



# **Practitioner Clinical Guide**

## **HEDIS MY2025**

### **Adult Measures**

**HEDIS Clinical Team contact information: [hedis@partnersbhm.org](mailto:hedis@partnersbhm.org)**

**Web address:**

**<https://providers.partnersbhm.org/quality-improvement-and-hedis/>**

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## HEDIS MY2025

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. HEDIS tracks how well health care organizations perform when providing or facilitating the use of important health services to enrolled populations. HEDIS is published across several volumes. HEDIS MY 2025 includes 87 measures across 6 domains:

- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.
- Health Plan Descriptive Information.
- Measures Reported Using Electronic Clinical Data Systems.

### **DEFINITIONS:**

- HEDIS: Healthcare Effectiveness Data and Information Set
- NCQA: National Committee for Quality Assurance
- DHHS: Department of Health and Human Services
- MRR: Medical Record Review
- OV: Office Visit
- DE: Data Entry
- DOB: Date of Birth
- DOS: Date of Service
- MY: Measurement Year (2025)
- PY: Prior Year (2024)
- CY: Calendar Year (2026)
- MY-2 or 2MY: Measurement year minus 2 years (2023)
- MY-3 or 3MY: Measurement year minus 3 years (2022)
- MY-4 or 4MY: Measurement year minus 4 years (2021)
- MY-5 or 5MY: Measurement year minus 5 years (2020)
- MY-6 or 6MY: Measurement year minus 6 years (2019)
- MY-7 or 7MY: Measurement year minus 7 years (2018)
- MY-8 or 8MY: Measurement year minus 8 years (2017)
- MY-9 or 9MY: Measurement year minus 9 years (2016)

## General Measures

### **AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis**

#### Description

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did **NOT** result in an antibiotic prescription being dispensed.

*A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment.  
Meaning it is better an antibiotic dispensing event did NOT occur.*

#### Measure Information

An antibiotic medication was dispensed on or 3 days after the episode date.

The timeframe for this measure is between July 1<sup>st</sup> of the prior year to June 30<sup>th</sup> of the measurement year.

#### **Situations where members are removed from this measure:**

- Members who received hospice care or died in the measurement year.
- The visit which contained the diagnosis of bronchitis/bronchiolitis resulted in an inpatient stay.
- Documentation in the 12 months prior to and including the episode date of a comorbid diagnosis.
  - HIV
  - Cancer
  - Emphysema
  - COPD
  - Disorders of the Immune System
  - Other Comorbid Conditions
- There was a competing diagnosis on or 3 days following the episode date.
  - Pharyngitis
  - Other Competing Diagnoses (1000s of them)
- An antibiotic was dispensed/received within 30 days prior to the episode date or was active on the episode date.

#### HEDIS Coding Guidelines

##### **ICD-10:**

##### **Competing Diagnosis**

Please refer to the most recent ICD-10 codes.

# AAP: Adults' Access to Preventive/Ambulatory Health Services

## Description

The percentage of members 20 years of age and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the 2 years prior to the measurement year.

## Measure Information

- Medicaid and Medicare: One or more ambulatory or preventive care visit during the measurement year.
- Commercial: One or more ambulatory or preventive care visit during the measurement year or the 2 years prior to the measurement year.

## **Situations where members are removed from this measure:**

- Members who received hospice care or died in the measurement year.

## HEDIS Coding Guidelines

### **CPT:**

92004, 92012, 92014, 98966-98968, 98970-98972, 98980, 98981, 99202-99205, 99211-99215, 99242-99245, 99304-99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99429, 99441-99443, 99457, 99458, 99483

### **HCPCS:**

G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250-G2252, S0620, S0621, T1015

## AIS-E: Adult Immunization Status

### Description

The 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.

