HEDIS® Quick Reference Guide Measurement Year 2025

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Glossary

- **Measurement Year (MY**): In HEDIS® reporting, the Measurement Year refers to the calendar year in which healthcare services are provided and for which performance is evaluated. For example, Measurement Year 2025 (MY2025) includes services rendered from January 1, 2025, to December 31, 2025, and the data is reported in 2026. Please note that specific HEDIS® measures may define different timeframes within the Measurement Year. For example, childhood immunizations must be completed on or before the child's second birthday, not by year-end. Providers should refer to measure-specific guidance to ensure compliance with timing and documentation requirements.
- **Previous Year (PY):** The Previous Year refers to the year preceding the current measurement year which has already been evaluated and reported.
- **HEDIS®**: The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. Through HEDIS®, Carolina Complete Health is accountable for the timeliness and quality of healthcare services (including acute, preventive, and mental health) delivered to its diverse membership. HEDIS® is a registered trademark of the NCQA.
- **Administrative Data:** Administrative data refers to information collected through health plan claims and encounter records—such as billing codes, diagnosis codes, and procedure codes—that are submitted when a provider delivers care to a patient. This data is used to measure performance on HEDIS quality measures. If the correct codes are submitted during the billing process, no additional documentation (like medical records) is needed for those measures. Using accurate and complete coding helps ensure that your care is captured correctly and counts toward quality performance.
- **Primary Care Provider (PCP):** In the context of HEDIS® reporting, a Primary Care Provider (PCP) is the healthcare professional identified as being primarily responsible for managing a member's overall health and coordinating their care. This could be general practitioner, nurse practitioner, PA etc.
- **Electronic Clinical Data Systems (ECDS):** A data network containing a member's personal health information and encounters within a health care system. The system data is structured so that automated quality measurement queries can be executed efficiently, providing prompt results to those responsible for the care of health plan members.
- **Emergency Department (ED):** a specialized unit within a hospital that provides immediate medical care for patients with acute illnesses or injuries.
- **Ear, Nose, and Throat (ENT) Specialist:** Also referred to as Otolaryngologists, are providers who specialize in the treatment of conditions for the ears, nose, and throat.
- **Over-the-Counter (OTC) medication:** Are medications that can be purchased without a prescription from a healthcare professional.
- **Magnetic Resonance Imaging (MRI):** Is medical imaging technology that utilizes magnetic fields, magnetic field gradients, and radio waves to generate images of the anatomy and physiology inside the body.
- **Index Prescription Start Date (IPSD):** The date of the earliest prescription filling for a specific medication that marks the beginning of a patient's treatment episode in a health care quality measurement.
- **Proportion of Days Covered (PDC):** A metric used to assess medication adherence, or the extent to which a patient takes their prescribed medications as directed.

Carolina Complete Health My Health Pays® Rewards

Some measures correlate to a My Health Pays® Carolina Complete Health member incentive and will have the following icon displayed near the measure name:

The member's My Health Pays® reward dollars are added to a rewards card after Carolina Complete Health processes the claim for each activity a member completes. The My Health Pays Visa® Prepaid Card will be mailed to member approximately 2 – 3 weeks after they become eligible with Carolina Complete Health.

Eligibility Statement: Eligibility requirements apply. Members must be a current Carolina Complete Health member to receive this Value-Added Service.

For the full list of healthy activities members can complete to earn My Health Pays® reward dollars, visit: carolinacompletehealth.com/myhealthpays

Ambetter of North Carolina Inc. My Health Pays® Rewards

Ambetter of North Carolian Inc. also offers a My Health Pays® Ambetter Health member incentive program. When members complete healthy activities, such as eating right, moving more, saving smart and living well, they can earn $500 in rewards!* Activities include:

- Ambetter Health Onboarding
- Annual Wellness Exam and Preventative Screenings
- Health Management
- Online Activities

*Restrictions apply. For more information, visit https://www.ambetterhealth.com/en/nc/health-plans/my-health-pays/

Cut Points

Medicaid Percentile	
★★★★	★★★★★
67.0	77.6
Marketplace Percentile	
★★★★	★★★★★
52.5	59.4

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

Lines of Business: Marketplace, Medicaid

Percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

BEST PRACTICES

Performance Improvement

- This measure is an inverse measure; a higher rate indicates appropriate acute bronchitis/bronchiolitis treatment.

HEDIS® Documentation Requirements

- Avoid prescribing antibiotics for acute bronchitis/bronchiolitis.

Member Experience

- Educate members/caregivers on comfort measures, worsening symptoms and when to contact PCP.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	J209, J439
CPT	In Person Visit: 99212-99215, 99201-99205 Telephone Visit: 99441-99443 Virtual/Online Visit: 99457, 99444
HCPCS	In Person Visit: G0438, G0439, G0463, T1015
Exclusions	Hospice in MY Deceased in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
Continuation	
56.8	64.0

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

Lines of Business: Marketplace, Medicaid

Percentage of members ages 6 – 12 years prescribed a new attention-deficit/hyperactivity disorder (ADHD) medication with at least three follow-up care visits within a 10-month period. The visits must be conducted according to the following timeframes:

Initiation Phase

The Initial follow-up visit must be with a practitioner with prescribing authority and occur within 30 days of the first ADHD medication being dispensed.

Continuation and Maintenance (C&M) Phase

At least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase. Members must also remain on the medication for at least 210 days and have the initial follow-up visit during the Initiation Phase.

BEST PRACTICES

Performance Improvement

- Schedule a follow-up appointment within 30 days for all children who are dispensed new ADHD medication at time of initial visit.
- Schedule telehealth visits if office visits are not available.
- Have staff reach out to reschedule canceled appointments.

HEDIS® Documentation Requirements

1. Evidence of dispensed ADHD medication
2. The date of the follow-up visit within 30 days after the IPSD
3. The date of the two follow-up visits within 31-300 days after the IPSD

Member Experience

- Have members or parents schedule a follow-up appointment before leaving the office when prescribed a new ADHD medication.

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	F90.0, F90.2, F90.9, F11.20, F99, F419
CPT	96152, 96150
HCPCS	H2010, S9485, H2012, G2012, S9484
Exclusions	Hospice in MY Deceased in MY Narcolepsy diagnosis

Cut Points

Medicaid Percentile	
★★★★	★★★★★
Flu	
17.9	26.3
Pneumococcal	
55.0	68.0
Td/Tdap	
47.3	57.6
Zoster	
13.4	20.5

Marketplace Percentile	
★★★★	★★★★★
Flu	
36.4	45.5
Pneumococcal	
36.4	45.5
Td/Tdap	
36.4	45.5
Zoster	
36.4	45.5

Adult Immunization Status (AIS-E)

Lines of Business: Marketplace, Medicaid

Percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, pneumococcal and hepatitis B.

BEST PRACTICES

Performance Improvement

- Encourage members to schedule follow up appointments near the time for their next immunization.
- Ensure vaccine was administered not just ordered.

HEDIS® Documentation Requirements

- Anaphylaxis or encephalitis due to vaccine administration must have clear documentation of the date the event occurred.

