HEDIS® Quality Toolkit

HEDIS® Measurement Year 2025

McLaren Health Plan

Providing health coverage to Michigan families since 1998

Contents

WELCOME

Welcome to our Healthcare Effectiveness Data and Information Set (HEDIS) Quality Toolkit. Developed by the National Committee for Quality Assurance (NCQA), HEDIS is a widely used set of performance measures in the managed care industry and an essential tool in ensuring that your patients and our members get the best health care possible.

McLaren Health Plan, Inc. (MHP) has been operating as a Michigan-based, licensed health maintenance organization (HMO) since 1998. MHP was started to serve Michigan's Medicaid population. Through the years, we've added a second HMO, McLaren Health Plan Community (MHP Community) that offers commercial coverage to individuals on and off exchange, as well as a Medicare Supplement plan and most recently, McLaren Medicare. Our third-party administrator, McLaren Health Advantage, offers administrative services for self-funded employer groups. Together, the three companies deliver health care benefits to more than 300,000 members. This manual applies to McLaren Health Plan, Inc. and MHP Community, and McLaren Medicare we will sometimes refer to the three companies collectively as "MHP."

Our mission is to provide quality health services to all families and individuals covered by McLaren Health Plan. In 2024, McLaren Health Plan, Inc. was awarded the right to operate in and service every county in the lower peninsula in the State of Michigan-the only provider- owned health plan to achieve this designation by the Michigan Department of Health and Human Services (MDHHS). MHP has earned 15 Pinnacle Awards since 2013 from the Michigan Association of Health Plans, and both HMOs are accredited by the National Committee for Quality Assurance (NCQA).

We've designed this manual to clearly define MHP criteria for meeting HEDIS guidelines. We welcome your feedback and look forward to supporting your efforts to provide quality health care to your patients and our members. Please call Customer Service at 888-327-0671 (TTY: 711) if you have questions or if we can be of assistance.

HOW TO USE THIS MANUAL

This manual is comprised of three (3) sections:

Section 1: Partnering with McLaren Health Plan (MHP) to Measure Quality. This section provides useful HEDIS information and an overview of the McLaren Health Plan Member and Provider Incentive Programs.

Section 2: HEDIS Measures. This section includes a description of each HEDIS measure, the correct billing codes and tips to help you improve your HEDIS scores. The measures are in alphabetical order.

Section 3: Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Access to Medical Care Requirements. This section includes useful information on the MHP CAHPS and accessibility standards.

What is the CMS Medicare Star Rating Program?

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure the experiences Medicare beneficiaries have with their health plan and health care system. This is the Star Rating Program. Health plans are rated on a scale of 1 to 5 stars, with 5 being the highest. These ratings are then published for consumers to gauge a plan's quality rating, ease of access to care, provider and health plan experience and satisfaction.

The Star Rating Program is intended to:

- Raise the quality of care for Medicare beneficiaries
- Strengthen beneficiary protections
- Help consumers compare health plans more easily

CMS Star Ratings Categories:

- Staying Healthy: Plans are rated on whether patients had access to preventive services to keep them healthy. This includes physical examinations, vaccinations like flu shots, preventive screenings and reported improvements in their physical and mental health.
- Managing Chronic Conditions: Plans are rated for care coordination and how frequently patients received services for long-term health conditions.
- Member Experience with the Health Plan: Plans are rated on member satisfaction with the plan and providers, including access to care based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey and Health Outcomes Survey (HOS).
- Member Complaints: Plans are rated on how frequently patients submitted complaints or left the plan, whether patients had issues getting needed services and whether plan performance improved from one year to the next.
- Health Plan Customer Service: Plans are rated for quality of call center services (including TTY and interpreter services) and processing appeals and new enrollments in a timely manner.

The Medicare star rating system is important because it:

- Helps members make informed decisions about health plans
- Promotes a higher quality of care for members
- Provides richer benefits for members

What are the CAHPS and HOS surveys?

The Centers for Medicare & Medicaid Services (CMS) develop, implement and administer different patient experience surveys. These surveys ask patients (or in some cases their family members or caregiver) about their experiences with, and ratings of, their health care providers and plans.

CAHPS Survey
Experience ≠ satisfaction

Patient experience surveys are sometimes mistaken for customer satisfaction surveys. However, they're very different.

Patient experience surveys do:

✓ Ask patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions and the coordination of their health care needs

✓ Focus on how patients' experiences are perceived as key aspects of their care

Patient experience surveys don't:

✕ Ask patients how satisfied they were with their care

✕Focus on amenities

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey assesses patients' experiences and satisfaction with health care. Each year, a random sample of health plan patients across commercial, Medicaid and Medicare product lines are selected to participate in the CAHPS survey. The CAHPS survey results also have an impact on the CMS Star ratings. The CAHPS survey is administered between March and June and focuses on matters that patients themselves say are important to them based on the patient doctor relationship, such as:

- Getting care quickly
- Getting needed care/access
- Care coordination between PCP and specialists
- Communication
- Annual flu vaccine
- Rating of health care

HOS Survey

The Medicare Health Outcomes Survey (HOS) is a patient survey that also impacts CMS Star ratings. The HOS assesses the ability of a Medicare organization to maintain or improve the physical and mental health of its Medicare patients over time.

A random sample of health plan patients is selected to participate in the HOS program each year. Two years later, the same patients receive a follow-up survey. The survey results are compared, and the overall health of the patients is rated as better than, the same as or worse than expected. The surveys are administered between August and November and measure the following:

- Improved or maintained mental health
- Improved or maintained physical health
- Monitored physical activity
- Improved bladder control
- Monitored physical activity
- Reduced risk of falling

Achieve excellence in CAHPS and HOS

As a provider, you can impact all aspects of the program (especially quality of care, access to care and beneficiary experience) by:

- Addressing patient concerns regarding the test/procedure
- Creating a workflow to identify non-compliant patients at appointments and their care gaps
- Getting to your patients as quickly as possible when they're in your office
- Encouraging your patients to get preventive screenings
- Getting to know your patients' needs and special needs
- Identifying barriers to care
- Keeping in touch with your patients:
    - Allowing extra time during appointments for questions and answers
    - Following up with all test results and future appointments
    - Making sure each patient has an annual well check and completes all needed tests and screenings
    - Reaching out to patients who haven't been seen
- Incorporating HOS questions into each visit by talking to patients about physical activity, physical and mental health, bladder control and falls prevention
- Reviewing the CAHPS survey to determine opportunities for you or your office to have an impact (e.g., getting your patients in for appointments as quickly as possible, reviewing tests results and coordination of care)

SECTION 1: Partnering with McLaren Health Plan to Measure Quality

What Is HEDIS?

Healthcare Effectiveness Data and Information Set (HEDIS)

The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral health care organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.

NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS, the performance measurement tool used by more than 90 percent of the nation's health plans.

- HEDIS is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service.
- HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to compare health care quality reliably.
- HEDIS consists of 88 measures across six (6) domains of care that address important health issues.
- All managed care companies that are NCQA-accredited perform a HEDIS review annually.
- HEDIS medical record review is a retrospective review of services, Health Plan performance and quality of care from the prior calendar year.
- HEDIS data is collected from multiple sources, including:
    - Administrative data comes from submitted claims and encounters
    - Hybrid data comes from chart collection/review
    - Electronic Clinical Data System (ECDS) Reporting (network of data containing health care system)
- HEDIS rates are calculated with administrative data or hybrid data. Administrative data includes claim data and Electronic Clinical Data Systems (ECDS) which providers submit to the health plan and supplemental data. Hybrid data includes both administrative data and a sample of medical record data. Hybrid measures require review of a random sample of medical records to abstract data for services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data may reduce the need for medical record review.

Annual HEDIS Timeline

January to May	June	September/October
Quality department staff work with provider offices to collect and review HEDIS data.	HEDIS results are certified and reported to NCQA.	NCQA releases health plan ratings and Quality Compass results nationwide for Medicaid.

How to Improve HEDIS Scores

- Work with MHP. We are your partners in care and will assist you in improving your HEDIS scores.
- Use member rosters to contact patients due for an exam or new to your practice.
- Most measures can be collected through claims when complete and accurate coding is used.
- FQHCs/RHCs When billing a T1015 encounter code, it is essential to use the correct diagnosis code and list the actual CPT/HCPCS procedure codes on the claim to identify the services included in the encounter.
- Provide outreach reminders to members for appointments and preventive screenings.
- Assign a Quality or HEDIS nurse or coordinator to perform internal reviews and serve as the point of contact.
- Most Electronic Health Records (EHRs) include options to create alerts and flags for required HEDIS services. Ensure these prompts are turned on or check with your software vendor to add these alerts.
- Take advantage of telehealth opportunities when appropriate.
- If time allows for a quality appointment, avoid missed opportunities by taking advantage of every office visit to provide a well-child visit, immunizations, lead testing and BMI percentile calculations. Many patients may not return to the office for preventive care.
- Use HEDIS-specific billing codes when appropriate. We have tip reference guides identifying what codes are needed for HEDIS.
- Improve Office Management processes and flow. Review and evaluate appointment hours, access and scheduling processes, billing and office/patient flow. We can help streamline processes.
- Review the next day's schedule at the end of each day.
- Identify appointments where test results, equipment or specific employees are available for the visit to be productive.
- Call patients 48 hours before appointments to remind them of the appointment and anything they need to bring. Ask them to make a commitment to be there. This will reduce no-show rates.
- Use non-physicians for items that can be delegated. Have staff prepare the room for items needed.
- Consider using an after-visit summary to ensure patients understand what they need to do and to increase provider communication.

HIPAA and HEDIS

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and the release of this information requires no special patient consent or authorization. Data is reported collectively without individual identifiers. All MHP HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities.

The Importance of Documentation

Principles of the medical record and proper documentation:

- Enables physicians and other healthcare professionals to evaluate a patient's healthcare needs and assess the efficacy of the treatment plan.
- Serves as the legal document to verify the care rendered and date of service. Ensures the date of care rendered is present and all documents are legible.
- Serves as a communication tool among providers and other healthcare professionals involved in the patient's care for improved continuity of care.
- Facilitates timely claim adjudication and payment.
- Appropriately documented clinical information can reduce many challenges associated with claims processing and HEDIS chart requests.
- Supports the ICD-10 and CPT codes reported on billing statements.

Common reasons members with PCP visits remain non-compliant:

- Missing or incomplete required documentation components.
- Service provided without claim/encounter data submitted.
- Lack of referral to obtain the recommended service (i.e., diabetic member eye exam to check for retinopathy, mammogram or other diagnostic testing).
- Service provided; however, outside of the required time frame or anchor date (i.e., lead screening performed after age two (2), postpartum visit occurring before or after 7-84 days of delivery).
- Incomplete services (i.e., Tdap given but no Meningococcal vaccine or HPV for adolescent immunization measure).
- Failure to document or code exclusion criteria for a measure.
- Slow copy vendor turn-around time for HEDIS medical record submission can impede the provider office HEDIS reviews, final rates and applicable value-based payments.

How to Submit HEDIS Data to McLaren Health Plan

Claims and Encounters

McLaren Health Plan prefers that you submit HEDIS information on a claim form (HCFA 1500 or UB04), an efficient and highly automated claims process that ensures prompt and appropriate payment for your services. The HEDIS Tips section of this manual contains the appropriate HCPCS, CPT, LOINC, and diagnosis codes needed to bill for a particular measure.

Members with Other Primary Insurance

Many of our members have primary insurance coverage other than MHP, such as Medicare. Even though the claim is paid by the primary insurance carrier, MHP needs this secondary claim for the P4T program and any other qualifying incentive. MHP accepts both electronic and paper claims when a member has another primary insurance carrier.

Exclusions:

Providers may submit supplemental data indicating exclusions for certain HEDIS measures. Examples include:

- Cervical cancer screening — member may have had a previous complete, radical or total hysterectomy. Please be specific in documentation about type of hysterectomy performed to be compliant
- Breast cancer screening — member may have had a previous bilateral mastectomy

To notify MHP of an exclusion, please fax the medical record documentation to 810-600-7985 or email records to MHPoutreach@mclaren.org. Identify the exclusion from a gap in care for the specific HEDIS measure. MHP will accept this information as supplemental data and build exclusion databased for its HEDIS submission.

HEDIS Measure Guide

This section details every HEDIS measure, including the name of the measure, abbreviation, the services needed to close the care opportunity as well as:

Billing codes

Billing codes identified in the HEDIS specification which make your patient compliant for the measure. Billing these codes doesn't supersede CMS billing guidelines and/or your provider contract with us and doesn't guarantee payment.

Frequency

The timeframe during which the service should be provided for your patient.

Exclusions

Required exclusions identify members who must be excluded from the measure, regardless of numerator compliance. They're listed as part of the eligible population criteria because members who meet the required exclusion criteria are removed when identifying the measure's denominator.

Optional exclusions should only be used to remove members that didn't meet the measure's numerator criteria. Organizations may choose whether to apply optional

exclusions.

Test, Service or Procedure to Close Care Opportunity

This lists information needed by the health plan to show the member is compliant and gives information on where to send it.

Medical Record Documentation

This is what we look for in the documentation for the measure. These items are based on compliant patients and provider best practices.

Common Chart Deficiencies

This section lists the most common areas for improvement in chart documentation.

Symbols

Indicates the measure is a CMS Medicare Star Ratings measure

Indicates that Supplemental data such as consultation reports, progress notes, health history, labs, pathology and diagnostic reports can be emailed or faxed to our HEDIS department to close your patient's care gap. Contact information is available on page 13 of this guide

Indicates the measure can be satisfied virtually

Indicates that the measure is an Electronic Clinical Data Systems (ECDS) reported measure

Indicates that the measure can be closed by submitting CPT II codes

Coding System Acronyms

CPT = Current Procedural Terminology

HCPCS = Healthcare Common Procedure Coding System

ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification

ICD-10-PCS = International Classification of Diseases, 10th Revision, Procedure Coding System

SNOMED CT = Systemized Nomenclature of Medicine – Clinical Terms

LOINC = Logical Observation Identifiers Names and Codes

UBREV = Uniform Billing Revenue

CVX = Vaccine Administered

The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule.

Test, service, or procedure to close HEDIS care opportunity

Document all current and past:

- Preventive screenings and/or positive history of the screening (mammograms, colonoscopy
- Immunizations (e.g., flu, MMR, VZV, Hep A) – Ensure that all immunizations are reported in the Michigan Immunization Care Registry (MCIR)
- Test results (e.g., A1c, nephrology, FOBT kits)
- Treatments
- Health education
- Assessments
- Prescriptions, OTC and herbal supplements

5 W's of good documentation for gap closure (EHR/EMR and paper)

Who provided the care?	• Provider should always sign and date with professional designation on every entry • Document who provided the care for test, cancer screenings etc.
What care or service was provided?	• Be specific and document what services were provided and what was discussed • Avoid subjective descriptions (e.g., well, better) • Never leave blank spaces or lines, to help prevent any altering of the notes • Use appropriate ICD-10, CPT and/or HCPCS codes • Bill CPT II codes when test results, BP readings, A1c values, etc. are recorded or reviewed When was the care provided to the patient? Give the date and time of all treatments, screenings and care
Why is good medical documentation so important?	• Defines the purpose for each encounter and the clinical circumstances • Creates consistent ongoing communication among health care providers • Helps support and improve quality of patient care • Improves medical chart reviews for HEDIS clinical care gap closures
Where should you send documentation to close care gaps?	Send medical record documentation to our HEDIS department: ✓ Electronically uploading medical records – please contact MHPQuality@mclaren.org to get a file set up or for more information ✓ Email: MHPQuality@mclaren.org ✓ Fax: 810-600-7985

Data collection methods

HEDIS measures are specified for one or more data collection methods:

- Administrative Method
- Hybrid Method
- Survey Method
- Electronic Clinical Data Systems (ECDS)

Each measure specifies the data collection methods that must be used. If a measure includes both the Administrative and Hybrid Methods, either method may be used.

- **Administrative Method:** Transaction data or other administrative data are used to identify the eligible population and numerator. The reported rate is based on all members who meet the eligible population criteria and who are found through administrative data to have received the service required for the numerator.
- **Hybrid Method:** Organizations look for numerator compliance in both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. Organizations review administrative data to determine if members in the systematic sample received the service and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator.
- **Survey Method:** Requires organizations to collect data through Consumer Assessment of Healthcare Providers & Systems (CAHPS®) and Health Outcomes Survey (HOS).
- **ECDS Method:** A reporting standard for collecting and sharing electronic clinical data from multiple sources.

Summary of Changes to HEDIS MY 2025

New measures:

- Documented Assessment After Mammogram (DBM-E)
- Follow-up After Abnormal Mammogram Assessment (FMA-E)
- Blood Pressure Control for Patients With Hypertension (BPC-E)

Retired measures:

- Childhood Immunization Status (CIS)*
- Immunizations for Adolescents (IMA)*
- Cervical Cancer Screening (CCS)*
- Antidepressant Medication Management (AMM)*

*Only the CIS-E, IMA-E, and CCS-E measures will be reported

Revised measures:

- For specific revisions, refer to the measure's Summary of Changes.

Member Incentive Programs

McLaren Health Plan Pay for Transformation Program for Medicaid.

The PCP Incentive Program, outlined below, provides incentives that optimize transformation activities, care coordination and quality by recognizing the outstanding efforts of our PCPS while improving health care outcomes.

Program	Measure	Incentive	Reimbursement Methodology
Pay for Transformation Program	Care Management/Care Coordination. E-prescriber & E-portal. HIE Participation. Asthma Medication Ratio at NCQA 75th percentile. PCMH Recognition. Adult Access to Preventive Care at NCQA 75th percentile.	$2 PMPM	Annual payout (within 6 months of the end of the measurement year)
Diabetic Core Measures	Must complete Both: 1. GSD & KED Additional Opportunity 2. BP control below 140/90 3. A1c Control < 8	$50 for completing test $25 for controlled BP $25 for controlled A1c	Annual payout (Within 4 months of the end of the measurement year)
Healthy Child Immunization	Childhood Series Completion by 2nd birthday & Adolescent Immunization Series Completion by 13th Birthday	CIS Combo 10 $100 per child IMA Combo 2 $50 per child	Annual payout (Within 4 months of the end of the measurement year)
Cervical Cancer Screening	PAP & HPV test completed Meet the NCQA 75th Percentile Standard Rate	Cervical Cancer Screening	PAP & HPV test completed Meet the NCQA 75th Percentile Standard Rate
Chlamydia Screening	Chlamydia Screening incentive for female members ages 16-24	$25 per eligible member screened	Annual payout (within 4 months of the end of the measurement year)
Breast Cancer Screening	Breast Cancer Screening incentive for female members ages 50-74	$50 per eligible member screened	Annual payout (within 4 months of the end of the measurement year)
Adolescent Well Visit Ages 12 - 17	Adolescent Well Visits Meet the NCQA 75th Percentile Standard Rate OR Meet the NCQA 90th Percentile Standard Rate	Achiever $25 OR High Achiever $50	Annual payout (Within 4 months of the end of the measurement year)

Provider Incentive Programs

McLaren Health Plan

2025 Pay for Transformation Program Quick Reference Guide.

Measures (2025)	Specifications	2025 Goal	Award Per Assigned Medicaid Member
Medicaid Care Management and Care Coordination Activities	Reporting of care management and care coordination services provided through embedded care managers by submitting claims with the appropriate codes listed below: G9001; G9002; G9007; G9008; 98966; 98967; 98968; 98961; 98962; 99495; 99496; S0257; G0511; G0512; 99497; 99498; 99487; 99490 Services must be billed in accordance with CPT guidelines and limitations. This component has a two-part scoring system. Each measure will be scored and awarded separately. You do not need to achieve both components to receive an award for this measure.	PCP Office with embedded Care Managers provide services for: At a minimum, 2% of assigned membership receive care management and care coordination services AND/OR At a minimum, 3codes per 100 member months	$0.25 = Achieving or exceeding the 2% of membership receiving care management and care coordination services AND/OR $0.25 = Achieving or exceeding the 3 codes submitted per 100 member months
Health Information Exchange/Health Information Technology Participation	Evidence of active participation in an HIE QO and provider's capability to receive admission, discharge and transfer (ADT) messages; Active Care Relationship Service (ACRS) enabling access to the Common Key Service; MiHIN Medication Reconciliation for the purpose of sharing patient medication information at multiple points of care; Quality Measure Information (QMI); and Health Provider Directory (HPD).	Documentation of the 5 key components of Statewide use cases	$0.25
Achieved Primary Care Medical Home (PCMH) recognition	Through Physician Group Incentive Program (PGIP) or the National Committee for Quality Assurance (NCQA) or a like industry standard activity defined as extended hours and patient disease registry.	Provide evidence of recognition and program/activity details if appropriate	$0.25
Medicaid Asthma Medication Ratio (AMR)	Achieve NCQA 75th percentile for assigned Medicaid membership in the measure.	72.22%	$0.50
Medicaid Adult Access to Preventive Care (AAP)	Achieve NCQA 75th percentile for assigned Medicaid membership in the measures.	79.54%	$0.50

Total Award Possible	Award based on pmpm at the end of calendar year Medicaid membership, if all qualifying requirements per program detail are met by PCP.	$2

**Please contact your Provider Relations Representative at 888-327-0671 (TTY: 711) for full program details, including qualifying requirements and payment distribution.*

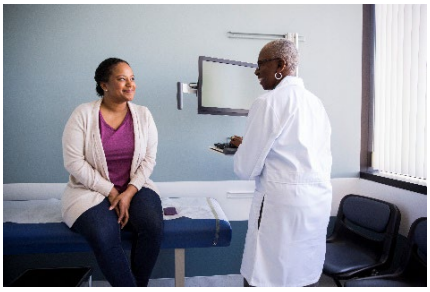
For additional information, please visit Provider Incentives..

SECTION 2: HEDIS Measures

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

What Is the Measure?

This measure examines whether adult members ages 20 years and older receive preventive and ambulatory services from an organization. It looks at the percentage of members who have had a preventive or ambulatory visit with their physician.