### Measure Information

#### ➤ Hepatitis B:

- At least three doses of the childhood hepatitis B vaccine with different dates of service on or before their 19<sup>th</sup> birthday.
  - One of the three vaccinations can be a newborn hepatitis B vaccine.
- A hepatitis B vaccine series on or after their 19<sup>th</sup> birthday, before or during the measurement year, including either of the following:
  - At least two doses of the recommended two-dose adult hepatitis B vaccine administered at least 28 days apart.
  - OR
  - At least three doses of any other recommended adult hepatitis B vaccine administered on different dates of service.
- A hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis B core antigen test, with a positive result any time before or during the measurement period. Any of the following meet criteria:
  - A test with a result greater than 10mIU/mL.
  - A test with a finding of immunity.
- A history of hepatitis B illness any time before or during the measurement year.
- Anaphylaxis due to the hepatitis B vaccine any time before or during the measurement year.

#### ➤ Influenza (Flu):

- At least one influenza vaccine administered on or between July 1<sup>st</sup> of the year prior to the measurement year and June 30<sup>th</sup> of the measurement year.
- Anaphylaxis due to the influenza vaccine any time before or during the measurement year.

#### ➤ Pneumococcal:

- At least one dose of an adult pneumococcal vaccine on or after their 19<sup>th</sup> birthday, before or during the measurement period.
- Anaphylaxis due to the pneumococcal vaccine any time before or during the measurement year.

#### ➤ Tetanus Diphtheria toxoids Acellular Pertussis (Tdap/TD):

- At least one Tdap/Td vaccine administered between 9 years prior to the start of the measurement year and the end of the measurement year.

- Anaphylaxis and/or Encephalitis due to the Tdap vaccine any time before or during the measurement year.

- Zoster:
- At least two doses of the herpes zoster recombinant vaccine at least 28 days apart, on October 1, 2017, through the end of the measurement year.
  - Anaphylaxis due to the herpes zoster vaccine any time before or during the measurement year.

**Situations where members are removed from this measure:**

- Members who received hospice care or died in the measurement year.

**HEDIS Coding Guidelines**

**CPT/HCPCS:**

Hepatitis B: 90697, 90723, 90739, 90740, 90743, 90744, 90746, 90747, 90748, 90759, G0010

**Influenza:**

90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756

**LAIV:** 90660, 90672

**Pneumococcal:** 90670, 90671, 90677, 90732

**Tdap:** 90715, G0009

**Td:** 90714

**Zoster:** 90750

## BPC-E: Blood Pressure Control for Patients with Hypertension

### Description

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

### Measure Information

The **most recent** BP reading in the measurement year, which is on or after the second diagnosis of hypertension is required. If there are multiple BPs on the most recent date of service in the measurement year, use the last BP reading from that date.

For the BP reading to be controlled, the systolic must be <140 **AND** the diastolic must be <90. Blood pressure readings are not acceptable if they are taken:

- During an acute inpatient stay.
- During an emergency department visit.
- On the same day as a diagnostic test or procedure that required a change in diet or medication on the day of the procedure or prior day, with the exception of fasting blood tests.
- By the member using a non-digital device.

Ranges and thresholds are **NOT** acceptable to use. A distinct numeric result for both the systolic and diastolic BP reading is required to meet criteria.

### **Situations where members are removed from this measure:**

- Members who received hospice or palliative care or died in the measurement year.
- Members who had a diagnosis of pregnancy in the measurement year.
- Members who had a nonacute inpatient admission during the measurement year.
- Members with evidence of ESRD, dialysis, nephrectomy (partial or total), or kidney transplant any time during the member's history on or prior to 12/31/MY.

### HEDIS Coding Guidelines

#### **CPT II:**

#### **Systolic Reading:**

3074F: Systolic <130 mmHg

3075F: Systolic between 130-139 mmHg

3077F: Systolic ≥ 140 mmHg

#### **Diastolic Reading:**

3078F: Diastolic <80 mmHg

3079F: Diastolic between 80-90 mmHg

3080F: Systolic ≥ 90 mmHg

## CBP: Controlling High Blood Pressure

### Description

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

### Measure Information

The **most recent** BP reading in the measurement year, which is on or after the second diagnosis of hypertension is required.

For the BP reading to be controlled, the systolic must be <140 **AND** the diastolic must be <90. Blood pressure readings are not acceptable if they are taken:

- During an acute inpatient stay.
- During an emergency department visit.
- On the same day as a diagnostic test or procedure that required a change in diet or medication on the day of the procedure or prior day, with the exception of fasting blood tests.
- By the member using a non-digital device.

