



HEDIS Benchmarks and Coding Guidelines for Quality Care

Electronic Clinical Data Systems



Healthy Blue



Missouri | Healthy Blue | MO HealthNet Managed Care (Medicaid)

<https://provider.healthybluemo.com>

Healthy Blue is a Medicaid product offered by Missouri Care, Incorporated, a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Incorporated and administered in the Kansas City service region by Missouri Care, Incorporated in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Incorporated and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross Blue Shield Association.

MOHB-CD-069505-24-CPN69339 January 2025

Table of contents

Electronic Clinical Data Systems	3
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	5
Adult Immunization Status (AIS-E).....	6
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	8
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E).....	9
Blood Pressure Control for Patients with Hypertension (BPC-E).....	12
Cervical Cancer Screening (CCS-E)	14
Childhood Immunization Status (CIS-E)	15
Colorectal Cancer Screening (COL-E)	17
Documented Assessment After Mammogram (DBM-E).....	18
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E).....	19
Depression Remission or Response for Adolescents and Adults (DRR-E)	20
Follow-Up After Abnormal Mammogram Assessment (FMA-E)	22
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E).....	24
Immunizations for Adolescents (IMA-E).....	26
Postpartum Depression Screening and Follow-Up (PDS-E)	28
Prenatal Depression Screening and Follow-up (PND-E)	31
Prenatal Immunization Status (PRS-E).....	33
Social Need Screening and Intervention (SNS-E).....	34
Appendix	40
Adult Immunization Status (AIS-E).....	41
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E).....	46
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E).....	52
Breast Cancer Screening (BCS-E).....	56
Blood Pressure Control for Patients With Hypertension (BPC-E)	60
Cervical Cancer Screening (CCS-E).....	62
Childhood Immunization Status (CIS-E)	65
Colorectal Cancer Screening (COL-E)	83
Documented Assessment After Mammogram (DBM-E).....	86
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E).....	87
Depression Remission or Response for Adolescents and Adults (DRR-E).....	90
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	92
Follow-Up After Abnormal Mammogram Assessment (FMA-E).....	93
Postpartum Depression Screening and Follow-Up (PDS-E)	96
Prenatal Depression Screening and Follow-up (PND-E).....	97
Prenatal Immunization Status (PRS-E)	100
Additional codes	102
Social Need Screening and Intervention (SNS-E)	104

Electronic Clinical Data Systems

HEDIS® is a widely used set of performance measures developed and maintained by NCQA. These are used to drive improvement efforts surrounding best practices.

The HEDIS quality measures reported using the Electronic Clinical Data Systems (ECDS) inspire innovative use of electronic clinical data to document high-quality patient care that demonstrates commitment to evidence-based practices. Organizations that report HEDIS using ECDS encourage the electronic exchange of the information needed to provide high-quality services, ensuring that the information reaches the right people at the right time:

- ECDS reporting is part of the National Committee for Quality Assurance’s (NCQA) larger strategy to enable a digital quality system and is aligned with the industry’s move to digital measures.
- The ECDS reporting standard provides a method to collect and report structured electronic clinical data for HEDIS quality measurement and improvement.
- According to the NCQA, the HEDIS hybrid data collection (medical record collection) will be phased-out in the coming years.
- Health plans and healthcare providers will need to take advantage of electronic data streams to ensure accurate reporting of measures that require data not typically found in claims.
- CPT® Category II codes can be used for performance measurement. The use of the CPT II decreases the need for record abstraction and chart review.
- CVX codes (vaccine administered code set) represent the type of product used in an immunization. Every immunization that used a given type of product will have the same CVX, regardless of who received it.
- Logical Observation Identifiers Names and Codes (LOINC) and SNOMED CT codes (supports the development of comprehensive high-quality clinical content in electronic health records) do not appear on claims and are quickly becoming vital to HEDIS reporting, especially for ECDS measures:
 - LOINC codes — while typically associated with lab data, there are several behavioral health screenings that can only be represented by LOINC codes for the purposes of HEDIS reporting and can be extracted from electronic medical record (EMR) systems.
 - SNOMED CT codes represent both diagnoses and procedures as well as clinical findings. SNOMED CT codes are the industry standard for classifying clinical data in EMR systems and can be extracted from EMR systems.
 - Because LOINC codes and SNOMED CT codes can only be obtained through supplemental data feeds, it is important that health plans and the provider community embrace the sharing of these EMR data to ensure the quality of care our members are receiving.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Helpful tips:

- Utilize this booklet as a reference to understand the ECDS measures and the coding associated with electronic data transmission.
- Contact your health plan representative to establish an electronic data transfer with the plan if your organization does not already have one.

