ADULT
HEDIS® CODING GUIDE 2022-2023

This guide provides HEDIS coding information only, not necessarily payment guidance. Refer to your state's guidance for payment details and telehealth regulations.

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Prevention and Screening			
Breast Cancer Screening (BCS)* Females 50-74 years	Women 50-74 years of age who had a mammogram to screen for breast cancer once every 27 months.	Biopsies, breast ultrasounds, or MRIs do not count towards this measure.	**CPT®:** 77061-3, 77065-7 *Potential exclusion for* **Bilateral Mastectomy** *in patient history* **ICD-10:** Z90.13
Care of Older Adults (COA) 66 years and older	Adults 66 years and older who had each of the following during the measurement year: • Medication Review • Functional Status Assessment • Pain Assessment Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the Advance Care Planning, Functional Assessments and Pain Assessment indicators.	**Medication Review:** A complete medication list, signed and dated during the measurement year by the appropriate practitioner type; member not required to be present. **Functional Status Assessment:** Documentation must include evidence of a complete functional status assessment and the date it was performed. Must include one of the following: • ADLs • IADLs • Standardized Functional Assessment Tool **Pain Assessment:** Evidence of assessment and date performed. Must include one of the following: • Documentation that patient was assessed for pain • Use of standardized assessment tool and result	Either of the following: **Medication Review CPT:** 90863, 99483, 99605-6 **CPTII:** 1160F And **Medication List HCPCS:** G8427 **CPTII:** 1159F ***– OR –*** **Transitional Care Management CPT:** 99495-96 **Functional Status Assessment** **CPT:** 99483 **HCPCS:** G0438, G0439 **CPTII:** 1170F **Pain Assessment** **CPTII:** 1125F, 1126F *Note: CPTII codes are for quality reporting purposes only, not for payment.*

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Prevention and Screening			
Cervical Cancer Screening (CCS)* Females 21-64 years	Women 21-64 years of age who were screened for cervical cancer using one of the following methods: • Women 21-64 years of age who had cervical cytology performed within the last three years • Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed during the measurement year or the four years prior, and who were 30 years or older as of the date of testing • Women 30-64 years of age who had cervical cytology/hrHPV co-testing during the measurement year or the four years prior	Cervical cytology during the measurement year or the two years prior. Documentation must include **both**: • A note indicating the date when the cervical cytology was performed • The result or findings Documentation must include **both**: • A note indicating the date when the cervical cytology and/or the HPV test were performed. The cervical cytology and HPV test must be from the same data source • The results or findings	**High Risk HPV CPT:** 87624-5 **HCPCS:** G0476 **Cervical Cytology CPT:** 88141-3, 88147-8, 88150, 88152-3, 88164-7, 88174-5 **HCPCS:** G0123-4, G0141, G0143-5, G0147-8, P3000-1, Q0091 *Potential exclusion from measure for* **Hysterectomy** *in patient history* **ICD-10:** Q51.5, Z90.710, Z90.712 **CPT:** 51925, 56308, 57530-1, 57540, 57545, 57550, 57555-6, 58150, 58152, 58200, 58210, 58240, 58260, 58262-3, 58267, 58270, 58275, 58280, 58285, 58290-4, 58548, 58550, 58552-4, 58570-3, 58575, 58951, 58953-4, 58956, 59135
Chlamydia Screening in Women (CHL) Females 16-24 years	Women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Women are considered sexually active if there is evidence of the following: • Contraceptives are prescribed • Via medical coding	**CPT:** 87110, 87270, 87320, 87490-87492, 87810
Colorectal Cancer Screening (COL)* 45-75 years	Adults 45-75 years of age who had appropriate screening for colorectal cancer. One or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test **Yearly** • FIT sDNA test **Every 3 Years** • CT Colonography **Every 5 Years**	Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).	**FOBT CPT:** 82270, 82274 **HCPCS:** G0328 **FIT – sDNA CPT:** 81528 **CT Colonography CPT:** 74261-74263 **Flexible Sigmoidoscopy CPT:** 45330-35, 45337-8, 45340-42, 45346-7, 45349, 45350 **HCPCS:** G0104 **Colonoscopy CPT:** 44388-94, 44397, 44401-8, 45355, 45378-93, 45398 **HCPCS:** G0105, G0121