Member Experience

- Educate members on the importance of immunizations including annual flu shots and other recommended vaccinations.

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

SNOWMED	**Influenza:** 787016008 **TD Immunization:** 866227002, 866161006, 395181003, 417211006, 868267006, 866185003, 416591003, 395178008, 417384007, 868266002, 866184004, 417615007, 395179000, 868268001, 870668008, 416144004, 395180002, 312869001, 866186002, 73152006, 632481000119106, 414619005, 871828004, 870670004, 870669000	**Tdap:** 390846000, 412755006, 412756007, 412757003, 428251000124104, 571571000119105 **Zoster:** 871898007, 871899004, 90750, 722215002 **Pneumococcal:** 12866006, 394678003, 871833000, 1119366009, 1119367000, 1119368005, 434751000124102
CPT	**Influenza:** 90672, 90660 **TD Immunization:** 908718, 90714 **Tdap:** 90715	**Zoster:** 90736 **Pneumococcal:** 90670, 90671, 90677, 90732
CVX	**Influenza:** 88, 135, 140, 141, 144, 150, 153, 155, 166, 168, 171,185, 186, 197, 205 **TD Immunization:** 09, 113, 115,138, 139 **Tdap:** 115	**Zoster:** 121, 187 **Pneumococcal:** 121, 187 **Hepatitis** B: 189
HCPCS	Pneumococcal: G0009	
Exclusions	Hospice or Deceased in MY	

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Cut Points

Medicaid Percentile	
★★★★	★★★★★
70.5	76.6
Marketplace Percentile	
★★★★	★★★★★
87.7	91.3

Asthma Medication Ratio (AMR)

Lines of Business: Marketplace, Medicaid

Percentage of members 5–64 years of age 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.

BEST PRACTICES

Performance Improvement

- Appropriate monitoring of asthma medication ratio can assist with decreasing asthma related ED visits and inpatient hospitalizations.
- Encourage regular and consistent use of controller medication to help decrease rescue medication use for breakthrough occurrence.

HEDIS® Documentation

- Dated evidence of having persistent asthma in the MY and PY.

1. At least one asthma controller or reliever medication dispensing event in the measurement year.
2. Evidence of a medication ratio ≥ 0.50.

- *Documentation of nasal spray is not the same as inhalation medication and does not satisfy measure compliance.*

Member Experience

- Educate patients or caregivers to report new or worsening symptoms immediately to primary care provider.
- Educate patients or caregivers on the proper use of a peak flow meter.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	J45.41, J45.901, J45.909
CPT	In Person Visit: 98966-98968, 99212-99215, 99201-99205 Telephone Visit: 99441-99443 Virtual/Online Visit: 99457, 99444
HCPCS	In Person Visit: G0463 Virtual/Online Visit: G2012
Exclusion Codes	J42, J96.00, J43.9
Exclusions	Hospice or Deceased in MY No dispensed asthma controller or reliever medications during MY Members with acute respiratory failure, COPD, cystic fibrosis, emphysema, chronic respiratory conditions due to fumes/vapors, or obstructive chronic bronchitis.

Cut Points

Medicaid Percentile	
★★★★	★★★★★
41.9	54.5

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

Lines of Business: Marketplace, Medicaid

Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported as the percentage of children and adolescents on antipsychotic medications who received:

- Blood glucose testing (or HbA1c).
- Cholesterol testing (or LDL-C).
- Blood glucose and cholesterol testing.

BEST PRACTICES

Performance Improvement

- At least one blood glucose (or HbA1c) and one cholesterol (or LDL-C) test are needed for measure compliance. They must be completed annually for continued compliance.
- CPT-II codes can help capture compliance with this measure.

HEDIS® Documentation Requirements

- Ensure medical record documentation includes the test type, test date, and result.
- For submission of SNOWMED or CPT-II codes for HbA1c and LDL-C Test Result or Finding **do not** include codes:
  - With a modifier (CPT CAT II Modifiers)
  - From laboratory claims (claims with POS code 81).

Member Experience

- Reach out to help caregivers who cancel appointments to reschedule as soon as possible.

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

CPT	HbA1c: 83036, 83037, 80053 LDL-C: 80061, 83721
CPT II	HbA1c: 3044F (< 7.0%), 3046F (> 9.0%), 3051F (7.0%-8.0%), 3052F (8.0%-9.0%) LDL-C: 3048F (< 100mg/dL), 3049F (100-129 mg/dL), 3050F (≥ 130 mg/dL)
Exclusions	Hospice in MY Deceased in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
64.1	74.1

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

Lines of Business: Marketplace, Medicaid

Percentage of members ages 1–17 who had a new antipsychotic medication prescription and documentation of psychosocial care as first-line treatment.

BEST PRACTICES

Performance Improvement

- Assist members with scheduling psychosocial care visits 90 days prior to starting a new antipsychotic medication or at least 30 days after (including transportation if needed).

HEDIS® Documentation Requirements

- The measure lookback period is October 1, PY - December 31, MY.
- Measure compliant visits include but are not limited to: Family psychotherapy, euthymic therapy, ecotherapy, stimulative therapy, antiphobic therapy, potential suicide care, hypnotherapy, hallucination management, behavioral healthcare center, etc.
- Residential BH treatment in a hospital residential program, non-hospital residential program, non-acute care in residential treatment program also satisfies measure compliance.

Member Experience

- Discuss options for assistance with members experiencing anxiety or depression (Including a specialist referral).
- Routinely assess members for emotional issues interfering with social or daily activities (addiction, anxiety, depression etc.).

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

Exclusion Codes ICD-10 Diagnosis	F31.32, F31.2, F20.9, F25.0, F25.9, F22	
CPT	In Person Visit: 98966-98968, 99212-99215, 99201-99205	Virtual/Online Visit: 99457, 99444 Telephone Visit: 99441-99443
HCPCS	In Person Visit: G0463, H0004 Virtual/Online Visit: G2012	
Exclusions	Hospice or Deceased in MY Members for whom first-line antipsychotic medications may be clinically appropriate; members with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder	

Antibiotic Utilization for Respiratory Conditions (AXR)

Lines of Business: Marketplace, Medicaid

The percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.

BEST PRACTICES

- Confirm strep with rapid test and/or culture before prescribing antibiotics.
- Implement virtual visits, extended/same-day access and testing to mitigate potentially preventable ED visits (PPVs).
- For recurrent respiratory issues, consider ENT Specialist referral.
- Accurately document and code if antibiotics are prescribed for a different condition; proper coding is essential for measure credit.

HEDIS® Documentation Requirements

- The lookback period for this measure is July 1st of the PY to June 30th of the MY.

Member Experience

- Educate on non-antibiotic symptom relief (fluids, rest, nasal spray, throat spray/lozenges, OTC medications).

