2025 HEDIS CODES (ADULT MEASURES)

MEASURE	AGE RANGE	CODES	LINE OF BUSINESS	CLAIM SUBMITTER	DOCUMENTATION REQUIREMENTS	RECOMMENDATIONS OF BEST PRACTICE
Annual Physical Exam (APE) 	20-64 yrs.	**ICD-10:** Z00.00 (Normal)/ Z00.01 (Abnormal) **CPT:** 99385-99387 (New patient) 99395-99397 (Established patient)	Medicaid Commercial	Primary Care Physician	Completed **APE form.** Forms available in our Provider Portal/Resources (highlights priority topics/measures to be addressed with Medicaid and Commercial patients) Frequency: **Annually**	**Utilize** the APE form to guide care and screening needs of patients. **Submit** completed APE form in the provider portal. **Schedule** the next APE appointment before the patient leaves practice and set reminder calls.
****Annual Wellness Visit (AWV)** 	65+ yrs.	**HCPCS:** G0402 (Welcome to Medicare) G0438 (Initial visit) G0439 (Subsequent visit)	Medicare	Primary Care Physician	Completed **AWV form** for Paper Chart and EMR Providers are available in our Provider Portal/Resources (highlights priority measures impacting Medicare patients) Frequency: **Annually**	**Utilize** the AWV form to guide care and screening needs of patient. **Submit** completed AWV form in the provider portal. **Schedule** the next AWV appointment before the patient leaves practice and set reminder calls.
Glycemic Status Assessment for Patients with Diabetes (GSD) 	18-75 yrs.	HbA1c **<8.0%** MEDICAID and COMMERCIAL; HbA1c **≤9.0%** MEDICARE **Diabetes ICD-10:** E10, E11, E13 **CPTII:** HbA1c <7.0% – 3044F ≥7.0% – <8.0% – 3051F ≥8.0% – ≤9.0% – 3052F >9.0% – 3046F	Medicare Medicaid Commercial	Lab or Primary Care Physician	Document medical records with the date and result. **Please note that result 8 or higher is considered non-compliant for Medicaid and Commercial** **& result higher than 9 is considered non-compliant for Medicare.** Frequency: **Annually**	**Obtain** at least one HbA1c value <8% for Medicaid and Commercial patients; at least one value ≤9% for Medicare patients. **Follow up** results and findings with the patient. **High priority measure!** Double weighted for Medicaid and Commercial. Triple weighted for Medicare patients.
Eye Exam for Patients with Diabetes (EED) 	18-75 yrs.	**Diabetes ICD-10:** E10, E11, E13 **Positive Retinal Eye Exam Reviewed** **CPTII:** 2022F, 2024F, 2026F **Negative Retinal Eye Exam Reviewed** **CPTII:** 2023F, 2025F, 2033F **CPTII:** 3072F (Negative retinopathy prior year)	Medicare Medicaid Commercial	Optometrist or Ophthalmologist or Primary Care Physician	Document the type of eye exam performed including findings. Documentation of only the order or statement that test was performed is not sufficient. **Please clarify if the result is Positive or Negative.** Frequency: **Positive - Annually** **Negative - Every 2 years**	**Refer** patients with a diagnosis of diabetes (Type 1 or Type 2) to optometrist or ophthalmologist for dilated retinal eye exam. **Follow up** and discuss the results and findings with the patient.
Kidney Health Evaluation for Patients with Diabetes (KED) 	18-85 yrs.	**ICD-10 Diabetes:** E10, E11, E13 **Estimated Blood Glomerular Filtration Rate (eGFR):** 80048, 80053, 80069, 82565 **Urine Albumin-Creatinine Ratio (uACR):** 82043, 82570	Medicare Medicaid Commercial	Lab	At least 1 estimated **Blood** glomerular filtration Rate **(eGFR) AND** Quantitative **urine** albumin test AND a urine creatinine test 4 or less days apart OR Urine and Albumin-Creatinine Ratio **(uACR)** **BOTH eGFR and uACR must be performed in the measurement year to be compliant** Frequency: **Annually**	**Refer** patients with diagnosis of diabetes (Type 1 or Type 2) to lab to receive a kidney health evaluation during the measurement year. Follow up with patients who have not completed tests. **Schedule** regular follow ups with patients to monitor changes, discuss lab results and educate on how diabetes can affect the kidneys by offering tips for prevention and diet. **Follow up** and discuss the results and findings with the patient.