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Prevention and Screening			
Colorectal Cancer Screening (COL)* 45-75 years	• Flexible sigmoidoscopy **Every 5 years** • Colonoscopy **Every 10 Years**		*Potential exclusion from measure* **Colorectal Cancer ICD-10:** Z85.038, Z85.048, C18.0-9, C19, C20, C21.2, C21.8, C78.5 **Total Colectomy CPT:** 44150-3, 44152-3, 44155-8, 44210-12
Respiratory Conditions			
Asthma Medication Ratio (AMR) 5-64 years	The percentage of those 5-64 years with persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	• Medications given as oral, inhaler, or as an injection are counted. • Controller medication(s) should account for ≥ 0.50 of total asthma medications dispensed.	Compliance occurs only if patient fills prescription. Encourage patient to fill prescriptions on time and take medications as prescribed.
Appropriate Testing for Pharyngitis (CWP) 3 years and older	Those 3 years and older with a diagnosis of pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.	Documentation in the medical record must include **all** of the following: • Diagnosis of pharyngitis • Antibiotic dispensed on or up to three days after date of service • And received group A strep test	Need evidence of **all three** components: • **Strep Test CPT:** 87070-1, 87081, 87430, 87650-2, 87880 ***– WITH –*** • **Pharyngitis Diagnostic ICD-10:** J02.0, J02.8-9, J03.00-1, J03.80-1, J03.90-1 ***– AND–*** • **Prescribed antibiotic is filled** by a pharmacy
Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)* 18-85 years	Adults 18-85 years with a diagnosis of essential hypertension and whose BP was adequately controlled during the measurement year. Telephone visits, e-visits and virtual check-ins are appropriate settings for BP readings. BPs can be taken by any digital device.	**Criteria for control** BP < 140/90 on or after the date of the 2nd diagnosis of hypertension. **Exclusions:** • Patients with evident ESRD • Diagnosis of pregnancy during the current year • Patients who had an admission to a non-acute inpatient setting in the current year	**Record Review** Notation of the **most recent BP** in the medical record. **Blood Pressure CPT II:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F **OR** Taken during **Outpatient, without Revenue Code:** 99201-5, 99211-5, 99241-45, 99341-5, 99347-50, 99381-7, 99391-7, 99401-4, 99411-2, 99429, 99455-6, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015 ***– OR –*** **Telephone Visit CPT:** 98966-8, 99441-3 ***– OR –*** **Online Assessment CPT:** 98969-72, 99421-3, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061, G2062, G2063 *Note: CPTII codes are for quality reporting purposes only, not for payment.*

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Cardiovascular Conditions			
Statin Therapy for Patients With Cardiovascular Disease (SPC)* Males 21-75 years Females 40-75 years	Adults who were identified as having clinical ASCVD and met the following criteria: • Received statin therapy • Were adherent to therapy at least 80% of treatment period	Patients should be dispensed at least one high or moderate-intensity statin and stay on medication for at least 80% of treatment period. Include patients with a **discharge diagnosis** of MI Patients with a diagnosis of CABG, PCI or any other revascularization process are automatically **included** in measure.	Compliance occurs only if patient fills prescription. Encourage patient to fill prescriptions on time and take medications as prescribed. Telehealth can be used to prescribe to eligible patients, if appropriate for the patient. **Exclusions** Frailty and advanced illness (must meet both), palliative care, ESRD, cirrhosis, pregnancy or IVF (current or prior year), and muscular pain or disease.*
Diabetes Care			
Statin Therapy for Patients With Diabetes (SPC)* 40-75 years	Adults who were identified as having diabetes and **DO NOT HAVE** clinical ASCVD and met the following criteria: • Received statin therapy • Were adherent to therapy at least 80% of treatment period	Patients who were identified as having diabetes with diagnosis of MI, CABG, PCI or any other revascularization process are automatically **excluded** in measure. Patients should be dispensed at least one high or moderate-intensity statin and stay on medication for at least 80% of treatment period.	Compliance occurs only if patient fills prescription. Encourage patient to fill prescriptions on time and take medications as prescribed. Telehealth can be used to prescribe to eligible patients, if appropriate for the patient.
Hemoglobin A1c Control for Patients With Diabetes (HBD)* 18-75 years with type 1 or type 2 diabetes	Adults whose hemoglobin A1c was at the following levels during the measurement year: • HbA1c control < 8% • HbA1c poor control > 9%	Notation of the most recent HbA1c screening noting date performed and result performed in current year. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance when documented in the medical record.	**HbA1c CPT:** 83036-7 **CPT II:** 3044F, 3046F, 3051F, 3052F *Note: CPTII codes are for quality reporting purposes only, not for payment*
Eye Exam for Patients With Diabetes (EED)* 18-75 years with type 1 or type 2 diabetes	Adults who had a screening or monitoring for diabetic retinal disease in the measurement year.	A retinal or dilated eye exam by an optometrist or ophthalmologist in current year, a negative retinal or dilated exam (negative for retinopathy) done by an optometrist or ophthalmologist in previous year.	**Eye Exam by Eye Care Professional** **CPT:** 67028, 67030-1, 67036, 67039-43, 67101, 67105, 67107-8, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220-1, 67227-28, 92002, 92004, 92012, 92014, 92018-9, 92134, 92201-2, 92225-28, 92230, 92235, 92240, 92250, 92260, 99203-5, 99213-5, 99242-5 **HCPCS:** S0620, S0621, S3000 **Eye Exam by any Professional CPT:** 92229 (automated eye exam) **CPT II:** 2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F *Note: CPTII codes are for quality reporting purposes only, not for payment*

