol 200 mg Medications List • Tapentadol 250 mg Medications List	50 mg 75 mg 100 mg 150 mg 200 mg 250 mg	0.4
Tramadol	• Tramadol 5 MGPML Medications List • Tramadol 50 mg Medications List • Tramadol 100 mg Medications List • Tramadol 150 mg Medications List • Tramadol 200 mg Medications List • Tramadol 300 mg Medications List	5 mg 50 mg 100 mg 150 mg 200 mg 300 mg	0.1
Tramadol	• Acetaminophen Tramadol 37.5 mg Medications List	37.5 mg	0.1

(IET) Initiation and Engagement of Substance Use Disorder (SUD) Treatment

Applicable Foster Care Measure

Lines of Business: Medicaid, Medicare, Marketplace

Time frame for measure: (to capture episodes) Nov. 15 of the year prior to the measurement period through Nov. 14 of the measurement period.

Measure evaluates the percentage of adolescent and adult persons with a new episode of substance use disorder (SUD) episodes during the measurement period that result in treatment initiation and engagement.

Two rates are reported:

1. **Initiation of SUD Treatment:** percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth, or medication treatment **within 14 days**.

2. **Engagement of SUD Treatment:** percentage of new SUD episodes that have evidence of treatment engagement **within 34 days of initiation**.

Tips

- Complete a comprehensive exam before diagnosing; co-existing disorders are not uncommon and can undermine effectiveness and adherence to treatment.
- Develop working alliances with specialists in substance use disorders for persons who would benefit from specialty care.
- Explain the importance of a follow-up to your persons.
- Schedule an initial follow-up appointment within 14 days.
- Reschedule persons as soon as possible if they do not keep initial appointments.
- Use telehealth where appropriate.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), or other community support groups.
- Maintain appointment availability in your practice for persons and schedule follow-up appointments before the person leaves the office.
- Submit applicable codes.

A diagnosis of Alcohol, Opioid, or Other Drug Abuse and Dependence with one of the following:

Description	Codes*
Acute or Nonacute Inpatient Admission	**UBREV:** 0100–0101, 0110–0114, 0116–0124, 0126–0134, 0136–0144, 0146–0154, 0156–0160, 0164, 0167, 0169–0174, 0179, 0190–0194, 0199–0204, 0206–0214, 0219, 1000–1002
Outpatient Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99252–99255 with POS 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71, 72

(continued)

(IET) Initiation and Engagement of Substance Use Disorder (SUD) Treatment *(continued)*

Lines of Business: Medicaid, Medicare, Marketplace

Description	Codes*
Behavioral Health Outpatient Visit	**CPT:** 98000–98007, 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347, 99348, 99350, 99381–99387, 99391–99397, 99401–99404, 99411–99412, 99483, 99492–99494, 99510 **HCPCS:** G0155, G0176, G0177, G0409, G0463, G0512, G0560, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, T1015
Intensive Outpatient Encounter or Partial Hospitalization	**CPT:** 90791–90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 52 or G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Non-residential Substance Abuse Treatment Facility	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 57, 58
An Outpatient Visit at a Community Mental Health Center	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 53
Telehealth Visit	**CPT:** 90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875–90876, 99221–99223, 99231–99233, 99238–99239, 99251–99255 with POS 02, 10
A Substance Use Disorder Service	**CPT:** 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
A Substance Use Disorder Counseling and Surveillance	**ICD-10:** Z71.41, Z71.51
Telephone Visit	**CPT:** 98966–98968, 99441–99443
An E-Visit or Virtual Check-In Visit	**CPT:** 98969–98972, 98980, 98981, 99421–99444, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2061–G2063, G2250–H2252
Opioid Treatment Service that Bills Monthly or Weekly	**HCPCS:** G2071, G2074–G2077, G2080, G2086, G2087
An Alcohol Use Disorder Medication Dispensing Event (For Alcohol Cohort)	Disulfiram (oral), naltrexone (oral and injectable), acamprosate (oral and delayed-release tablet)
An Opioid Use Disorder Medication Dispensing Event (For Opioid Use Cohort)	Naltrexone (oral and injectable), buprenorphine (sublingual tablet, injection, implant), buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) **HCPCS:** G2069, G2070, G2072, G2073, H0020, H0033, J0570–J0575, J2315, Q9991, Q9992, S0109, G2067–G2070, G2072, G2073