Ranges and thresholds are **NOT** acceptable to use. A distinct numeric result for both the systolic and diastolic BP reading is required to meet criteria.

### ***Situations where members are removed from this measure:***

- Members who received hospice or palliative care or died in the measurement year.
- Members who had a diagnosis of pregnancy in the measurement year.
- Members who had a nonacute inpatient admission during the measurement year.
- Members with evidence of ESRD, dialysis, nephrectomy (partial or total), or kidney transplant any time during the member's history on or prior to 12/31/MY.

### HEDIS Coding Guidelines

#### **CPT II:**

#### **Systolic Reading:**

3074F: Systolic <130 mmHg

3075F: Systolic between 130-139 mmHg

3077F: Systolic ≥ 140 mmHg

#### **Diastolic Reading:**

3078F: Diastolic <80 mmHg

3079F: Diastolic between 80-90 mmHg

3080F: Systolic  $\geq 90$  mmHg

## COL-E: Colorectal Cancer Screening

### Description

The percentage of members 45-75 years of age who had an appropriate screening for colorectal cancer.

### Measure Information

Below are the different colorectal cancer screenings which meet criteria, provided they are done in the appropriate timeframe.

- Colonoscopy: (MY or 9 years prior)
- Flexible Sigmoidoscopy: (MY or 4 years prior)
- CT Colonography: (MY or 4 years prior)
- Stool DNA (sDNA) with FIT test (Cologuard): (MY or two years prior)
- Fecal Occult Blood Test (FOBT) done in the measurement year.
  - A FOBT done in the provider's office using a sample from a digital rectal exam does NOT meet criteria.

A result is needed for the screening. The only exception to this is if the colorectal cancer screening performed is clearly documented as part of the member's past medical history. This historical documentation must contain the date of the screening along with what type of screening was performed.

### **Situations where members are removed from this measure:**

- Members who received hospice or palliative care or died in the measurement year.
- Members who have had colorectal cancer.
- Members who have had a TOTAL Colectomy.

### HEDIS Coding Guidelines

#### **CPT / HCPCS:**

##### **Colonoscopy:**

44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398, G0105, G0121

##### **Flexible Sigmoidoscopy:**

45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350, G0104

##### **CT Colon:**

74261-74263

##### **sDNA Fit Test:**

81528

##### **FOBT:**

82270, 82274, G0328

## CWP: Appropriate Testing for

### Description

The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

### Measure Information

Documentation of a group A strep test (results not required) 3 days prior to the diagnosis of pharyngitis through 3 days after the episode date for a total of 7 days.

The timeframe for this measure is between July 1<sup>st</sup> of the prior year to the measurement year and June 30<sup>th</sup> of the measurement year.

### **Situations where members are removed from this measure:**

- Members who received hospice care or died in the measurement year.
- If the member did not receive antibiotics on or up to 3 days after the episode date.
- The visit which contained the diagnosis of pharyngitis resulted in an inpatient stay.
- Documentation in the 12 months prior to and including the episode date of a comorbid diagnosis.
  - HIV
  - Cancer
  - Emphysema
  - COPD
  - Disorders of the Immune System
  - Other Comorbid Conditions
- There was a competing diagnosis on or 3 days following the episode date.
- An antibiotic was dispensed/received within 30 days prior to the episode date or was active on the episode date.

### HEDIS Coding Guidelines

#### **CPT:**

#### **Group A Strep Test**

87070, 87071, 87081, 87430, 87650-87652, 87880

## LBP: Use of Imaging Studies for Low Back

### Description

The percentage of members 18-75 years of age with a primary diagnosis of low back pain who did **NOT** have an imaging study (plain X-Ray, MRI, CT scan) within 28 days of the diagnosis. *The higher the rate of members without imaging is better.*

### Measure Information

An imaging study with a diagnosis of uncomplicated low back pain on the date of diagnosis or the 28 days following (total of 29 days).

The timeframe for this measure for the initial diagnosis is between January 1<sup>st</sup> and December 3<sup>rd</sup> of the measurement year.