Codes to Identify AAP:

Description	Code Type	Codes
Ambulatory Visits	**CPT**	**CPT I:** * 92002, 92004 ,92012, 92014, 98966-98968, 98970-98972, 98980, 98981, 99202-99205, 99211-99215, 99241-99245, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99429, 99441-99443, 99457, 99458, 99483
	HCPCS:	* G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250-G2252, S0620, S0621, T1015
	ICD-10:	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
	SNOMED	1269517007, 1269518002, 162651007, 162655003, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004,170309003, 18170008, 185317003, 19681004, 207195004, 209099002, 210098006, 243788004, 268563000, 268565007, 281029006, 281031002, 314849005, 386472008, 386473003, 401140000, 401267002,410620009, 410622001, 410623006,410624000, 410625004,410626003, 410627007, 410628002,410629005, 410630000, 410631001, 410632008,410633003, 410634009, 410635005,410636006, 410637002,410638007, 410639004, 410640002, 410641003,410642005, 410643000, 410644006, 410645007,410646008,410647004, 410648009, 410649001, 410650001, 442162000, 699134002, 712791009, 713020001, 783260003
	UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983

Frequency/ occurrence	• Medicaid and Medicare patients every year
Required Exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Educate patients on the importance of having at least one (1) ambulatory or preventive care visit during each calendar year.
- Contact patients who have not had a preventive or ambulatory health visit.
- Report the appropriate codes for members with one (1) or more AAP visits during the measurement year or the two (2) years before.
- Report all services provided and utilize appropriate billing codes.
- Request AAP gaps in care lists for your group. Provider rosters can change throughout the year, and newly assigned members need to have care initiated.

Asthma Medication Ratio (AMR)

What Is the Measure?

This measure assesses the percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Summary of Changes:

- Added albuterol-budesonide as an asthma reliever medication

Product Lines	Quality programs affected	Collection of reporting method
Commercial Medicaid	**NCQA State Performance Measure**	**Administrative** • **Claim data** • **Pharmacy data**
Numerator Compliance	**Patients who have a medication ratio of >=0.50 during the measurement year**	
Time Period	**January 1, 2025- December 31, 2025**	
Description	**Code Type**	**Codes**
Asthma	**ICD 10**	E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.81, J44.89, J44.9, J68.4, J96.00, J96.01, J96.02, J96.20, J96.21, J96.22, J98.2, J98.3
	SNOMED	1010333003, 1010334009, 106001000119101, 1296527009, 1296528004, 135836000, 13645005, 15908004, 16003001, 16846004, 1751000119100, 185086009, 190905008, 190909002, 195951007, 195957006, 195958001, 195959009, 195963002, 196001008, 196025000, 196026004, 233674008, 233675009, 233677001, 235978006, 23958009, 266355005, 266356006, 285381006, 293241000119100, 308905009, 313296004, 313297008, 313299006, 31803008, 31898008, 32544004, 33325001, 43098002, 47895001, 4981000, 54288002, 57686001, 60805002, 61233003, 66110007, 66987001, 68328006, 69454006, 70756004, 708030004, 720401009, 72163003, 74800004, 762269004, 762270003, 762271004, 77690003, 81423003, 836477007, 86092005, 86555001, 86680006, 87433001

To comply with this measure, a patient must have the appropriate ratio of controller medication to total asthma medications:

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	Dupilumab	Dupilumab Medications List	Injection

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

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Required exclusions	• Acute respiratory failure • Chronic Obstructive Pulmonary Disease (COPD) • Chronic respiratory conditions due to fumes/vapers • Cystic fibrosis • Emphysema • Obstructive chronic bronchitis
Required exclusions	• Patients who use hospice services • Patients who had no asthma controller or reliever medications dispensed during the measurement year • Patients who had a diagnosis that requires a different treatment approach than patients with asthma

How to Improve Your Quality Score:

- **Educate patients** about the difference between controller and rescue medications/inhalers, the importance of controller medications in their treatment plan and utilizing more controller (preventive) medication instead of rescue medications to manage their asthma.
- **Prescribe a long-term controller medication** with 90-day refills and prescribe the same day if a patient requires a rescue inhaler for multiple locations (school, home, daycare). All inhalers of the same medication dispensed on the same day count as one dispensing event.
- **Monitor member's compliance** with medication and ensure the member is not using more rescue medications than controller medications.
- **Verify that the patient's diagnoses** are coded correctly.
- **Regularly evaluate** the patient's inhaler technique.
- **Ask the patient** if they have any barriers to filling their prescriptions.
- **Assess asthma symptoms** at every visit to determine if preventive medication action is needed (i.e., new controller medication, step up in therapy prescription, reinforcement of adherence).
- **Help patients to identify their asthma triggers.** Educate patients on the importance of an asthma-friendly home environment and perform allergen sensitivity testing if needed. Use the Centers for Disease Control & Prevention's (CDC's) Home Assessment Checklist to guide patients in assessing their home environment. CDC Home Assessment Checklist
- **Ensure proper coding** to avoid coding asthma if not formally diagnosing asthma and only asthma-like symptoms are present (for example, wheezing during a viral URI and acute bronchitis is not asthma).

Blood Pressure Control for Patients with Diabetes (BPD)

What Is the Measure?

The Blood Pressure Control for Patients with Diabetes measure evaluates patients 18-75 years of age with diabetes (types 1 and 2) and whose blood pressure (BP) is adequately controlled (<140/90 mmHg) during the measurement year.

Codes to Identify Blood Pressure Control for Patients with Diabetes:

Description	CPT/HCPCS/ICD-10-CM		
Numerator Compliance	The most recent BP reading taken during an outpatient visit in the measurement year is < 140/90 mmHg		
Time period	January 1, 2025- December 31, 2025		
Billing Codes	**Description**	**Code Type**	**Codes**
	Diastolic less than 80	CPT II	3078F
	Diastolic between 80-89	CPT II	3079F
	Diastolic >= to 90	CPT II	3080F
	Systolic less than 130	CPT II	3074F
	Systolic between 130-139	CPT II	3075F
	Systolic >= to 140	CPT II	3077F
Frequency/Occurrence	Every visit (office and telehealth)		
Required Exclusions	• Members who use hospice services • Members receiving palliative care • Medicare members 66 years of age and older as of December 31 of the MY who are enrolled in an institutional SNP or living long-term in an institution • Members 66 years of age and older as of December 31 of the MY with frailty and advanced illness/dispensed dementia medication		

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

Earn incentive dollars when your members meet this measure! *

For each of your MHP Medicaid members with diabetes, ages 18-75, whose A1c is appropriately controlled with an A1c below 8 and blood pressure below 140/90, you will receive $25.00 for each controlled measure.

How to Improve Your Quality Score:

- **Document all BP readings at every visit**
  - ✓ BP readings can be patient-reported during a telehealth visit, telephonic visit, e-visit or virtual check-in if the BP is taken on a digital device and must be recorded, dated and maintained in the patient's medical record.
  - ✓ If the patient's BP is 140/90 or higher at the start of the visit, recheck the BP at the end of the visit
  - ✓ If the recheck BP is still 140/90 or greater, schedule a follow-up appointment. When multiple reading during the same visit are taken, record all BP readings taken during appointment.
  - ✓ Use CPT II codes when billing office/telephone/virtual visits to capture blood pressure result
  - ✓ Timely submission of claim data

- ✓ **Blood pressure service date and values can be accepted as supplemental data. Educate patients** on the importance of having at least one (1) ambulatory or preventive care visit during each calendar year.

- **Contact patients** who have not had a diabetes management ambulatory health visit.
- **Request BPD gaps** in care lists for your group. Provider rosters can change throughout the year, and newly assigned members need to have care initiated.

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

What Is the Measure?

The Blood Pressure Control for Patients with Hypertension measure evaluates patients 18-85 years of age with a diagnosis of hypertension (HTN) and dispensed at least one antihypertensive medication and whose most blood pressure (BP) is adequately controlled (<140/90 mmHg) during the measurement year.

Summary of Changes:

- This is a first-year measure

Description	CPT/HCPCS/ICD-10-CM		
Numerator Compliance	The most recent systolic and diastolic BP values <140/90 during the measurement period, on or after the date of the second hypertension event		
Time period	January 1, 2025- December 31, 2025		
Billing Codes	**Description**	**Code Type**	**Codes**
	Diastolic less than 80	CPT II	3078F
	Diastolic between 80-89	CPT II	3079F
	Diastolic >= to 90	CPT II	3080F
	Diastolic Blood Pressure	LOINC	75995-1, 8453-3, 8454-1, 8455-8, 8462-4, 8496-2, 8514-2, 8515-9, 89267-9
		SNOMED	271650006
	Systolic less than 130	CPT II	3074F
	Systolic between 130-139	CPT II	3075F
	Systolic >= to 140	CPT II	3077F
	Systolic Blood Pressure	LOINC	75997-7, 8459-0, 8460-8, 8461-6, 8480-6, 8508-4, 8546-4, 8547-2, 89268-7
		SNOMED	271649006
Required Exclusions	• Members who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year • Members receiving palliative care any time during the measurement year • Patients who had an encounter for palliative care (ICD10 CM code Z51.5) any time during the measurement year • Patients with a nonacute inpatient admission during the measurement year • Patients with a diagnosis that indicates end-stage renal disease (ESRD) any time during the measurement period • Patients who had dialysis, nephrectomy, or kidney transplant any time during the patient's history on or prior to the last day of the measurement period • Patients with a diagnosis of pregnancy any time during the measurement period; do not include laboratory claims with POS 81 • Medicare patients 66 years of age and older as of December 31 of the measurement year who are enrolled in an institutional SNP (I-SNP) or living long-term in an institution • Patients 66-88 years of age as of December 31 of the measurement year with facility and advance illness criteria: 1. Frailty. At least two indications of frailty with different dates of service during the measurement year 2. Advanced illness. Any of the following during the measurement year or the year prior to the measurement year		

	○ Advanced illness on at least 2 different dates of service ○ Dispensed dementia medication • Patients 81 years of age and older with at least 2 indications of frailty

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Document all BP readings at every visit
  - ✓ If the patient's BP is 140/90 or higher at the start of the visit, recheck the BP at the end of the visit
  - ✓ If the recheck BP is still 140/90 or greater, schedule a follow-up appointment before the end of the measurement year. When multiple reading during the same visit are taken, record all BP readings taken during appointment.
  - ✓ Telephone visit, e-visits and virtual visits are appropriate settings for BP readings and allow patient reported BP's taken with a digital device
  - ✓ Use CPT II codes when billing office/telephone/virtual visits to capture blood pressure result
  - ✓ Timely submission of claim data
  - ✓ Blood pressure service date and values can be accepted as supplemental data.

Breast Cancer Screening (BCS-E)

What Is the Measure?

The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had one (1) or more mammograms any time on or between October 1, two (2) years prior to the measurement period and the end of the measurement period.

Summary of Changes:

- Added a laboratory claim exclusion to the Absence of Left Value Set and Absence of Right Breast Value Set

Product Lines	Quality of Programs Affected	Collection and reporting method
Commercial Medicaid Medicare	• CMS Star Ratings	• ECDS
Numerator Compliance	One or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period	
Time Period	January 1, 2025- December 31, 2025 October 1, 2023- December 31, 2025	

Description	Code Type	Codes
Mammography	**CPT I:**	* 77061-77063, 77065-77067
	LOINC:	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, 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, 39150-8, 39152-4, 39153-2, 39154-0, 42168-5, 42169-3, 42174-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46342-2, 46350-5, 46351-3, 46354-7, 46355-4, 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
	SNOMED:	12389009, 241055006, 241057003, 241058008, 24623002, 258172002, 384151000119104, 392521000119107, 392531000119105, 43204002, 439324009, 450566007, 566571000119105,572701000119102, 71651007, 723778004, 723779007, 723780005, 726551006, 833310007, 866234000, 866235004, 866236003, 866237007
Absence of Left Breast	**ICD 10 diagnosis**	Z90.12

	SNOMED	429009003, 137671000119105
Absence of Right Breast	**ICD 10 Diagnosis**	Z90.11
	SNOMED	429242008, 137681000119108
Bilateral Mastectomy	**SNOMED**	1268980002, 1269061009, 1279986002, 14693006, 14714006, 17086001, 22418005, 27865001, 456903003, 52314009, 60633004, 726636007, 76468001, 836436008, 870629001
	ICD 10 PCS	0HTV0ZZ
Unilateral Mastectomy with a bilateral modifier	**CPT**	19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307
	Modifier	50
Unilateral Mastectomy Right	**SNOMED**	429400009, 726430006, 726434002, 726436000, 741010006, 741019007, 836435007, 451201000124106
Unilateral Mastectomy Left	**SNOMED**	428571003, 726429001, 726435001, 726437009, 741009001, 741018004, 836437004, 451211000124109
Clinical Unilateral Mastectomy with a bilateral qualifier value modifier code	**SNOMED**	1208601007, 172043006, 237367009,237368004, 274957008, 287653007,287654001, 318190001, 359728003,359731002, 359734005, 359740003,384723003, 395702000, 406505007, 428564008, 446109005, 446420001, 447135002, 447421006, 66398006, 70183006
	SNOMED CT Modifier	51440002
History of Bilateral Mastectomy	**ICD 10 Diagnosis**	Z90.13
	SNOMED	428529004, 136071000119101, 16087411000119102
Gender dysphoria	**ICD 10 Diagnosis**	F64.1, F64.2, F64.8, F64.9, Z87.890
Sex assigned at birth female	**LOINC**	76689-9, LA3-6
Sex assigned at birth male	**LOINC**	76689-9, LA2-8
Frequency/occurrence	**Every 2 years**	

Exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year • Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy: ✓ Bilateral mastectomy ✓ Unilateral mastectomy with a bilateral modifier (CPT modifier code 50) (same procedure) ✓ Unilateral mastectomy found in clinical data with a bilateral qualifier value (SNOMED CT Modifier code 51440002) (same procedure) ✓ History of bilateral mastectomy • Any combination of codes that indicate a mastectomy on both the left and right side on the same date of service or on different dates of service • Members who had a gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period. • Medicare members 66 years of age and older by the end of the measurement period who meet either of the following: ✓ Enrolled in an institutional SNP any time during the measurement period ✓ Living long-term in an institution any time during the measurement period ✓ Members 66 years of age and older by the end of the measurement period with frailty **and** advanced illness. Members must meet **both** frailty **and** advance illness criteria to qualify • Members receiving palliative care any time during the measurement period • Members who had an encounter for palliative care (ICD 10 CM code Z51.5) any time during the measurement period.

2025 Mammogram Screening Incentive:

For each of your MHP Medicaid female members age 50-74 who receive a mammogram screening by December 31, 2025, using the following procedure codes, you will receive $50.00

Procedure Code:	McLaren Health Plan Incentive
77061-77063 77065-77067	**$50.00**

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities

- Use EMR alerts for patients due for a mammogram
- Don't miss an opportunity to schedule a mammogram for the patient while at the office visit
- Ensure that an order for a mammogram is given at well-woman exams for women 50-74 years of age.
- All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) meet the numerator compliance. Do not count biopsies, breast ultrasounds or MRIs.
- Refer patients to local mammography imaging centers. Follow up to confirm completion.
- Schedule mobile mammography events at clinics or during health fairs, etc.
- Educate patients on the importance of routine screening (at least once every 24 months). Remind patients that preventive screenings are covered under health care reform. Depending on risk factors, mammograms may be completed more often.
- Discuss possible concerns or fears patients may have about the screening.
- As an administrative measure, it is important to submit the appropriate ICD 10 diagnosis code that reflects a patient's history of bilateral mastectomy (Z90.13) or absence of right or left breast (Z90.11, Z90.12 respectively)
- Develop standing orders with automated referrals (if applicable) for members 50-74 years of age.
- Discuss the importance of breast cancer screenings and ensure members are up to date with their annual mammograms.
- Note the date of the mammogram with proof of completion in the medical record to confirm that the screening was ordered and completed. Discuss the results or findings with the patient.

Cervical Cancer Screening (CCS-E)

What Is the Measure?

The percentage of members, assigned female at birth, 21–64 years of age, who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three (3) years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five (5) years.
- Members 30–64 years of age were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) testing within the last five (5) years.

Product lines	Quality programs affected	Collection and reporting method
Commercial Medicaid	**NCQA Health Plan Ratings**	**ECDS**
Numerator Compliance	Patients recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria: • Members 24-64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology during the measurement period or the 2 years prior to the measurement period. • Members 30-64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus testing during the measurement period or the 4 years prior to the measurement period, and who were 30 years or older on the test date	
Time Period	Medicaid: January 1, 2025- December 31, 2025 Commercial: January 1 2023- December 31, 2025	
Description	**Code Type**	**Codes**
Cervical Cytology	**CPT**	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
	HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
	LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
	SNOMED	171149006, 416107004, 417036008, 440623000, 448651000124104
Cervical cytology result or finding	**SNOMED**	168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 268543007, 269957009,269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000,439776006,439888000, 441087007,

		441088002, 441094005, 441219009, 441667007, 700399008, 700400001, 1155766001, 62051000119105, 62061000119107, 98791000119102
High risk HPV test	**CPT**	87624, 87625
	HCPCS	G0476
	LOINC	21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0,82354-2, 82456-5, 82675-0, 95539-3
	SNOMED	35904009, 448651000124104
Cytology examination positive for high-risk human papillomavirus (finding)	**SNOMED**	718591004
Absence of cervix diagnosis	**ICD 10 diagnosis**	Q51.5, Z90.710, Z90.712
	SNOMED	37687000, 248911005, 428078001, 429290001, 429763009, 473171009, 723171001, 10738891000119107
Hysterectomy with no residual cervix	**CPT**	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135
	ICD 10 PCS	0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ
	SNOMED	24293001, 27950001, 31545000, 35955002, 41566006, 46226009 59750000, 82418001, 86477000 88144003, 116140006, 116142003, 116143008, 116144002, 176697007, 236888001, 236891001, 287924009, 307771009, 361222003, 361223008, 387626007, 414575003, 440383008, 446446002,446679008,708877008, 708878003, 739671004, 739672006, 739673001, 739674007, 740514001, The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 227 740515000, 767610009, 767611008, 767612001, 1163275000
Sex assigned at birth female	**LOINC**	76689-9, LA3-6
Sex assigned at birth male	**LOINC**	76689-9, LA2-8
Exclusions	• History of hysterectomy with no residual cervix • History of acquired absence of cervix any time in a patient's history • History of cervical agenesis • Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit nay time during the measurement year • Patients who had an encounter for palliative care any time during the measurement year	

	• Members with Sex Assigned at Birth of male at any time during the patient's history
Common chart deficiencies	Documentation of hysterectomy alone does not meet criteria for exclusion ✓ Documentation must include the words "total", "complete", or "radical" abdominal or vaginal hysterectomy ✓ Documentation of a "vaginal pap smear" with documentation of "hysterectomy"

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

2025 Cervical Cancer Screening Incentive:

In order to receive your incentive payment for each of your MHP Medicaid female members ages 21-64, the member must be seen by December 31, 2025, with claim submitted to MHP by March of 2026.

Incentive	NCQA Percentile	Compliance Rate
$25 per member	NCQA 75%	61.56% Overall Compliance Rate
$50 per member	NCQA 90%	67.46% Overall Compliance Rate

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities
- Discuss existing barriers to regular cervical cancer screenings
- Request to have results of pap tests sent to you if screening was performed by an OB/GYN or another provider
- Use EHR/EMR alters for patients due for a cervical cancer screening
- Display culturally appropriate posters and brochures around patient areas to encourage patients to talk to providers about cervical cancer screening.
- Educate patients that cervical cancer screening is a covered preventive service.
- Help members schedule their routine cervical cancer screening.
- Use needed services lists to identify women who need a Pap test.
- Avoid missed opportunities. If time allows complete Pap tests during regularly scheduled well-woman visits, sick visits, urine pregnancy tests, UTI and chlamydia/STI screenings.
- Document in the medical record if a patient had a hysterectomy, including the year completed. Remember synonyms (total, complete, radical) must be included in the documentation for the member to be excluded.
- Assess the patient's risk, which may include sexual history, contraceptive practices, and family history of cancer.
- Implement standing orders for cervical cancer screening.
- Review and document your patient's surgical and preventive screening history with results.

Chlamydia Screening (CHL)

What Is the Measure?

The Chlamydia Screening measure evaluates members 16-24 years of age who were identified as sexually active (identified through pharmacy and claim data) and had at least one test to screen for chlamydia in the measurement year (MY).

Summary of changes to HEDIS MY2025

Updated the measure title from Chlamydia Screening in Women to Chlamydia Screening
Replaced references to "women" with members recommended for routine chlamydia screening
Added an exclusion for members who were assigned male at birth.

Description		
Numerator Compliance	**At least one chlamydia test during the measurement year**	
Time period	January 1, 2025- December 31, 2025	
Billing Codes		
Description	**Code Type**	**Codes**
Chlamydia Screening	**CPT**	87110, 87320, 87810, 87270, 87491, 87490, 87492
	LOINC	14463-4, 14464-2, 14465-9, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 34710-4, 42931-6, 43304-5, 43404-3, 44806-8, 44807-6, 45068-4, 45069-2, 45072-6, 45073-4, 45075-9, 45084-1, 45089-0, 45090-8, 45091-6, 45093-2, 45095-7, 4993-2, 50387-0, 53925-4, 53926-2, 57287-5, 6353-7, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 80363-5, 80364-3, 80365-0, 80367-6, 82306-2, 87949-4, 87950-2, 88221-7, 89648-0, 91860-7, 91873-0
	SNOMED	310862001, 310861008, 104175002, 407707008, 134289004, 315095005, 121956002, 285586000, 122173003, 122254005, 122321005, 395195000, 315099004, 134256004, 315087006, 398452009, 122322003, 390784004, 104290009, 104281002, 104282009, 121957006, 121958001, 121959009, 117775008, 399193003, 442487003, 707982002, 171120003, 390785003
Sex assigned at birth female	**LOINC**	76689-9, LA3-6
Sex assigned at birth male	**LOINC**	76689-9, LA2-8
Frequency/Occurrence	Every year	
Required Exclusions	• Sex assigned at birth as male any time in the patient's history • Patients who use hospice services or elect to use hospice benefit at any time during the measurement year or elect to use a hospice benefit any time during the measurement year	

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

2025 Chlamydia Screening Incentive

As an incentive for your cooperation with screening MHP female Medicaid members ages 16-24, MHP will reimburse you as described below:

Procedure Code:	McLaren Health Plan Incentive:
87110, 87270, 87320, 87810, 87490-87492	**$25.00**

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities
  - ✓ Educate patients about the importance of screening and encourage testing during preventive and/or sick visits
  - ✓ Utilize preventive health flowsheets or progress notes to document chlamydia test dates, test results and when patients are due for their next screening
- Lab results for chlamydia screening can be accepted as supplemental data.