**Codes subject to change.*

(continued)

(IET) Initiation and Engagement of Substance Use Disorder (SUD) Treatment *(continued)*

Lines of Business: Medicaid, Medicare, Marketplace

Medication Treatment Events:

- ✓ **Alcohol Use Disorder Treatment Medications:** Disulfiram (oral), naltrexone (oral and injectable), acamprosate (oral; delayed-release tablet).
- ✓ **Opioid Use Disorder Treatment Medications:** Naltrexone (oral and injectable), buprenorphine (sublingual tablet, injection, and implant), buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film).
- ✓ Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

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

Line of Business: Medicaid

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

Two rates are reported:

1. **Depression Screening.** The percentage of deliveries in which persons were screened for clinical depression using a standardized instrument during the postpartum period (7-84 days following the date of delivery).
2. **Follow-Up on Positive Screen.** The percentage of deliveries in which persons received follow-up care on or up to 30 days after the date of the first positive depression screen finding (31 total days).

Note: A LOINC code submission via flat file is required to be adherent for the depression screening numerator.

Tips

- Use age-appropriate screening instruments.
- If there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow up.
- Train staff on the importance of depression screenings and recognizing the risk factors for depression during and post pregnancy.
- Develop a workflow that includes utilizing a standardized instrument for depression screenings at every visit.
- Ask your provider relations representative about ways to submit data to the health plan directly from your EHR/EMR.
- Document follow-up on positive screen on or up to 30 days after the first positive screen.

(continued)

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

Line of Business: Medicaid

Depression Screening instrument: A standard assessment instrument that has been normalized and validated for the appropriate person population. Eligible screening instruments with thresholds for positive findings for numerator 1 include:

Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score ≥60
Instruments for Adults (18+ years)	**Total Score LOINC Codes**	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety—Depression Scale (DUKE-AD)®	90853-3	Total score ≥30
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3)®	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score ≥60
PROMIS Emotional Distress-Depression-Short Form	77861-3	Total score ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

✓ If the depression screening is positive, the person must receive follow-up care on or up to 30 days after the date of the first positive screening.

(continued)

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

Line of Business: Medicaid

Description	Codes*
An Outpatient, Telephone, E-visit, or Virtual Check-In Follow-Up Visit with a Diagnosis of Depression or Other Behavioral Health Condition	**UBREV:** 0510, 0513, 0516, 0517, 0519–0523, 0526–0529, 0982, 0983 **CPT:** 98960–98962, 98966–98968, 98970–98972, 98980, 98981, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99441–99443, 99457, 99458, 99483 **HCPCS:** G0071, G0463, G2010, G2012, G2250–G2252, T1015
Depression Case Management Encounter that Documents Assessment for Symptoms of Depression (i.e., SNOMED) or a Diagnosis of Depression or Other Behavioral Health Condition	**CPT:** 99366, 99492–99494 **HCPCS:** G0512, T1016, T1017, T2022, T2023
Behavioral Health Encounter, Including Assessment, Therapy, Collaborative Care, or Medication Management	**CPT:** 90791, 90792, 90832–90834, 90836–90839, 90845–90847, 90849, 90853, 90865, 90867–90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493 **HCPCS:** G0155, G0176, G0177, G0409–G0411, G0511, G0512, H0002, H0004, H0031, H0034–H0037, H0039, H0040, H2000, H2001, H2010–H2020, S0201, S9480, S9484, S9485 **UBREV:** 0900–0905, 0907, 0911–0917, 0919
Exercise Counseling	**ICD-10:** Z71.82
Dispensed Antidepressant Medication	

Documentation of an additional depression screening on a full-length instrument (i.e., PHQ-9®) indicating either no depression or no symptoms that require follow-up (i.e., negative screen) on the same day as a positive screen on a brief screening instrument (i.e., PHQ-2®).