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	J31.0, R05.3, R06.2, R09.81, R09.82
Exclusions	Hospice in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
56.6	63.4

Marketplace Percentile	
★★★★	★★★★★
75.7	79.3

Breast Cancer Screening (BCS-E)

Lines of Business: Marketplace, Medicaid

Percentage of members 40–74 years of age* who had a mammogram to screen for breast cancer.
**The initial population starts at 42 years of age due to the two-year lookback period.*

BEST PRACTICES

Performance Improvement

- This measure evaluates primary screening only. This does not count biopsies, breast ultrasounds, or MRIs.
- Mammograms completed after 10/1 are compliant for 27 months.
- Document the date and specific procedure when reviewing member's history.
- Member reported results are acceptable if specific and include the date and procedure completed within the medical record.

HEDIS® Documentation Requirements

- The date of mammogram must be documented in the medical record.
  - The result of the screening is not required documentation, only that the screening has been completed.

Member Experience

- Assess transportation limitations and assist members if necessary
- Educate members on the importance of routine screenings including mammograms

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

CPT	77063, 77607
HCPCS	G0202, G0204, G0206, G9054, M1017

Measure continued on next page.

Exclusions	• Palliative care, hospice or deceased in MY.
	• Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness.
	• Bilateral mastectomy or history of bilateral mastectomy.
	• Unilateral mastectomy with a bilateral modifier (same procedure).
	  ○ CPT Modifier: 50
	• Unilateral mastectomy found in clinical data with a bilateral qualifier value (same procedure).
	  ○ SNOMED CT Modifier: 51440002
	• Gender-affirming chest surgery with a gender dysphoria diagnosis.
	  ○ CPT: 19318
	• Member is male.
	  ○ LOINC: 76689-9 or LA2-8
	• Unilateral mastectomy on both the left and right side on the same or different dates of service.
	  ○ Left Mastectomy:
	  • Unilateral mastectomy with a left-side modifier (same procedure).
	  ▪ CPT Modifier: LT
	  • Unilateral mastectomy found in clinical data with a left-side qualifier value (same procedure).
	  ▪ SNOMED CT Modifier: 7771000
	  • Absence of the left breast.
	  • Left unilateral mastectomy.
	  ○ Right Mastectomy:
	  • Unilateral mastectomy with a right-side modifier (same procedure).
	  ▪ CPT Modifier: RT
	  • Unilateral mastectomy found in clinical data with a right-side qualifier value (same procedure).
	  ▪ SNOMED CT Modifier: 24028007
	  • Absence of the right breast.
	  • Right unilateral mastectomy.

Cut Points

Medicaid Percentile	
★★★★	★★★★★
71.7	77.3

Blood Pressure Control for Patients with Diabetes (BPD)

Lines of Business: Marketplace, Medicaid

Members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

BEST PRACTICES

- Document BP readings at every visit
- BP readings that are 140/90 or greater should be re-taken
- Consider referral to cardiologist for those whose BP goal cannot be attained, or for complicated patients
- Make sure the proper cuff size is used.
- Ensure patients do not cross their legs and have their feet flat on the floor during the reading
- Make sure the elbow is at the same level as the heart.

*Note: ED visits cannot be used to for this measure.

HEDIS® Documentation Requirements

- Most recent BP taken in the MY is used for this measure calculation regardless of compliance.
- BP readings taken by the member and documented in the member's legal health record are eligible for use (as long as it does not meet exclusion criteria).
- Ranges and thresholds do not meet criteria for this measure.
- BP taken during common low intensity procedures can be utilized.

Member Experience

- Help members schedule their diabetes follow-up appointments to ensure continuity of care and higher likelihood of care gap closure.

Measure Steward: HEDIS®

Data Collection: Administrative, Hybrid

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	I10
CPT II	Systolic BP: 3074F, 3075F, 3077F Diastolic BP: 3078F, 3079F, 3080F *Both Systolic and Diastolic must be billed.
Exclusions	• Palliative Care, Hospice, or Deceased in MY • ESRD Diagnosis, Kidney Transplant, Dialysis or Nephrectomy in MY • Pregnancy in MY • Frailty, Advanced Illness

Cut Points

Medicaid Percentile	
★★★★	★★★★★
67.3	72.7
Marketplace Percentile	
★★★★	★★★★★
72.9	76.9

Controlling High Blood Pressure (CBP)

Lines of Business: Medicaid, Marketplace

Percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

BEST PRACTICES

- Document BP readings at every visit.
- BP readings that are 140/90 or greater should be re-taken
- Consider referral to cardiologist for those whose BP goal cannot be attained, or for complicated patients
- Make sure the proper cuff size is used.
- Ensure patients do not cross their legs and have their feet flat on the floor during the reading
- Make sure the elbow is at the same level as the heart.

*Note: ED visits cannot be used for this measure.

HEDIS® Documentation Requirements

- Most recent BP taken in the MY is used for this measure regardless of compliance.
- BP readings taken by the member and documented in the member's legal health record are eligible for use (as long as it does not meet exclusion criteria).
- Ranges and thresholds do not meet criteria for this measure.
- BP taken during common low intensity procedures can be used.

Member Experience

- Educate members on the risks associated with hypertension and ways to keep their BP under control.
- Check for any barriers that may be keeping members from filling their prescriptions and/or attending routine check-ups.

Measure Steward: HEDIS®

Data Collection: Administrative, Hybrid

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	I10
CPT II	Systolic BP: 3074F, 3075F, 3077F Diastolic BP: 3078F, 3079F, 3080F *Both Systolic and Diastolic must be billed.
Exclusions	• Palliative Care, Hospice, or Deceased in MY • ESRD Diagnosis, Kidney Transplant, Dialysis or Nephrectomy in MY • Pregnancy in MY • Frailty, Advanced Illness

Cut Points

Medicaid Percentile	
★★★★	★★★★★
60.0	67.4
Marketplace Percentile	
★★★★	★★★★★
65.0	71.8

Cervical Cancer Screening ECDS (CCS-E)

Lines of Business: Commercial, Medicaid, Marketplace

The percentage of members 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 had cervical cytology performed within the last 3 years.
- Members 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

BEST PRACTICES

Performance Improvement

- Documentation MUST state “complete, total, or radical” hysterectomy to meet exclusion criteria.
- Biopsy is considered a diagnostic test and not a screening test.
- "Unknown" is not considered a result/finding for medical record reporting.

HEDIS® Documentation Requirements

- Medical record must include the date test performed and results.

Member Experience

- Educate members on the importance of screening and early detection.
- Assist members with scheduling an appointment to complete their cervical cancer screening.

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

Exclusion Codes ICD-10 Diagnosis	58571, 58552, 58150
CPT	HPV: 87624, 87625 PAP: 88175
HCPCS	HPV: G0476 PAP: G0145, Q0091
Exclusions	Hysterectomy with no residual cervix any time during the member’s history through December 31 of the MY. Palliative Care, Hospice, or Deceased in MY. Members assigned Male at birth.

Cut Points

Medicaid Percentile	
★★★★	★★★★★
61.4	69.0

Marketplace Percentile	
★★★★	★★★★★
Ages 16-20	
51.5	61.6
Ages 21-24	
51.5	61.6

Chlamydia Screening (CHL)

Lines of Business: Marketplace, Medicaid

Percentage of women aged 16 – 24 years identified as sexually active and who had at least one test for chlamydia during the measurement year.