Blood Pressure Control for Patients with Diabetes (BPD) 	18-75 yrs.	Systolic BP: < 130 mmHg – **CPTII:** 3074F 130-139 mmHg – **CPTII:** 3075F Diastolic BP: < 80 mmHg – **CPTII:** 3078F 80-89 mmHg – **CPTII:** 3079F	Medicaid Commercial	Primary Care Physician	Record the patient's blood pressure at every office visit. If multiple readings were recorded for a single date, use the lowest systolic and diastolic BP on that date. Submit one systolic CPT and one diastolic CPT with an office visit code on the claim/encounter. **Blood pressure equal to or above 140/90 is considered as non-compliant.** Frequency: **Annually**	**Educate** patients to report blood pressure readings via telehealth encounters if they have digital monitors. **Encourage** patients to take blood pressure at home, keep a log, and report back to the provider at their next in person visit or telehealth visit. **Reassess** patient for compliance and medication regimen while stressing the importance of healthy diet, exercise, and medication intake if blood pressure readings are compromised. **High priority measure!**

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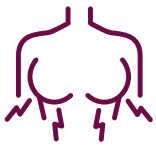
2025 HEDIS CODES (ADULT MEASURES)

MEASURE	AGE RANGE	CODES	LINE OF BUSINESS	CLAIM SUBMITTER	DOCUMENTATION REQUIREMENTS	RECOMMENDATIONS OF BEST PRACTICE
Colorectal Cancer Screening (COL) 	45-75 yrs.	Colonoscopy/ CT Colonography/ Sigmoidoscopy Upload report if gap exists	Medicaid Medicare Commercial	Gastroenterologist or Radiology Imaging Center	Document the date, type, and result of colorectal cancer screening clearly. Patient reported colonoscopy is acceptable by documenting the date and as much detail as the patient can offer. Frequency: **FOBT Annually; FIT DNA test every 3 years; CT Colonography every 5 years; Flexible Sigmoidoscopy every 5 years; Colonoscopy every 10 years.**	**Educate** patients about the importance of colorectal cancer screening. Discuss different screening options if the patient is hesitant. Provide at-home FOBT kits if refused other options. **Create** referral and/or standing order to share with the patient. **Provide** a list of locations where colorectal cancer screening can be performed based on the recommendations and the patient's preference. **Follow up** and discuss the results and findings with the patient
		iFOBT/FIT DNA – Codes submitted by laboratories		Lab		
		Exclusions Colorectal Cancer – **ICD-10:** C18.0-C18.9, C19, C20, Z85.038, Z85.048 Colectomy – **CPT:** 44150–44158, 44210–44212				
Depression Screening and Follow-Up for Adolescents and Adults (DSF) 	12yrs.and older	**Captured Through EHR System:** PHQ-2 **LOINC:** 55758–7 PHQ-9 **LOINC:** 44261–6 PHQ-Teens **LOINC:** 89204–2	Medicare Medicaid Commercial	Primary Care Physician	Utilize validated tools PHQ9/PHQ2 and ensure that the total score is written clearly on the form with DOS. Please upload your completed assessment forms of PHQ9/PHQ2 on to the Provider Portal Record notation of patient refusal on medial record. Frequency: **Annually**	**Screen** for depression and mood changes at every visit using validated tools (i.e., PHQ9/PHQ2) **Educate** the patient on the importance of follow-up and adherence to treatment recommendations. **Schedule the next** DSF appointment before the patient leaves practice and set reminder calls. **Refer** to practitioner who is qualified to diagnose and treat depression, as needed.
Chlamydia Screening (CHL) 	16-24 yrs.	**CPT:** 87110, 87270, 87320, 87490-87492, 87810	Medicaid Commercial	Lab	Document the date and findings of the most recent screening. Frequency: **Annually patients within the age range identified as sexually active**	**Educate** patients on the importance of CHL. Conduct chlamydia screening via urine test as part of the annual physical exam. Parental consent is not required. **Follow up** and discuss the results and findings with the patient.