- Make full use of CPT II codes to submit care quality findings, many HEDIS gaps could be closed via claims if CPT II codes were fully utilized.
- Ensure the EMR systems are set up to link the clinical and behavior health entries to LOINC codes and SNOMED CT codes:
 - Ensure that the extracts are inclusive of LOINC codes for BH screenings among other things and SNOMED CT codes.

Our Supplemental Data team is here to help.

For additional support in submitting supplemental data for ECDS measures, send inquiries to supplementaldata@wellpoint.com.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

This measure looks at the percentage of children ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10-month) period, one of which was within 30 days of when the first ADHD medication was dispensed during the measurement year.

Two rates are reported:

- Initiation phase: the percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
- Continuation and maintenance (C&M) phase: the percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

Record your efforts:

When prescribing a new ADHD medication:

- Be sure to schedule a follow-up visit right away — within 30 days of ADHD medication initially prescribed or restarted after a 120-day break.
- Schedule follow-up visits while members are still in the office.
- Have your office staff call members at least three days before appointments.
- After the initial follow-up visits, schedule at least two more office visits in the next nine months to monitor patients' progress.
- Be sure that follow-up visits include the diagnosis of ADHD.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year
- Members with a diagnosis of narcolepsy any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS code 81)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Adult Immunization Status (AIS-E)

This measure looks at 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 and pneumococcal and hepatitis B during the measurement year.

Record your efforts:

Document the required age vaccines were received according to the time interval specified in the measure:

- Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period
- or*
- Members with anaphylaxis due to the influenza vaccine any time before or during the measurement period
- Members who received at least one Td vaccine or one Tdap vaccine between 9 years prior to the start of the measurement period and the end of the measurement period
- or*
- Members with a history of at least one of the following contraindications any time before or during the measurement period:
 - Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine.
 - Encephalitis due to the diphtheria, tetanus, or pertussis vaccine.
- Members who received 2 doses of the herpes zoster recombinant vaccine at least 28 days apart, on [Date] through the end of the measurement period
- or*
- Members with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period.
- Members who received at least one dose of an adult pneumococcal vaccine) on or after their 19th birthday and before or during the measurement period or members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period
- or*
- Members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.
- Members who received at least three doses of the childhood hepatitis B vaccine with different dates of service on or before their 19th birthday:

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

- One of the three vaccinations can be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth.
- Members who received a hepatitis B vaccine series on or after their 19th birthday, before or during the measurement period, 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 days of service.
- Members who had 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 result greater than 10 mIU/mL:
 - A test with a finding of immunity.
- Members with a history of hepatitis B illness any time before or during the measurement period. Do not include laboratory claims (POS 81).
- Members with anaphylaxis due to hepatitis B any time before or during the measurement period.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

This measure looks at the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during the measurement year. Three rates are reported:

- The percentage of children and adolescents on antipsychotics who received blood glucose testing (blood glucose or HbA1c)
- The percentage of children and adolescents on antipsychotics who received cholesterol testing (LDL-C or cholesterol)
- The percentage of children and adolescents on antipsychotics who received both blood glucose and cholesterol testing.

Record your efforts:

- Members who received at least one test for blood glucose or HbA1c during the measurement period
- Members who received at least one test for LDL-C or cholesterol during the measurement period
- Members who were compliant for both the blood glucose and cholesterol indicators:
 - At least one test for blood glucose or HbA1c
 - At least one test for LDL-C or cholesterol

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

This measure looks at the percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care during the measurement year:

- Unhealthy Alcohol Use Screening: the percentage of members who had a systematic screening for unhealthy alcohol use
- Follow-Up Care on Positive Screen: the percentage of members receiving brief counseling or other follow-up care within 60 days (2 months) of screening positive for unhealthy alcohol use

Record your efforts:

A standard assessment instrument that has been normalized and validated for the adult patient population to include *AUDIT*, *AUDIT-C*, and a *Single-Question Screen*. Screening requires completion of one or more instruments. The threshold for a positive finding is indicated below for each instrument:

Screening instrument	Total score LOINC codes	Positive finding
<i>Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument</i>	75624-7	Total score \geq 8
<i>Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument</i>	75626-2	Total score \geq 4 for men Total score \geq 3 for women
<i>Single-question screen (for men): “How many times in the past year have you had 5 or more drinks in a day?”</i>	88037-7	Response \geq 1
<i>Single-question screen (for women and all adults older than 65 years): “How many times in the past year have you had 4 or more drinks in a day?”</i>	75889-6	Response \geq 1

Any of the following on or up to 60 days after the first positive screen:

- Feedback on alcohol use and harms
- Identification of high-risk situations for drinking and coping strategies
- Increase the motivation to reduce drinking
- Development of a personal plan to reduce drinking
- Documentation of receiving alcohol misuse treatment

Exclusions:

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year
- Members with alcohol use disorder that starts during the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members with history of dementia any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS code 81).

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Breast Cancer Screening (BCS-E)

This HEDIS measure looks at members 50 to 74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer from October 1, two years prior to the measurement period through the end of the measurement period.

Record your efforts:

Include documentation of all types and methods of mammograms including:

- Screening
- Diagnostic
- Film
- Digital
- Digital breast tomosynthesis

In establishing health history with new members, please make sure you ask about when members last mammogram was performed, document at a minimum, year performed in your health history.

Gaps in care are not closed by the following, as they are performed as an adjunct to mammography:

- Breast ultrasounds
- MRIs
- Biopsies

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:
 - Bilateral mastectomy
 - Unilateral mastectomy with a bilateral modifier
 - Unilateral mastectomy found in clinical data with a bilateral qualifier value
 - History of bilateral mastectomy
- Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet *both* frailty and advanced illness criteria to be excluded.
- Members receiving palliative care any time during the measurement year
- Members who had an encounter for palliative anytime during the measurement year. Do not include laboratory claims (claims with POS code 81).

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

This measure looks at the percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.

Record your efforts:

Members who are 18-85 years old as of the last day of the measurement period who meet either of the following criteria:

- At least two outpatient visits, telephone visits, e-visits or virtual check-ins on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.
- At least one outpatient visit, telephone visit, e-visit or virtual check-in with a diagnosis of hypertension and at least one dispensed antihypertensive medication on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement period
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members with a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 - Confirm the stay was for nonacute care based on the presence of a nonacute code the claim.
 - Identify the admission date for the stay
- Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to the last day of the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members with a procedure that indicates ESRD: dialysis or kidney transplant any time during the member's history on or prior to the last day of the measurement period.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

- Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members 66 to 80 years of age as of the last day of the measurement period (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:
 - Frailty. At least two indications of with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81).
 - Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period:
 - Advanced illness on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
 - Dispensed dementia medication.
- Members 81 years of age and older as of the last day of the measurement period (all product lines) with at least two indications of frailty with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81).

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Cervical Cancer Screening (CCS-E)

This measure looks at 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 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Record your efforts:

Make sure your medical records reflect:

- The date when the cervical cytology was performed.
- The results or findings
- Notes in patient's chart if patient has a history of hysterectomy:
 - Complete details if it was a complete, total, or radical abdominal, vaginal, or unspecified hysterectomy with no residual cervix; also, document history of cervical
 - agenesis or acquired absence of cervix. Include, at a minimum, the year the surgical procedure was performed.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year
- Hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year
- Cervical agenesis or acquired absence of cervix any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care any time during the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members with Sex Assigned at Birth of Male at any time during the patient's history.

Childhood Immunization Status (CIS-E)

The percentage of children turning 2 years of age who had who had appropriate doses of the following vaccines on or before their second birthday:

- At least 4 diphtheria, tetanus, and acellular pertussis, *DTaP* vaccine with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
 - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine
 - Encephalitis due to the diphtheria, tetanus or pertussis vaccine
- At least 3 polio, *IPV* vaccine with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
 - Anaphylaxis due to the IPV vaccine
- At least 1 measles, mumps and rubella, *MMR* vaccine (can only be given on or between first and second birthday to close the gap)
 - All of the following any time on or before the child's second birthday (on the same or different date of service). Do not include laboratory claims (claims with POS code 81):
 - History of measles illness
 - – History of mumps illness
 - – History of rubella illness
 - Anaphylaxis due to the MMR vaccine on or before the child's second birthday.
- At least 3 haemophilus influenza type B, *Hib* vaccine with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
 - Anaphylaxis due to the HiB vaccine
- At least 3 hepatitis B, *HepB* vaccine (One of the three vaccinations can be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends 7 days after the date of birth.)
 - History of hepatitis B illness Do not include laboratory claims (claims with POS code 81).
 - Anaphylaxis due to hepatitis B vaccine
- At least 1 chicken pox, *VZV* vaccine with a date of service on or between first and second birthdays:
 - History of varicella zoster (for example, chicken pox) illness on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).
 - Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the child's second birthday
- At least 4 pneumococcal conjugate, *PCV* vaccine with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
 - Anaphylaxis due to the pneumococcal vaccine
- At least 1 hepatitis A, *HepA* vaccine with a date of service on or between first and second birthday:
 - History of hepatitis A illness on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).
 - Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the child's second birthday.
- At least 2 two-dose rotavirus, *RV* vaccine, on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

- At least three doses of the three-dose rotavirus, *RV* vaccine on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least one dose of the two-dose rotavirus, *RV* vaccine and at least two doses of the three-dose rotavirus, *RV* vaccine all on different dates of service, on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
 - Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103) on or before the child's second birthday.
- At least 2 influenza, *Flu* vaccine with different dates of service. Do not count a vaccination administered prior to 180 days after birth.
 - An influenza vaccination recommended for children 2 years and older (for example, LAIV) administered on the child's second birthday meets criteria for one of the two required vaccinations.
 - Anaphylaxis due to the influenza vaccine

Record your efforts:

Once you give our members their needed immunizations, let us and the state know by:

- Recording the immunizations in your state registry.
- Documenting the immunizations (historic and current) within medical records to include:
 - A note indicating the name of the specific antigen and the date of the immunization.
 - The certificate of immunization prepared by an authorized health care provider or agency.
 - Parent refusal, documented history of anaphylactic reaction to serum/vaccinations, illnesses, or seropositive test result.
 - The date of the first hepatitis B vaccine given at the hospital and name of the hospital if available.
 - A note that the *member is up to date* with all immunizations but does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members who had a contraindication to a childhood vaccine on or before their second birthday.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Colorectal Cancer Screening (COL-E)

This measure looks at the percentage of members 45 to 75 years of age who had appropriate screening for colorectal cancer.

Record your efforts:

- Members with one or more screenings for colorectal cancer. Any of the following meet criteria:
 - Fecal occult blood test (FOBT) during the measurement period
 - Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
 - Colonoscopy during the measurement period or the 9 years prior to the measurement period
 - CT colonography during the measurement period or the 4 years prior to the measurement period
 - Stool DNA (sDNA) with fecal immunochemical test (FIT) test during the measurement period or the 2 years prior to the measurement period

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded.
- Members receiving palliative care any time during the measurement year.
- Members who had an encounter for palliative care any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who had colorectal cancer any time during the member's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who had a total colectomy any time during the member's history through December 31 of the measurement period.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Documented Assessment After Mammogram (DBM-E)

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

Record your efforts:

The National Comprehensive Cancer Network (NCCN) provides breast cancer screening follow-up and diagnostic guidelines based on the ACR's BI-RADS assessment categories.

- BI-RADS 0: Incomplete- Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison, as needing additional imaging.
- Patients with BI-RADS Category 1: Negative, and Category 2: Benign, are recommended for continued routine screening.
- Patients with BI-RADS Category 3: Probably Benign, are recommended for mammography surveillance.
- Patients with BI-RADS Categories 4: Suspicious, and 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.
- Patients with Category 6: Known Biopsy- Proven

[nccn.org/](https://www.nccn.org/)

Exclusions:

- Members who die any time during the measurement period.
- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

This measure looks at the percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter with a *Patient Health Questionnaire-9 (PHQ-9)* score present in their record in the same assessment period as the encounter.

Record your efforts:

The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.

The measurement period is divided into three assessment periods with specific dates of service:

- *Assessment Period 1*: January 1 to April 30
- *Assessment Period 2*: May 1 to August 31
- *Assessment Period 3*: September 1 to December 31

The measure allows the use of two *PHQ-9* assessments. Selection of the appropriate assessment should be based on the member's age:

- *PHQ-9*: 12 years of age and older
- *PHQ-9 Modified for Teens*: 12 to 17 years of age

The *PHQ-9* assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal.