**Codes subject to change.*

(PND-E) Prenatal Depression Screening

Line of Business: Medicaid

Measure evaluates the percentage of deliveries with at least 37 weeks of gestation in which persons were screened for clinical depression while pregnant and, if screened positive, received follow-up care during the measurement period.

Two rates are reported:

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

Note: Applicable LOINC codes are required for numerator 1 (Depression Screening).

Depression Screening instrument: A standard assessment instrument that has been normalized and validated for the appropriate person population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Positive Finding	LOINC Code (Required for numerator 1)
Patient Health Questionnaire (PHQ-9)®	Total score ≥10	44261-6
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10	89204-2
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8	89208-3
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	Total score ≥17	89205-9
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10	99046-5
PROMIS Depression	Total score ≥60	71965-8
Instruments for Adults (18+ years)	**Positive Finding**	**LOINC Code (Required for numerator 1)**
Patient Health Questionnaire (PHQ-9)®	Total score ≥10	44261-6
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3	55758-7
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8	89208-3
Beck Depression Inventory (BDI-II)	Total score ≥20	89209-1
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	Total score ≥17	89205-9
PROMIS Emotional Distress Depression — Short Form	Total score ≥60	77861-3
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥30	90853-3
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10	99046-5

[1]*Brief screening instrument. All other instruments are full-length.*

[2]*Proprietary; may be cost or licensing requirement associated with use.*

(continued)

(PND-E) Prenatal Depression Screening *(continued)*

Line of Business: Medicaid

Instruments for Adults (18+ years)	Positive Finding	LOINC Code (Required for numerator 1)
My Mood Monitor (M-3)®	Total score ≥5	71777-7
PROMIS Depression	Total score ≥60	71965-8
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥31	90221-3

Tips

- Use age-appropriate screening instruments.
- If there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.
- Train staff on the importance of depression screenings and recognizing the risk factors for depression in pregnancy.
- Develop a workflow that includes utilizing a standardized instrument for depression screenings at every visit.
- Ask your provider relations representative about ways to submit data to the health plan directly from your EHR/EMR.
- Document follow-up on positive screen on or up to 30 days after the first positive screen.

Description	Codes*
Behavioral Health Encounter	**CPT:** 90791, 90792, 90832–90839, 90845–90849, 90853, 90865–90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493 **HCPCS:** G0155, G0176, G0177, G0409–G0411, G0511, G0512, H0002, H0004, H0031, H0034–H0037, H0039, H0040, H2000, H2001, H2010–H2020, S0201, S9480, S9484, S9485
Depression Case Management Encounter	**CPT:** 99366, 99492–99494 **HCPCS:** G0512, T1016, T1017, T2022, T2023
Outpatient, Telephone, E-Visit, or Virtual Check-In with a Diagnosis of Depression or other Behavioral Health Condition	**CPT:** 98960–98962, 98966–98968, 98970–98972, 98980, 98981, 99078, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99441–99443, 99457, 99458, 99483, G0071, G0463, G2010, G2012, G2250, G2252, T1015 **ICD-10:** Applicable code between F01.511–F94.7, O90.6, O99.340–O99.345
Exercise Counseling	**ICD-10:** Z71.82
Dispensed Antidepressant Medication	

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

**Codes subject to change.*

(POD) Pharmacotherapy for Opioid Use Disorder

Line of Business: Medicaid

Measure evaluates the percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among persons 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event during the measurement period.

Measure must meet the following requirements:

- ✓ Persons 16 years of age and older.
- ✓ OUD dispensing event is captured between a 12-month period that begins on Jul. 1 of the year prior to the measurement period and ends on Jun. 30 of the measurement period (intake period).
- ✓ Persons must have a negative medication history (no OUD pharmacotherapy medications) as of 31 days prior to the new OUD pharmacotherapy.

Care Gap Closure: The measure is event-based, and it is met when the person adheres to OUD pharmacotherapy for 180 days or more without a gap in treatment of more than eight days.

Tips

- Closely monitor medication prescriptions and do not allow any gap in treatment of eight or more consecutive days.
- Offer mutual help like peer recovery support, harm reduction, 12-step fellowships such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).
- Provide timely submission of claims with correct medication name, dosage, frequency, and days covered.
- Reach out proactively within 24 hours if the person does not keep scheduled appointment to schedule another.
- Inform person of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment.