### Situations where members are removed from this measure:

- Members who received hospice or palliative care or died in the measurement year.
- Events 90 days prior to the diagnosis through 28 days after the low back pain diagnosis:
  - Recent Trauma
  - Fragility fracture
- Events 180 days prior to the diagnosis through 28 days after the low back pain diagnosis:
  - Primary diagnosis of uncomplicated low back pain
- Events 365 days prior to the diagnosis through 28 days after the low back pain diagnosis:
  - IV drug abuse
  - Neurologic impairment
  - Spinal infection
- Prolonged Use of Corticosteroids for 90 consecutive days any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.
- Events any time in the member's history through 28 days after the low back pain diagnosis:
  - A diagnosis of osteoporosis and/or a dispensed prescription to treat osteoporosis.
  - Organ Transplant
  - Lumbar surgery
  - Spondylopathy
  - Cancer
  - HIV

### HEDIS Coding Guidelines

#### **CPT:**

#### **Imaging Study**

72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080-72084, 72100, 72110, 72120, 72125-72133, 72141, 72142, 72144, 72146-72149, 72156-72158, 72200, 72202, 72220

#### **Diagnosis related to removal from this measure:**

Please refer to most recent applicable ICD-10, HCPCS, and CPT codes.

## Diabetes Measures

### **BPD: Blood Pressure Control for Patients with Diabetes**

#### Description

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

#### Measure Information

The **most recent** BP in the measurement year is required.

For a member's BP to be controlled, the systolic must be <140 AND the diastolic must be

<90. Blood pressure readings are **NOT** acceptable if they are taken:

- During an acute inpatient stay.
- During an emergency department visit.
- On the same day as a diagnostic test or procedure that required a change in diet or medication on the day of the procedure or prior day, with the exception of fasting blood tests.
- By the member using a non-digital device.

Ranges and thresholds are **NOT** acceptable to use. A distinct numeric result for both the systolic and diastolic BP reading is required to meet criteria.

#### ***Situations where members are removed from this measure:***

- Members who received hospice or palliative care or died in the measurement year.

#### HEDIS Coding Guidelines

##### **CPT II:**

##### **Systolic Reading:**

3074F: Systolic <130 mmHg

3075F: Systolic between 130-139 mmHg

3077F: Systolic  $\geq$  140 mmHg

##### **Diastolic Reading:**

3078F: Diastolic <80 mmHg

3079F: Diastolic between 80-90 mmHg

3080F: Systolic  $\geq$  90 mmHg

## EED: Eye Exam for Patients with Diabetes

### Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam in the measurement year which was positive **or** negative for retinopathy.

A retinal eye exam in the prior year, which was negative for retinopathy, also meets criteria.

### Measure Information

Screening/monitoring for diabetic retinal disease. One of the following must be completed:

- A retinal or dilated eye exam or retinal photos reviewed by an eye care professional, AI interpretation, or qualified reading center in the measurement year or year prior to the measurement year with a result.
  - Positive or Negative retinopathy findings in the measurement year meets criteria.
  - **ONLY** Negative retinopathy findings in the prior year meets criteria.
    - If the exam in the prior year was positive for retinopathy it is **NOT** acceptable.
- Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both eyes by any provider.

Documentation which is **NOT** acceptable:

- An eye exam result/finding of “Unknown.”
- “Diabetic Eye Exam” or Diabetes without complications.

### **Situations where members are removed from this measure:**

- Members who received hospice or palliative care or died in the measurement year.
- Documentation of Bilateral Eye Enucleation.

### HEDIS Coding Guidelines

**CPT:** 92134, 92201, 92202, 92230, 92235    **Retinal Imaging:** 92250, 92227, 92228

**HCPCS:** S0620/S3000

### **CPT II:**

#### **Negative for Retinopathy:**

**2023F:** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.

**2025F:** Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.

**2033F:** Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed, without evidence of retinopathy.

#### **Positive for Retinopathy:**

**2022F:** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.

**2024F:** Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.

**2026F:** Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy.

## GSD: Glycemic Status Assessment for Patients with Diabetes

### Description

The 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% (*A lower rate for >9 indicates better performance.*)

### Measure Information

The **most recent/last** A1c or GMI in the MY with the following documentation.