BEST PRACTICES

Performance Improvement

- Chlamydia screening can be performed through urine tests or throat swabs (when symptoms are oral).
- Sexually active members are identified by encounter and claim data for dispensed contraceptive prescriptions and sexual activity.
- Remember to code for Chlamydia when using global prenatal or postpartum visit as the screening may not be captured.

HEDIS® Documentation Requirements

- Members with documentation of sexually active or a prescription for contraceptives are included in the numerator.
- There must be at least one test for chlamydia with documentation of the date the test was completed for measure compliance.

Member Experience

- Educate members on the importance of screenings and early detection.
- Educate members about safe sex and abstinence.
- Informing members about sexually transmitted diseases, their symptoms, and treatment.
- Document all screenings in the medical record.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	O80, O76
CPT	87110, 87270, 87320, 87490, 87491, 87492, 87810
Exclusions	• Hospice in MY • Deceased in MY • Members sex assigned male at birth

Cut Points

Medicaid Percentile	
★★★★	★★★★★
Combo 10	
31.3	42.3

Marketplace Percentile	
★★★★	★★★★★
Combo 10	
48.0	58.8

Childhood Immunization Status (CIS-E)

Lines of Business: Marketplace, Medicaid

Percentage of members aged two years who have completed all required dosages for DTaP, IPV, MMR, HiB, VZV, PCV, Hep A, Hep B, RV, and flu vaccines or allowed combinations before or on their second birthday.

BEST PRACTICES

Performance Improvement

- Refer to the CDC website for current immunization schedules https://www.cdc.gov/vaccines/hcp/imz-schedules/index.html
- Be sure to document both the vaccination name and date it was administered in the medical record.
- Submit all immunizations to North Carolina Immunization Registry (NCIR).

HEDIS® Documentation Requirements

- For full measure compliance members must receive the following vaccines by their 2nd birthday:
  - 4 diphtheria, tetanus, and acellular pertussis (DTaP)
  - 3 polio (IPV)
  - 1 measles, mumps, and rubella (MMR)
  - 3 haemophilus influenza type B (HIB)
  - 3 hepatitis B (HepB)
  - 1 chicken pox (VZV)
  - 4 pneumococcal conjugate (PCV)
  - 1 hepatitis A (HepA)
  - 2 or 3 rotavirus (RV)
  - 2 influenza (flu)

Member Experience

- Educate members on the importance of obtaining timely vaccines.
- Submit claims and/or encounter data for each service rendered.
- Schedule the next appointment while the patient is in the office.
- Call members and remind them about upcoming appointments.

Measure Steward: HEDIS®

Data Collection: ECDS

Measure continued on next page.

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

DTaP (4 dose)	**CVX:** 20, 50, 106, 107, 110, 120, 146, 198 **CPT:** 90698, 90697, 90700, 90723
Pneumococcal Conjugate PCV (4 dose)	**CVX:** 109, 133, 152, 215, 216 **CPT:** 90670, 90671, 90677 **HCPCS:** G0009
HiB (3 dose)	**CVX**: 17, 46, 47, 48, 49, 50, 51, 120, 146, 148, 198 **CPT:** 90644, 90647, 90648, 90697, 90698, 90748
Hep B* (3 dose) *One of the three can be the newborn hepatitis B vaccination.	**CVX:** 08, 44, 45, 51, 110, 146, 198 **CPT:** 90697, 90723, 90740, 90744, 90747, 90748 **HCPCS:** G0010
IPV (3 dose)	**CVX:** 10, 89, 110, 120, 146 **CPT:** 90697, 90698, 90713, 90723
MMR (1 dose)	**CVX:** 03, 94 **CPT:** 90707, 90710
Varicella VZV (1 dose)	**CVX:** 21, 94 **CPT:** 90710, 90716
Hep A (1 dose)	**CVX:** 31, 83, 85 **CPT:** 90633
Influenza* (2 dose) *If LAIV vaccination administered it must be **ON** the members 2nd birthday.	**CVX:** 88, 140, 141, 150, 153, 155, 158, 161, 171, 186 **CPT:** 90655, 90657, 90661, 90673, 90674, 90685-90689, 90756 *LAIV vaccination codes* **CVX:** 111, 149 **CPT: 90660,** 90672
Rotavirus (2 dose)	**CPT:** 90681
Rotavirus (3 dose)	**CVX:** 116, 122 **CPT:** 90680
Exclusion Codes ICD-10 Diagnosis	T80.52XA, T80.52XD, T80.52XS
Exclusions	• Hospice in MY • Deceased MY • Members who had a contraindication to a childhood vaccine on or before their second birthday.

Cut Points

Medicaid Percentile	
★★★★	★★★★★
Total	
62.8	68.1

Colorectal Cancer Screening ECDS (COL-E)

Lines of business: Marketplace, Medicaid

Members aged 45-75 who had an appropriate screening for colorectal cancer within the measurement timeframe.

BEST PRACTICES

Performance Improvement

- Have standing orders and FIT Kits available in the office to increase compliance.
- Results and test type must be documented for FIT-DNA and iFOBT.
- Digital rectal exams do not count as FOBT tests or as samples collected for FOBT testing.
- Member reported screenings are acceptable if performed within the acceptable timeframe and documented within the medical record.

HEDIS® Documentation Requirements

- The list of screenings below meet measure compliance for the following timeframes:
  - Fecal Occult Blood Testing-FOBT, good for 1 year
  - Stool DNA (sDNA) with FIT test, good for 3 years
  - CT Colonography/Virtual Colonoscopy, good for 5 years
  - Flexible Sigmoidoscopy, good for 5 years
  - Colonoscopy, good for 10 years
- Type of screening, date and result are needed for measure compliance.
  - Test result is not required if documentation is part of the member's medical history and includes month and year performed.

Member Experience

- Educate members on the importance of preventative screening and early detection.

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

Exclusion Codes ICD-10 Diagnosis	C18.0 – C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
CPT	FOBT Test - 82774 & G0328 FIT immunoassay (iFOBT) - 8227 Colonoscopy - 45380, 45385, 45378 FIT-DNA - 81528
HCPCS	FIT immunoassay (iFOBT) - G0328 Colonoscopy - G0121 FIT-DNA - G0464
Exclusions	Palliative Care, Hospice, or Deceased in MY History of colorectal cancer and/or total colectomy Frailty and advance illness diagnosis

Cut Points

Medicaid Percentile	
★★★★	★★★★★
85.1	89.1

Appropriate testing for Pharyngitis (CWP)

Lines of Business: Medicaid, Marketplace

The percentage of members 3 years older who have had diagnosis of pharyngitis, were prescribed an antibiotic, and had a group A streptococcus (strep) test for the encounter. Services must be completed between July 1, PY (2024) – June 30, MY (2025).