Child and Adolescent Well-Child Visits (WCV)

What Is the Measure?

This measure assesses the percentage of members 3–21 years of age who had at least one (1) comprehensive well-child visit with a PCP or an OB/GYN practitioner during the measurement year.

- It is recommended that well-child visits follow the American Academy of Pediatrics Bright Futures Periodicity Schedule: Periodicity Schedule

The American Academy of Pediatrics (AAP) Bright Futures initiative recommends that the well-child visits for ages 3-11 years include, but are not limited to:

- An initial/interval medical history
- Physical exam
- Developmental assessment
- Anticipatory guidance

The American Academy of Pediatrics (AAP) Bright Futures initiative recommends that the well-child visits for ages 12-21 years include, but are not limited to:

- Concerns of the adolescent and the parent(s)
- Address social determinants of health
- Physical growth and development
- Emotional well-being
- Risk reduction (pregnancy and sexually transmitted infections, tobacco, e-cigarettes, alcohol)
- Safety (seat belt and helmet use, sun protection, substance use, firearm safety)

Codes to Identify WCV:

Product Lines	Collection and reporting method	
Medicaid	Administrative • Claim data	
Numerator Compliance	One or more well-care visits with a PCP or an OB/GYN during the measurement year	
Time period	January 1, 2025- December 31, 2025	
Description	**Code Type**	**Codes**
Encounter for Well-Child	**ICD-10**	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2
Well-Child Visits	**CPT**	99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395
	HCPCS	G0438, G0439, S0302, S0610, S0612, S0613

	SNOMED	103740001, 1269518002, 170150003, 170159002, 170168000, 170281004, 170290006, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 410620009, 410634009, 410635005,410636006, 410637002, 410638007,410639004, 410640002, 410641003,410642005, 410643000, 410644006,410645007, 410646008, 410647004,410648009, 410649001, 410650001, 444971000124105, 669251000168104, 669261000168102,669271000168108, 669281000168106, 783260003
Frequency/occurrence	Every year	
Required Exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year	
Common chart deficiencies	• All components of a well-child/adolescent visit are not documented in the medical record: ✓ Physical exam ✓ Health history ✓ Physical development ✓ Mental development ✓ Anticipatory guidance	

Important Notes:

- Physical Exam
  - ✓ Vital signs alone are not enough to meet compliance
- Health history
  - ✓ Assessment of history of disease or illness
  - ✓ Notation of allergies, medication or immunizations alone won't meet compliance; documenting all three will meet compliance
- Physical developmental history
  - ✓ Assessment of physical developmental milestones and progress toward developing the skills needed to become a healthy child/adolescent
  - ✓ Notation of Tanner stage won't meet compliance
  - ✓ "Appropriate for age" without a specific reference to development won't meet compliance
- Mental development history
  - ✓ Assessment of mental developmental milestone and progress toward developing the skills needed to become a healthy child
  - ✓ Notation of "appropriately responsive for age" or "well-developed" alone will not meet compliance
- Anticipatory guidance/health education
  - ✓ Given to the parents or guardians to educate them on emerging issues, expectations and things to watch for at the child's age
- Information about medications or immunizations or their side effects will note meet compliance

The components of care can be completed at any appointment- not just a well-care visit

The following table offers examples of evaluations to help complete each component of care:

Physical exam	Health history	Physical development	Mental development	Anticipatory Guidance
Assessment of multiple body systems	Birth history	Throws, kicks a ball	Knows full name	Safety, poison control
Auscultation of heart and lung sounds	Medical, surgical history	Hops, skips, runs	Colors, writes, reading, counting	Nutrition and exercise
Measurements of weight and length	History or absence of past illness	Rides a tricycle or bike	Uses imagination, shares with others	Interacts with others
Vital signs	Family illness/disease history	Puberty	Smoking, alcohol, drug use	Limit TV/screen time
Hearing and vision	History/absence of allergies	Start of menses	Depression	Safe sex
Reflexes	Immunization history	Acne	Grades	Self-exams- breast or testicular
Extremities	Medication	Growth spurts	Personal hygiene	Oral health/dental

+three or more of these components are required to constitute a comprehensive health history

** Required as a primary diagnosis for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) billing.*
*** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

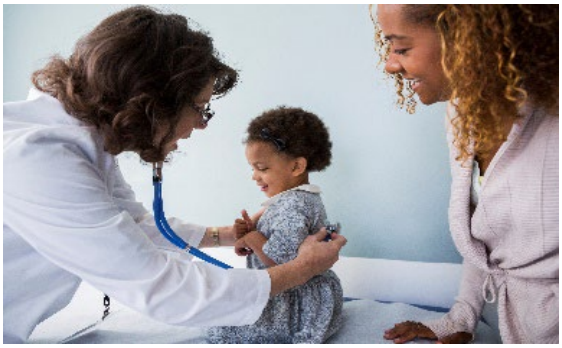
- Make every office visit count. If time allows for additional quality procedures, avoid missed opportunities by taking advantage of every office visit, including sick visits and sports/daycare/camp physicals, to provide a well-child visit, immunizations, lead testing, developmental screening, BMI calculations and counseling.
- Educate staff to schedule the recommended well-child visits within the guideline time frames.
- Inform caregivers about the importance of annual well-child visits.
- Actively pursue missed appointments with reminder letters, calls and text messages.
- Make outreach calls to members who are not on track to complete an annual well-child visit.
- Ensure the medical record includes the date that a health and developmental history and physical exam were performed, and health education/anticipatory guidance was given.
- Set care gap "alerts" in your electronic medical record.
- Encourage parents/patients to maintain the relationship with a PCP to promote consistent and coordinated health care.

Childhood Immunization Status (CIS-E)

What Is the Measure?

This measure assesses the percentage of children two (2) years of age who had the following vaccines by their second birthday:

- 4 DTaP (diphtheria, tetanus, acellular pertussis)
- 1 HepA (hepatitis A)
- 3 HepB (hepatitis B)
- 3 HiB (H influenza type B)
- 2 Flu (influenza)
- 3 IPV (polio)
- 1 MMR (measles, mumps, rubella)
- 2 or 3 RV (rotavirus)
- 4 PCV (pneumococcal conjugate)
- 1 VZV (chicken pox)



CIS assesses receive of these ACIP-recommended vaccines by the second birthday and includes a rate for each type of vaccine and the following combination rates:

CIS-E Combo	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Immunization billing codes

DTaP

Number of doses: 4

Numerator compliance:

Children with any of the following on or before their second birthday meet criteria:

- At least 4 DTaP vaccinations with different dates of service
- Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine
- Encephalitis due to the diphtheria, tetanus or pertussis vaccine

Do not count a vaccination administered from birth through 42 days	
CPT	90697, 90698, 90700, 90723
CVX	20, 50, 106, 107, 110, 120, 146
SNOMED	310306005, 310307001, 310308006, 312870000, 313383003, 390846000, 390865008, 399014008, 412755006, 412756007, 412757003, 412762002, 412763007, 412764001, 414001002, 414259000, 414620004, 415507003, 415712004, 770608009, 770616000, 770617009, 770618004, 787436003, 866158005, 866159002, 866226006, 868273007, 868274001, 868276004, 868277008, 1162640003, 428251000124104, 571571000119105, 572561000119108, 16290681000119103
Anaphylaxis due to diphtheria, tetanus or pertussis vaccine	
SNOMED	428281000124107, 428291000124105
Encephalitis Due to Diphtheria, Tetanus or Pertussis vaccine	
SNOMED	192710009, 192711008, 192712001

Polio **Number of Doses: 3**	
Numerator compliance: Children with either of the following on or before their second birthday meet criteria: • At least 3 IPV vaccinations with different dates of service • Anaphylaxis due to the IPV vaccine Do not count a vaccination administered from birth through 42 days	
CPT	90697, 90698, 90713, 90723
CVX	10, 89, 110, 120, 146
SNOMED	310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 390865008, 396456003, 412762002, 412763007, 412764001, 414001002, 414259000, 414619005, 414620004, 415507003, 415712004, 416144004, 416591003, 417211006, 417384007, 417615007, 866186002, 866227002, 868266002, 868267006, 868268001, 868273007, 868274001, 868276004, 868277008, 870670004, 572561000119108, 16290681000119103
Anaphylaxis due to the IPV vaccine	
SNOMED	471321000124106

MMR **Number of Doses: 1**
Numerator compliance: Children with any of the following meet criteria: • At least one MMR vaccination on or between the child's first and second birthdays • All of the following any time on or before the child's second birthday (on the same or different date of service) ✓ History of measles illness ✓ History of mumps illness ✓ History of rubella illness • Anaphylaxis due to the MMR vaccine on or before the child's second birthday

CPT	90707, 90710
CVX	03, 94
SNOMED	38598009, 170431005, 170432003, 170433008, 432636005, 433733003, 871909005, 571591000119106, 572511000119105
History of Measles	
ICD 10 diagnosis	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
SNOMED	14189004, 28463004, 38921001, 60013002, 74918002, 111873003, 161419000, 186561002, 186562009, 195900001, 240483006, 240484000, 359686005, 371111005, 406592004, 417145006, 424306000, 105841000119101
History of Mumps	
ICD 10 diagnosis	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
SNOMED	10665004, 17121006, 31524007, 31646008, 36989005, 40099009, 44201003, 63462008, 72071001, 74717002, 75548002, 78580004, 89231008, 89764009, 111870000, 161420006, 235123001, 236771002, 237443002, 240526004, 240527008, 240529006, 371112003. 1163539003, 105821000119107
History of Rubella	
ICD 10 diagnosis	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
SNOMED	10082001, 13225007, 19431000, 36653000, 51490003, 64190005, 79303006, 128191000, 161421005, 165792000, 186567003, 186570004, 192689006, 231985001, 232312000, 240485004, 253227001, 406112006, 406113001, 1092361000119109, 10759761000119100
Anaphylaxis due to the MMR vaccine	
SNOMED	471331000124109

HiB

Number of Doses: 3

Special circumstances: don't count dose administered from birth through 42 days

Numerator compliance:

Children with either of the following on or before their second birthday meet criteria:

- At least three HiB vaccinations with different dates of service
- Anaphylaxis due to the HiB vaccine

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

CPT	90644, 90647, 90648, 90697, 90698, 90748
CVX	17, 46, 47, 48, 49, 50, 51, 120, 146, 148
SNOMED	127787002, 170343007, 170344001, 170345000, 170346004, 310306005, 310307001, 310308006, 312869001, 312870000, 313383003, 414001002, 414259000, 415507003, 415712004, 428975001, 712833000, 712834006, 770608009, 770616000, 770617009, 770618004, 786846001, 787436003, 1119364007, 1162640003, 16292241000119109

Anaphylaxis due to the MMR vaccine	
SNOMED	471331000124109

Hep B **Number of Doses: 3**	
Numerator Compliance: Children with either of the following on or before their second birthday meet criteria: • At least three hepatitis B vaccinations with different dates of service • One of the three vaccinations may be a newborn hepatitis B vaccination during the 8 day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8. • History of hepatitis B illness • Anaphylaxis due to the hepatitis B vaccine	
CPT	90697, 90723, 90740, 90744, 90747, 90748
HCPCS	G0010
CVX	08, 44, 45, 51, 110, 146
SNOMED	16584000, 170370000, 170371001, 170372008, 170373003, 170374009, 170375005, 170434002, 170435001, 170436000, 170437009, 312868009, 396456003, 416923003, 770608009, 770616000, 770617009, 770618004, 786846001, 1162640003, 572561000119108
Newborn hepatitis B ICD 10 PCS	3E0234Z
History of hepatitis B	
ICD 10 diagnosis	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
SNOMED	1116000, 13265006, 26206000, 38662009, 50167007, 53425008, 60498001, 61977001, 66071002, 76795007, 111891008, 165806002, 186624004, 186626002, 186639003, 235864009, 235865005, 235869004, 235871004, 271511000, 313234004, 406117000, 424099008, 424340000, 442134007, 442374005, 446698005, 838380002, 153091000119109, 551621000124109
Anaphylaxis due to the hepatitis B vaccine	
SNOMED	428321000124101

Varicella (VSV) **Number of dosses: 1** **Special circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
Numerator compliance: Children with any of the following meet criteria: • At least 1 VZV vaccination with a date of service on or between the child's first and second birthday • History of varicella zoster (e.g. chicken pox) illness on or before the child's second birthday.	

• Anaphylaxis due to the VZV vaccine on or before the child's second birthday	
CPT	90710, 90716
CVX	**21, 94**
SNOMED	425897001, 428502009, 432636005, 433733003, 737081007, 871898007, 871899004, 871909005, 572511000119105
History of Varicella Zoster	
ICD 10 diagnosis	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, B02.7, B02.9
SNOMED	4740000, 10698009, 21954000, 23737006, 24059009, 36292003, 38907003, 42448002, 49183009, 55560002, 87513003, 111859007, 111861003, 161423008, 186524006, 186525007, 195911009, 230176008, 230198004, 230262004, 230536009, 232400003, 235059009, 240468001, 240470005, 240471009, 240472002, 240473007, 240474001, 309465005, 371113008, 397573005, 400020001, 402897003, 402898008, 402899000, 410500004, 410509003, 421029004, 422127002, 422446008, 422471006, 422666006, 423333008, 423628002, 424353002, 424435009, 424801004, 424941009, 425356002, 426570007, 428633000, 713250002, 713733003, 713964006, 715223009, 723109003, 838357005, 1163465001, 1163483009, 1179456002, 12551000132107, 12561000132105, 12571000132104, 98541000119101, 331071000119101, 681221000119108, 1087131000119102, 15678761000119105, 15678801000119102, 15678841000119100,15680201000119106, 15680241000119108, 15680281000119103,15685081000119102,15685121000119100, 15685201000119100, 15685281000119108,15936581000119108,15936621000119108, 15989271000119107, 15989311000119107, 15989351000119108,15991711000119108, 15991751000119109, 15991791000119104,15992351000119104, 16000751000119105, 16000791000119100,16000831000119106
Anaphylaxis due to the VZV vaccine	
SNOMED	471341000124104

Pneumococcal Conjugate (PCV) **Number of Doses:** 4 **Special circumstances:** don't count dose administered from birth through 42 days	
Numerator compliance: Children with either of the following on or before their second birthday meet criteria: • At least 4 pneumococcal conjugate vaccinations with different dates of service • Anaphylaxis due to the pneumococcal vaccine Do not count a vaccination administered prior to 42 days after birth	
CPT	90670
HCPCS	G0009
CVX	109, 133, 152
SNOMED	1119368005, 434751000124102
Anaphylaxis due to the pneumococcal vaccine	
SNOMED	471141000124102

Hep A **Number of Doses: 1** **Special circumstances:** Vaccine must be administered on or between a child's first and second birthdays	
Numerator compliance: Children with any of the following meet compliance: • At least one hepatitis A vaccination with a date of service on or between the child's first and second birthdays • History of hepatitis A illness on or before the child's second birthday. Do not include laboratory claims • Anaphylaxis due to the hepatitis A vaccine on or before the child's second birthday	
CPT	90633
CVX	31, 83, 85
SNOMED	170378007, 170379004, 170380001, 170381002, 170434002, 170435001, 170436000, 170437009, 243789007, 312868009, 314177003, 314178008, 314179000, 394691002, 871752004, 871753009, 871754003, 571511000119102
History of Hepatitis A	
ICD 10 diagnosis	B15.0, B15.9
SNOMED	16060001, 18917003, 25102003, 40468003, 43634002, 79031007, 111879004, 165997004, 206373002, 278971009, 310875001, 424758008, 428030001, 105801000119103
Anaphlaxis due to the Hepatitis A vaccine	
SNOMED	471311000124103

Rotavirus **Number of Doses: 2 or 3** **Special circumstances: Vaccine must be administered on or between a child's first and second birthdays**	
Numerator compliance: Children with any of the following meet criteria: • At least 2 doses of the two-dose rotavirus vaccine on different dates of service on or before the child's second birthday • At least 3 doses of the three-dose rotavirus vaccine on different dates of service on or before the child's second birthday • At least 1 dose of the two-dose rotavirus vaccine and at least 2 doses of the three-dose rotavirus vaccine all on different dates of service, on or before the child's second birthday • Anaphylaxis due to the rotavirus vaccine on or before the child's second birthday Do not count a vaccination administered prior to 42 days after birth	
2 Dose Vaccine	
CPT	90681
CVX	**119**
SNOMED	434741000124104
3 Dose Vaccine	
CPT	90680

CVX	116, 122
SNOMED	434731000124109
Anaphylaxis due to the rotavirus vaccine	
SNOMED	428331000124103

Influenza **Number of doses: 2** **Special circumstances:** Don't count dose administered prior to age 6 months **Numerator compliance:** Children with either of the following on or before their second birthday meet criteria: • At least 2 influenza vaccinations with different dates of service • An influenza vaccination recommended for children 2 years and older (e.g. LAIV) administered on the child's second birther meets criteria for one of the two required vaccinations • Anaphylaxis due to the influenza vaccine Do not count a vaccination administered prior to 180 days after birth	
CPT	90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756
HCPCS	G0008
CVX	88, 140, 141, 150, 153, 155, 158, 161, 171, 186
SNOMED	86198006
Live Attenuated Influenza Virus (LAIV)	
CPT	90660, 90672
CVX	111, 149
SNOMED	78706008
Anaphylaxis due to the influenza vaccine	
SNOMED	471361000124100

Exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year. • Members who had a contraindication to a childhood vaccine on or before their second birthday. Either of the following meet criteria: ✓ Contraindications to Childhood Vaccines ✓ Organ and Bone Marrow transplants
Common chart deficiencies	Immunization records not obtained from previous primary care providers

McLaren Health Plan offers a 2025 Healthy Child Immunization Incentive. This incentive is for completion of Childhood Immunization Combo 10 by the Member's 2nd birthday and Adolescent Immunization Combo 2 by the Member's 13th birthday.

Childhood Immunization Combo 10 → $100
Adolescent Immunization Combo 2 → $50

How to Improve Your Quality Score:

- Use Michigan's Care Improvement Registry (MCIR) to register Immunizations: mcir.org – Improving Healthcare in Michigan
- Review a child's immunization record before every visit (preventive and sick) and administer needed vaccines.
- If applicable, give immunizations during a sick visit if the child's immunizations are behind.
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations. Talking with Parents about Vaccines for Infants | CDC
- Schedule appointments for your patient's next vaccination before they leave your office
- Remind parents on the importance of keeping immunizations on track
- Use phone calls, emails, text messages and/or postcards/letters to help keep parents engaged
- Check at each visit for any missing immunizations.
- Educate staff to schedule vaccination/well-child visits prior to the second birthday.
- Refresh staff knowledge by completing CDC's "You Call the Shots" interactive web-based immunization training course: You Call the Shots: Vaccines Web-based Training Course | CDC
- Use your electronic medical record system for pre-visit planning and to set alerts.
- Use combination vaccines (DTaP-HepB-IPV, DTaP-HiB-IPV, DTaP-IPV-HiB-HepB) when possible.
- General Best Practice Guidelines for Immunization from the Centers for Disease Control and Prevention can be found: ACIP General Best Practice Guidelines for Immunization | CDC
- Documentation that a member is up to date with all immunizations but doesn't include a list of the immunizations and dates they were administered will not meet compliance.

Immunization records can be accepted as supplemental data

**This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

Note: *To receive reimbursement for Vaccine for Children (VFC) administration, please refer to the IHCP Injections Vaccines and Other Physician-Administered Drugs Module.*

Colorectal Cancer Screening (COL-E)

What Is the Measure?

This measure assesses the percentage of members 45-75 years of age who had appropriate screening for colorectal cancer.

NOTE: the CMS Star Rating specifications for the Medicare population differs from the HEDIS specifications and assesses patients 50-75 years of age.