Breast Cancer Screening (BCS) 	Female 40-74 yrs.	Mammography **CPT:** 77065–77067	Medicare Medicaid Commercial	Radiology Imaging Center	This measure should be collected and reported through the E-clinical data system. Document the month and year of the most recent mammogram with the result and/or mastectomy status in the medical record. Patient reported mammograms are acceptable by documenting the date. BI-RADS screening, regardless of the result, can close gaps. Biopsies, breast ultrasounds, or MRIs do not count towards this measure. Frequency: **Every 2 years**	**Educate** patients on the importance of early detection and encourage screening. **Discuss** possible fears the patient might have about mammograms and advise them that the present available testing methods are less uncomfortable and require less radiation. **Create** referral and/or standing order to share with the patient. **Provide** a list of locations where mammogram screening can be performed. **Follow up** and discuss the results and findings with the patient
		Digital Breast Tomosynthesis **CPT:** 77061–77063				
		Exclusion – History of Bilateral Mastectomy – **ICD-10:** Z90.13				

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Cervical Cancer Screening (CCS) 	Patients 21-64 yrs.	Pap Smear / Cytology **HCPCS**: G0123 HPV Test **HCPCS:** G0476 Exclusions – Acquired absence of cervix **ICD-10:** Z90.712 (w/uterus) & **ICD-10:** Z90.710 (w/o uterus) Total abdominal hysterectomy **CPT:** 58150	Medicaid Commercial	Lab or Gynecologist or Primary Care Physician	Document the date when cervical cancer screening was performed with specific test names and results in the medical record. The cervical cytology and HPV test must be from the same data source. Request to have the results of pap tests sent over if completed by OB/GYN. Frequency: **Patients 21-64 years of age who had cervical cytology in the measurement year or 2 years prior; Patients 30-64 years of age who had cervical high-risk human Papillomavirus (hrHPV) testing performed in the measurement year or 4 years prior; Patients 30-64 years of age who had cervical cytology and human papillomavirus (hrHPV) co-testing performed in the measurement year or 4 years prior.**	**Educate** patients about the importance of cervical cancer screening. **Create** referral and/or standing order to share with the patient. **Provide** a list of locations where cervical cancer screening can be performed. **Follow up** and discuss the results and findings with the patient.
Prenatal and Postpartum Care (PPC) 	All Ages	Timeliness of Prenatal Care **ICD-10:** Z34.90 Primary diagnosis codes for pregnancy must be present **CPTII:** 0500F (initial), 0502F (subsequent) Postpartum Care **ICD-10:** Z01.411 **CPTII:** 0503F	Medicaid Commercial	OBGYN or Primary Care Physician	Prenatal document must include the date of visit and indicate at least one of the following: Fetal heat tone auscultation; Pelvic exam with OB observations; Fundal heigh measurement. Pre-Frequency: **1st trimester or within 42 days after enrollment Postpartum, document must include the date and at least one of the following: Pelvic exam; Evaluation of weight, BP, breast, and abdomen; notation of postpartum care; depression screening and follow up.** Post-Frequency: **On or between 7-84 days (1-12 weeks after delivery)**	**Encourage** and stress the importance of prenatal visits. **Refer** the patient to an OB/GYN for continued prenatal care. **Schedule** the next visit before the patient leaves the office. Utilizing telehealth visits if the patient cannot make it to the office. **Encourage** a postpartum visit between 7-84 days of delivery.
Controlling High Blood Pressure (CBP) 	18-85 yrs.	Systolic BP: < 130 mmHg – **CPTII:** 3074F 130-139 mmHg – **CPTII:** 3075F ≥140 mmHg – **CPTII:** 3077F Diastolic BP: < 80 mmHg – **CPTII:** 3078F 80-89 mmHg – **CPTII:** 3079F	Medicare Medicaid Commercial	Primary Care Physician	Record the patient's blood pressure at every office visit. If multiple readings were recorded for a single date, use the lowest systolic and diastolic BP on that date. Submit one systolic CPT and one diastolic CPT with an office visit code on the claim/encounter. **Blood pressure equal to or above 140/90 is considered as non-compliant.** Frequency: **Annually**	**Educate** patients to report blood pressure readings via telehealth encounters if they have digital monitors. **Encourage** patients to take blood pressure at home, keep a log, and report back to the provider at their next in person visit or telehealth visit. **Reassess** patient for compliance and medication regimen while stressing the importance of healthy diet, exercise, and medication intake if blood pressure readings are compromised. **High priority measure!** **Double weighted for Medicaid and Commercial.** **Triple weighted for Medicare patients.**
Osteoporosis Management in Women who had a Fracture (OMW) 	67-85 yrs.	BMD Test **CPT:** 77078 (CT), 77080 (DEXA) Osteoporosis Meds **HCPCSII:** J0897, J1740, J3110–J3111, J3489,		Orthopedist or Radiology Imaging Center or Primary Care Physician	Documentation should include Bone Mineral Density (BMD) testing on the day of fracture or within 180 days (6months) after the fracture. Inpatient BMD test is acceptable. **OR** Prescribe medication to treat osteoporosis on the day of fracture or **within 180 days (6 months) of fracture.** Frequency: **180 days (6months) after the fracture.**	**Discuss** osteoporosis prevention tips with the female patients within the age range. Ask if the patient had any recent fractures or falls that the provider is not aware of.