- Type of test.
- Date of Service.
- Numeric Result/Value.

Documentation which is NOT acceptable:

- A result of “Unknown.”
- Ranges/thresholds/averages, as there must be a specific numeric value for the result.

### **Situations where members are removed from this measure:**

- Members who received hospice or palliative care or died in the measurement year.

### HEDIS Coding Guidelines

#### **CPT II:**

#### **HbA1c Results:**

3044F: HbA1C < 7%

3051F: HbA1C ≥ 7% but < 8%

3052F: HbA1C ≥ 8% but ≤ 9%

3046F: HbA1C > 9%

## KED: Kidney Health Evaluation for Patients with Diabetes

### Description

The percentage of members 18–85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **AND** a urine albumin-creatinine ratio (uACR), during the measurement year:

### Measure Information

Members who received **BOTH** an eGFR **AND** an uACR during the measurement year. This can be on the same or different dates of service in the measurement year.

There are two different ways to meet criteria for uACR.

- A Urine Albumin Creatinine Ratio test.
- OR**
- A quantitative Urine Albumin test AND a Urine Creatinine test with dates of service no more than four days apart.

Documentation which is **NOT** acceptable:

- A result of "Unknown."
- A regular/basic urinalysis.

### Situations where members are removed from this measure:

- Members who received hospice or palliative care or died in the measurement year.
- Members with a diagnosis of ESRD or who had dialysis any time in the member's history on or prior to 12/31/MY.

### HEDIS Coding Guidelines

#### **eGFR: Estimated Glomerular Filtration Rate:**

**CPT:** 80047, 80048, 80050, 80053, 80069, 82565

**LOINC:** 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6, 102097-3

#### **uACR: Urine Albumin Creatinine Ratio:**

**LOINC:** 9318-7, 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9

**BOTH tests listed below are required to meet criteria for uACR IF an Albumin Creatinine ratio test was not performed.**

#### **Quantitative Urine Albumin:**

**CPT:** 82043

**LOINC:** 1754-1, 14957-5, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7, 100158-5

#### **Urine Creatinine:**

**CPT:** 82570

**LOINC:** 2161-8, 20624-3, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5

## **OB/GYN Measures**

### **BCS-E: Breast Cancer Screening**

#### **Description**

The percentage of members 40-74 years of age who had a routine breast cancer screening (mammogram) to screen for breast cancer.

#### **Measure Information**

The member received at least one mammogram on or between October 1<sup>st</sup> two years prior to the measurement year through December 31<sup>st</sup> of the measurement year.

There are many different types of mammograms which meet criteria:

- Screening
- Diagnostic
- Full Field
- Digital
- Digital Tomosynthesis

#### **Situations where members are removed from this measure:**

- Members who received hospice or palliative care or died in the measurement year.
- Documentation of a bilateral or two Unilateral Mastectomies.

#### **HEDIS Coding Guidelines**

##### **CPT:**

**Mammography:** 77061-77063, 77065-77067

##### **ICD-10:**

**History of Bilateral Mastectomy:** Z90.13

## CCS-E: Cervical Cancer Screening

### Description

The percentage of members 21-64 years of age who were screened for cervical cancer.

### Measure Information

Below are the different cervical cancer screenings which meet criteria provided they are done in the acceptable timeframe.

- For women, 21-64 years on the date of the screening, a Cervical Cytology (Pap) performed during the measurement year or 2 years prior to the measurement year.
- For women, 30-64 years old on the date of the screening, a HrHPV performed during the measurement year or 4 years prior to the measurement year.
- For women, 30-64 years old on the date of the screening, a Pap and HrHPV co-test performed during the measurement year or 4 years prior to the measurement year.

Documentation must include the date and type of screening performed along with the result. Documentation which is **NOT** acceptable:

- A statement the member is not sexually active.
- Biopsies as they are considered diagnostic and/or therapeutic, not screenings.
- Documentation of "hysterectomy" only with no additional documentation to indicate if the cervix was removed.