Type of Screening	Compliant for:
Colonoscopy	10 years
Flexible Sigmoidoscopy	5 years
sDNA (stool DNA + FIT test), also known as Cologuard®	3 years
FIT (Fecal Immunochemical Test) **FOBT** (Fecal Occult Blood Test)	1 year
CT-Colonography (virtual colonoscopy)	5 years

Product Lines	Quality programs affected	Collection and reporting methods
Commercial **Medicaid** **Medicare**	• CMS Star Ratings • NCQA Health Plan Ratings	• ECDS
Numerator Compliance	Members with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test during the measurement period • Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period • Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period • CT colonography during the measurement period or the 4 years prior to the measurement period • Colonoscopy during the measurement period or the 9 years prior to the measurement period	
Time Period	January 1, 2025- December 31, 2025	

Description	Code Type	Codes
Colonoscopy Screening	**CPT**	44388, 44389, 44390, 44391, 44392, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398
	HCPCS	G0105, G0121
	SNOMED	8180007, 12350003, 25732003, 34264006,73761001, 174158000, 174185007, 235150006, 235151005, 275251008, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000
CT colonography	**CPT**	74261, 74262, 74263
	LOINC	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
	SNOMED	418714002

FIT lab test	**CPT**	81528
	HCPCS	77353-1, 77354-9
Flexible Sigmoidoscopy	**CPT**	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
	HCPCS	G0104
	SNOMED	44441009, 396226005, 425634007
Fecal Occult Blood Test (FOBT)	**CPT**	82270, 82274
	HCPCS	G0328
	LOINC	12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
	SNOMED	104435004, 441579003, 442067009, 442516004, 442554004, 442563002
FOBT test results	**SNOMED**	59614000, 167667006, 389076003, 71711000112103
History of colorectal cancer	**ICD 10 diagnosis**	C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
	SNOMED	93683002, 93761005, 93771007, 93826009, 93980002, 93984006, 94006002, 94072004, 94105000, 94179005, 94260004, 94271003, 94328005, 94509004, 94513006, 94538001, 94604000, 94643001, 109838007, 109839004, 187757001, 187760008, 254582000, 254586002, 269533000, 269544008, 276822007, 285312008, 285611007, 285612000, 301756000, 312111009, 312112002, 312113007, 312114001, 312115000, 314965007, 314966008, 315058005, 363351006, 363406005, 363407001, 363408006, 363409003, 363410008, 363412000, 363413005, 363414004, 363510005, 369448007, 369449004, 369450004, 369451000, 369452007, 369453002, 369454008, 369455009, 369456005, 369457001, 369458006, 369459003, 369460008, 369461007, 395705003, 422375001, 422581008, 422985007, 425178004, 425213009, 429084005, 429699009, 443488001, 447886005, 448994001, 449218003, 713573006, 721695008, 721696009, 721697000, 721698005, 721699002, 721700001, 721701002, 726654006, 737058005, 766979005, 766981007, 1156783003, 1156788007, 1156795003, 1156797006, 1163568002, 1701000119104, 96281000119107, 96981000119102, 123701000119104, 123721000119108, 130381000119103, 133751000119102, 184881000119106, 286771000119106, 286791000119107, 681601000119101, 681651000119102, 10987871000119109,16636051000119105, 16636101000119105
Stool DNA based colorectal cancer screening positive (finding)	**SNOMED**	708699002
History of flexible sigmoidography (situation)	**SNOMED**	841000119107
History of colonoscopy (situation)	**SNOMED**	851000119109
History of total colectomy (situation)	**SNOMED**	119771000119101

Frequency/occurrence	• Colonoscopy – every 10 years • Flexible sigmoidoscopy/CT Colonography- every 5 years • FIT-DNA- every 3 years • FIT/FOBT- every year
Required exclusions	• Diagnosis of colorectal cancer any time in a patient's history • Total colectomy any time in a patient's history

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Educate patients on the importance of early detection and encourage colorectal cancer screening. For patients who refuse a colonoscopy, discuss noninvasive screening options such as Cologuard® or FIT.
- Assess existing barriers to colorectal cancer screening (i.e., access, fear/anxiety, etc.).
- Update patient history every year regarding colorectal cancer screening with testing date (documenting the year of the procedure is acceptable)
- Use EHR/EMR alerts and standing orders and empower office staff to distribute FOBT kits to patients who need colorectal cancer screening or prepare referrals for colonoscopy.
- Implement a FLU-FOBT program to increase access to colorectal cancer screening by offering home tests to patients at the time of their flu shots.
- Have FIT kits readily available to give patients during the visit.
- Fecal Immunochemical Test (FIT) and Cologuard® (sDNA + FIT) tests are NOT the same screening. FIT uses antibodies to detect blood in the stool (completed annually), and sDNA combines the FIT with a test that detects altered DNA in the stool (completed every three (3) years).
- Colonoscopy must be complete, or evidence must show that the scope advanced beyond splenic flexure to be considered compliant within the time frame. An incomplete colonoscopy or evidence that the scope advanced into the sigmoid colon can be considered compliant as a flexible sigmoidoscopy.
- Lab results/consultation reports for colorectal cancer screening can be accepted as supplemental data

Controlling High Blood Pressure (CBP)

What Is the Measure?

The Controlling High Blood Pressure measure evaluates patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure is adequately controlled (<140/90 mmHg) during the measurement year (MY).

Definitions

- Adequate Control: Both a representative systolic BP <140 mmHg and a representative diastolic BP of <90 mmHg
- Representative BP: The most recent BP reading during the MY on or after the second diagnosis of hypertension. If no BP is recorded during the MY, the patient is considered "not controlled".

Codes to Identify Controlling High Blood Pressure for Adults:

Description	CPT/HCPCS/ICD-10-CM		
Numerator Compliance	The most recent BP reading < 140/90 mmHg taken during the measurement year		
Time period	January 1, 2025- December 31, 2025		
Billing Codes	**Description**	**Code Type**	**Codes**
	Diastolic less than 80	CPT II	3078F
	Diastolic between 80-89	CPT II	3079F
	Diastolic >= to 90	CPT II	3080F
	Systolic less than 130	CPT II	3074F
	Systolic between 130-139	CPT II	3075F
	Systolic >= to 140	CPT II	3077F
	History of kidney transplant	ICD-10 diagnosis	Z94.0
Frequency/Occurrence	Every visit		
Required Exclusions	• Members who use hospice services • Members receiving palliative care • Medicare members 66 years of age and older as of December 31 of the MY who are enrolled in an institutional SNP or living long-term in an institution • Members 66 years of age and older as of December 31 of the MY with frailty **and** advanced illness/dispensed dementia medication • History of dialysis, end-stage renal disease (ESRD), kidney transplant, or nephrectomy • Patients with a diagnosis of pregnancy during the measurement year		

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities
- Document all BP readings at every visit
  - ✓ If the patient's BP is 140/90 or higher at the start of the visit, recheck the BP at the end of the visit
  - ✓ If the recheck BP is still 140/90 or greater, schedule a follow-up appointment. When multiple reading during the same visit are taken, record all BP readings taken during appointment.
  - ✓ Telephone visits, e-visits, and virtual visits are appropriate settings for BP readings and allow patient reported BP's taken with a digital device
  - ✓ BP readings can be patient-reported during a telehealth visit, telephonic visit, e-visit or virtual check-in, if the BP is taken on a digital device, it must be recorded, dated and maintained in the patient's medical record.
  - ✓ Use CPT II codes when billing office/telephone/virtual visits to capture blood pressure result
  - ✓ Be sure to bill code for both systolic and diastolic results
  - ✓ Timely submission of claim data
- Blood pressure service date and values can be accepted as supplemental data.

Important Notes:

The last BP result of the year is the result that will determine if your patient is compliant for this measure.

Eye Exam for Patients with Diabetes (EED)

What Is the Measure?

The Eye Exam for Patients with Diabetes measure evaluates patients 18-75 years of age with diabetes (types 1 and 2) who had a retinal or dilated eye exam by an ophthalmologist or optometrist in the measurement year (MY).

Summary of Changes:

- Moved bilateral eye nucleation from the numerator to required exclusions
- Removed the Hybrid Data Collection Method

Description	CPT/HCPCS/ICD-10-CM	
Numerator Compliance	Screening or monitoring for diabetic retinal disease by an eye care professional. This includes: • A retinal or dilated eye exam in the measurement year • A negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement year.	
Time period	January 1, 2025- December 31, 2025	
Billing Codes		
Description	**Code Type**	**Codes**
Retinal Eye Exams	**CPT**	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
	HCPCS	S0620, S0621, S3000
	SNOMED	18188000, 21593001, 252779009, 252780007, 252781006, 252782004, 252783009, 252784003, 252788000, 252789008, 252790004, 252846004, 274795007, 274798009, 308110009, 30842004, 314971001, 314972008, 36844005, 390852004, 391999003, 392005004, 410441007, 410450009, 410451008, 410452001, 410453006, 410455004, 416369006, 417587001, 420213007, 425816006, 426880003, 427478009, Supplemental data accepted The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 37 53524009, 56072006, 56204000, 6615001, 700070005, 722161008
Any code in the retinal eye exam value set with a diagnosis of diabetes without complications	**ICD10**	E10.9, E11.9, E13.9
	SNOMED	111552007, 1217044000, 1217068008, 1290118005, 481000119100, 190412005, 31321000119102, 313435000, 313436004, 721111000124107, 721121000124104, 721201000124104
Eye Exam with evidence of retinopathy	**CPTII**	2022F, 2024F, 2026F

Eye Exam without evidence of retinopathy	**CPTII**	2023F, 2025F, 2033F
Retinal Imaging	**CPT**	92227, 92228
Diabetic retinal screening negative in prior year (billed by any provider)	**CPT II**	3072F
Automated eye exam	**CPT**	92229
Frequency/Occurrence	Every year	
Required Exclusions	• Bilateral eye enucleation any time during the patient's history • Two unilateral eye enucleations with service dates 14 days or more apart • Let unilateral eye enucleation and right unilateral eye enucleation on the same or different dates of service • A unilateral eye enucleation and a left unilateral eye enucleation with service dates 14 days or more apart • Members who use hospice services • Members receiving palliative care • Medicare members 66 years of age and older as of December 31 of the measurement year who re enrolled in an institutional SNP or living long-term in an institution • Members 66 years of age and older as of December 31 of the measurement year with facility and advanced illness/dispensed dementia medication	

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities
  - ✓ Always list the date of service, test, result and eye care professional's name and credentials together if you're documenting the history of a dilated eye exam in a patient's chart and you don't have the eye exam report from the eye care professional. The care provider must be an optometrist or ophthalmologist.
  - ✓ A chart of photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an ophthalmologist or optometrist reviewed the results will be compliant. The fundus photography must include the result, date and signature of the reading eye care professional for compliance.
  - ✓ Create a process to follow-up with patients within 60 days of referral if eye exam isn't completed
  - ✓ Use EHR/EMR alerts for patients due for a retinal eye exam

- ✓ The use of CPT II odes helps identify clinical outcomes such as diabetic retinal screening with an eye care professional. It can also reduce the need for chart review.
- ✓ Timely submission of claim data

- Dilated retinal eye exams with results can be accepted as supplemental data.

Important Notes:

- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefor do not require an exam
- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that patients with evidence of any type of retinopathy have an eye exam annually, while patients who remain free of retinopathy (i.e. the retinal exam was negative for retinopathy) are screened every other year.

Follow-up After Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions (FMC)

What Is the Measure?

The Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions measure evaluates patients 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service with a care provider within seven (7) days of the ED visit.

Description	CPT/HCPCS/ICD-10-CM		
Numerator Compliance	A follow-up service within 7 days after the ED visit. Include visits that occur on the date o the ED visit (8 total days)		
Time period	January 1, 2025 – December 31, 2025		
Eligible chronic condition diagnoses	Acute myocardial infarction Atrial fibrillation Alzheimer's disease and related disorders Chronic Kidney Disease	COPD, Asthma, or unspecified bronchitis Depression Heart Failure Stroke or TIA	
Billing Codes	**Description**	**Code Type**	**Code**
	Outpatient visit, telephone visit, e-visit or virtual check-in		
	Outpatient and telehealth	CPT	98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99455, 99456, 99457, 99458, 99483
		HCPCS	G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015
		SNOMED	77406008, 84251009, 185317003, 185463005, 185464004, 185465003, 281036007, 314849005, 386472008, 386473003, 401267002, 439740005, 3391000175108, 444971000124105
		UBREV	0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
	Transitional Care Management Services		
	Transitional care management	CPT	99495, 99496
	Case Management Visits		
		CPT	99366

	Care management	HCPCS	T1016, T1017, T2022, T2023
		SNOMED	386230005, 416341003, 425604002
	Complex Care Management Visits		
	Complex care management	CPT	99439, 99487, 99489. 99490, 99491
		HCPCS	G0506
	Outpatient or telehealth behavior health visit with outpatient place of service		
	Visit Setting Unspecified	CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
	Outpatient POS	POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Outpatient or telehealth behavioral health visit		
	Behavioral health outpatient	CPT	98960, 98961, 98962, 99078, , 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, , 99344, 99345,99347, 99348, 99349, 99350 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
		HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2016, H2017, H2018, H2019, H2020, T1015
		UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
		SNOMED	185463005, 185464004, 185465003, 209099002, 281036007, 3391000175108, 391223001, 391224007, 391225008, 391233009, The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 100 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 444971000124105,456201000124103, 50357006,77406008, 84251009, 86013001, 866149003, 90526000
	Outpatient or telehealth behavioral health visit with appropriate place of service		
	Visit setting unspecified	CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

	Outpatient POS	POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Intensive outpatient encounter or partial hospitalization		
	Partial hospitalization or intensive outpt visit	HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
	Intensive outpatient encounter or partial hospitalization with appropriate place of service		
	Visit setting unspecified	CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
	Partial hospitalization POS	POS	52
	Community mental health center visit with appropriate place of service		
	Visit setting unspecified	CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
	Community mental health center POS	POS	53
	Electroconvulsive therapy with appropriate outpatient place of service		
	Electroconvulsive therapy	CPT	90870
		ICD10PCS	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
		SNOMED	1010696002, 1010697006, 10470002, 11075005, 231079005, 231080008, 23835007, 284468008, 313019002, 313020008
	Ambulatory surgical center	POS	24
	Community mental health center POS	POS	53
	Outpatient POS	POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Partial hospitalization POS	POS	52
	Telehealth visit with telehealth place of service		

	Visit setting unspecified	CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
	Telehealth POS	POS	02, 10
	Substance use disorder service		
	Substance use disorder services	CPT	99408, 99409
		HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
		SNOMED	182969009, 20093000, 23915005, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 428211000124100, 445628007, 445662007, 450760003, 56876005, 61480009, 64297001, 67516001, 704182008, 707166002, 711008001, 713106006, 713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 87106005
		UBREV	0906, 0944, 0945
	Substance use disorder counseling and surveillance	ICD10	Z71.41, Z71.51
Frequency/ Occurrence	After every emergency department discharge for people with multiple high-risk chronic conditions		
Exclusions	Patients who use hospice services or elect to use a hospice benefit anytime during the measurement year		
Test, service or procedure to close care opportunity	• Outpatient follow-up appointment after every emergency department discharge between January 1 and December 24 of the measurement year		
Medical Record Documentation	Consultation reports, diagnostic reports, health history and physical		

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Schedule a follow-up appointment within seven days of discharge

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

What Is the Measure?

The Follow-Up After Emergency Department Visit for Substance Abuse measure evaluates patients 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose and who had a follow-up visit. This measure assesses the following.

1. Patients who received a follow-up visit within 7 days after emergency department visit discharge
2. Patient who received a follow-up visit within 30 days after the emergency department visit discharge

Note: Follow-up visits may not occur on the same date of inpatient or residential treatment discharge or detoxification visit.

Description		
Numerator Compliance	A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days) or within 30 days after the ED visit (31 days total). Include visits and pharmacotherapy events that occur on the date of the ED visit.	
Time period	January 1, 2025- December 31, 2025	
Billing Codes		
Description	**Code Type**	**Codes**
Outpatient visit with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose.		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
Outpatient visit with appropriate place of service with a mental health provider		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
Outpatient visit with any diagnosis of substance use disorder, substance use, or drug overdose		
Behavioral health outpatient	**CPT**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, Supplemental data accepted The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 179 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510

	HCPCS	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
	UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
Outpatient visit with a mental health provider		
Behavioral health outpatient	**CPT**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
	HCPCS	G0155, G0176, G0177, G0409, G0463, , G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
	UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
Intensive outpatient encounter or partial hospitalization with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Partial hospitalization POS	**POS**	52
Intensive outpatient encounter or partial hospitalization with appropriate place of service with a mental health provider		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Partial hospitalization POS	**POS**	52
Intensive outpatient encounter or partial hospitalization with any diagnosis of substance use disorder, substance use, or drug overdose		
Partial hospitalization or intensive outpatient	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
Intensive outpatient encounter or partial hospitalization with a mental health provider		
Partial hospitalization or intensive outpatient	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485

Non-Residential substance abuse treatment facility visit with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose.		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Non-residential substance abuse treatment facility POS	**POS**	57, 58
Non-residential substance use treatment facility visit with appropriate place of service with a mental health provider		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Non-residential substance abuse treatment facility POS	**POS**	57, 58
Community mental health center with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Community mental health POS	**POS**	53
Community mental health center visit with appropriate place of service with a mental health provider		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Community mental health POS	**POS**	53
Peer support service with any diagnosis of substance use disorder, substance use, or drug overdose		
Peer support service	**HCPCS**	G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016
Opioid treatment service that bills monthly or weekly with any diagnosis of substance use disorder, substance use, or drug overdose.		
OUD weekly non-drug service	**HCPCS**	G2071, G2074, G2075, G2076, G2077, G2080
OUD monthly office-based treatment	**HCPCS**	G2086, G2087
Telehealth visit with appropriate place of service with any diagnosis of substance use disorder, substance use, or drug overdose		

Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Telehealth POS	**POS**	02, 10
Telehealth visit with appropriate place of service with a mental health provider		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Telehealth POS	**POS**	02, 10
Telephone visit with any diagnosis of substance use disorder, substance use, or drug overdose		
Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
Telephone visit with a mental health provider		
Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
E-visit or virtual check-in with any diagnosis of substance use disorder, substance use, or drug overdose		
Online assessments	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
	HCPCS	G0071, G2010, G2012, G2061, G2062, G2062, G2063, G2250, G2251, G2252
Substance use disorder service		
Substance use disorder services	**CPT**	99408, 99409
	HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
	SNOMED	182969009, 20093000, 23915005, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 428211000124100, 445628007, 445662007, 450760003, 56876005, 61480009, 64297001, 67516001,704182008, 707166002, 711008001, 713106006,713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 87106005
	UBREV	0909, 0944, 0945
Substance use disorder counseling and surveillance		
Substance abuse counseling and surveillance	**ICD 10 diagnosis**	Z71.41, Z71.51
A behavioral health screening or assessment for substance use disorder or mental health disorders		
Behavioral health assessment	**CPT**	99408, 99409
	HCPCS	G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
	SNOMED	171208001, 314077000, 370854007, 391281002, 40823001, 410223002, 410229003, 414283008, 414501008, 415662004, 428211000124100, 439320000, 49474007, 58473000, 64792006, 703257008, 713106006, 713107002, 713127001, 713132000, 713137006, 89732002
Substance use service		
Substance use services	**HCPCS**	H0006, H0028

A pharmacotherapy dispensing event or medication treatment event		
Alcohol use disorder treatment medications	**Description**	**Prescription**
	Aldehyde dehydrogenzse inhibitor	• Disulfiram (oral)
	Antagonist	• Naltrexone (oral and injectable)
	Other	• Acamprosate (oral; delayed release tablet)
Opioid use disorder treatment medications	**Description**	**Prescription**
	Antagonist	• Naltrexone (injectable) • Naltrexone (oral)
	Partial agonist	• Buprenorphine (implant) • Buprenorphine (injection) • Buprenorphone (sublingual tablet)
Medication treatment event	**HCPCS**	G2069, G2070, G2072, G2073, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992, S0109
Weekly drug treatment service	**HCPCS**	G2067, G2068, G2069, G2070, G2072, G2073
Substance Use Disorder	**ICD 10 diagnosis**	F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230-F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-F10.282, F10.288, F10.29, F11.10, F11.120-F11.122, F11.129, F11.14, F11.150, F11.151, The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 184 F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220-F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120- F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220-F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180-F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230-F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280-F13.282, F13.288, F13.29, F14.10, F14.120-F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180-F14.182, F14.188, F14.19, F14.20, F14.220-F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280- F14.282, F14.288, F14.29, F15.10, F15.120-F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.182, F15.188, F15.19, F15.20, F15.220-F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-F15.282, F15.288, F15.29, F16.10, F16.120-F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120-F19.122, F19.129, F19.14, F19.150, F19.151, F19.159- F19.182, F19.188, F19.19, F19.20, F19.220-F19.222, F19.229, F19.230-F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26- F19.282, F19.288, F19.29

Substance use	**ICD 10 diagnosis**	F10.920, F10.921, F10.929, F10.930, F10.931, F10.932, F10.939, F10.84, G10.950, F10.951, F10.959, F10.96. F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, F11.90, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.90, F12.920, F12.921, F12.922, F12.929, F12.93, F12.950, F12.951, F12.959,F12.980, F12.988, F12.99, F13.90, F13.920, F13.921, F13.921, F13.929, F13.930, F13.931, F13.932, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982,F13.988, F13.99, F14.90, F14.920, F14.921, F14.922, F14.929, F14.93, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.90, F15.920, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981,F15.982, F15.988, F15.99, F16.90, F16.920, F16.921, F16.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.90, F19.920, F19.921, F19.922, F19.929,F19.930, F19.931, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99
Drug overdose	**ICD 10 diagnosis**	T40.0X1A, T40.0X1D, T40.0X1S, T40.0X4A, T40.0X4D, T40.0X4S, T40.1X1A, T40.1X1D,T40.1X1S, T40.1X4A, T40.1X4D, T40.1X4S, T40.2X1A, T40.2X1D, T40.2X1S, T40.2X4A, T40.2X4D, T40.2X4S, T40.3X1A, T40.3X1D,T40.3X1S, T40.3X4A, T40.3X4D, T40.3X4S, T40.411A, T40.411D, T40.411S, T40.414A, T40.414D, T40.414S, T40.421A, T40.421D,T40.421S, T40.424A, T40.424D, T40.424S, T40.491A, T40.491D, T40.491S, T40.494A, T40.494D, T40.494S, T40.5X1A, T40.5X1D,T40.5X1S, T40.5X4A, T40.5X4D, T40.5X4S, T40.601A, T40.601D, T40.601S, T40.604A, T40.604D, T40.604S, T40.691A, T40.691D,T40.691S, T40.694A, T40.694D, T40.694S, T40.711A, T40.711D, T40.711S, T40.714A, T40.714D, T40.714S, T40.721A, T40.721D,T40.721S, T40.724A, T40.724D, T40.724S, T40.7X1A, T40.7X1D, T40.7X1S, T40.7X4A, T40.7X4D, T40.7X4S, T40.8X1A, T40.8X1D,T40.8X1S, T40.8X4A, T40.8X4D, T40.8X4S, T40.901A, T40.901D, T40.901S, T40.904A, T40.904D, T40.904S, T40.991A, T40.991D,T40.991S, T40.994A, T40.994D, T40.994S, T41.0X1A, T41.0X1D, T41.0X1S, T41.0X4A, T41.0X4D, T41.0X4S, T41.1X1A, T41.1X1D,T41.1X1S, T41.1X4A, T41.1X4D, T41.1X4S, T41.201A, T41.201D, T41.201S, T41.204A, T41.204D, T41.204S, T41.291A, T41.291D,T41.291S, T41.294A, T41.294D, T41.294S, T41.3X1A, T41.3X1D, T41.3X1S, T41.3X4A, T41.3X4D, T41.3X4S, T41.41XA, T41.41XD,T41.41XS, T41.44XA, T41.44XD, T41.44XS, T41.5X1A, T41.5X1D, T41.5X1S, T41.5X4A, T41.5X4D, T41.5X4S, T42.3X1A, T42.3X1D,T42.3X1S, T42.3X4A, T42.3X4D, T42.3X4S, T42.4X1A, T42.4X1D, T42.4X1S, T42.4X4A, T42.4X4D, T42.4X4S, T43.601A, T43.601D,T43.601S, T43.604A, T43.604D, T43.604S, T43.621A, T43.621D, T43.621S, T43.624A, T43.624D, T43.624S, T43.631A, T43.631D,T43.631S, T43.634A, T43.634D, T43.634S, T43.641A, T43.641D, T43.641S, T43.644A, T43.644D, T43.644S, T43.691A, T43.691D,T43.691S, T43.694A, T43.694D, T43.694S, T51.0X1A, T51.0X1D, T51.0X1S, T51.0X4A, T51.0X4D, T51.0X4S
Frequency/Occurrence	Every mental health emergency department visit discharge	
Test, service or procedure to close this care opportunity	• Follow-up care after emergency department visit for mental illness • Follow-up for substance use disorder can be any of the following: ✓ Group visits with an appropriate place of service code and diagnosis code ✓ Medication dispensing event with diagnosis code ✓ Medication treatment with diagnosis code ✓ Online assessment with diagnosis code	

	✓ Stand-alone visits with an appropriate place of service code and diagnosis code ✓ Telephone visit with diagnosis code

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Review the MiHIN admission, discharge or transfer service report
  - ✓ Schedule follow-up appointment within 7 days of discharge
  - ✓ Encourage the use of telehealth appointments when appropriate

- Mental health visits can be accepted as supplemental data.