BEST PRACTICES

Performance Improvement

- Eligible visits include outpatient visit, ED visit, telephone visit, or telehealth visit with a diagnosis of pharyngitis
- For a qualifying visit confirm that an antibiotic was dispensed on or up to 3 days after the encounter.
- Antibiotics should not be prescribed to treat viral pharyngitis.
- A patient may have multiple episodes during the measure year. Be sure to document the date of the diagnosis and the date the group A streptococcus test completed.

HEDIS® Documentation Requirements

- Document the date of the group A streptococcus test for the encounter.
- A group A streptococcus test completed in the 7-day period from 3 days prior to the episode date through 3 days after the episode would be compliant for the CWP measure.
- Use the appropriate code for encounters.

Member Experience

- If an antibiotic is prescribed, encourage members to start and complete the treatment as soon as possible.
- Educate patients on how to treat symptoms at home.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	Pharyngitis: J02.0, J02.8, J02.9, J03.00, J03.02, J03.80, J03.81, J03.90, J03.91
CPT	Group A Test: 87070, 87071, 87081, 87430, 87650-87652,87880

Cut Points

Medicaid Percentile	
★★★★	★★★★★
57.0	64.0
Marketplace Percentile	
★★★★	★★★★★
52.9	62.1

Eye Exam for Patients with Diabetes (EED)

Lines of Business: Marketplace, Medicaid

The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

BEST PRACTICES

Performance Improvement

- Follow-up on member reported exams with an outside provider. Add letters from eye care providers (ophthalmologists or optometrists) to the patients record.
- Link health-promotion activities

HEDIS® Documentation Requirements

- Documentation member-reported eye exams. Include the date of service, result of eye exam and the name of provider.
- Exams indicating **positive or negative diabetic retinopathy** would be compliant for the current measure year.
- Exams indicating **negative retinopathy** in the previous year will be compliant for the current measure year.

Member Experience

- Encourage patients with diabetes to have a yearly dilated/retinal eye exam. Discuss the effects of diabetes on all organs including the eye.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD10 Diagnosis	E11.9, E11.65, E11.69
CPT II	2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F
HCPCS	S0621
Exclusion Codes ICD10 Diagnosis	E09.65, E09.9
Exclusions	Bilateral absence of eyes Bilateral eye enucleation Palliative Care, Hospice, or Deceased in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
7 Days	
27.6	37.4

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

Lines of Business: Marketplace, Medicaid, Medicare

Description
Percentage of emergency department (ED) visits among members 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, who had a follow-up visit within 7 days and within 30 days after their ED visit for SUD.

BEST PRACTICES
Performance Improvement

- Follow-up appointments within 7 days of discharge help reduce readmissions.
- Schedule the first follow-up visit within 5 days to allow rescheduling flexibility to meet the 7-day requirement.
- If the member is not seen within 7 days after discharge, ensure a follow-up appointment occurs within 30 days of discharge.
- Include the SUD diagnosis during outpatient visit to meet measure criteria.

HEDIS® Documentation Requirements

- A follow-up visit or a pharmacology dispensing event within 7 days of discharge and 30 days after discharge will satisfy the measure.

Member Experience

- Talk with your patient about ways to get assistance, including a specialist referral, when experiencing anxiety or depression.
- Regularly assess if emotional problems, such as addiction, anxiety, or depression, interfere with your patients social or daily activities.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	F10.10, F10.20, F15.20
CPT	In Person Visit: 99212-99215, 99201-99205 Telephone Visit: 99441-99443 Virtual/Online Visit: 99457, 99444
HCPCS	In Person Visit: G0402, G0438, G0439, G0463, T1015 Virtual/Online Visit: G2012
Exclusions	Hospice in MY Deceased during MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
7 Days	
42.8	57.6

Marketplace Percentile	
★★★★	★★★★★
7 Days	
56.2	64.6
30 Days	
56.2	64.6

Follow-Up After Hospitalization for Mental Illness (FUH)

Lines of Business: Marketplace, Medicaid

Percentage of members 6 years of age and older who were hospitalized with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 and 30 days after discharge.

BEST PRACTICES

Performance Improvement

- Follow-up appointments within 7 days of discharge help reduce readmissions.
- Schedule the first follow-up visit within 5 days to allow rescheduling flexibility to meet the 7-day requirement.
- If the member is not seen within 7 days after discharge, ensure a follow-up appointment occurs within 30 days of discharge.
- Visits occurring on the date of discharge do not count towards measure compliance.

HEDIS® Documentation Requirements

- The following criteria must be met to meet measure compliance:
  - Date of discharge with a principal diagnosis for mental illness or intentional self-harm
  - A follow-up service for mental health within 7 days after discharge.
  - A follow-up service for mental health within 30 days after discharge.

Member Experience

- Talk with your patient about ways to get assistance, including a specialist referral, when experiencing anxiety or depression.
- Regularly assess if emotional problems, such as addiction, anxiety, or depression, interfere with your patients social or daily activities.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	F99, F29, F33.1, F419, F250, F411, F4320
CPT	In Person Visit: 99201-99205 Telephone Visit: 99441-99443 Virtual/Online Visit: 99457, 99444
HCPCS	In Person Visit: G0402, G0438, G0439, G0463, T1015 Virtual/Online: G2012
Exclusions	Hospice or Deceased in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
7 Day	
37.6	50.7

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

Lines of Business: Medicaid, Medicare

The percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Visits within 7-days and 30-days of discharge are evaluated in this measure.

BEST PRACTICES

Performance Improvement

- Offer Telehealth visits, e-visits, or virtual check-ins with the primary diagnosis of substance abuse disorder.
- Address social drivers of health, health equity and quality care.
- Coordinate care between physical and behavioral health providers to address any comorbidity.

HEDIS® Documentation Requirements

- Use the primary diagnosis for substance use disorder at each follow-up visits or encounter. A non-mental illness diagnosis code will not fulfill the measure.
- Follow-up visits on the day of discharge will not fulfill this measure.
- Schedule 7-day and 30-day post discharge follow up visits or encounters.
- The FUI measure is based on episodes, not members. The member could be in the measure more than once.

Member Experience

- Express empathy and engage the patient and guardian
- Encourage questions
- Help patient understand their diagnosis. Use plain language to educate the patient and guardian

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

CPT	98960, 98961, 98962, 99078, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 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-H2018

Cut Points

Medicaid Percentile	
★★★★	★★★★★
7 Day	
44.3	59.9

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

Lines of Business: Marketplace, Medicaid

Percentage of emergency department (ED) visits for members ages 6 years and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 and 30 days after ED discharge.

BEST PRACTICES

Performance Improvement

- Follow-up appointments within 7 days of discharge help reduce readmissions.
- Schedule the first follow-up visit within 5 days to allow rescheduling flexibility to meet the 7-day requirement.
- If the member is not seen within 7 days after discharge, ensure a follow-up appointment occurs within 30 days of discharge.
- Visits occurring on the date of discharge do not count towards measure compliance.

HEDIS® Documentation Requirements

- The following criteria must be met to meet measure compliance:
  - Date of discharge with a principal diagnosis for mental illness or intentional self-harm
  - A follow-up service for mental health within 7 days after discharge.
  - A follow-up service for mental health within 30 days after discharge.