### **Situations where members are removed from this measure:**

- Member who received hospice care or died in the measurement year.
- History/documentation of a full, total, radical, complete, vaginal, simply hysterectomy,
- History/documentation of a TAH, TVH, LAVH, VH.

### HEDIS Coding Guidelines

#### **CPT:**

**Pap Screening:** 88141-88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174-88175

**HPV Screening:** 87624, 87625

#### **HCPCS:**

**Pap Screening:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

**HPV Screening:** G0476

### **Hysterectomy With NO Residual Cervix:**

#### **CPT:**

57530, 57531, 57540, 57545, 57550, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58580, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-57573, 58575, 58951, 58953, 58954, 58956, 59135

**Absence of Cervix:**

ICD-10: Q51.5, Z90.710, Z90.712

## CCP: Contraceptive Care-Postpartum

### Description

The percentage of women ages 15 to 44, as of 12/31/MY, who had a live birth on or between January 1<sup>st</sup> and September 30<sup>th</sup> of the measurement year who were provided:

- The most effective or moderately effective method of contraception within 3 days of delivery and within 90 days of delivery.
- A long-acting reversible method of contraception (LARC) within 3 days of delivery and within 90 days of delivery.

### Measure Information

Women who were provided contraception within 3 days or within 90 days after delivery.

- Most to moderately effective method of contraception.
  - Most effective:
    - Sterilization
    - Contraceptive implants
    - Intrauterine devices or systems (IUD/IUS)
  - Moderately effective:
    - Injectables
    - Oral Pills
    - Patch
    - Ring
- Long-acting reversible method of contraception (LARC).
  - Contraceptive implants
  - Intrauterine devices or systems (IUD/IUS)

### **Situations where members are removed from this measure:**

- There was no live birth.
- The live birth occurred after September 30<sup>th</sup> of the measurement year.

### HEDIS Coding Guidelines

N/A

## CCW: Contraceptive Care-All Women

### Description

The percentage of women ages 15 to 44, as of 12/31/MY, at risk of unintended pregnancy who were provided the following during the measurement year:

- A most effective or moderately effective method of contraception.
- A long-acting reversible method of contraception (LARC).

### Measure Information

Women who were provided contraception.

- Most to moderately effective method of contraception.
  - Most effective:
    - Sterilization
    - Contraceptive implants
    - Intrauterine devices or systems (IUD/IUS)
  - Moderately effective:
    - Injectables
    - Oral Pills
    - Patch
    - Ring
- Long-acting reversible method of contraception (LARC).
  - Contraceptive implants
  - Intrauterine devices or systems (IUD/IUS)

### **Situations where members are removed from this measure:**

- Women who are unable to reproduce due to menopause or oophorectomy.
- Women who are still pregnant at the end of the measurement year AND an absence of any indication of a non-live birth.
- When a live birth occurred in the last 3 months of the measurement year because there may not have been an opportunity to provide them with contraception.

### HEDIS Coding Guidelines

N/A

## CHL: Chlamydia Screening

### Description

The percentage of members 16-24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and who had at least one test for chlamydia during the measurement year.

### Measure Information

At least one chlamydia test during the measurement year.

Documentation which is **NOT** acceptable:

- A statement the member is not sexually active.
- Documentation birth control pills are being used to regulated menses.

### ***Situations where members are removed from this measure:***

- Members who received hospice care or died in the measurement year.
- A pregnancy test WITH an x-ray on the same DOS or within 6 days after the pregnancy test.
- A pregnancy test WITH a prescription for isotretinoin (retinoid medications) on the date of the pregnancy test or within 6 days after the pregnancy test.
- Members who were assigned male at birth.

### HEDIS Coding Guidelines

#### **CPT:**

87110, 87270, 87320, 87490-87492, 87810

## DBM-E: Documented Assessment After Mammogram

### Description

The percentage of mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram for members 40–74 years of age.

### Measure Information

Mammograms on or between December 18<sup>th</sup> of the year prior to the measurement to December 17<sup>th</sup> of the measurement year which received a BI-RADS score on or within 14 days after the mammogram date (15 days total).

BI-RADS standardizes the reporting of findings into assessment categories for further management.