Follow-Up After Hospitalization for Mental Illness (FUH)

What Is the Measure?

The Follow-Up After Hospitalization for Mental Illness measure evaluates patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who have a follow-up visit with a mental health provider. Timely follow-up visits with qualified mental health providers are critical for their well-being. This measure assesses the following.

1. Patient received follow-up within 30 days after discharge with a mental health provider
2. Patient received follow-up within 7 days after discharge with a mental health provider

Note: the follow-up visit must be on a different date than the discharge date.

Summary of changes:

- Modified the denominator criteria to allow intentional self-harm diagnoses to take any position on the acute inpatient discharge claim
- Added phobia, anxiety and additional intentional self-harm diagnoses to the denominator in the event/diagnosis
- Added visits with any diagnosis of a mental health disorder to the numerator
- Added peer support and residential treatment services to the numerator.

Numerator Compliance	A follow-up visit with a mental health provider within 7 days after discharge or within 30 days after discharge	
Time period	January 1, 2025- December 31, 2025	
Billing Codes		
Description	**Code Type**	**Codes**
Outpatient visit with a mental health provider and with appropriate outpatient place of service code:		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
	POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
Outpatient visit with appropriate outpatient place of service with any diagnosis of mental health disorder		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
Mental Health Disorder Diagnosis	**ICD10 Diagnosis**	F03.90-F99

Behavioral health outpatient visit with a mental health provider		
Behavioral health outpatient	**CPT**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
	HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
	UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
Outpatient behavioral health visit with any diagnosis of mental health disorder		
Behavioral health Outpatient	**CPT**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
	HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
	UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
Mental Health Diagnosis	**ICD10 diagnosis**	F03.90-F99
Intensive outpatient or partial hospitalization with appropriate place of service code		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
Psychiatric facility-partial hospitalization POS	**POS**	52
Intensive outpatient or partial hospitalization		
Partial hospitalization or intensive outpatient visits	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
	UBREV	0905, 0907, 0912, 0913
Intensive outpatient or partial hospitalization with a community mental health center and with appropriate place of service		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

Behavioral health outpatient	**CPT**	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350. 99383, 99384, 99385, 99386, 99387, 99393, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 95510
Transitional care management services	**CPT**	99495, 99496
Community mental health POS	**POS**	53
Electroconvulsive therapy with ambulatory surgical center POS/community mental health center POS/outpatient POS, partial hospitalization POS		
Electroconvulsive Therapy	**CPT**	90870
	ICD10 PCS	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
	SNOMED	1010696002, 1010697006, 10470002, 11075005, 231079005, 231080008, 23835007, 284468008, 313019002, 313020008
POS	**Ambulatory POS**	24
	Community mental health POS	53
	Outpatient POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Partial hospitalization	52
Telehealth visit with a mental health provider with the appropriate telehealth place of service		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
Telehealth POS	**POS**	02, 10
Transitional Care Management services with a mental health provider		
Transitional Care Management	**CPT**	99495, 99496
Transitional Care Management services with any diagnosis of mental health disorder		
Transitional Care Management	**CPT**	99495, 99496
Mental health disorder diagnosis	**ICD10 Diagnosis**	F03.90-F99
Visit in a behavioral healthcare setting		

Behavioral healthcare setting	**UBREV**	0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 1001
Telephone visit with a mental health provider		
Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
Telephone visit with any diagnosis of mental health disorder		
Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
Mental health diagnosis	**ICD10 diagnosis**	F03.90-F99
Psychiatric collaborative care management		
Psychiatric collaborative care management	**CPT**	99492, 99493, 99494, G0512
	HCPCS	G0512
Peer support services with any diagnosis of mental health disorder		
Peer Support Services	**HCPCS**	G0140, G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016
Mental Health diagnosis	**ICD10 diagnosis**	F03.90-F99
Psychiatric residential treatment		
Residential behavioral health treatment	**HCPCS**	H0017, H0018, H0019, T2048
Psychiatric residential treatment with the appropriate psychiatric residential treatment center place of service		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, . 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
Psychiatric residential treatment center	**POS**	56
Frequency/Occurrence	Every mental health discharge	
Required Exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year	

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Review the MiHIN admission, discharge or transfer service report
  - ✓ Refer patient to a mental health provider to be seen within seven days of discharge
  - ✓ Even patients receiving medication from their primary care provider still need post-discharge supportive therapy with a licensed mental health clinician such as a therapist or social worker
  - ✓ Ensure the patient has a plan for follow-up visit with a mental health provider within 7 and 30 days after discharge. Don't include visits that occur on the date of discharge
  - ✓ Schedule the patient's aftercare appointments prior to discharge
  - ✓ Review medications with patients to ensure they understand the purpose, appropriate frequency/occurrence and method of administration
  - ✓ Use EHR/EMR alerts for patients due for a follow-up visit after hospitalization for a mental illness
- Hospital follow-up visits can be accepted as supplemental data.

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

What Is the Measure?

The Follow-Up After Emergency Department Visit for Mental Illness measure evaluates patients 6 years of age and older who had a principal diagnosis of a mental health disorder or intentional self-harm diagnoses and who have a follow-up visit with a practitioner. This measure assesses the following.

1. Patient received follow-up with any practitioner within 7 days after emergency department visit
2. Patient received follow-up with any practitioner within 30 days after emergency department visit.

Note: the follow-up visit must be on a different date than the discharge date.

Summary of changes:

- Modified the denominator criteria to allow intentional self-harm diagnoses to take any position on the claim
- Added phobia, anxiety and additional intentional self-harm diagnoses to the denominator in the event/diagnosis
- Modified the numerator criteria to allow a mental health diagnosis to take any position on the claim
- Added peer support and residential treatment services to the numerator
- Added visits in a behavioral healthcare setting and psychiatric collaborative care management services to the numerator

Description		
Numerator Compliance	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days) or within 30 days after the ED visit (31 total days)	
Time period	January 1, 2025- December 31, 2025	
Billing Codes		
Description	**Code Type**	**Codes**
Outpatient visit with any diagnosis of a mental health disorder with outpatient place of service		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834,90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238,99239, 99252, 99253, 99254, 99255
Mental health disorder diagnosis	**ICD 10 diagnosis**	F03.90 – F99
Outpatient POS	**POS**	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72

Intensive outpatient encounter or partial hospitalization with the appropriate partial hospitalization place of service		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
Partial hospitalization	**POS**	52
Intensive outpatient encounter or partial hospitalization with any diagnosis of a mental health disorder		
Partial hospitalization or intensive outpatient visits	**HCPCS**	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
	SNOMED	305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000, 7133001
	UBREV	0905, 0907, 0912, 0913
Mental health disorder diagnosis	**ICD 10 diagnosis**	F03.90-F99
Community mental health center visit with appropriate place of service code		
Visiting setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
Community health POS	**POS**	53
Electroconvulsive therapy with ambulatory surgical center POS/community mental health center OPS/outpatient POS/or partial hospitalization POS		
Electroconvulsive therapy	**CPT**	90870
Ambulatory surgical center POS	**POS**	24
Community mental health POS		53
Outpatient POS		03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
Partial hospitalization POS		52

Telehealth visit with the appropriate place of service with any diagnosis of a mental health disorder		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876
Telehealth POS	**POS**	02, 10
Mental health disorder	**ICD 10 diagnosis**	F03.90-F99
Telephone visit with any diagnosis of a mental health disorder		
Telephone visits	**CPT**	98966, 98967, 98968, 99441, 99442, 99443
Mental Health disorder	**ICD 10 diagnosis**	F03.90-F99
E-visit or virtual check-in with any diagnosis of a mental health disorder		
Online assessment (e-visit/virtual check-in)	**CPT**	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
	HCPCS	G0071, G2010, G2012, G2061, G2062, G2063
Mental health disorder	**ICD 10 diagnosis**	F03.90-F99
Intentional self-harm	**ICD 10 diagnosis**	T14.91XA, T14.91XD, T14.91XS; and all codes ending with 2A, 2D, or 2S from T36.0X-T71.23
Psychiatric collaborative care management		
Psychiatric collaborative care management	**CPT**	99492, 99493, 99494
	HCPCS	G0512
Peer support services		
Peer support services	**HCPCS**	G0140, G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016
Psychiatric residential treatment		
Residential behavioral health treatment	**HCPCS**	H0017, H0018, H0019, T2048
Psychiatric residential treatment with the appropriate place of service code		
Visit setting unspecified	**CPT**	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255
Psychiatric residential treatment center	**POS**	56
A visit in a behavioral healthcare setting		

Behavioral healthcare setting	**UBREV**	0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 1001
Frequency/Occurrence	Every mental health emergency department visit discharge	
Required Exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year	

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- ✓ Ensure the patient has a plan for follow-up with a practitioner within 7 and 30 days after discharge. Don't include visits that occur on the date of discharge.
- ✓ Encourage the use of telehealth appointments when appropriate
- ✓ Use EHR/EMR alerts for patients due for a follow-up visit after emergency department visits for a mental illness

- Mental health visits can be accepted as supplemental data.

Glycemic Status Assessment for Patients with Diabetes (GSD)

What Is the Measure?

The percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%
- Glycemic Status >9.0%* (inverted measure)
- *Inverted measure; Because the GSD measure rate indicates the percentage of members with an uncontrolled glycemic status, a lower rate in this measure indicates better performance.

Compliance:

HbA1c Controlled

- Member has a HbA1c of <8.0% within the current year
- Member is not compliant if the most recent HbA1c is ≥ 8.0%

HbA1c Poorly Controlled

- Member has a HbA1c of >9.0% within the current year
- The member is numerator compliant if HbA1c is >9.0%

Note: Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators. The result of the most recent glycemic status assessment (HbA1c or GMI) performed during the measurement year through laboratory data or medical record review is required. Documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result. Low rates of Glycemic Status >9% indicate better care.

Codes to Identify GSD:

Description	Code Type	Codes
HbA1c Lab Test	**CPT**	83036, 83037
	LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4
	SNOMED	313835008, 43396009
HbA1c Test Result of Finding (Do not include CPT II codes with a modifier POS81		
HbA1c <7%	**CPT II**	3044F
	SNOMED	165679005
HbA1c >= 7% and <8%	**CPT II**	3051F
HbA1c >= to 8% and <9%	**CPTII**	3052F
HbA1c >=9%	**CPT II**	3046F
	SNOMED	451061000124104

Frequency/occurrence	Every year at minimum; every three months if uncontrolled
Required exclusions	• Members who use hospice services • Members receiving palliative care • Medicare members 66 years of age and older as of December 31 of the measurement year who are enrolled in an institutional SNP or living long-term in an institution • Members 66years of age and older as of December 31 of the measurement year with frailty and advanced illness/dispensed dementia medication
Common chart deficiencies	• No HbA1c or GMI test for the measurement year • No results in the medical record for a claim reported date of service

* *This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

2025 Diabetic Measures Incentive:

Complete All Services	McLaren Health Plan Incentive
1. HbA1c test or glucose management indicator	$50.00
2. Estimated glomerular filtration rate (eGFR) & urine albumin-creatinine ratio (uACR)	
Diabetic Management	**McLaren Health Plan Incentive**
1. Controlled blood pressure <140/90	$25 for each controlled measure
2. Controlled A1c <8	

How to Improve Your Quality Score:

- Consider using a flag to review the potential need for diabetes services at each visit.
- Send results of A1c tests as part of HEDIS medical record. Results are required.
- Educate members on the importance of all aspects of diabetes care and testing (A1c, BP, eye exam, kidneys, etc.), including healthy nutrition, exercise, and lifestyle.
- Consider referral to a diabetic educator or nutritionist.
- Evaluate and document HbA1c every three (3) to six (6) months.
- Outreach to patients with sub-optimal HbA1c.
- Remind patients to bring logbooks or glucose monitors to appointments.
- Ensure patients understand education materials for new-onset diabetes and HbA1c.
- Ensure labs are ordered prior to patient appointments, and members come in for regular office visits for diabetes care versus only getting medication refills.

HbA1c test results can be accepted as supplemental data

Immunizations for Adolescents (IMA-E)

What Is the Measure?

The percentage of adolescents who turn 13 years of age in the measurement year and receive the following vaccinations on or before their 13th birthday:

- Meningococcal vaccine, given between 10th and 13th birthdays.
- Tdap/Td vaccine, given between 10th and 13th birthdays.
- At least two (2) HPV vaccines, between the 9th and 13th birthday with at least 146 days between the doses (2-dose vaccination series) with different dates of service between the 9th and 13th birthdays (male and female), or at least three (3) HPV vaccines with different dates of service between the 9th and 13th birthdays (male and female).

Summary of Changes:

- Added the pentavalent meningococcal vaccine to the meningococcal indicator numerator and expanded the age range from 11-13 to 10-13.

Codes to Identify IMA:

Time period	January 1, 2025 – December 31, 2025
Meningococcal **Number of Doses: 1**	
Numerator compliance: **Members with any of the following meet criteria:** • At least one meningococcal vaccine with a date of service on or between the ember's 10 and 13th birthdays • Anaphylaxis due to the meningococcal vaccine any time on or before the member's 13th birthday	
CPT	* 90619, 90733, 90734
CVX	32, 108, 114, 136, 147, 167, 203
SNOMED	871874000, 428271000124109, 16298691000119102

Tdap **Number of Doses: 1**
Numerator compliance: **M**embers with any of the following meet criteria: • At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthdays • Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine anyh time on or before the member's 13th birthday • Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday

CPT	90715
CVX	115
SNOMED	390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105
Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine	
SNOMED	428281000124107, 428291000124105
Encephalitis due to the tetanus, diphtheria or pertussis vaccine	
SNOMED	192710009, 192711008, 192712001

HPV **Number of Doses: 2**	
Numerator compliance: Members with any of the following meet criteria: • At least 2 HPV vaccines on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. • At least 3 HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays • Anaphylaxis due to the HPV vaccine any time on or before the member's 13th birthday	
CPT	90649, 90650, 90651
CVX	62, 118, 137, 165
SNOMED	428741008, 428931000, 429396009, 717953009, 724332002, 734152003, 761841000
Anaphylaxis due to the HPV vaccine	
SNOMED	428241000124101

Exclusions	• Anaphylactic reaction to the vaccine or its components • Anaphylactic reaction to the vaccine serum • Encephalopathy with a vaccine adverse-effect code
Common chart deficiencies	Immunization records not obtained from previous primary care providers

**This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

McLaren Health Plan offers a 2025 Healthy Child Immunization Incentive. This incentive is for completion of Childhood Immunization Combo 10 by the Member's 2nd birthday and Adolescent Immunization Combo 2 by the Member's 13th birthday.

Childhood Immunization Combo 10 → $100
Adolescent Immunization Combo 2 → $50

How to Improve Your Quality Score:

- Use Michigan's Care Improvement Registry (MCIR) to register Immunizations: mcir.org – Improving Healthcare in Michigan
- Review a child's immunization record before every visit (preventive and sick) and administer needed vaccines.
- If applicable, give immunizations during a sick visit if the child's immunizations are behind.

- **Recommend immunizations to parents**. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations. Talking with Parents about Vaccines for Infants | CDC
- **Schedule appointments** for your patient's next vaccination before they leave your office
- **Remind parents** on the importance of keeping immunizations on track
- **Offer options** such as nurse visit for immunizations only, extended hours, walk-in, or vaccination clinics
- **Use phone calls, emails, text messages and/or postcards/letters to help keep parents engaged**
- **Check at each visit** for any missing immunizations.
- **Schedule 13-year** well-visits on or before the 13th birthday.
- **Train office staff** to prepare the chart before the visit and identify overdue immunizations.
- **Ensure each patient leaves the office with a set appointment** for the second and third dose of the HPV vaccine series.
- **Consider starting the HPV** series at age nine (9). The HPV series can be administered between 9 and 13 years of age, with at least 146 days between doses one (1) and two (2).
- Immunization records can be accepted as supplemental data

Kidney Health Evaluation for Patients with Diabetes (KED)

What Is the Measure?

The Kidney Health Evaluation for Patients with Diabetes measure evaluates patients 18-85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year (MY).

Codes to Identify Eye Exam for Patients with Diabetes:

Description		
Numerator Compliance	Patients who received **both** an eGFR and a uACR during the measurement year on the same or different dates of service • At least one eGFR • At least one uACR identified by either of the following: ▪ **Both** a quantitative urine albumin test **and** a urine creatinine test **with** service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year. ▪ A uACR	
Time period	January 1, 2025- December 31, 2025	
Billing Codes		
Description	**Code Type**	**Codes**
Estimated Glomerular Filtration Rate (eGFR) lab test	**CPT**	80047, 80048, 80050, 80053, 80069, 82565
	LOINC	50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6
	SNOMED	12341000, 18207002, 241373003, 444275009, 444336003, 446913004, 706951006, 763355007
Quantitative urine albumin lab test	**CPT**	82043
	LOINC	100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
	SNOMED	104486009, 104819000
Urine creatinine lab test	**CPT**	82570
	LOINC	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
	SNOMED	8879006, 36793009, 271260009, 444322008
Urine albumin creatinine ratio lab test	**LOINC**	13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7
Frequency/Occurrence	At least once a year	
Required Exclusions	• End-stage renal disease (ESRD) diagnosis any time during the patient's history • Patients who had dialysis any time during the patient's history • Dispensed dementia medication	

	• Members who use hospice services • Members receiving palliative care • Medicare members 66 years of age and older as of December 31 of the measurement year who re enrolled in an institutional SNP or living long-term in an institution • Members 66 years of age and older as of December 31 of the measurement year with facility and advanced illness/dispensed dementia medication

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

2025 Diabetic Measures Incentive:

Complete All Services	McLaren Health Plan Incentive
3. HbA1c test or glucose management indicator	$50.00
4. Estimated glomerular filtration rate (eGFR) & urine albumin-creatinine ratio (uACR)	
Diabetic Management	**McLaren Health Plan Incentive**
3. Controlled blood pressure <140/90	$25 for each controlled measure
4. Controlled A1c <8	

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities
  - ✓ Use EHR/EMR alerts for patients due for an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR)
  - ✓ Coordinate care with specialists such as an endocrinologist or nephrologist as needed
  - ✓ Visit Kidney Health Toolkit - NCQA to learn more about best practices in promoting kidney health
  - ✓ Refer your patients at risk for kidney disease to Are You The 33%? Campaign | National Kidney Foundation of Michigan
- eGFR and uACR lab reports can be accepted as supplemental data.

Lead Screening in Children (LSC)

What Is the Measure?

This measure assesses the percentage of children two (2) years of age who received one (1) or more capillary or venous blood tests for lead poisoning on or before their second birthday.

Numerator compliance	At least one lead capillary or venous blood test on or before the child's second birthday	
Time period	Patients turning 2 years old in 2025	
Description	**Code Type**	**Code**
Lead Test	**CPT**	83655
	LOINC	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7
	SNOMED	8655006, 35833009
Required exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year	

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- All children should be screened for a history of lead exposure at well-visits, per Bright Futures/AAP Periodicity Schedule Periodicity Schedule. Screening or risk assessment questionnaires are readily available online and can be incorporated into routine, well-visit workflow.
- Make every office visit count. If time allows for additional quality procedures, avoid missed opportunities by taking advantage of every office visit, including sick visits and daycare physicals, to provide a well-child visit, immunizations, lead testing, developmental screening and counseling.
- Both the date of the test and the test result must be documented with the notation of the lead screening test.
- Obtaining a lead screen sample in the practice setting (by venipuncture or CLIA-waived point-of-care (POC) screening) is associated with higher screening rates. This is more successful than sending the child/family to an external lab for a lead test.
- Consider a standing order for in-office testing.
- Identify children at greatest risk and screen beginning at six (6) months of age. Be sure to utilize standardized lead screening questionnaires to see if a child is at risk.
- Educate parents about the dangers of lead poisoning and the importance of testing.
- Bill in-office testing when permitted by the state fee schedule.
- Test ALL children, regardless of their risk factors, at one (1) and two (2) years of age, and children 3-6 years of age if never tested.

Oral Evaluation, Dental Services (OED)

What Is the Measure?

This measure assesses the percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation by a dental provider during the measurement year.