Note: Persons can have multiple treatment period start dates and treatment periods during the measurement period. Treatment periods can overlap.

Description	Codes*
Buprenorphine/Naloxone (Sublingual Tablet, Buccal Film, Sublingual Film)	**HCPCS:** J0572, J0573, J0574, J0575
Buprenorphine Oral, Implant, and Injectable**	**HCPCS:** H0033, J0570, J0571, Q9991, Q9992
Methadone	**HCPCS:** G2067, G2078, H0020, S0109
Naltrexone Injection	**HCPCS:** G2073, J2315

**Codes subject to change.*

***Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

(SAA) Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Lines of Business: Medicaid, Medicare

The index prescription start date (IPSD) is the earliest prescription dispensing data for any antipsychotic medication during the measurement period.

The treatment period is defined as the time beginning on the IPSD through the last day of the measurement period.

Measure evaluates the percentage of persons 18 years of age and older during the measurement period with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication using the prescription with the longest days' supply.

Tips

- Consider the use of long-acting injectable antipsychotic medications to increase adherence.
- Provide education on how to take the medication, expected side effects, and the importance of talking to the prescriber before stopping the medication.

Oral Antipsychotics				
• aripiprazole • asenapine • brexpiprazole • cariprazine • clozapine	• haloperidol • iloperidone • loxapine • lumateperone • lurasidone	• molindone • olanzapine • paliperidone • quetiapine • risperidone	• ziprasidone • chlorpromazine • fluphenazine • perphenazine • prochlorperazine	• thioridazine • trifluoperazine • amitriptyline- • perphenazine • thiothixene

Long-Acting Injections	
Description	**Prescription**
Long-acting Injections 14-Day Supply	• risperidone (excluding Perseris®)
Long-acting Injections 28-Day Supply	• aripiprazole • aripiprazole lauroxil • fluphenazine decanoate • haloperidol decanoate • olanzapine
Long-acting Injections 30-Day Supply	• risperidone (Perseris®)
Long-acting Injections 35-Day supply	• paliperidone palmitate (Invega Sustenna)
Long-acting Injections 104-Day supply	• paliperidone palmitate (Invega Trinza)
Long-acting Injections 201-Day Supply	• paliperidone palmitate (Invega Hafyera)

(SMC) Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Line of Business: Medicaid

Measure evaluates the percentage of persons 18 to 64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease who had an LDL-C test during the measurement period.

Tips

- Provide persons/caregivers with lab orders for HbA1c or glucose lab test and cholesterol or LDL-C to be completed yearly.
- Educate the person and caregiver about the risks associated with taking antipsychotic medications and the importance of regular follow-up care.
- Consider using standing orders to get lab tests.
- Educate persons and their caregivers on the importance of completing annual visits and blood work.
- Discuss weight management options and encourage persons to increase physical activity, improve sleep, and maintain a well-balanced diet.
- Submit applicable codes.

Description	Codes*
LDL-C Lab Test	**CPT:** 80061, 83700, 83701, 83704, 83721

LDL-C Test Result or Finding	Codes*
Most Recent LDL-C Less Than 100 mg/dL (CAD) (DM)	**CPT-CAT-II:** 3048F
Most Recent LDL-C 100-129 mg/dL (CAD) (DM)	**CPT-CAT-II:** 3049F
Most Recent LDL-C Greater Than or Equal to 130 mg/dL (CAD) (DM)	**CPT-CAT-II:** 3050F

**Codes subject to change.*

(SMD) Diabetes Monitoring for People With Diabetes and Schizophrenia

Line of Business: Medicaid

Measure evaluates the percentage of persons 18 to 64 years of age (as of the last day of the measurement period) with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement period.

Tips

- Provide persons/caregivers with lab orders for HbA1c or glucose lab test and cholesterol or LDL-C to be completed yearly.
- Educate the person and caregiver about the risks associated with taking antipsychotic medications and the importance of regular follow-up care.
- Consider using standing orders to get lab tests.
- Educate persons and their caregivers on the importance of completing annual visits and blood work.
- Discuss weight management options and encourage persons to increase physical activity, improve sleep, and maintain a well-balanced diet.
- Submit applicable codes.