Exclusions:

- Members with any of the following at any time during member's history through the end measurement period. Do not include laboratory claims (claims with POS code 81):
 - Bipolar disorder
 - Personality disorder
 - Psychotic disorder
 - Pervasive developmental disorder
- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

Depression Remission or Response for Adolescents and Adults (DRR-E)

This measure looks at the percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120 to 240 days (4 to 8 months) of the elevated score during the measurement year.

- Follow-Up PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within 120 to 240 days (4 to 8 months) after the initial elevated PHQ-9 score.
- Depression Remission. The percentage of members who achieved remission within 120 to 240 days (4 to 8 months) after the initial elevated PHQ-9 score.
- Depression Response. The percentage of members who showed response within 120 to 240 days (4 to 8 months) after the initial elevated PHQ-9 score.

Record your efforts:

The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period:

- May 1 of the year prior to the measurement period through December 31 of the measurement period
- May 1 of the year prior to the measurement period through April 30 of the measurement period
- The 120- to 240-day period after the index episode start date.
- Index episode start date: The earliest date during the intake period when a member has a diagnosis of major depression or dysthymia *and* a *PHQ-9* total score > 9 documented within a 31 day period, including and around (15 days before and 15 days after) an interactive outpatient encounter with a diagnosis of major depression or dysthymia.

The measure allows the use of two *PHQ-9* assessments. Selection of the appropriate assessment should be based on the member's age:

- *PHQ-9*: 12 years of age and older
- *PHQ-9 Modified for Teens*: 12 to 17 years of age

The *PHQ-9* assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

- Members with any of the following any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS code 81):
 - Bipolar disorder
 - Personality disorder
 - Psychotic disorder
 - Pervasive developmental disorder

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Follow-Up After Abnormal Mammogram Assessment (FMA-E)

This measure looks at the percentage of episodes for members 40–74 years of age with inconclusive or high-risk BI-RADS assessments who received appropriate follow-up within 90 days of the assessment.

Record your efforts:

High-risk and inconclusive BI-RADS assessment during the Intake Period that 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 episode date (91 days total).
- An inconclusive BI-RADS assessment (BI-RADS 0: Incomplete — Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison), that received a mammogram or ultrasound on or within 90 days after the episode date (91 days total).

The National Comprehensive Cancer Network (NCCN) provides breast cancer screening follow-up and diagnostic guidelines based on the ACR's BI-RADS assessment categories.

- BI-RADS 0: Incomplete- Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison, as needing additional imaging.
- Patients with BI-RADS Category 1: Negative, and Category 2: Benign, are recommended for continued routine screening.
- Patients with BI-RADS Category 3: Probably Benign, are recommended for mammography surveillance.
- Patients with BI-RADS Categories 4: Suspicious, and 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.
- Patients with Category 6: Known Biopsy- Proven

nccn.org/

Exclusions:

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

This measure looks at the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care during the measurement year:

- **Depression Screening.** The percentage of members who were screened for clinical depression using a standardized instrument.
- **Follow-Up on Positive Screen.** The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

Record your efforts:

The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.

This measure requires the use of an age-appropriate screening instrument. The member’s age is used to select the appropriate depression screening instrument.

Depression screening instrument:

- A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for adolescents (≤ 17 years)	Total score LOINC codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire Modified for Teens (PHQ- 9M)</i> [®]	89204-2	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Center for Epidemiologic Studies Depression Scale – Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	99046-5	Total score ≥ 10
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60

1 Brief screening instrument. All other instruments are full-length.

2 Proprietary; may be cost or licensing requirement associated with use.

Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8

Instruments for adults (18+ years)	– Total score LOINC codes	Positive finding
<i>Beck Depression Inventory (BDI-II)</i>	89209-1	Total score ≥ 20
<i>Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Duke Anxiety-Depression Scale (DUKE-AD)²</i>	90853-3	Total score ≥ 30
<i>Geriatric Depression Scale Short Form (GDS)¹</i>	48545-8	Total score ≥ 5
<i>Geriatric Depression Scale Long Form (GDS)</i>	48544-1	Total score ≥ 10
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	99046-5	Total score ≥ 10
<i>My Mood Monitor (M-3)[®]</i>	71777-7	Total score ≥ 5
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
<i>Clinically Useful Depression Outcome Scale (CUDOS)</i>	90221-3	Total score ≥ 31

1 Brief screening instrument. All other instruments are full-length.

2 Proprietary; may be cost or licensing requirement associated with use.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members with depression that starts during the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunizations for Adolescents (IMA-E)

This measure reviews members 13 years of age 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. The measure calculates a rate for each vaccine and two combination rates.