Member Experience

- Educate the patient and parent(s) on the importance of the 7-day and the 30-day follow-up care appointments.
- Offer telehealth/phone visits if unable to come into the office.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

C Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	F99, F29, F33.1, F419, F250, F411, F4320
CPT	In Person Visit: 99201-99205 Telephone Visit: 99441-99443 Virtual/Online Visit: 99457, 99444
HCPCS	In Person Visit: G0402, G0438, G0439, G0463, T1015 Virtual/Online: G2012
Exclusions	Hospice or Deceased in MY ED visits that result in inpatient stays.

Cut Points

Medicaid Percentile	
★★★★	★★★★★
<8%	
59.6	63.5
Marketplace Percentile	
★★★★	★★★★★
>9%	
22.6	18.7

Glycemic Status Assessment for Patients with Diabetes (GSD)

Lines of Business: Marketplace, Medicaid

Percentage of members 18–75 years of age with diabetes (types 1 and 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%)*
**This is an inverse sub-measure, a lower rate indicates better performance.*

BEST PRACTICES

Performance Improvement

- Document all A1c lab values with dates of service (result date) in the medical record.
- Document all the glucose management indicator (GMI) values and dates in the medical record.

HEDIS® Documentation Requirements

- To satisfy this measure the following must be documented:
  - A note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed
  - The result of the assessment

Member Experience

- Provide education to members regarding the need to monitor and manage their blood sugars.
- Assist members if needed to schedule lab visits for regular A1c testing and to include transportation assistance when possible.

Measure Steward: HEDIS®

Data Collection: Administrative, Hybrid

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

Exclusion Codes ICD-10 Diagnosis	E09.65, E09.9, E28.2, O24.410
ICD-10 Diagnosis	E11.9, E11.65, E11.69
CPT	83036, 83037
CPT II	3044F (<7.0%), 3046F (>9.0%), 3051F (7.0% - 8.0%), 3052F (8.0% - 9.0%)
Exclusions	Palliative Care, Hospice, or Deceased in MY Frailty & Advanced Illness, Over age 65 and in a SNP or LTI anytime in the MY Members who did not have a diagnosis of diabetes, PCOS, Gestational, or Steroid-induced diabetes diagnosis in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
Combo 2	
38.6	48.6

Marketplace Percentile	
★★★★	★★★★★
Combo 2	
33.6	45.2

Immunizations for Adolescents (IMA-E)

Lines of Business: Marketplace, Medicaid

The percentage of adolescents who turn 13 years of age during the measurement year who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday

BEST PRACTICES

Performance Improvement

- Refer to the CDC website for current immunizations schedules https://www.cdc.gov/vaccines/hcp/imz-schedules/index.html
- Be sure to document both the vaccination name and date it was administered in the medical record.
- Submit all immunizations to NCIR.

Member Experience

- Educate parents on the importance of vaccinations and provide the CDC recommended immunization schedule Info.

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

HPV (at least 2 doses)	**CVX:** 62, 118, 137, 165 **CPT:** 90649, 90650, 90651
Tdap (at least 1 dose)	**CPT:** 90715
Meningococcal (at least 1 dose)	**CVX:** 32, 108, 114, 136, 147, 167, 203, 316 **CPT:** 90619, 90623, 90733, 90734
Exclusion Codes ICD-10 Diagnosis	ICD10: T80.52XA, T80.52XD, T80.52XS
Exclusions	• Hospice in MY • Deceased in MY

Cut Points	
Medicaid Percentile	
★★★★	★★★★★
42.0	49.7
Marketplace Percentile	
★★★★	★★★★★
55.4	61.4

Kidney Health Evaluation for Patients with Diabetes (KED)

Lines of Business: Marketplace, Medicaid

Description
The percentage of adults 18-85 years of age with diabetes (Type 1 and Type 2) who received a kidney health evaluation in measurement year.

BEST PRACTICES

Performance Improvement

- Promote diabetes management to include kidney health. Link health promotion activities to well-promoted initiatives like National Kidney Month (March) or Diabetes Awareness Month (November).
- Develop an outreach program aimed at patients who have not had yearly diabetic lab work and/ or screenings completed.

HEDIS® Documentation Requirements

- This two-part measure requires both blood and urine assessments. Documentation of the test name, date of service, and the test result will make this patient compliant for the MY.
- The tests, estimated glomerular filtration rate (eGFR) and the urine albumin-creatine ratio (uACR), may be assessed on different dates in the measure year.

Member Experience

- Educate members on why good kidney function is important as they work to manage their health and diabetes.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Codes below are examples only and not recommendations. Diagnostic and Outpatient Visit Codes

CPT	Estimated Glomerular Filtration Rate Lab (eGFR): 80053, 80048, 80050 Quantitative Urine Albumin Lab test: 82043 Urine Creatinine Lab Test: 82570
Exclusions	Palliative Care, Hospice or Deceased in MY ESRD diagnosis of history of dialysis

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Cut Points

Medicaid Percentile	
★★★★	★★★★★
75.97	80.45
Marketplace Percentile	
★★★★	★★★★★
60.7	66.1

Medical Assistance with Smoking and Tobacco Use Cessation (MSC)

Lines of Business: Medicaid

Description

Percentage of members 18 years and older who are current smokers or tobacco users and have received advice to quit during the measurement year. There are three components in this: Advising Smokers and Tobacco Users to Quit, Discussion Cessation Medications, and Discussing Cessation Strategies.

BEST PRACTICES

Performance Improvement

- Discuss the benefits of quitting smoking or using tobacco products with your patients.
- Assess the patient's readiness to quit. Then, ask patients to identify an achievable goal, document the goal, then ask the patients about their progress on the next visit.
- Suggest the patient select a support person to help them reach their goal. Consider referring patients to Health Coaching, counseling, support groups and the QuitlineNC for support.

HEDIS® Documentation Requirements

- This measure evaluates whether healthcare providers discussed cessation, offered strategies for cessation, and discussed medical options.

Member Experience

- Suggest the patient select a support person to help them reach their goal. Consider referring patients to Health Coaching or the QuitlineNC for support

Measure Steward: HEDIS®

Data Collection: CAHPS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	Z72.0 (Smoking disorder), Z71.6 (Tobacco use counseling)
CPT	99406, 99407

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

Lines of Business: Marketplace, Medicaid

Percentage of deliveries in which pregnant members were screened for clinical depression and, if screened positive, received follow-up care.

BEST PRACTICES

Performance Improvement

- Screening instruments with no thresholds for positive findings are not acceptable for measure compliance.
- Depression screening instruments must be age-appropriate for measure compliance (i.e., adolescents versus adult instruments).