Description	Codes*
Glucose Lab Test	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
HbA1c Lab Test	**CPT:** 83036, 83037 **LOINC:** 17855-8, 17856-6, 4548-4, 4549-2, 96595-4
HbA1c Test Result or Finding	**CAT II:** 3044F, 3046F, 3051F, 3052F
LDL-C Lab Test	**CPT:** 80061, 83700, 83701, 83704, 83721 **LOINC:** 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7
LDL-C Test Result or Finding	**CAT II:** 3048F, 3049F, 3050F

**Codes subject to change.*

(SSD) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

Line of Business: Medicaid

Measure evaluates the percentage of persons 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.

Identify persons with diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder, and conduct a glucose or HbA1c lab test.

Tips

- Provide persons/caregivers with lab orders for HbA1c or glucose lab test to be completed yearly.
- Educate the person and caregiver about the risks associated with taking antipsychotic medications and the importance of regular follow-up care.
- Consider using standing orders to get lab tests.
- Educate persons and their caregivers on the importance of completing annual visits and blood work.
- Discuss weight management options and encourage persons to increase physical activity, improve sleep, and maintain a well-balanced diet.
- Submit applicable codes.

Description	Codes*
Glucose Lab Test	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
HbA1c Lab Test	**CPT:** 83036, 83037
HbA1c Test Result or Finding	**CPT II:** 3044F, 3046F, 3051F, 3052F

**Codes subject to change.*

*Note: Do **not** include a modifier when using CPT II codes.*

(UOP) Use of Opioids From Multiple Providers

Lines of Business: Medicaid, Medicare

Measure evaluates the percentage of persons 18 years and older receiving prescription opioids for ≥15 days during the measurement period who received opioids from multiple providers.

Three rates are reported:

1. **Multiple Prescribers.** Identify all opioid medication dispensing events during the measurement period. Include persons who received opioids from four or more different prescribers during the measurement period. Use the NPI to determine if the prescriber for medication dispensing events was the same or different.
2. **Multiple Pharmacies.** Identify all opioid medication dispensing events during the measurement period. Include persons who received opioids from four or more different pharmacies during the measurement period. Use the NPI to determine if the pharmacy for medication dispensing events was the same or different.
3. **Multiple Prescribers and Multiple Pharmacies.** Identify all opioid medication dispensing events during the measurement period. Include persons who received opioids from four or more different prescribers and four or more different pharmacies during the measurement period (i.e., persons who are numerator compliant for both the Multiple prescribers and Multiple pharmacies rates).

Decreased score indicates improvement.

Tips

- Use the state Prescription Drug Monitoring Program (PDMP) database prior to initiating opioid therapy and periodically, ranging from every prescription to every three months.
- Educate persons on opioid safety and risk associated with long-term use and use of multiple opioids from different providers.

Opioid Medications Lists

- Acetaminophen Benzhydrocodone Medications List
- Buprenorphine Medications List
- Butorphanol Medications List
- Acetaminophen Butalbital Caffeine Codeine Medications List
- Acetaminophen Codeine Medications List
- Aspirin Butalbital Caffeine Codeine Medications List
- Aspirin Carisoprodol Codeine Medications List
- Codeine Sulfate Medications List
- Acetaminophen Caffeine Dihydrocodeine Medications List
- Fentanyl Medications List
- Acetaminophen Hydrocodone Medications List
- Hydrocodone Medications List
- Hydrocodone Ibuprofen Medications List
- Hydromorphone Medications List
- Levorphanol Medications List
- Meperidine Medications List
- Methadone Medications List
- Morphine Medications List
- Belladonna Opium Medications List
- Opium Medications List
- Acetaminophen Oxycodone Medications List
- Aspirin Oxycodone Medications List
- Ibuprofen Oxycodone Medications List
- Oxycodone Medications List
- Oxymorphone Medications List
- Naloxone Pentazocine Medications List
- Tapentadol Medications List
- Acetaminophen Tramadol Medications List
- Tramadol Medications List