Vaccines administered on or before their 13th birthday:

- At least one meningococcal vaccine with the date of service on or between 11th and 13th birthdays.
- Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday.
- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthdays
- Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
- Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
- At least two doses of HPV vaccine with on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart.
- At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday.

Record your efforts:

Immunization information obtained from the medical record:

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered
- Document in the medical record parent or guardian refusal

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

This measure assesses the percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care during the measurement year:

- Depression Screening. The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (7 to 84 days following the delivery date).
- Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding (31 total days).
 - Any of the following on or up to 30 days after the first positive screen:
 - An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
 - A depression care management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
 - A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
 - A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82). Do not include laboratory claims (claims with POS code 81).
 - A dispensed antidepressant medication
 - Or
 - Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (in other words, a negative screen) on the same day as a positive screen on a brief screening instrument

Record your efforts:

The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period:

- The delivery date through 60 days following the date of delivery
- Include deliveries that occur in any setting
- Determine the delivery date using the date as of the end of the delivery
- If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.
 - Note: Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and participation before removing multiple deliveries in a 180-day period.

A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for adolescents (≤ 17 years)	Total score LOINC codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire Modified for Teens (PHQ-9M)</i> [®]	89204-2	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	99046-5	Total score ≥ 10
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Beck Depression Inventory (BDI-II)</i>	89209-1	Total score ≥ 20
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Duke Anxiety-Depression Scale (DUKE-AD)</i> ^{®2}	90853-3	Total score ≥ 30
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	99046-5	Total score ≥ 10
<i>My Mood Monitor (M-3)</i> [®]	71777-7	Total score ≥ 5
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
<i>Clinically Useful Depression Outcome Scale (CUDOS)</i>	90221-3	Total score ≥ 31

1 Brief screening instrument. All other instruments are full-length.

2 Proprietary; may be cost or licensing requirement associated with use.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

This measure assesses the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care during the measurement year:

- **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
- **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Record your efforts:

The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period:

- 28 days prior to the delivery date through the delivery date
- A pregnancy episode in which the delivery date occurs during the measurement period
- Include deliveries that occur in any setting.
- Determine the delivery date using the date as of the end of the delivery.
- If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.
 - Note: Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and participation before removing multiple deliveries in a 180-day period.

A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for adolescents (≤ 17 years)	Total score LOINC codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire Modified for Teens (PHQ-9M)</i> [®]	89204-2	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	99046-5	Total score ≥ 10
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3

Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
<i>Beck Depression Inventory-Fast Screen (BDI-FS)^{1,2}</i>	89208-3	Total score ≥ 8
<i>Beck Depression Inventory (BDI-II)</i>	89209-1	Total score ≥ 20
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Duke Anxiety-Depression Scale (DUKE-AD)²</i>	90853-3	Total score ≥ 30
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	99046-5	Total score ≥ 10
<i>My Mood Monitor (M-3)[®]</i>	71777-7	Total score ≥ 5
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
<i>Clinically Useful Depression Outcome Scale (CUDOS)</i>	90221-3	Total score ≥ 31

1 Brief screening instrument. All other instruments are full-length.

2 Proprietary; may be cost or licensing requirement associated with use.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Deliveries that occurred at less than 37 weeks gestation. Length of gestation in weeks is identified by one of two methods:
 - Gestational age assessment (SNOMED CT code 412726003; value <37 weeks), or
 - Gestational age diagnosis

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Prenatal Immunization Status (PRS-E)

This measure assesses the percentage of deliveries in the measurement period (January 1 to December 31) in which women had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Record your efforts:

The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period:

- 28 days prior to the delivery date through the delivery date
- A pregnancy episode in which the delivery date occurs during the measurement period
- Include deliveries that occur in any setting.
- Determine the delivery date using the date as of the end of the delivery.
- If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable, include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.
 - Note: Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and participation before removing multiple deliveries in a 180-day period.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Deliveries that occurred at less than 37 weeks gestation. Length of gestation in weeks is identified by one of two methods:
 - Gestational age assessment (SNOMED CT code 412726003; value <37 weeks), or
 - Gestational age diagnosis (Weeks of Gestation Less Than 37 Value Set).