HEDIS® Documentation Requirements

- Depression Screening Instruments with applicable Total Score LOINC Codes capture screening compliance for measure.
  - If depression screening is positive follow-up care is required within 30 days.
  - Follow up care can include, but is not limited to:
    - Outpatient, telephone, e-visit or virtual check-in with a depression or other behavioral health diagnosis.
    - Case management encounter with assessment documented for depression symptoms, depression diagnosis, or other behavioral health condition
    - Behavioral health encounters including: assessment, therapy, collaborative care or medication management
    - Encounter diagnosis for exercise counseling (ICD10CM code Z71.82).
    - A dispensed antidepressant medication
    - An additional depression screening indicating either no depression or no symptoms requiring follow-up (i.e., negative screen) on the same day as a positive screen.

Member Experience

- Educate pregnant members on the symptoms of depression
- Assist pregnant members with scheduling prenatal appointments

Measure Steward: HEDIS®

Data Collection: ECDS

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

CPT	Follow Up Visit: 99211-99215, 99381-99387
Exclusion Codes (less than 37 weeks gestation)	ICD-10: Z3A.20-Z3A.36 SNOWMED CT: 412726003 value <37 weeks
Exclusions	• Deliveries that occur at less than 37 weeks gestation in MY • Hospice in MY • Deceased in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
29.0	36.7

Pharmacotherapy for Opioid Use Disorder (POD)

Lines of Business: Marketplace, Medicaid

The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.

BEST PRACTICES

- Ensure strict adherence to medication regimens, avoiding treatment gaps of 8 or more consecutive days.
- Employ empathic listening and nonjudgmental discussions to explore triggers for use or cravings and develop coping mechanisms.
- Utilize urine drug screens and/or breathalyzers as clinically indicated to monitor for ongoing or new substance use.
- Ensure prompt submission of all relevant claims.

HEDIS® Documentation Requirements

For measure compliance documentation must include the following:

- A diagnosis of opioid use disorder (OUD)
- A new opioid use disorder (OUD) pharmacotherapy event (OUD dispensing or medication administration) received for 180 or more days without a gap in treatment of 8 or more consecutive days.

**Methadone (oral) is only acceptable when billed on a medical claim. A pharmacy claim would be indicative of treatment for pain rather than OUD.*

Member Experience

- Implement strategies to assist patients in managing stressors and identifying triggers for relapse.
- Involve parents/guardians/family/support systems and/or significant others in the treatment plan, emphasizing the importance of treatment adherence and appointment attendance.
- Educate members with OUD on the risks and benefits of pharmacotherapy, non-pharmacological treatment, and no treatment. Detail potential medication side effects and management strategies.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	F11.10, F11.120, F11.13, F11.19, F11.23, F11.20
Exclusions	Hospice or Deceased in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
Prenatal	
86.8	91.8
Postpartum	
82.4	86.6
Marketplace Percentile	
★★★★	★★★★★
Prenatal	
90.4	94.7
Postpartum	
88.3	93.3

Timeliness of Prenatal & Postpartum Care (PPC)

Lines of Business: Marketplace, Medicaid

The percentage of deliveries of live births on or between October 8 of the prior measurement year and October 7 of the current measurement year. This measure assesses the following:

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

**The First Trimester is defined as 280–176 days prior to delivery (or estimated delivery date [EDD]).*

BEST PRACTICES

Performance Improvement

Prenatal Care

- Prenatal visits must be completed by an OB/GYN, other prenatal care practitioner, or PCP.
  - If visits are completed by a PCP documentation must include a diagnosis of pregnancy (Z34).
- Use prenatal visits as an opportunity to discuss the mother's immunization record, educate member about vaccines, and complete other screenings (e.g., behavioral health, postpartum depression).
- Provide documentation of EDD in chart.
- Ensure GYN consults are ordered for pregnant Members during ED visits.
- Nurse visits and genetic counselor notes must be signed off by an OBGYN to be acceptable for PPC documentation.
- A bundled service code used on the date of delivery can be used to identify when prenatal care was initiated only if the claim form indicates the date when prenatal care was initiated.

Postpartum Care

- A Postpartum visit, cervical cytology, and bundled service documenting date when postpartum care was rendered meet all criteria.
- Include the dates of service for all visits with the bundled charge.

HEDIS® Documentation Requirements

Prenatal Care

Prenatal visit must include at least one of the following:

- Basic obstetrical exam that includes auscultation for fetal heart tone, pelvic exam, or fundal height measurement
- Obstetric panel screening

Measure continued on next page.

- Ultrasound of pregnant uterus
- TORCH antibody panel
- Rubella antibody test AND ABO, Rh, or ABO/Rh test

Postpartum Care
Medical record must include the date, notation of postpartum care, and at least one of the following:

o Pelvic exam (PAP test meets criteria).
o Evaluation of weight, BP, breasts (or notation of breastfeeding), and abdomen.
o Notation of postpartum care documented during the visit such as PP care, PP check, 6-week check, preprinted postpartum care form, or perineal or cesarean incision/wound check.
o Documentation of infant care, breastfeeding, family planning, sleep/fatigue, and/or resumption of physical activity and attainment of healthy weight.
o Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.

Note: L&D admissions are not acceptable documentation for the PPC measure.

Member Experience

- Provide educational materials, exercises, resources, and recommendations for prenatal care.
- Schedule a postpartum visit at the time of discharge from the hospital.

Measure Steward: HEDIS®

Data Collection: Administrative, Hybrid

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	O99.342, O26.813, O26.812, 10E0XZZ, O99.981, O34.211, O480, O2683
CPT	59430, 59400 Cervical cytology: 88141
CPT II	0503F, 0502F, 0500F, 0501F,
HCPCS	G0101, G0463, T1015
Exclusions	• Pregnancy resulting in a non-live birth • Member received hospice care in MY • Member death during MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
80% Coverage	
66.1	74.8

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Lines of Business: Marketplace, Medicaid

Percentage of members 18 years of age and older with schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication and remained on them for at least 80% of their treatment period* during the MY.

**Treatment period starts at the time of first medication refill through the end of MY.*

BEST PRACTICES

Performance Improvement

- Consider utilizing long-acting injections versus oral medication to help increase compliance.

HEDIS® Documentation Requirements

For diagnosis with the administrative process:

- At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder

  OR

- At least two outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient visits, on different service dates, with any schizophrenia or schizoaffective disorder diagnosis.

For pharmacy data all the following data elements must be present:

- Generic name (or brand name)
- Strength/dose, route (e.g., oral, injection)
- Date when medication was dispensed or shipped to the member

Member Experience

- Educate the member on the importance of taking prescribed medication.
- Remind members of the importance of scheduling and keeping all appointments
- Offer telehealth and phone visits if unable to come into the office.

Measure Steward: HEDIS®

Data Collection: Administrative, Pharmacy Data

Measure continued on next page.

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	F20.9, F25.0, F25.9
CPT	In Person Visit: 99201-99205, 99212-99215, 98966-98968 Telephone Visit: 99441-99443 Virtual/Online Visit: 99457, 99444
HCPCS	In Person Visit: G0463 Virtual/Online Visit: G2012
Exclusion Codes ICD-10 Diagnosis	Dementia: G30.9, F03.90, F03.92
Exclusions	• Did not have at least two antipsychotic medication dispensing events. • Dementia diagnosis, Hospice, or Deceased in MY • Frailty and advanced illness (66-80 years of age). • At least two frailty indications on different dates of service during MY (81 years and older).