Numerator compliance	A comprehensive or periodic oral evaluation with a dental provider during the measurement year	
Time period	January 1, 2025 - December 31, 2025	
Description	**Code Type**	**Codes**
Oral Evaluation (billed by dental providers only)	**CDT**	D0120, D0145, D0150
Dental 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
Frequency/occurrence	Every year	
Required exclusions	Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year	
Common chart deficiencies	No discussion of importance of oral health, No discussion of dental visit No referral to dental provider	

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

Recommendations for Success:

- Encourage patients to establish a dental home to ensure good routine oral healthcare and follow ups
- Document history of dental evaluation

PCP engagement opportunities:

- PCP's can educate patient and/or family regarding the importance of dental/oral health
- PCP's should ask when the last dental appointment was during every well visit
- Educate patient and/or family regarding the importance of dental/oral referral.
- Remind patients of the dental benefits available to them under Medicaid.
- Remind expectant mothers to make dental appointments for the baby either at the eruption of the first tooth or by the age of one (1) year.
- Remind patients to brush their teeth for two (2) minutes, two (2) times a day and floss daily as soon as the teeth start touching.

- Educate patients to supervise their young child's toothbrushing.
- The PCP has a vital role in the ability to impact the OED measure. Parents/caregivers may not be aware of dental benefits and/or the need for children to start dental visits by the age of one (1) year or when the first tooth erupts.

Osteoporosis Management in Women Who Had a Fracture (OMW)

What Is the Measure?

Women who suffer a fracture are at increased risk of additional fractures and more likely to have osteoporosis. The Osteoporosis Management in Women Who Had a Fracture measure evaluates women 67-85 years of age who had a fracture and had either a bone mineral density (BMD) test or received a prescription to treat osteoporosis within six months after the fracture of an ER or inpatient discharge date.

Note: Fractures of finger, toe, face and skull are not included in this measure.

Definitions

- **Intake Period:** July 1 of the year prior to the measurement year to June 30 of the measurement year. The intake period is used to capture the first fracture.
- **Episode date:** The date of service for an eligible encounter during the intake period with a diagnosis of fracture
    - For an outpatient or ED visit, the episode is the date of service
    - For an inpatient stay, the episode is the date of discharge
    - For direct transfers, the episode date is the discharge date from the last admission
- **Index episode start date (IESD):** The earliest episode date during the intake period that meets all eligible population criteria.
- **Direct transfer:** A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:
    - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer
    - An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer
    - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays
    - Note: The direct transfer does not require a fracture diagnosis
- **Use the following method to identify admissions to and discharges from inpatient setting:**
    - Identify all acute and nonacute inpatient stays (inpatient Stay Value Set)
    - Identify the admission and discharge dates for the stay

Description	CPT/HCPCS/ICD-10-CM		
Numerator Compliance	Appropriate bone mineral density (BMD) testing or medication treatment for osteoporosis 180 days after the fracture		
Time period	July 1 of the year prior to the measurement year to June 30 of the measurement year		
To comply with this measure, a patient must have a BMD test or be prescribed at least one of the following osteoporosis medications within 180 days of their discharge for a fracture:			
Drug Category	**Medications**		
Bisphosphonates	Alendronate Alendronate-cholecalciferol	Ibandronate Risedronate	Zoledronic acid
Other agents	Abaloparatide Denosumab	Raloxifene Romosozumab	Teriparatide
Billing Codes	**Description**	**Code Type**	**Codes**
	Bone Mineral Density Tests	CPT	76977, 77078, 77080, 77081, 77085, 77086
		ICD10PCS	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
		SNOMED	22059005, 312681000, 385342005, 391057001, 391058006, 391059003, 391060008, 391061007, 91062000, 391063005, 391064004, 91065003, 391066002, 391069009, 91070005, 391071009, 391072002, 391073007, 391074001, 391076004, 91078003, 391079006, 391080009, 391081008, 391082001, 4211000179102, 440083004, 440099005, 440100002, 449781000, 707218004
	Long-acting osteoporosis medications	HCPCS	J0897, J1740, J3489
	Osteoporosis medication therapy	HCPCS	J0897, J1740, J3110, J3111, J3489
Required Exclusions	• Patients who use Hospice services or elect to use a hospice benefit any time during the measurement year • Patients receiving palliative care any time during the intake period through the end of the measurement year • Patients who had an encounter for palliative care (ICD10-CM Z51.5) any time during the intake period through the end of the measurement year • Patients 67 years of age and older as of December 31 of the measurement year who are enrolled in an institutional SNP (I-SNP) or living long-term in an institution during the intake period through the end of the measurement year • Patients 67-80 years of age as of December 31 of the measurement year with frailty and advanced illness/dispensed dementia medication • Patients 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the intake period through the end of the measurement year		

Dementia Medications	
Description	Prescription
Cholinesterase Inhibitors	Donepezil Galantamine Rivastigmine
Miscellaneous central nervous system agents	Memantine
Dementia Combinations	Donepezil-memantine
Test, service or procedure to close care opportunity	• BMD test in any setting on the Index Episode Start Date (IESD) or in the 180-day period after the IESD • If the IESD was an inpatient stay, a BMD test during the inpatient stay • Osteoporosis therapy on the IESD or in the 180-day period after the IESD • If the IESD was an inpatient stay, long-acting osteoporosis therapy during the inpatient stay • A dispensed prescription to treat osteoporosis on the IESD or in the 180-day period after the IESD

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

Plan All-Cause Readmissions (PCR)

What Is the Measure?

The Plan All-Cause Readmissions (PCR) measure evaluates patients 18 years of age and older who had an acute inpatient and observation stay that were followed by an unplanned acute readmission for any diagnosis within 30 days of the initial discharge.

PCR focusses on better care coordination aimed at avoiding unnecessary readmissions. Seeing patients within seven days of discharge is one of the very best interventions you can provide to reduce readmission. A lower calculated performance rate for this measure indicates better clinical care.

Description	CPT/HCPCS/ICD-10-CM
Numerator Compliance	At least one acute readmission for any diagnosis within 30 days of the index Discharge Date
Time period	Inpatient or observation stay with a discharge date on or between January 1, 2025 – December 31, 2025
Required Exclusions	• Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Coordinating care from the hospital to home and ensuring a follow-up visit with the primary care physician can help your patients avoid a readmission
- You can help your patients avoid readmissions by:
  - Following up with them within 1 week of their discharge
  - Schedule same-day appointments when possible
  - Request discharge summaries from the hospital prior to the follow-up call or home visit
  - Implement a safe discharge plan that includes ap post-discharge telephone or telehealth visit to review discharge instruction, care plan, and medication instructions, and to answer any questions
  - Review discharge instructions and medications with patients and/or caregivers
  - Let patients know when to call their physician, when and how to take medications
  - Discuss any challenges the patient may have (need additional help at home, transportation, DME services, etc.)
    - Feeling unprepared for discharge
    - Difficulty accessing discharge medications
    - Trouble adhering to discharge medications
    - Difficulty performing daily activities
    - Lack of social support

Important Note: Supplemental data may not be used for this measure, except for required exclusions.

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

What Is the Measure?

The Postpartum Depression Screening and Follow-Up (PDS-E) measure evaluates women who had a delivery and were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care within 30 days of a positive finding.

Two rates are reported for the PDS-E measure:

- Depression Screening: Deliveries in which patients were screened for clinical depression using a standardized instrument with recorded result during pregnancy
- Follow-Up on Positive Screen: Deliveries in which patients received follow-up care within 30 days of a positive depression screen finding

The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and anxiety symptoms using a standardized validation tool.

Screening Instrument for Adolescents (<= 17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)	Total Score >= 10
Patient Health Questionnaire Modified for Teens (PHQ-9M)	Total Score >= 10
Patient Health Questionnaire -2 (PHQ-2)	Total Score >= 3
Beck Depression Inventory -Fast Screen (BDI-FS)	Total Score >= 8
Center for Epidemiologic Studies Depression Scale -Revised (CESD-R)	Total Score >= 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score >= 10
PROMIS Depression	Total Score (T score) >= 60
Screening Instrument for Adolescents (18 years)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)	Total Score >= 10
Patient Health Questionnaire -2 (PHQ-2)	Total Score >= 3
Beck Depression Inventory -Fast Screen (BDI-FS)	Total Score >= 8
Beck Depression Inventory (BDI-11)	Total Score >= 20
Center for Epidemiologic Studies Depression Scale -Revised (CESD-R)	Total Score >= 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score >= 10
My Mood Monitor (M-3)	Total Score >= 5
PROMIS Depression	Total Score (T score) >= 60
Clinically Useful Depression Outcome Score (CUDOS)	Total Score >= 31

Description	CPT/HCPCS/ICD-10-CM
Numerator Compliance	Depression Screening • Deliveries where patients had a documented depression screening and the result of the screening, using an age-appropriate standardized instrument, performed during the 7-84 days following the date of delivery

<table>
<tr><td></td><td colspan="3">Follow-Up on Positive Screen:
Deliveries where patients received follow-up care on or up to 30 days after the date of the first positive screen (31 days total)
Any of the following on or up to 30 days after the first positive screen meet criteria:
An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition
A depression care-management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition
A behavioral health encounter, including assessment, therapy, collaborative care or medication management
OR
Receipt of an assessment on the same day and subsequent to the positive screen
Documentation of additional depression screening indicating either no depression or no symptoms that require follow-up
For example, if the initial positive screen resulted from a PHQ-2 score, documentation of a negative finding from a subsequent PHQ-9 performed on the same day qualifies as evidence of follow-up</td></tr>
<tr><td rowspan="11">Billing Codes</td><td>Description</td><td>Code Type</td><td>Codes</td></tr>
<tr><td rowspan="4">Behavioral health encounter</td><td>CPT</td><td>90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865,90867, 90868, 90869, 90870, 90875,90876, 90880, 90887, 99484, 99492, 99493</td></tr>
<tr><td>HCPCS</td><td>G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485</td></tr>
<tr><td>SNOMED</td><td>5694008, 10197000, 10997001, 38756009, 45392008,79094001,88848003,90407005, 91310009, 165171009, 165190001, 225337009,370803007, 372067001, 385721005,385724002, 385725001, 385726000,385727009, 385887004, 385889001,385890005, 401277000, 410223002,410224008, 410225009, 410226005,410227001, 410228006, 410229003,410230008, 410231007, 410232000,410233005, 410234004, 439141002</td></tr>
<tr><td>UBREV</td><td>0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919</td></tr>
<tr><td rowspan="3">Depression care Management Encounter</td><td>CPT</td><td>99366, 99492, 99493, 99494</td></tr>
<tr><td>HCPCS</td><td>G0512, T1016, T1017, T2022, T2023</td></tr>
<tr><td>SNOMED</td><td>182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002,425604002, 737850002</td></tr>
<tr><td>Patient Health Questionnaire 9 item (PHQ-</td><td>LOINC</td><td>44261-6</td></tr>
</table>

9) total score (Reported)		
Patient Health Questionnaire 2 item (PHQ-2) total score (Reported)	**LOINC**	55758-7
Edinburgh Postnatal Depression Scale (EPDS)	**LOINC**	71354-5
Total score (M3)	**LOINC**	71777-7
PROMIS-29 Depression score T-score	**LOINC**	71965-8
Patient Health Questionnaire-9: Modified for Teens total score (Reported.PHQ.Teen)	**LOINC**	89204-2
Center for Epidemiologic Studies Depression Scale-Revised total score (CESD-R)	**LOINC**	89205-9
Beck Depression Inventory Fast Screen total score (BDI)	**LOINC**	89208-3
Beck Depression Inventory II total score (BDI)	**LOINC**	89209-1
Total Score (CUDOS)	**LOINC**	90221-3
Final score (DUKE-AD)	**LOINC**	90853-3

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

Perinatal depression refers to minor and major depression episodes during pregnancy and/or the first 12 months after childbirth and is a common condition that affects functional outcomes both for affected women and for their families.

Women with untreated depression during pregnancy are at risk for developing severe postpartum depression and suicidality, and of delivering premature or low birth-weight infants. Routine postpartum care has the potential to improve health outcomes and promote on gong health and well-being for women, infants and their families.

- Ensure all staff have received training on depression screening and care
- Normally following childbirth, a new mom may experience the following: difficulty sleeping, appetite changes, excessive fatigue, decreased libido, and frequent mood changes.
    - However, with clinical depression, these could also be heightened and/or accompanied by other symptoms such as feelings of hopelessness and helplessness, depressed mood, thoughts of death or suicide or thoughts of hurting someone else
- Ensure depression screening and treatment are culturally appropriate and offered in the patient's first language whenever possible.
- Provide mom tips for coping after childbirth:
    - Encourage mom to ask for help
    - Be realistic about expectations
    - Expect some good days and some bad days
- Refer patients to the appropriate resource (counselors, psychiatry) if screened positive
- Follow-up with patients who screen positive
- Continue to screen patients during pregnancy and postpartum

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

What Is the Measure?

The Prenatal Depression Screening and Follow-Up (PND-E) measure evaluates women who had a delivery and were screened for clinical depression while pregnant, and if screened positive, received follow-up care within 30 days of a positive finding.

Two rates are reported for the PND-E measure:

- Depression Screening: Deliveries in which patients were screened for clinical depression using a standardized instrument with recorded result during pregnancy
- Follow-Up on Positive Screen: Deliveries in which patients received follow-up care within 30 days of a positive depression screen finding.

The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and anxiety symptoms using a standardized validation tool.

Screening Instrument for Adolescents (<= 17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)	Total Score >= 10
Patient Health Questionnaire Modified for Teens (PHQ-9M)	Total Score >= 10
Patient Health Questionnaire -2 (PHQ-2)	Total Score >= 3
Beck Depression Inventory -Fast Screen (BDI-FS)	Total Score >= 8
Center for Epidemiologic Studies Depression Scale -Revised (CESD-R)	Total Score >= 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score >= 10
PROMIS Depression	Total Score (T score) >= 60
Screening Instrument for Adolescents (18 years)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)	Total Score >= 10
Patient Health Questionnaire -2 (PHQ-2)	Total Score >= 3
Beck Depression Inventory -Fast Screen (BDI-FS)	Total Score >= 8
Beck Depression Inventory (BDI-11)	Total Score >= 20
Center for Epidemiologic Studies Depression Scale -Revised (CESD-R)	Total Score >= 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score >= 10
My Mood Monitor (M-3)	Total Score >= 5
PROMIS Depression	Total Score (T score) >= 60
Clinically Useful Depression Outcome Score	Total Score >= 31

Description	CPT/HCPCS/ICD-10-CM
Numerator Compliance	Depression Screening • Deliveries where patients had a documented depression screening and the result of the screening, using an age-appropriate standardized instrument, performed during pregnancy Follow-Up on Positive Screen:

<table>
<tr><td></td><td colspan="3">

Deliveries where patients received follow-up care on or up to 30 days after the date of the first positive screen (31 days total)

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

An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition
A depression care-management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition
A behavioral health encounter, including assessment, therapy, collaborative care or medication management

OR

Documentation of additional depression screening indicating either no depression or no symptoms that require follow-up (i.e. a negative screen) on the same day qualifies as evidence of follow-up

</td></tr>
<tr><td>Billing Codes</td><td>
<table>
<tr><th>Description</th><th>Code Type</th><th>Codes</th></tr>
<tr><td rowspan="3">Behavioral health encounter</td><td>CPT</td><td>90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865,90867, 90868, 90869, 90870, 90875,90876, 90880, 90887, 99484, 99492,99493</td></tr>
<tr><td>HCPCS</td><td>G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037,H0039, H0040, H2000, H2001, H2010,H2011, H2012, H2013, H2014, H2015,H2016, H2017, H2018, H2019, H2020,S0201, S9480, S9484, S9485</td></tr>
<tr><td>SNOMED</td><td>5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 262 410233005, 410234004, 439141002</td></tr>
<tr><td>Depression care Management Encounter</td><td>UBREV</td><td>0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919</td></tr>
<tr><td rowspan="3">Follow-Up Visit</td><td>CPT</td><td>99366, 99492, 99493, 99494</td></tr>
<tr><td>HCPCS</td><td>G0512, T1016, T1017, T2022, T2023</td></tr>
<tr><td>SNOMED</td><td>182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002,425604002, 737850002</td></tr>
<tr><td>Follow-Up Visit</td><td>CPT</td><td>98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99457, 99483</td></tr>
</table>
</td></tr>
</table>

		HCPCS	G0071, G0463, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252, T1015
		SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008,386473003, 390906007, 401267002,406547006, 870191006
		UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Exclusions	• Deliveries that occurred at less than 37 weeks gestation		

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

Perinatal depression refers to minor and major depression episodes during pregnancy and/or the first 12 months after childbirth and is a common condition that affects functional outcomes both for affected women and for their families.

Women with untreated depression during pregnancy are at risk for developing severe postpartum depression and suicidality, and of delivering premature or low birth-weight infants. It is important to therefore routinely assess mom for issues such as depression and detect depression early if finding screening positive.

- Ensure all staff have received training on depression screening and care
- Ensure all staff recognize risk factors and are versed in strategies to engage patients on completing and understanding the standardized screening tool
- Ensure depression screening and treatment are culturally appropriate and offered in the patient's first language whenever possible.
- Refer patients to the appropriate resource (counselors, psychiatry) if screened positive
- Follow-up with patients who screen positive
- Continue to screen patients during pregnancy and postpartum

Prenatal and Postpartum Care (PPC)

What Is the Measure?

Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization. This measure evaluates the timeliness of prenatal care. *Note: "Enrollment" is enrollment in a McLaren Health Plan insurance plan.*

Definition:

First trimester: 280-176 days prior to delivery (or estimated delivery date {EDD})

Numerator compliance	A prenatal visit in the first trimester or within 42 days of enrollment	
Time period	October 8, 2024- October 7, 2025	
Code Description	**Code Type**	**Codes**
Prenatal bundled services	**CPT**	59400, 59425, 59426, 59510, 59610, 59618
	HCPCS	H1005
Prenatal visits (including virtual care)	**CPT**	98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483
	HCPCS	G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015
	ICD 10 diagnosis	Pregnancy-related diagnosis code
	SNOMED	185317003, 281036007, 314849005, 386472008, 386473003, 401267002, 77406008
Stand-alone prenatal visits (Do not include codes with a modifier)	**CPT**	99500
	CPTII	0500F, 0501F, 0502F
	HCPCS	H1000, H1001, H1002, H1003, H1004
	SNOMED	134435003, 135892000, 169600002, 169602005, 169603000, 169712008, 169713003, 169714009, 169715005, 169716006, 169717002, 169718007, 169719004, 169720005, 169721009, 169722002, 169723007, 169724001, 169725000, 169726004, 169727008, 171054004, 171055003, 171056002, 171057006, 171058001, 171059009, 171060004, 171061000, 171062007, 171063002, 171064008, 17629007, 18114009, 386235000, 386322007, 397931005, 406145006, 409010002, 422808006, 424441002, 424525001, 424619006, 439165004, 439733009, 439816006, 439908001, 440047008, 440227005, 440309009, 40536005, 440638004, 440669000, 440670004, 440671000, 441839001, 58932009, 66961001, 700256000, 702396006, 702736005, 702737001, 702738006, 702739003, 702740001, 702741002, 702742009, 702743004, 702744005, 710970004, 713076009, 713233004, 713234005, 713235006, 713237003, 713238008, 713239000, 713240003, 713241004, 713242006, 713386003, 713387007, 717794008, 717795009
Frequency/Occurrence	Every new diagnosis of pregnancy	
Medical record documentation (including but not limited to)	• Prenatal Care Visit with an OB/GYN, PCP or prenatal care provider, **which must include one of the following:** ○ A diagnosis of pregnancy **and:** --Documentation in a standard prenatal flow sheet **or** --Documentation of LMP, EDD, or gestational age **or** --A positive pregnancy test result **or**	

	--Documentation of gravidity and parity **or** --Documentation of complete obstetrical history **or** --Documentation of prenatal risk assessment and counseling/education o A basic physical obstetrical examination that includes auscultation for fetal heart tones, **or** measurement of fundus height (a standardized prenatal flow sheet may be used) o Evidence that a prenatal care procedure was performed, such as: --Screening test in the form of an obstetric panel (must include all the following: Hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) **or** --TORCH antibody panel alone **or** --A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing **or** --Ultrasound of pregnant uterus
Common chart deficiencies	• No documentation of prenatal visit in the first trimester • Scheduling initial prenatal visit after the first trimester

How to Improve Your Quality Score:

- When scheduling an initial prenatal visit, do not delay; it must occur in the first 12 weeks and six (6) days of pregnancy with an OB/GYN, PCP or another prenatal care practitioner
- When documenting a prenatal visit:
  - Include diagnosis of pregnancy, last menstrual period (LMP) or estimated due date (EDD).
  - Medical records must include a note indicating evidence of prenatal care, such as prenatal risk assessment, complete obstetrical history, fetal heart tone, screening tests, etc
- Understand the population that you serve. Be aware of/accommodate cultural and linguistic preferences regarding prenatal care and ask front office staff to prioritize new pregnant and postpartum patients
- Educate members on the importance of prenatal care throughout pregnancy, including the postpartum visit
- Telehealth services can be offered if in-person visits are unnecessary

- Submit CPTII codes to help identify clinical outcomes such as prenatal care
- If using bundled codes, ensure you report the earliest prenatal visits and/or the date of the postpartum visit

- Timely for submission of claim data.

McLaren Health Plan provides a 2025 Timelines of OB Care Incentive for Medicaid Members. This incentive is designed to reward and recognize MHP's OB-GYN and Primary Care Providers who meet the requirement of providing timely prenatal care within the first trimester AND a timely postpartum visit within 7-84 days of an MHP Medicaid mom's delivery.

McLaren Health Plan Incentive $100.00

Prenatal and Postpartum Care (PPC)

What Is the Measure?

Timeliness of Postpartum Care: The Postpartum Care Measure evaluates patients who had a live birth that had a postpartum care visit on or between 7 and 84 days after delivery.