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Diabetes Care			
Blood Pressure Control for Patients With Diabetes (BPD)* 18-75 years with type 1 or type 2 diabetes	Adults with diabetes whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Note the most recent BP in the medical record.	**Blood Pressure CPT II:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F **Taken During Outpatient CPT:** 99201-5, 99211-5, 99241-5, 99341-5, 99347-50, 99381-7, 99391-7, 99401-4, 99411-2, 99429, 99455-6, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015 **Blood Pressure CPT II:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F **Online Assessment CPT:** 98969-72, 99421-3, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061 *Note: CPTII codes are for quality reporting purposes only, not for payment*
Kidney Health Evaluation for Patients With Diabetes (KED)* 18-85 years with type 1 or 2 Diabetes	Percentage of adults with diabetes (type 1 and type 2) who received a kidney health evaluation during the measurement year.	Defined by an estimated glomerular filtration rate (eGFR) AND a urine albumin-creatinine ratio (uACR; both quantitative urine albumin test and urine creatinine test with service dates four or less days apart). **Exclusion:** ESRD or dialysis at any time during patients history.	**eGFR CPT:** 80047-8, 80050, 80053, 80069, 82565 **With Urine Albumin Creatinine Ratio Lab Test (uACR)** ***– OR –*** **Quantitative Urine Albumin CPT:** 82043 **With Urine Creatinine CPT:** 82570
Medication Management and Care Coordination			
Transitions of Care (TRC) 18 years and over Medicare only	The percentage of adult discharges who had each of the following: • Notification of inpatient admission • Receipt of discharge information • Patient engagement after inpatient discharge • Medication reconciliation post-discharge	Notification of inpatient admission requires documentation in medical record 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 documented in medical record on the day of discharge through two days after the discharge (three total days). Patient Engagement provided within 30 days after discharge • Medication reconciliation by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge.	**Any of following meet patient engagement** **Outpatient Visit CPT:** 99201-5, 99211-5, 99241-5, 99341-5, 99347-50, 99381-7, 99391-7, 99401-4, 99411-2, 99429, 99455-6, 99483 **HCPCS:** G0402,G0438-9, G0463, T1015 **Telephone Visit CPT:** 98966-8, 99441-3 **Transitional Care Management (TCM) Services CPT:** 99495-6 **Online Assessment CPT:** 98969-72, 99421-3, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061, G2062, G2063