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Care for Older Adults (COA) 	66+ yrs.	Functional Status Assessment **CPTII**: 1170F	Medicare (Only for Dual Eligible Special Needs)	Primary Care Physician	Functional assessment was conducted to evaluate the patient's ability to independently perform **activities of daily living (ADLs)-**bathing, dressing, eating, toileting, transferring and **instrumental activities of daily living (IADL)-**transportation, cooking, managing medication, finances, housekeeping, and related activities. Frequency: **Annually**	**Encourage** regular physical activity and exercise to maintain and improve strength and mobility. **Evaluate** the need for additional home support services or caregiver assistance in functional decline is observed.
		Medication Review **CPTII:** 1159F (list) **and** **CPTII:** 1160F (review)			Comprehensive medication review was conducted to evaluate the appropriateness, safety, and efficacy of the medication regimen for the patient Documentation of the current medications, medication reconciliation to identify discrepancies of current and past list. Any adverse drug reactions, allergies, medication compliance and adherence, patient education and follow up care. Frequency: **Annually**	**Educate** patients on their condition and the portance of taking medication as prescribed. **Encourage** medication compliance and adherence. Timely medication pickup. **Discuss** follow-up care assessment, medication assessment and adjustment when applicable.
		Pain Assessment **CPTII:** 1125F (+pain) **CPTII:** 1126F (-pain)			Pain assessment was conducted using validated scale, such as for example, the Numerical Rating Scale (NRS). Documentation that the patient was able to report the intensity of pain on the scale provided. Documentation of the patient's pain level during the visit, description of the pain intensity and location of pain. Frequency: **Annually**	**Develop** a plan of care with patient with set goals to improve pain management and enhance overall well-being. **Discuss** pain reassessment plan to evaluate the effectiveness of the treatment plan (with medication or without). **Schedule** follow up care visit to monitor progress.
Transition of Care (TRC) 	18+yrs.	Patient Engagement after Inpatient Discharge **CPT:** 99211–99215, 99395–99397	Medicare	Primary Care Physician	Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. **Patient engagement that takes place on the day of discharge is not measure compliance.** Frequency: **Within 30 days of every inpatient discharge**	**Time sensitive measure!!** **Schedule** the patient for a post discharge visit once you are notified that the patient is admitted. This appointment should be made **within 7 days of hospital discharge.** **Outpatient visits,** including office or home visits. Utilize telehealth visits when possible. If the patient is unable to communicate, the provider can interact with the caregiver. **Review** discharge summaries and work with the hospital to obtain access to the electronic medical records for the patient. **Identify** all TRC visits within the measurement year, if a patient has multiple hospital admissions
		Medication Reconciliation Post – Discharge **CPTII:** 1111F			Documentation of medication reconciliation of the current and newly prescribed medications. **Patient engagement that takes place on the day of discharge is not measure compliance.** Frequency: **Within 30 days of every inpatient discharge**	
Follow-Up after Emergency Department Visit (FMC) 	18+yrs	**Multiple CPT codes:** Requires reviewing codes and provider workflow to meet claims submission requirement **Outpatient and Telehealth Visits CPT:** 98966-98981, 99202- 99205, 99211- 99215, 99241-99245 **Please see page 24 of Quality Booklet for additional common codes** **Transitional Care Management CPT:** 99495, 99496	Medicare	Primary Care Physician	Document visit within 7 days of discharge (8 total days) with the reason and outcome of the hospitalization along with the reconciliation of any changes to medication due to the ED visit. Visits on the day of ED visits, are measure compliance. ED visits resulting in inpatient care are excluded. If the patient has more than one ED visit within an 8-day period, include only the first eligible visit. Frequency: **Within 7 days of every ER discharge**	**Time sensitive measure!!** **Follow up** post emergency department visit for people with 2+ chronic conditions prior to the ED visit, within 7 days of discharge (8 total days). Outpatient office or telehealth visits. **Identify** all ED visits within the measurement year, if a patient had multiple ED visits.

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