Numerator Compliance	A postpartum visit on or between 7 and 84 days after delivery	
Time period	October 8, 2024- October 7, 2025	
Description	**Code Type**	**Codes**
Post Partum Care (Do not include codes with a modifier)	**CPT**	57170, 58300, 59430, 99501
	CPT II	0503F
	HCPCS	G0101
	SNOMED	133906008, 133907004, 169762003, 169770008, 169771007, 169772000, 384634009, 384635005, 384636006, 408883002, 408884008, 408886005, 409018009, 409019001, 431868002 440085006, 717810008
Encounter for Postpartum Care (Do not include laboratory codes with POS 8)	**ICD 10**	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical cytology lab test	**CPT**	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
	HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
	LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
	SNOMED	171149006, 416107004, 417036008, 440623000, 448651000124104
Cervical cytology result or finding	**SNOMED**	1155766001, 168406009, 168407000, 168408005, 168410007 168414003, 168415002, 168416001, 168424006, 250538001,269957009, 269958004,269959007,269960002, 269961003, 269963000,275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004,416033009,439074000, 439776006,439888000,441087007, 441088002,441094005, 441219009, 441667007,620510001191 05, 620610001191 07,700399008, 700400001, 987910001191 02
Postpartum bundled services	**CPT**	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
	(Because bundled service codes are used in the data of delivery not on the date of the postpartum visit, these codes maybe used only if the claim form indicates when postpartum care was rendered)	
Frequency/occurrence	After every delivery	

Medical Record Documentation (including but not limited to)	• Documentation in the medical record must include a not indicating the date when a postpartum visit occurred and one of the following: ✓ Pelvic Exam ✓ Evaluation of weight, BP, breasts and abdomen ✓ Notation of postpartum care ✓ Perineal or cesarean incision/wound check ✓ Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting metal health disorders ✓ Glucose screening for members with gestational diabetes ✓ Documentation of any of the following topics: --infant care or breastfeeding --resumption of intercourse, birth spacing, or family planning --sleep/fatigue --resumption of physical activity --attainment of healthy weight
Common chart deficiencies	• No notation of postpartum care

** Global maternity "bundle" codes are only covered for members with third-party liability (TPL) resources, including Medicare and/or commercial insurance, and their Medicaid coverage. Please see IHCP Bulletin BT202343 for further billing guidance.*
*** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

McLaren Health Plan provides a 2025 Timelines of OB Care Incentive for Medicaid Members. This incentive is designed to reward and recognize MHP's OB-GYN and Primary Care Providers who meet the requirement of providing timely prenatal care within the first trimester AND a timely postpartum visit within 7-84 days of an MHP Medicaid mom's delivery.

McLaren Health Plan Incentive $100.00

How to Improve Your Quality Score:

- When scheduling a post-delivery follow-up visit, schedule the PP care visit prior to discharge. The PP visit must occur on or between seven (7) and 84 days after delivery. Perineal or cesarean incision/wound check is acceptable documentation for postpartum care.
- When documenting the postpartum (PP) visit, detail PP care, PP check or six (6) week check. It can be a brief note documenting a pelvic exam or an evaluation of weight, blood pressure, breasts and abdomen. Breastfeeding notation is acceptable for the breast evaluation.

- Understand the population that you serve. Be aware of/accommodate cultural and linguistic preferences regarding prenatal care and ask front office staff to prioritize new pregnant and postpartum patients.
- Educate members on the importance of prenatal care throughout pregnancy, including the postpartum visit.
- Telehealth services can be offered if in-person visits are unnecessary.
- If using bundled codes, ensure you report the earliest prenatal visits and/or the date of the postpartum visit.

Postpartum care visits can be accepted as supplemental data

Social Need Screening and Intervention (SNS-E)

What Is the Measure?

Members who were screened, using prespecified instruments, at least once during the measure period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

Six rates are reported for the SNS-E measure:

- Food screening: Members who were screened for food insecurity
- Food intervention: Members who received a corresponding intervention within 1 month of screening positive for food insecurity
- Housing screening: Members who were screening for housing instability, homelessness or housing inadequacy
- Housing intervention: Members who received a corresponding intervention within 1 month of screening positive for housing instability, homeless or housing inadequacy
- Transportation screening: Members who were screened for transportation insecurity
- Transportation intervention: Members who received a corresponding intervention within 1 month of screening positive for transportation insecurity

Definitions:

- Food insecurity: Uncertain, limited or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways
- Housing instability: Currently consistently house but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction
- Homelessness: Currently living in an environment that is not meant for permanent human habitation (e.g. cares, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.
- Housing inadequacy: Housing does not meet habitability standards
- Transportation insecurity: Uncertain, limited or no access to safe, reliable, accessible, affordable, and socially acceptable transportation, infrastructure and modalities necessary for maintaining one's health, well-being or livelihood

Food insecurity eligible screening instruments with thresholds for positive findings include:

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3

	88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel	95251-5	LA33-6
Hunger Vital Sign (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)	95400-8	LA33-6
	95264-8	LA30985-8 LA30986-6
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, homelessness and housing inadequacy eligible screening instruments with thresholds for positive findings include:

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
Children's Health Watch Housing Stability Vital Signs	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
Health Leads Screening Panel	99550-6	LA33-6
	93033-9	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

Transportation insecurity eligible screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes

Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool (HRSN)	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel	99553-0	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)	93030-5	LA30133-5 LA30134-3
PROMIS	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

Numerator Compliance	**Food Screening** • Patients had a documented result for food insecurity screening performed in the measurement period **Food Intervention** • Patients who screened positive for food insecurities and received a food insecurity intervention on or up to 30 days after the first positive food insecurity screen (31 days total) **Housing Screening** • Patients who had a document result for housing instability, homelessness or housing inadequacy screening performed in the measurement period **Housing Intervention** • Patients who screened positive for housing instability, homelessness or housing inadequacy and received an intervention corresponding the type of housing need identified on or up to 30 days after the date of the first positive housing screen (31 days total) **Transportation Screening** • Patients who had a documented result for transportation insecurity screening performed in the measurement year **Transportation Intervention:** • Patients who screened positive for transportation insecurity and received transportation insecurity intervention on or up to 30 days after the first positive transportation screen (31 days total)
Interventions	**An intervention corresponding to the type of need identified on or up to 30 days after the first positive screening during the measurement period** • A positive food insecurity screen finding must be met by a food insecurity intervention • A positive housing instability or homelessness screen finding must be met by a housing instability or homelessness intervention • A positive housing inadequacy screen finding must be met by a housing inadequacy intervention • A positive transportation insecurity screen finding must be met by a transportation insecurity intervention **Intervention may include an of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral**

Description	Code Type	Codes
Food Insecurities	**CPT**	96156, 96160, 96161, 97802, 97803,97804
	HCPCS	S5170, S9470
	SNOMED	1759002, 61310001, 103699006, 308440001, 385767005,710824005, 710925007, 711069006, 713109004, 1002223009, 1002224003, 1002225002, 1004109000, 004110005, 1148446004, 441041000124100,441201000124108, 441231000124100,441241000124105, 441251000124107,441261000124109, 441271000124102,441281000124104, 441291000124101,441301000124100, 441311000124102,441321000124105, 441331000124108,441341000124103, 441351000124101,445291000124103, 445301000124102,445641000124105, 462481000124102462491000124104, 464001000124109,464011000124107, 464021000124104,464031000124101, 464041000124106,464051000124108, 464061000124105,464071000124103, 464081000124100,464091000124102, 464101000124108,464111000124106, 464121000124103,464131000124100, 464141000124105,464151000124107, 464161000124109, 464171000124102, 464181000124104, 464191000124101, 464201000124103 464211000124100, 464221000124108, 464231000124106, 464241000124101, 464251000124104,464261000124102, 464271000124109,464281000124107, 464291000124105,464301000124106, 464311000124109, 464321000124101, 464331000124103,464341000124108, 464351000124105, 464361000124107, 464371000124100,464401000124102, 464411000124104, 464421000124107, 464431000124105, 464611000124102, 464621000124105,464631000124108, 464641000124103, 464651000124101, 464661000124104,464671000124106, 464681000124109,464691000124107, 464701000124107,464721000124102, 467591000124102, 467601000124105, 467611000124108, 467621000124100, 467631000124102, 467641000124107, 467651000124109, 467661000124106, 467671000124104, 467681000124101, 467691000124103, 467711000124100, 467721000124108, 467731000124106, 467741000124101, 467751000124104, 467761000124102, 467771000124109, 467781000124107, 467791000124105, 467801000124106, 467811000124109, 467821000124101, 470231000124107, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472331000124100
Homelessness	**CPT**	96156, 96160, 96161
	SNOMED	308440001, 710824005, 711069006, 1148446004, 1148447008, 1148812007, 1148814008, 1148817001, 1148818006, 462481000124102, 462491000124104,464001000124109, 464011000124107,464021000124104, 464131000124100,464161000124109, 464291000124105,464301000124106, 464311000124109,464611000124102, 470231000124107,470471000124109, 470481000124107,470491000124105, 470501000124102,470581000124106, 470591000124109,470601000124101, 470611000124103,470781000124104, 470791000124101,470801000124100, 470811000124102, 470821000124105,470831000124108, 470841000124103, 471021000124108, 471031000124106, 471041000124101, 471071000124109, 471081000124107, 471091000124105, 471101000124104, 471111000124101, 471121000124109, 471131000124107, 472031000124103 472041000124108, 472051000124105, 472081000124102,472091000124104, 472101000124105, 472111000124108, 472121000124100, 472131000124102, 472141000124107, 472151000124109, 472161000124106, 472191000124103, 472221000124105, 472241000124103, 472261000124104, 472301000124108 472311000124106, 472321000124103, 472331000124100, 472341000124105, 472351000124107, 472361000124109,

		480791000124106,480801000124107, 480811000124105, 480821000124102, 480831000124104, 480871000124101, 480901000124101, 480921000124106, 480931000124109,480941000124104, 480961000124100,480971000124107, 480981000124105
Inadequate Housing	**CPT**	96156, 96160, 96161
	SNOMED	49919000, 308440001, 710824005, 711069006, 1148446004, 1148813002, 1148815009, 1148823006, 462481000124102,462491000124104, 464001000124109,464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470431000124106, 470441000124101, 470451000124104,470461000124102, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472201000124100, 472211000124102, 472231000124108, 472251000124101, 472331000124100, 472371000124102, 480881000124103, 480891000124100, 480911000124103, 480951000124102
Transportation Insecurity	**CPT**	96156, 96160, 96161
	SNOMED	308440001, 710824005, 711069006, 1148446004, 462481000124102, 462491000124104,464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105,464301000124106, 464311000124109, 464611000124102, 470231000124107, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472331000124100
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living (CMS Assessment)	**LOINC**	101351-5
Housing status	**LOINC**	71802-3
Within the past 12 months we worried whether our food would run out before we got money to buy more (U.S. FSS)	**LOINC**	88122-7
Food insecurity risk (HVS)	**LOINC**	88124-3
Access to transportation status (CUBS)	**LOINC**	89569-8
Current level of confidence I can	**LOINC**	92358-1

use public transportation (PROMIS)		
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living	**LOINC**	93030-5
Have you or your family members you live with been unable to get any of the following when it was really needed in the past 1 year (PRAPARE)	**LOINC**	93031-3
Are you worried about losing your housing (PRAPARE)	**LOINC**	93033-9
Did you or others you live with eat smaller meals or skip meals because you didn't have money for food in the past 2 months (WellRx)	**LOINC**	93668-2
Are you homeless or worried that you might be in the future (WellRx)	**LOINC**	93669-0
Do you have trouble finding or paying for transportation (WellRx)	**LOINC**	93671-6
In the past 12 months, did you ever eat less than you felt you should because there wasn't	**LOINC**	95251-5

enough money for food (U.S. FSS)		
Food security status (U.S. FSS)	**LOINC**	95264-8
Within the past 12 months the food we bought just didn't last and we didn't have money to get more Caregiver (U.S. FSS)	**LOINC**	95399-2
Within the past 12 months we worried whether our food would run out before we got money to buy more Caregiver (U.S. FSS)	**LOINC**	95400-8
Always has enough food for family Caregiver	**LOINC**	96434-6
At risk of becoming homeless Caregiver	**LOINC**	96441-1
Problems with place where you live	**LOINC**	96778-6
Behind on rent or mortgage in past 12 months	**LOINC**	98976-4
Number of residential moves in past 12 months	**LOINC**	98977-2
Homeless in past 12 months	**LOINC**	98978-0
You or your families' health is affected by environmental conditions in the home	**LOINC**	99134-9
Environmental conditions in the home that affect	**LOINC**	99135-6

you or your families' health		
Worried about housing stability in next 2 months	**LOINC**	99550-6
Went without healthcare due to lack of transportation in last 12 months	**LOINC**	99553-0
Delayed medical care due to distance or lack of transportation	**LOINC**	99594-4
At risk	**LOINC**	LA19952-3
Often true	**LOINC**	LA28397-0
Mold	**LOINC**	LA28580-1
My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured	**LOINC**	LA29232-8
My transportation is available, unpredictable, unaffordable; may have car but no insurance, license, etc.	**LOINC**	LA29233-6
I have no access to transportation, public or private; may have care that is inoperable	**LOINC**	LA29234-4
I am not confident at all	**LOINC**	LA30024-6
I am a little confident	**LOINC**	LA30026-1
I am somewhat confident	**LOINC**	LA30027-9
Food	**LOINC**	LA30125-1
Yes, it has kept me from medical	**LOINC**	LA30133-5

appointments or from getting my medications		
Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need	**LOINC**	LA30134-3
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)	**LOINC**	LA30190-5
Low food security	**LOINC**	LA30985-8
Very low food security	**LOINC**	LA30986-6
I have a place to live today, but I am worried about losing it in the future	**LOINC**	LA31994-9
I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	**LOINC**	LA31995-6
Pests such as bugs, ants or mice	**LOINC**	LA31996-4
Lead paint or pipes	**LOINC**	LA31997-2
Lack of heat	**LOINC**	LA31998-0

Oven or stove not working	**LOINC**	LA31999-8
Smoke detectors missing or not working	**LOINC**	LA32000-4
Water leaks	**LOINC**	LA32001-2
Bug infestation	**LOINC**	LA32691-0
Lead paint/pipes	**LOINC**	LA32693-6
Inadequate heat	**LOINC**	LA32694-4
Non-functioning oven/stove	**LOINC**	LA32695-1
No or non-working smoke detectors	**LOINC**	LA32696-9
No	**LOINC**	LA32-8
Yes, it has kept me from medical appointments or getting medications	**LOINC**	LA33093-8
Yes	**LOINC**	LA33-6
Sometimes true	**LOINC**	LA6729-3

**This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Create a culture of health equity and a team-based approach to address SDOH within your practice
- Screen your patients for social needs and identify local resources to address their challenges
- Engage with your community to address the underlying drivers of health equities

Statin Therapy for Patients with Cardiovascular Disease (SPC)

What Is the Measure?

The Statin Therapy for Patients with Cardiovascular Disease measure evaluates males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD)and met the following criteria:

- Received Statin Therapy- Patients who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year
- Statin Adherence 80%- Patients who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period

Definitions

- **Index prescription start date (IPSD):** The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year
- **Treatment period:** The period of time beginning on the IPSD through the last day of the measurement year
- **Proportion of days covered (PDC):** The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period

Description	CPT/HCPCS/ICD-10-CM	
Numerator Compliance	Males 21-75 years of age and females 40-75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication and who remained on the statin medication for at least 80% of the treatment period	
Time period	January 1, 2025 – December 31, 2025	
To comply with this measure, one of the following medications must have been dispensed:		
Description	**Prescription**	
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg Atorvastatin 40-80 mg Ezetimibe-simvastatin 80 mg	Rosuvastatin 20-40 mg Simvastatin 80 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg Atovastatin 10-20 mg Ezetimibe-simvastatin 20-40 mg Fluvastatin 40-80 mg Lovastatin 40 mg	Pitavastatin 1-4 mg Pravastatin 40-80 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg
Test, service or procedure to close care opportunity	Patients who had at least one filled prescription for a high or moderate-intensity statin therapy medication and who achieved a PDC at least 80% during treatment period are administratively compliant with this measure	
Required Exclusions	• Cirrhosis during the measurement year or the year prior to the measurement year • Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement yar • ESRD or dialysis during the measurement year or the year prior to the measurement year • In vitro fertilization (IVF) in the measurement year or the year prior to the measurement year	

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Myalgia, myositis, myopathy or rhabdomyolysis diagnosis during the measurement year
Patients with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year
Patients who use hospice services
Patients receiving palliative care
Medicare patients 66 years of age and older as of December 31 of the measurement year who are enrolled in an institutional SNP (I-SNP) or living long-term in an institution.
Patients 66 years of age and older as of December 31 of the measurement year with facility and advanced illness/dispensed dementia mediation

Estrogen Agonists Medications
<table>
<tr><td>Description</td><td>Prescription</td></tr>
<tr><td>Estrogen Agonists</td><td>Clomiphene</td></tr>
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Dementia Medications
<table>
<tr><td>Description</td><td>Prescription</td></tr>
<tr><td>Cholinesterase inhibitors</td><td>Donepezil
Galantamine
Rivastigmine</td></tr>
<tr><td>Miscellaneous central nervous system agents</td><td>Memantine</td></tr>
<tr><td>Dementia Combinations</td><td>Donepezil-memantine</td></tr>
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<td>Common Chart Deficiencies</td>
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No documentation of review of medications at every visit
No documentation of conversation about he importance of medication adherence

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** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities
- Prescribe a high-intensity or moderate-intensity statin medication to patients with ASCVD when clinically appropriate
- Integrate statin therapy evaluation into every encounter with a cardiovascular patient
- Follow up to ensure they fill out their statin prescriptions and are taking them as prescribed
- Educate patients on the benefits of statin medication to prevent cardiovascular events
- Educate and encourage patients to contact you if they think they're experiencing side effects

If a patient has had previous intolerance to statins, consider a statin re-challenge using a different moderate to high-intensity statin. Hydrophilic statins such as pravastatin, Fluvastatin and rosuvastatin, may have lower risk of myalgia side effects.

Transitions of Care (TRC)

What Is the Measure?

The Transitions of Care measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year, who had each of the following:

- 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)
- Receipt of discharge information- Documentation of receipt of discharge information on the day of discharge through two days after the discharge (3 days total)
- Patient engagement after inpatient discharge- Documentation of patient engagement (office visit, visits to the home, telehealth) provided within 30 days after discharge
- Medication reconciliation post-discharge- Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 days total)

Definitions

- **Medication reconciliation:** A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record
- **Medication list:** A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies

Summary of 2025 Changes:

- Added examples to clarify what is not considered evidence that the provider was aware o the member's hospitalization or discharge when reporting the Medication Reconciliation Post-Discharge Indicator.

Description	CPT/HCPCS/ICD-10-CM
Numerator Compliance	• Evidence of notification of inpatient admission three days after the admission • Evidence of receipt of discharge information three days after the discharge • Patient engagement within 30 days after discharge • Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 days total)
Time period	January 1, 2025 – December 31, 2025
Frequency/ occurrence	Every acute and nonacute inpatient admission and discharge
Required exclusions	Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year
Common Chart Deficiencies	• No documentation of notification of inpatient admission and/or discharge • No documentation of patient engagement after discharge • No documentation of medication reconciliation

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- **Review admission, discharge or transfer service reports** to identify all acute and nonacute inpatient admissions
- Review the daily inpatient/discharge reports from the hospitals, request a copy of the discharge summary and have staff schedule office follow-up visits or telehealth visits within one week to check progress and address any barriers to the discharge plan (i.e. prescriptions filled, DME delivered, home care set up, etc.)

Transitions of Care (TRC) Patient Engagement After Inpatient Discharge

What Is the Measure?

The Transitions of Care Patient Engagement After Inpatient Discharge measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with documentation of patient engagement completed within 30 days of the inpatient discharge.

Description	CPT/HCPCS/ICD-10-CM		
Numerator Compliance	• Patient engagement within 30 days of patient discharge		
Time period	January 1, 2025 – December 1, 2025		
Billing Codes	**Description**	**Code Type**	**Code**
	An outpatient visit, telehealth, e-visit, or virtual check-in		
	Outpatient and Telehealth	CPT	98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483
		HCPCS	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015
		SNOMED	185317003, 185463005, 185464004, 185465003, 209099002, 281036007, 314849005, 3391000175108, 386472008, 386473003, 401267002, 439740005, 444971000124105, 456201000124103, 50357006, 77406008, 84251009, 86013001, 866149003, 90526000
		UBREV	0510, 0511, , 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
	Transitional Care management services	CPT	99495, 99496
Frequency/ Occurrence	Every acute and nonacute inpatient discharge		
Test, service or procedure to close care opportunity	Patient engagement the day after inpatient discharge through 30 days after can include: • An outpatient visit, including office visits and home visits • E-visit or virtual check-in • Virtual visit- must include real time interaction with the care provider		
Medical Record Documentation	Medical record dates: 01/01/2025 – 12/31/2025 • Health history, home health records, progress notes, SOAP notes		

	• Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria: • An outpatient visit, including office and home visits • A telephone visit • A telehealth visit where real-time interaction with between provider and patient and using audio/visual communication • An E-visit or virtual check-in Note: If the patient is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria
Common Chart Deficiencies	No documentation of notification of post-discharge engagement

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Review admission, discharge or transfer service reports to identify all inpatient discharges
- Use EMR reminders to alert of need for follow up appointments post-discharge
- Progress notes for the office visit within 30 days of an inpatient discharge can be accepted as supplemental data

Transitions of Care (TRC) Receipt of Discharge Information

What Is the Measure?

The Transitions of Care measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Summary of Changes

- Added examples to the Note to clarify what is considered evidence that the provider was aware of the patient's hospitalization or discharge when reporting the Medication Reconciliation Post-Discharge indicator

Description	CPT/HCPCS/ICD-10-CM
Numerator Compliance	• Evidence of receipt of discharge information three days after the discharge
Time period **Inpatient Admission Date**	January 1, 2025 – December 31, 2025 January 1, 2025 – December 1, 2025
Frequency/ occurrence	Every acute and nonacute inpatient discharge
Required exclusions	Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year
Test, service or procedure to close care opportunity	Documentation of receipt of discharge information on the day of discharge through 2 days
Medical Record documentation (including but not limited to)	**Inpatient admission and discharge dates 01/01/2025 - 12/01/2025** Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following: • The practitioner responsible for the member's care during the inpatient stay. • Procedures or treatment provided. • Diagnoses at discharge. • Current medication list. • Testing results, or documentation of pending tests or no tests pending. The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 92 • Instructions for patient care post-discharge. **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 2 days after the discharge (3 total

	days). When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria.
Common Chart Deficiencies	No documentation of notification of inpatient discharge care plan/summary with all the above requirements to close care opportunity

**This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Review admission, discharge or transfer service reports to identify all acute and nonacute inpatient admissions

Important Notes:

- When using a shared EMR system, documentation of a "received date" in the EMR isn't required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 days total) meets criteria.
- 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 2 days after the discharge (3 days total).