Cut Points

Medicaid Percentile	
★★★★	★★★★★
Received Therapy	
67.0	71.4
Adherence	
70.9	79.7

Statin Therapy for Patients with Diabetes (SPD)

Lines of Business: Marketplace, Medicaid

Percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy and remained on their statin medication for 80% of their treatment period.

BEST PRACTICES

- Consider prescribing a 90-day supply of medication for members to cut down on frequent trips to the pharmacy.
- Schedule appropriate follow-up with members to assess if medication is taken as prescribed.

HEDIS® Documentation Requirements

- Members must have a diagnosis of diabetes during the measurement year or year prior.
- There are two rates for this measure, for members to be fully compliant they must meet the criteria listed for both:
  - Received Statin Therapy: Members who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication during the measurement year.
  - Statin Adherence 80%: Members who meet the numerator criteria for Rate 1 and achieved a Proportion of Days Covered (PDC) of at least 80% during the treatment period.

Member Experience

- Remind members to report any side effects right away to their provider.
- Educate members on the importance of statin medication adherence.

Measure Steward: HEDIS®

Data Collection: Administrative

Measure continued on next page.

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

Exclusion Codes ICD-10 Diagnosis	ESRD: N18.6, Z99.2
Exclusions	Any of the following diagnosis in the MY or year prior: • Pregnancy • In vitro fertilization • ESRD • Dialysis • Cirrhosis Myalgia, myositis, myopathy, or rhabdomyolysis in MY Myalgia or rhabdomyolysis caused by statins at any point during the members history into the end of MY Palliative Care, Hospice or Deceased in MY Members with at least one of the following in the year prior to MY: • Myocardial Infarction (MI). Discharged from an inpatient setting with an MI on the discharge claim. • Coronary Artery Bypass Grafting (CABG). Members who had CABG in any setting. • Percutaneous Coronary Intervention (PCI). Members who had PCI in any setting. • Other revascularization. Members who had any other revascularization procedure in any setting. Members who had at least one encounter with a diagnosis of ischemic vascular disease (IVD) during both MY and year prior. The following encounters meet criteria: • An outpatient visit, telephone visit, e-visit, virtual check-in, or acute inpatient encounter with an IVD diagnosis. • At least one acute inpatient discharge with an IVD diagnosis on the discharge claim.

Cut Points

Marketplace Percentile	
★★★★	★★★★★
0-14 Months	
84.5	90.1
15-30 Months	
84.5	90.1

Well-Child Visits 0- 30 Months (W30)

Lines of Business: Marketplace, Medicaid

Percentage of members who turned 15 months during the measurement year who received 6 or more well-child visits between 0-15 months.
And
Percentage of members who turned 30 months during the measurement year who received 2 or more well-child visits between 15-30 months.

BEST PRACTICES
Performance Improvement

- Utilize sick visits and sports physicals as an opportunity to complete screenings and immunizations as needed.
- Visit needs to be completed with a PCP but does not have to be completed with their assigned PCP.
- Visits with a nurse practitioner or physician assistant meet the measure.
- Educate staff to schedule visits within the guideline timeframes.

HEDIS® Documentation Requirements

- To satisfy the numerator of the W30 measure using supplemental data, documentation in the medical record must include the following:
  - Well-Child Visits in the First 15 Months. For children who turned 15 months old during the MY: Six or more well-child visits.
  - Well-Child Visits for 15-30 Months. For children who turned 30 months old during the MY: Two or more well-child visits.

  Do not include services rendered during an inpatient or ED visit

Member Experience

- Educate parents/caregivers of screenings and immunizations needed and the frequency requirement.

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z76.2
CPT	99381- 99385, 99391- 99395,99461
Exclusions	Hospice or Deceased in MY

Cut Points

Medicaid Percentile	
★★★★	★★★★★
BMI Percentile	
86.1	91.2
Marketplace Percentile	
BMI Percentile	
★★★★	★★★★★
78.0	83.9
Nutrition	
78.0	83.9
Exercise	
78.0	83.9

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

Lines of Business: Marketplace, Medicaid

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

- BMI Percentile documentation
- Counseling for Nutrition
- Counseling for Physical Activity

BEST PRACTICES

Performance Improvement

- Document the BMI percentile in the member's chart.
- Counsel on nutrition and physical activity.
- Be sure to document physical activity for ages 3-5.
- Nutrition must address diet; appetite and observations of "well-nourished" would not fulfill measure compliance.

HEDIS® Documentation Requirements

- Documentation in the medical record must include all the following for measure compliance:
  - BMI percentile documented on an age-growth chart meets criteria.
  - Nutrition Counseling
  - Physical Activity Counseling
  - Documentation does not have to occur on the same date of service.
  - Compliance for Nutrition and Physical Activity counseling documentation must not be related to an acute or chronic condition visit (unless it is related to an eating disorder or obesity). It can be documented as counseling separate from the acute or chronic condition being addressed in the visit.

Member Experience

- Remind members/caregivers to schedule yearly appointment for well-child visits, especially during adolescence.

Measure Steward: HEDIS®

Data Collection: Administrative, Hybrid

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	BMI: Z68.51, Z68.52, Z68.53, Z68.54 Nutrition: Z71.3 Physical Activity: Z02.5, Z71.82
CPT	Nutrition: 97802, 97803, 97804
HCPCS	Nutrition: G0270, G0271, G0447, S9449, S9452, S9470 Physical Activity: G0447, S9451
Exclusions	• Hospice in MY • Deceased in MY • Members who have diagnosis of pregnancy during MY

Cut Points

Marketplace Percentile	
★★★★	★★★★★
Total	
59.6	69.0

Child and Adolescent Well-Care Visits (WCV)

Lines of Business: Marketplace, Medicaid

Percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

BEST PRACTICES

- Use standardized templates in charts and EMRs
- Set care gap "alerts" in your electronic medical record
- Consider offering extended practice hours to increase care access

HEDIS® Documentation Requirements

- Members must have at least one comprehensive well-care visit with the appropriate provider during the MY.
- Telehealth/telephone well-visits have been removed from the numerator as of 2025.
- Comprehensive well-care visits can be conducted during acute or chronic condition visits.

Member Experience

- Encourage caregivers/patients to maintain the relationship with a PCP to promote consistent and coordinated health care
- Educate caregivers/patients on the importance of having preventive care visits
- Remind patients of their appointment by making calls or sending texts

Measure Steward: HEDIS®

Data Collection: Administrative

Common Codes and Exclusions

Diagnostic and outpatient visit codes below are examples only and not recommendations.

ICD-10 Diagnosis	Z00.00, Z00.01, Z00.129
CPT	9381 – 99385, 99391-99395
HCPCS	G0438, G0439
Exclusions	Hospice in MY Members deceased during MY

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Ambetter of North Carolina Inc. is underwritten by Ambetter of North Carolina Inc. which is a Qualified Health Plan issuer in the North Carolina Health Insurance Marketplace.