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Medication Management and Care Coordination			
Transitions of Care (TRC) 18 years and over Medicare only			**Medication Reconciliation CPT:** 99483, 99495-6 **CPT II:** 1111F *Note: CPTII codes are for quality reporting purposes only, not for payment.*
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) 18 years and over Medicare only	The percentage of adult emergency department (ED) visits who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit.	Follow-up within seven days after the ED visit (eight total days). Visits that occur on the date of the ED visit **do** count. This measure addresses the need for medication management and care coordination for this vulnerable population.	**Outpatient Visit CPT:** 99201-05, 99211-5, 99241-5, 99341-5, 99347-50, 99381-7, 99391-97, 99401-04, 99411-12, 99429, 99455-56, 99483, 99492-4 **HCPCS:** G0402, G0438, G0439, G0463, T1015 **UBREV:** 0510-23, 0526-29, 0982-83 ***– OR –*** **Telephone Visit CPT:** 98966-8, 99441-3 ***– OR –*** **TMC Services CPT:** 99495-6 ***– OR –*** **Case Management CPT:** 99366 **HCPCS:** T1016-17, T2022-23 ***– OR –*** **Complex Care Management CPT:** 99439, 99487, 99489-91 **HCPCS:** G0506 ***– OR –*** **Outpatient/Telehealth Behavioral Visit, Setting Unspecified CPT:** 90791-2, 90832-4, 90836-40, 90845, 90847, 90849, 90853, 90875-6, 99221-3, 99231-3, 99238-9, 99251-5 **With POS:** 03, 05, 07, 09, 11-20, 22, 33, 49, 50, 71, 72 ***– OR –*** **BH Outpatient CPT:** 98960-2, 99078, 99201-5, 99211-5, 99241-5, 99341-5, 99347-50, 99381-7, 99391-7, 99401-4, 99411-2, 99483, 99510 **HCPCS:** G0155, G0176-7, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036-7, H0039, H0040, H2000, H2010, H2011, H2013-20, T1015 **Revenue:** 0510, 0513, 0515-17, 0519-23, 0526-9, 0900, 0902-4, 0911, 0914-17, 0919, 0982-3 ***– OR –*** **CMHC Outpatient Visit Setting, Unspecified CPT With CMHC POS:** 53 ***– OR –*** **Telehealth Visit Outpatient Setting, Unspecified CPT** **With Telehealth POS:** 02, 10

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Medication Management and Care Coordination			
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) 18 years and over Medicare only			***– OR –*** **Observation Visit CPT:** 99217-20 ***– OR –*** **Online Assessment CPT:** 98969-72, 99421-3, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061-3 ***– OR –*** **SUD Services CPT:** 99408-9 **HCPCS:** G0396-7, G0443, H0001, H0005, H0007, H0015-6, H0022, H0047, H0050, H2035-6, T1006, T1012 **UBREV:** 0906, 0944-5
Access/Availability of Care			
Adults' Access to Preventive/ Ambulatory Health Services (AAP) 20 years and over	Adults who had an ambulatory or preventive care visit.	This measure looks at whether adult patients receive preventive and ambulatory services. To qualify, the patient must receive an evaluation and management care during an ambulatory visit with a medical professional. Care received in an emergency department or inpatient setting does **not** qualify. Telehealth is an option for this measure.	**CPT:** 99201-5, 99211-5, 99241-5, 99341-2, 99343-5, 99347-50, 99381-7, 99391-7, 99401-4, 99411-2, 99429, 99483, 92002, 92004, 92012, 920914, 99304-10, 99315-6, 99318, 99324-8, 99334-7 **HCPCS:** G0402, G0438-9, G0463, T1015, S0620-1 **ICD10:** Z00.00-01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0-6, Z02.71, Z02.79, Z02.81-3, Z02.89, Z02.9, Z76.1, Z76.2 **Revenue Code:** 0510-0517, 0519-23, 0526-9, 0982-3, 0524-5 **Telephone Visit CPT:** 98966-8, 99441-3 **Online Assessment CPT:** 98969-98972, 99421-99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061-3
Prenatal and Postpartum Care All Ages	The measure assesses the following facets of prenatal and postpartum care: • **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.	A qualified prenatal care visit with an OB/GYN or other prenatal care practitioner or PCP. Documentation must include the date the visit occurred and include at least one of the following: • Auscultation for fetal heart tones • Pelvic exam with OB observations (a pap test alone does **not** count) • Measurement of fundal height • Basic OB visit that includes one of the following prenatal procedures: - Complete OB lab panel - TORCH antibody panel - Rubella antibody with Rh incompatibility blood typing - Ultrasound of pregnant uterus	**Stand-Alone Prenatal Visit** **CPT:** 99500 **CPT II:** 0500F, 0501F, 0502F **HCPCS:** H1000-H1004 ***– OR –*** **Prenatal Bundled Services** **CPT:** 59400, 59425-6, 59510, 59610, 59618 **HCPCS:** H1005 ***– OR –*** Any of the following **WITH** an appropriate pregnancy diagnosis **Prenatal Visit CPT:** 99201-99205, 99211-99215, 99241-99245, 99483 **HCPCS:** G0463, T1015 **Telephone Visit CPT:** 98966-8, 99441-3