- BI-RADS 0: Incomplete. Needs Additional Imaging Evaluation and/or Prior Mammograms for Comparison, as needing additional imaging.
- *BI-RADS Category 1*: Negative.
- *BI-RADS Category 2*: Benign. Recommended for continued routine screening.
- *BI-RADS Category 3*: Probably Benign. Recommended for mammography surveillance.
- *BI-RADS Categories 4*: Suspicious.
- *BI-RADS Category 5*: Highly Suggestive of Malignancy. Should be managed using core needle biopsy, also called percutaneous core breast biopsy, as the preferred method for tissue diagnosis.
- *BI-RADS Category 6*: Known Biopsy- Proven.

### **Situations where members are removed from this measure:**

- Members who received hospice or died in the measurement year.

### HEDIS Coding Guidelines

#### **CPT:**

**Mammography:** 77061-77063, 77065-77067

#### **RadLex Radiology Lexicon: BI-RADS Assessment**

|                      |                       |                      |
|----------------------|-----------------------|----------------------|
| BI-RADS 0 - RID36036 | BI-RADS 4 - RID36030  | BI-RADS 5 - RID36034 |
| BI-RADS 1 - RID36028 | BI-RADS 4A - RID36031 | BI-RADS 6 - RID36035 |
| BI-RADS 2 - RID36029 | BI-RADS 4B - RID36032 |                      |
| BI-RADS 3 - RID36041 | BI-RADS 4C - RID36033 |                      |

## FMA-E: Follow-Up After Mammogram Assessment

### Description

The percentage of mammograms with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the mammogram for members 40-74 years of age.

### Measure Information

Mammograms on or between October 3<sup>rd</sup> of the year prior to the measurement year to October 2<sup>nd</sup> of the measurement year with high-risk or inconclusive BI-RADS assessment which received appropriate follow-up. Appropriate follow-up is defined as either of the following:

- A high-risk BI-RADS assessment result that received a breast biopsy on or within 90 days after the mammogram date (91 days total).
- An inconclusive BI-RADS assessment that received a mammogram or ultrasound on or within 90 days after the mammogram date (91 days total).
- BI-RADS standardizes the reporting of findings into assessment categories for further management.
- BI-RADS 0: Incomplete. Needs Additional Imaging Evaluation and/or Prior Mammograms for Comparison, as needing additional imaging.
- *BI-RADS Category 1:* Negative.
- BI-RADS Category 2: Benign. Recommended for continued routine screening.
- BI-RADS Category 3: Probably Benign. Recommended for mammography surveillance.
- *BI-RADS Categories 4:* Suspicious.
- *BI-RADS Category 5:* Highly Suggestive of Malignancy. Should be managed using core needle biopsy, also called percutaneous core breast biopsy, as the preferred method for tissue diagnosis.
- *BI-RADS Category 6:* Known Biopsy- Proven.

### **Situations where members are removed from this measure:**

- Members who received hospice or died in the measurement year.

### HEDIS Coding Guidelines

#### **CPT:**

**Mammography:** 77061-77063, 77065-77067

**Breast Biopsy:** 19081, 19083, 19085, 19100, 19101

**Breast Ultrasound:** 76641, 77642

#### **RadLex Radiology Lexicon: BI-RADS Assessment**

BI-RADS 0 - RID36036

BI-RADS 1 - RID36028

BI-RADS 2 - RID36029

BI-RADS 4 - RID36030

BI-RADS 4A - RID36031

BI-RADS 4B - RID36032

BI-RADS 5 - RID36034

BI-RADS 6 - RID36035

BI-RADS 3 - RID36041

BI-RADS 4C - RID36033

## PPC: Prenatal and Postpartum Care

### Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

For these members, the measure assesses the following qualities 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.
- **Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