Transitions of Care (TRC) Medication Reconciliation Post-Discharge

What Is the Measure?

The Transitions of Care Patient Inpatient Notification measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 days total).

Description	CPT/HCPCS/ICD-10-CM		
Numerator Compliance	• Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days)		
Time period	January 1, 2025 – December 31, 2025		
Billing Codes	**Description**	**Code Type**	**Code**
	Medication reconciliation encounter	CPT	99483, 99495, 99496
	Medication reconciliation intervention	CPT II	1111F
		SNOMED	430193006, 428701000124107
Frequency/ Occurrence	Every visit		
Exclusions	Patients who use hospice services or elect to use a hospice benefit anytime during the measurement year		
Test, service or procedure to close care opportunity	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date o the discharge through 30 days after discharge (31 total days). Either of the following meet criteria: • Medication Reconciliation Encounter Value Set • Medication Reconciliation Intervention Value Set		
Medical Record Documentation	Medical record dates: 01/01/2025 – 12/01/2025 • Health history and physical, home health records, progress notes, SOAP notes • Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria: o Documentation of the current medications with a notation that the provider reconciled the current and discharge medications o 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) o Documentation of the member's current medications with a notation that the discharge medications were reviewed o Documentation of the 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 member was seen for post-discharge hospital follow-up with evidence of medication reconciliation for review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge ○ 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 o the date of discharge through 30 days after discharge (31 total days) ○ Notation that no medications were prescribed or ordered upon discharge Note: the following notations or examples of documentation DO NOT count as numerator compliant: • Notification of Inpatient Admission and Receipt of Discharge information: ○ Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge ○ Documentation of notification that does not include a time frame or date when the documentation was received • Medication Reconciliation Post-Discharge: ○ The following examples (without reference to "hospitalization", "admission", or "inpatient stay") ARE NOT considered evidence that the provider was aware of the member's hospitalization or discharge: ▪ Documentation of "post-op/surgery follow-up" ▪ Documentation only of a procedure that is typically inpatient (e.g. open -heart surgery) ▪ Documentation indicating that the visit was with the same provider who admitted the member or who performed the surgery
Common Chart Deficiencies	No documentation of notification of post-discharge engagement

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Document evidence of medication reconciliation of discharge and current medications
- Discharge medication post-discharge doesn't require the patient to be present
- Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse
- Medication reconciliation must be completed within 30 days of discharge
- A medication list must be present in the medical record to fully comply with this measure
- Submit the appropriate CPTII codes for post-discharge medication reconciliation
- Medication reconciliation does not require the member to be present
- Progress notes for medication reconciliation can be accepted as supplemental data

Transitions of Care (TRC) Notification of Inpatient Admission

What Is the Measure?

The Transitions of Care Inpatient Notification measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Description	CPT/HCPCS/ICD-10-CM
Numerator Compliance	• Evidence of notification of inpatient admission on the day of admission or through 2 days after the admission (3 days total)
Time period	January 1, 2025 – December 31, 2025
Frequency/ occurrence	Every acute and nonacute inpatient admission
Required exclusions	Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year
Test, service or procedure to close care opportunity	Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 days total)
Medical Record documentation (including but not limited to)	**Inpatient admission and discharge dates 01/01/2025 - 12/01/2025** • Inpatient admission receipt of information Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that included evidence of the date when the documentation was received. Any of the following examples meet criteria: • Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax) • Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax) • Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system • Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule. 90 criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria • Communication about admission to the member's PCP or ongoing care provider from the member's health plan • Communication about admission to the member's PCP or ongoing care provider from the member's health plan • Indication that the member's PCP or ongoing care provider admitted the member to the hospital • Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider

	• Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay
	• Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission
	  ○ The time frame for communicating the planned inpatient admission is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admission date also meets criteria
	  ○ The planned admission documentation or preadmission exam must clearly pertain to the denominator event
	
	Note: When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.

Common Chart Deficiencies	No documentation of notification of inpatient admission within 3 days of admission

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

How to Improve Your Quality Score:

- Review admission, discharge or transfer service reports to identify all acute and nonacute inpatient admissions

Important Notes:

The following notations or examples of documentation do not count as numerator compliant:

- Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge
- Documentation of notification that does not include a time frame or date when the documentation was received.

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

What Is the Measure?

The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure evaluates children and adolescents 3-17 years of age who had an outpatient visit with a primary care provider or OB/GYN and had the following services during the measurement year.

- Body Mass Index (BMI) percentile (height, weight, and BMI percentile) *
- Counseling for nutrition
- Counseling for physical activity

*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than the absolute BMI value.

Definitions

- BMI percentile: The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

Codes to Identify Well-Child Visits:

Description		
Numerator Compliance	BMI percentile, counseling for nutrition and counseling for physical activity	
Time period	January 1, 2025 - December 31, 2025	
Billing Codes		
Description	**Code Type**	**Codes**
BMI percentile	**ICD 10 diagnosis**	Z68.51 BMI percentile < 85% for age Z68.53 BMI percentile 85% to 95% for age Z68.54 BMI percentile >95% for age
	LOINC	59574-4, 59575-1, 59576-9
Nutrition counseling	**CPT**	97802, 97803, 97804
	HCPCS	G0270, G0271, G0447. S9449, S9452, S9470
	SNOMED	11816003, 61310001, 183059007, 183060002, 183061003, 183062005, 183063000, 183065007, 183066008, 183067004, 183070000, 183071001, 226067002, 266724001, 275919002, 281085002, 284352003,305849009, 305850009, 305851008, 306163007, 306164001, 306165000, 306626002, 306627006, 306628001, 313210009, 370847001,386464006, 404923009, 408910007, 410171007, 410177006, 410200000, 429095004,431482008, 443288003, 609104008, 698471002, 699827002, 699829004,699830009, 699849008, 700154005,700258004, 705060005, 710881000, 1230141004, 14051000175103, 428461000124101, 428691000124107,441041000124100, 441201000124108,

		441231000124100,441241000124105, 441251000124107,441261000124109, 441271000124102,441281000124104, 441291000124101, 441301000124100, 441311000124102, 441321000124105, 441331000124108, 441341000124103, 441351000124101, 445291000124103 445301000124102,445331000124105, 445641000124105
Physical activity counseling	**HCPCS**	G0447, S9451
	SNOMED	G0447, S9451 SNOMED 103736005, 183073003, 281090004, 304507003, 304549008,304558001, 310882002, 386291006386292004, 386463000, 390864007, 390893007, 398636004,398752005, 408289007, 410200000, 410289001, 410335001, 429778002,710849009, 435551000124105
Encounter for physical activity and counseling	**ICD 10 diagnosis**	Z02.5, Z71.82
Frequency/occurrence	Every year	
Required exclusions	• Any diagnosis of pregnancy during the measurement year • Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit any time during the measurement year	
Medical Record documentation (including but not limited to)	Medical record dates: 01/01/2025 – 12/31/2025 • Progress notes • Health history and physical • Growth chart **BMI Percentile**: • Documentation must include the height, weight, and BMI percentile and date of service • Only eveidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria **Counseling for Nutrition:** • Documentation must include a note indiecating the date and **at least one** of the following: ✓ Discussion of current nutrition behaviors (e.g. eating habits, dieting behaviors) ✓ Checklist indicating nutrition was addressed ✓ Counseling or referral for nutrition education ✓ Member receive educational materials on nutrition during a face-to-face visit ✓ Anticipatory guidance for nutrition ✓ Weigth or obesity counseling **Counseling for Physical Activity:** • Documentation must include a note indicating the date and at least one of the following: ✓ Discussion of current physical activity behaviours (e.g. exercise routine, particiaption in sports activities, exam for sports participation) ✓ Checklist indicating physical activity was addressed ✓ Counseling or refereral for physical activity ✓ Patients received educational materials on physical activty duing a face-to-face visit ✓ Anticipatory guidance specific to the child's physical activity ✓ Weight or obesity counseling	
Common chart	• Not documenting height, weight and BMI percentile at well and sick visits	

deficiencies	• Notivation of BMI as a value only • Notation of height and weight only • Documentation of "well nourished" during an exam is not compliant because it does not indicate counseling for nutrition • Using the term "good appetite" (does't state what the patient is eating) • Notation of "health education" or "anticipatory guidance" without specific mention of nutrition or physical activity • No counseling/education on physical activity • Using the term "active" (doesn't state physcially active)

**The billing codes listed throughout this guide are for HEDIS compliance and are subject to plan coverage and contracted fee schedule.*

How to Improve Your Quality Score:

- Check your Gaps in Care Report to identify your patients with open care opportunities
- Weight assessment and counseling for nutrition and physical activity can be completed at any appointment- not just a well-care visit. However, services specific to an acute or chronic condition won't meet compliance for counseling for nutrition or physical activity. For example: Patient has exercise-induced asthma or decreased appetite because of flu symptoms.
- Make every office visit count. If time allows for additional quality procedures, avoid missed opportunities by taking advantage of every office visit, including sick visits and sports/daycare/camp physicals, to provide a well-child visit, immunizations, lead testing, developmental screening, BMI calculations and counseling.
- Always record height, weight, and nutrition and physical activity counseling in medical record for each visit.
- Services rendered during telephone, e-visit or virtual check-in. BMI Percentile calculation (height, weight and/or BMI reported by parents) or counseling for physical activity and/or nutrition that takes place during a telephone visit, e-visit or virtual check-in meets numerator compliance.
- Height, weight, or BMI percentile reported by the parents and documented into the patient's official medical record by a provider is acceptable patient reported data.
- For ages 3-17, a BMI percentile or BMI percentile plotted on an age growth chart meets compliance. A BMI value won't meet compliance for this age group.
- BMI percentile ranges or thresholds won't meet compliance
- Use appropriate CPT, HCPCS and ICD-10 diagnosis codes to report rendered services and reduce medial record review
- Educate staff to schedule the recommended well-child visits within the guideline time frames.
- Inform caregivers about the importance of annual well-child visits.
- Actively pursue missed appointments with reminder letters, calls and text messages.
- Make outreach calls to members who are not on track to complete an annual well-child visit.
- Set care gap "alerts" in your electronic medical record.
- Encourage parents/patients to maintain the relationship with a PCP to promote consistent and coordinated health care.

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

What Is the Measure?

This measure assesses the percentage of members who had the following number of well-child visits with a Primary Care Physician (PCP) during the last 15 months. The following rates are reported:

1. Well-Child Visits in the First 15 Months: Children who turned 15 months of age during the measurement year who had six (6) or more well-child visits from 0-15 months of age.
2. Well-Child Visits for Age 15 Months–30 Months: Children who turned 30 months of age during the measurement year who had two (2) or more well-child visits from 15-30 months of age.

Summary of Changes:

- Removed telehealth visits from the numerator

✓ It is recommended that well-child visits follow the American Academy of Pediatrics Bright Futures Periodicity Schedule: Periodicity Schedule

Newborn	First Week (3 to 5 days)	1 month	2 months	4 months	6 months
9 months	12 months	15 months	18 months	24 months	30 months

The American Academy of Pediatrics (AAP) Bright Futures initiative recommends that the well-child visits include, but are not limited to:

- An initial/interval medical history
- Physical exam
- Developmental assessment:
  - Physical development: assessment of age-appropriate physical development milestones
  - Mental development: assessment of specific age-appropriate mental development milestones
- Anticipatory guidance- age-appropriate anticipatory guidance and health education topics on

Numerator compliance	Six or more well-child visits with a PCP on different dates of service on or before the 15-month birthday Two or more well-child visits with a PCP on different dates of the service between the child's 15-month birth plus 1 day and the 30-month birthday	
Time period	Patients turning 15 months in 2025 Patients turning 30 months in 2025	
Description	**Code Type**	**Code**
Well-Child Visits	**CPT**	99381, 99382, 99391, 99392, 99461
	HCPCS	G0438, G0439, S0302
	SNOMED	103740001, 171387006, 171409007, 171410002, 171416008, 171417004, 410620009, 410621008, 410623006, 410624000, 410626003,410627007, 410628002, 410629005, 410631001, 410632008, 410633003, 446301000124108, 446381000124104
	ICD 10	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2
Required exclusions	Patients who use hospice services or elect to use hospice benefit any time during the measurement year or elect to use a hospice benefit anytime during the measurement year	
Medical record documentation (including but not limited to)	• Well child forms • Health history and physical: assessment of history of disease or illness including the notation of allergies, medication and immunizations meet compliance • Progress notes • Growth charts • Mental developmental history: assessment of specific age-appropriate mental developmental milestone and progress toward developing the skills needed to become a healthy child • Physical developmental history: assessment of specific age-appropriate physical developmental milestones and progress toward developing the skills needed to become a healthy child • Anticipatory Guidance/health education given to parents to educate them on emerging issues, expectations, and things to watch for at the child's age	

** This is a comprehensive list of codes related to the HEDIS measure. Not all codes are included in each Health Plan's covered fee schedule. Please refer to Health Plan-specific documents for an accurate list of covered service codes.*

*** Required as a primary diagnosis for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) billing.*

The following table offers examples of evaluations to help complete each component of care:

Physical Exam	Health history	Physical development	Mental development	Anticipatory Guidance
Assessment of multiple body systems	Birth history	Follow parents with eyes	Coos, babbles	Safety (water, child proofing, fire/gun)
Auscultation of heart and lung sounds	Medical, surgical history	Sits, crawls, walks	Easily consoled	Nutrition, weaning from bottle/breast
Measurements of weight and length	History or absence of illness	Standing up	Fears strangers, experiences separation anxiety	Developmental milestones

Vital signs	Immunization history+	Turns face to side when on stomach	Looks for toys that fall out of sight	Sleep patterns
	Medications+	Holding up head	Waving hello/bye	Car seats
	Frequency/occurrence of feeding+	Drinking from cup	Counting	Exposure to secondhand smoke
	Allergies+	Building with blocks	Joins sentences	Oral health

+ Three or more of these components are required to constitute a comprehensive health history

How to Improve Your Quality Score:

- **Make every office visit count.** If time allows for additional quality procedures, avoid missed opportunities by taking advantage of every office visit, including sick visits and daycare physicals, to provide a well-child visit, immunizations, lead testing, developmental screening, BMI calculations (24+ months) and counseling.
- **Educate staff** to schedule the recommended AAP visits within the guideline time frames.
- **Allow 1-2 weeks of scheduling room to make up visits** before the child turns 15 or 30 months old. The well-child visits are to be completed on different dates of service on or before the 15-month and 30-month birthdays.
- **Inform caregivers** about the importance of frequent well-child visits during the first 30 months.
- **Actively pursue missed appointments** with reminder letters, calls and text messages.
- **Make outreach calls** to members who are not on track to complete the recommended number of well-child visits by 30 months of age.
- **Ensure the medical record includes** the date when a health and developmental history and physical exam were performed, and health education/anticipatory guidance was given.

SECTION 3: Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Access to Medical Care Requirements

CAHPS Survey

McLaren Health Plan is committed to improving the healthcare experiences for our members. The CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey is required annually by NCQA to capture members' experience with health care. The survey evaluates key areas of care and service with the health plan, providers and member experience. This survey is sent to members every year. Health plans report survey results as part of HEDIS data collection.

The majority of CAHPS survey questions surround member experience and satisfaction with their doctor and health plan. Every encounter the provider office has with a member is an invaluable opportunity to elevate the member's health care experience. These interactions can potentially impact how members respond to ALL questions on the CAHPS survey.

There is one (1) HEDIS measure that is incorporated into the CAHPS survey:

Medical Assistance with Smoking and Tobacco Use Cessation (MSC)

Members 18 and older who are current smokers or tobacco users who also received smoking/ tobacco cessation education and counseling between July 1 of the measurement year and when the CAHPS survey was completed.

The CAHPS survey questions inquire if the member experienced the following:

- Received advice to quit
- Discussed or were recommended cessation medications
- Discussed or were provided cessation methods or strategies

Provider Tips for a Successful Survey:

- Discuss alcohol and tobacco use and discuss the risks of both, including cessation programs.
- Screen for high blood pressure and cholesterol.
- Give the flu shot during flu season.
- Listen closely to the patient.
- Be respectful.
- Ensure patient concerns are addressed.
- Get patients scheduled appropriately for their symptoms.
- Assist in coordination of non-emergency transportation.
- Document and discuss all the medications each patient is prescribed.
- Practice empathy.
- Create a welcoming environment.
- Practice cultural sensitivity.
- Review patient satisfaction survey data.
- Ensure compliance with Access to Care Standards, included in the following pages.

Relevant CAHPS Questions:

- When you needed care right away, how often did you get care as soon as you needed it?
- When you made an appointment for a check-up or routine care at a doctor's office or clinic, how often did you get an appointment as soon as needed?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor spend enough time with you?
- How often did your personal doctor explain things in a way that was easy for you to understand?
- How much did a doctor or other health provider talk about the reasons you might want to take a medicine?

Access to Medical Care Requirements

Access to Care Time Frames

The established monitoring standards are set as minimum guidelines of measurement. The following are the MHP Commercial, Marketplace, Medicaid/Healthy Michigan Plan and McLaren Medicare standards for PCP accessibility to members:

Type of Service	Standard
Emergency Services	Immediately 24 hours per day / 7 days per week
Urgent Care	Within 48 hours
Routine/Regular Care including preventive services (physicals)	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
In Office Wait Time	Patient seen within 30 minutes of time of their appointment
After-Hours Coverage (Information/advice is given to patients when medical care is needed after regular office hours)	100%
MHP Customer Service Line – Speed to Answer	80% of calls are answered within 30 seconds
MHP Customer Service Line – Abandonment Rate	5% or less

The following are the McLaren Health Plan Commercial, Marketplace, Medicaid and Medicare monitoring standards for high-volume and high impact specialty care provider accessibility to members:

Type of Service	Standard
Routine Specialty Care (non-urgent)	Within 6 weeks of request
Acute Specialty Care	Within 5 business days of request

The following are the McLaren Health Plan Commercial, Marketplace Medicaid and Medicare monitoring standards for mental health (MH) provider accessibility to members:

Type of Service	Standard
MH Non-Life-Threatening Emergency	Within 6 hours of request
MH Urgent	Within 48 hours of request
MH Initial Visit for Routine Care	Within 10 business days of request
MH Follow-up for Routine Care	Within 45 business days of request

The following are the McLaren Health Plan Commercial, Marketplace, and Medicaid monitoring standards for prenatal care provider accessibility to pregnant members:

Type of Service	Standard
Initial prenatal appointment (Obstetrician, OB-GYN, PCP, certified nurse midwife, or other advanced practice registered nurse with experience, training and demonstrated competence in prenatal care)	If member is in first or second trimester: Within 7 business days of member being identified as pregnant.
	If member is in third trimester: Within 3 business days of member being identified as pregnant.
	If there's any indication of the pregnancy being high-risk (regardless of trimester): Within 3 business days.

Providers must offer hours of operation that are no less than the hours of operation offered to commercial members, or hours of operation must be comparable to Medicaid fee-for-service office hours if the provider serves only Medicaid enrollees. Results are reported to the Quality Improvement committee. MHP requires an 80 percent compliance rate for all access measures. Those providers who do not meet the 80 percent requirement will be notified and requested to submit a corrective action plan to MHP within 30 days. Failure to comply with this requirement may result in departicipation.

Glossary

Below is a list of definitions used in this manual.

Anchor Dates

A measure may require a member to be enrolled and to have a benefit on a specific date.

Continuous Enrollment

Specifies the minimum amount of time that a member must be enrolled in an organization before becoming eligible for a measure. It ensures that the organization has enough time to render services. The continuous enrollment period and allowable gaps in coverage are specific to each measure.

Denominator

Entire health plan population that is eligible for the specific measure.

Eligible Population

Members who satisfy all specified criteria, including age, continuous enrollment, benefit, event and the anchor date enrollment requirement for the measure.

Exclusion

Member becomes ineligible and is removed from the sample based on specific criteria (e.g., incorrect gender, age).

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance and other plans to national and regional benchmarks.

HEDIS® Measure

Term for how each domain of care is further broken down. Specifications outline measure definition and details, which outline the specifications required to evaluate the recommended standards of quality for the element(s) in the measure. NCQA defines how data can be collected for a measure:

- Administrative Measures, the total eligible population, is used for the denominator. Only data considered "administrative" is allowed. Medical, pharmacy, supplemental data, and/or encounter claims count toward the numerator. Medical record review is not permitted for these measures during the Annual Project.
- Hybrid Measures data is collected during the Annual Project through medical record reviews but can also be collected Prospectively. Most allow administrative data to be included. For the Annual HEDIS Audit Season, the denominator is a random sample of 411 members. This is created from a health plan's total

eligible population by the software following NCQA requirements. The numerator includes data from medical and pharmacy claims, encounters, medical record review data and supplemental data.

HEDIS® Measure Abbreviation
The three-letter acronym used by NCQA to identify a specific HEDIS measure.

Measure
A quantifiable clinical service provided to patients to assess how effectively the organization carries out specific quality functions or processes.

Measurement Year (MY)
The year health plan gathers data.

Method of Measurement
Appropriate forms and methods of submitting data to McLaren Health Plan to get credit for a specific measure.

NDC
The National Drug Code is a unique ten-digit number and serves as a product identifier for human drugs in commercial distribution. This number identifies the labeler, product and trade package size.

Numerator
The number of members who are compliant with the measure.

Payout
PMP Pay for Transformation bonus is available if you are a contracted provider with McLaren Health Plan.

Reporting Year
Calendar year after the end of the MY during which the Annual HEDIS Audit occurs. (e.g., For MY2023, the Report Year is 2024)

Sub-Measure
A measure can be broken down into more specific data elements of care.

Supplemental Data (Non-Standard)
Data collected prospectively, not in a standard file layout. (e.g., medical record reviews)

Supplemental Data (Standard)

Standardized file process to collect data from sites to close gaps.

Telehealth

Telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code.

- Synchronous telehealth requires real-time interactive audio and video telecommunications. Telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present).
- Asynchronous telehealth sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the member and provider. Asynchronous telehealth can occur using a patient portal, secure text messaging or email.