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Access/Availability of Care			
Prenatal and Postpartum Care All Ages	• **Postpartum Care** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. Services provided via telephone, e-visit or virtual check-in **are** eligible for both measures.	• Documentation indicating pregnancy which includes: - Standardized prenatal flow sheet - LMP or EDD or gestational age - Prenatal risk assessment and counseling/education - A complete obstetrical history - Gravidity and parity - Positive pregnancy test result • Visits with a PCP or other family practitioner must follow the same guidelines but also include a documented diagnosis of pregnancy. A qualified postpartum visit must include a note indicating the date the visit occurred and include at least one of the following: • Notation of postpartum care • Pelvic exam • Evaluation of weight, blood pressure, breasts and abdomen (must have all four components) • Perineal or cesarean incision/ wound check • Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders • Glucose screening for women with gestational diabetes • Documentation of infant care or breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity, attainment of healthy weight	**Online Assessment CPT:** 98969-98972, 99421-4, 99457 **HCPCS:** G0071, G2010, G2012, G2061-3 **Postpartum Visit** **CPT:** 57170, 58300, 59430, 99501 **HCPCS:** G0101 **CPT II:** 0503F **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 ***– OR –*** **Postpartum Bundled CPT:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 **Cervical Cytology CPT:** 88141-3, 88147-8, 88150, 88152-4 88164-88167, 88174-5 **HCPCS:** G0123-4, G0141, G0143-5, G0147-8, P3000, P3001, Q0091 *Note: CPTII codes are for quality reporting purposes only, not for payment.*

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Overuse/Appropriateness			
Use of Opioids at High Dosage (HDO)* 18 years and over	The proportion of patients 18 years and older receiving prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90mg) for ≥15 days during the measurement year.	Reduce the number of adults prescribed high dose opioids for ≥15 days. A lower rate indicates better performance. Increasing total MME dose of opioids is related to increased risk of overdose and adverse events. Necessity of use of high doses should be clear. Patients with cancer, sickle cell disease or members receiving palliative care are excluded from this measure.	Patients are considered out of compliance if their prescription average MME was ≥ 90mg during the treatment period. This measure does not include the following opioid medications: • Injectables • Opioid cough and cold products • Ionsys® (fentanyl transdermal patch) • Methadone for the treatment of opioid use disorder
Use of Opioids at Multiple Providers (UOP)* 18 years and over	The proportion of patients 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported: **Multiple Prescribers** Patients receiving prescriptions for opioids from four or more different prescribers during the calendar year. **Multiple Pharmacies** Patients receiving prescriptions for opioids from four or more different pharmacies during the current calendar year. **Multiple Prescribers and Multiple Pharmacies** Patients receiving prescriptions for opioids from four or more different prescribers **and** four or more different pharmacies during the calendar year.	Reduce the number of adults prescribed opioids for ≥15 days by multiple providers. A lower rate indicates better performance for all three rates. Patient use of increasing number of prescribers or pharmacies may signal risk for uncoordinated care. Clinical correlation is encouraged so that providers can evaluate for risk of diversion, misuse or a substance use disorder. Providers are encouraged to communicate with each other for ideal management of member.	**Multiple Prescribers** Patients are considered out of compliance if they received prescription opioids from four or more different prescribers. **Multiple Pharmacies** Patients are considered out of compliance if they received prescription opioids from four or more different pharmacies. **Multiple Prescribers and Multiple Pharmacies** Patients are considered out of compliance if they received prescription opioids from four or more different prescribers **and** four or more different pharmacies. The following opioid medications are excluded from this measure: • Injectables • Opioid cough and cold products • Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder • Ionsys® (fentanyl transdermal patch • Methadone for the treatment of opioid use disorder

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*Palliative Care is a required exclusion for this measure.

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Please Note: The codes in this document are derived from the NCQA HEDIS Volume 2 Technical Specifications for Health Plans. These codes are examples of codes typically billed for this type of service and are subject to change. Billing these codes does not guarantee payment. CPTII codes are for quality reporting purposes only. Submitting claims using these codes helps improve reporting of quality measure performance.