### Measure Information

- Prenatal care visit (PNV) which occurred during the 1<sup>st</sup> trimester or within 42 days after enrollment with the health plan.
  - This visit **MUST** be with an OB/GYN, primary care physician (PCP), or another prenatal type of practitioner.
  - Any of the following meet's criteria for a PNV:
    - A diagnosis of pregnancy, documentation indicating the member is pregnant or references to the pregnancy such as:
      - Standardized prenatal flow sheet.
      - A positive pregnancy test result.
      - Last menstrual period (LMP) estimated delivery date (EDD), or gestational age (GA).
      - Complete obstetrical history (OB) history.
        - ❖ Documentation of gravidity and parity (G/P) meet criteria for OB history.
      - Prenatal risk assessment and counseling/ education.
    - A basic OB physical exam to include at least one of the following:
      - Fetal heart tones.
      - Pelvic exam with obstetrical observations.
      - Measurement of the fundus height.
    - Evidence a prenatal care procedure was performed with any of the following meeting criteria. Remember these services **MUST** be in conjunction with a visit with a provider. **BOTH** the visit and this service must be in the allowable timeframe, but they do not have to be on the same day.
      - OB lab panel which must include all 8 elements listed below:
        - ❖ Hematocrit/ Differential WBC count/ Platelet count/ Hepatitis B surface antigen/ Rubella antibody/ Syphilis test/ RBC antibody screen/ RH and ABO blood typing.
      - TORCH antibody panel.
      - Rubella antibody test/ titer with an Rh incompatibility (ABO/Rh) blood typing.

- Ultrasound of pregnant uterus.

- Postpartum care visit documentation in the medical record must include a note indicating a date which is on or between 7 and 84 days after delivery **AND** one of the following.  
(The delivery date is used to determine the postpartum window.)
  - This visit **MUST** be with an OB/GYN, primary care physician (PCP), or another prenatal type of practitioner.
  - Any of the following meet's criteria for a postpartum visit:
    - Notation of Postpartum care such as PP Care/PP check/6-Week Check.
    - Pelvic examination.
    - Perineal or Cesarean incision/wound check related to delivery.
    - Evaluation of WT/BP/Breast and Abdomen. All four must be documented.
    - Glucose screening for members with gestational diabetes.
    - Screenings for any one the following items:
      - Depression/ Anxiety/ Tobacco use/ Substance use disorder/ Pre-existing mental health disorders.
    - Documentation of any one of the following:
      - Infant care OR Breastfeeding.
      - Resumption of intercourse, birth spacing, or family planning.
      - Sleep/fatigue.
      - Resumption of physical activity.
      - Attainment of health weight.

**Situations where members are removed from this measure:**

- Members who received hospice or died in the measurement year.
- The member did NOT have a live birth in the measure timeframe.

**HEDIS Coding Guidelines**

**Prenatal Care:**

**CPT:** 59400, 59425, 59426, 59510, 59610, 59618, 99500

**CPT II:** 0500F-0502F

**HCPCS:** H1000-H1005

**ICD-10:** Z34.80-Z34.83, Z34.90-Z34.93, Z36.9

**Postpartum Care:**

**CPT:** 99501 **CPT II:** 0503F **HCPCS:** G0101

**ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

## PRS-E: Prenatal Immunization Status

### Description

Percentage of deliveries in the measurement year in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

### Measure Information

- Influenza Status:
  - Deliveries where members received an adult influenza vaccine on or between July 1<sup>st</sup> of the year prior to the measurement period and the delivery date.
  - Deliveries where members had anaphylaxis due to the influenza vaccine.
- Tdap Status:
  - Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date).
  - Deliveries where members had any of the following:
    - Anaphylaxis OR Encephalitis due to the diphtheria, tetanus, or pertussis vaccine on or before the delivery date.
- Combination Status:
  - Deliveries that where the member had both the influenza and Tdap vaccines.

### **Situations where members are removed from this measure:**

- Members who received hospice care or died in the measurement year.
- Member delivered at less than 37 weeks gestation.

### HEDIS Coding Guidelines

#### **CPT/HCPCS:**

##### **Influenza:**

90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756

##### **Tdap:**

Tdap: 90715

| Document Name                             | Name            | Date Updated | Comments     |
|-------------------------------------------|-----------------|--------------|--------------|
| Adult Measure Practitioner Clinical Guide | Patricia Carter | 10/1/2024    | Date Created |
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## HEDIS Clinical Team contact information:

**Web address:**