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Social Need Screening and Intervention (SNS-E)

This measure assesses the percentage of members who were screened, using prespecified instruments, at least once during the measurement period (January 1-December 31) for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive:

- Food Screening. The percentage of members who were screened for food insecurity.
- Food Intervention. The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity.
- Housing Screening. The percentage of members who were screened for housing instability, homelessness or housing inadequacy.
- Housing Intervention. The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for housing instability, homelessness or housing inadequacy.
- Transportation Screening. The percentage of members who were screened for transportation insecurity.
- Transportation Intervention. The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for transportation insecurity.

Record your efforts:

- Food insecurity: Uncertain, limited, or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways.
- Housing instability: Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.
- Homelessness: Currently living in an environment that is not meant for permanent human habitation (for example, cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.
- Housing inadequacy: Housing does not meet habitability standards.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

- Transportation insecurity: Uncertain, limited or no access to safe, reliable, accessible, affordable, and socially acceptable transportation infrastructure and modalities necessary for maintaining one’s health, well-being, or livelihood.

Eligible screening instruments with thresholds for positive findings include:

Food insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form</i>	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
<i>Health Leads Screening Panel®1</i>	95251-5	LA33-6
<i>Hunger Vital Sign™1 (HVS)</i>	88124-3	LA19952-3
<i>Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1</i>	93031-3	LA30125-1
<i>Safe Environment for Every Kid (SEEK)®1</i>	95400-8	LA33-6
	95399-2	LA33-6
<i>U.S. Household Food Security Survey (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6
<i>U.S. Adult Food Security Survey (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6
<i>U.S. Child Food Security Survey (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6
<i>U.S. Household Food Security Survey—Six-Item Short Form (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Food insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>We Care Survey</i>	96434-6	LA32-8
<i>WellRx Questionnaire</i>	93668-2	LA33-6

Housing instability and homelessness instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	71802-3	LA31994-9
		LA31995-6
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	99550-6	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	71802-3	LA31994-9 LA31995-6
<i>Children’s Health Watch Housing Stability Vital Signs™1</i>	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
<i>Health Leads Screening Panel®1</i>	99550-6	LA33-6
<i>Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE)®1</i>	93033-9	LA33-6
	71802-3	LA30190-5
<i>We Care Survey</i>	96441-1	LA33-6
<i>WellRx Questionnaire</i>	93669-0	LA33-6

Housing inadequacy instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	96778-6	LA31996-4
		LA28580-1
		LA31997-2
		LA31998-0
		LA31999-8

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Housing inadequacy instruments	Screening item LOINC codes	Positive finding LOINC codes
		LA32000-4 LA32001-2
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form</i>	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
<i>Norwalk Community Health Center Screening Tool [NCHC]</i>	99134-9	LA33-6
	99135-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
Transportation insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	93030-5	LA33-6
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	99594-4	LA33-6
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form</i>	99594-4	LA33093-8 LA30134-3

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Transportation insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Comprehensive Universal Behavior Screen (CUBS)</i>	89569-8	LA29232-8 LA29233-6 LA29234-4
<i>Health Leads Screening Panel</i> ^{*1}	99553-0	LA33-6
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)—version 4.0 [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Discharge from Agency [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Resumption of Care [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Start of Care [CMS Assessment]	93030-5	LA30133-5 LA30134-3
<i>Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)</i> ^{*1}	93030-5	LA30133-5 LA30134-3
<i>PROMIS</i> ^{*1}	92358-1	LA30024-6 LA30026-1 LA30027-9
<i>WellRx Questionnaire</i>	93671-6	LA33-6

1 Proprietary; may be cost or licensing requirement associated with use.

Note: The SNS-E screening numerator counts only screenings that use instruments in the measure specification as identified by the associated LOINC code(s). Allowed screening instruments and LOINC codes for each social need domain are listed above.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Appendix

Coding for ECDS measures

There are many approved NCQA codes used to identify the services included in the measures listed below. The following are just a few of the approved codes. Please see the NCQA website for a complete list [ncqa.org/](https://www.ncqa.org/).

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

Description	CPT/HCPCS/POS
Outpatient POS	POS 03: School 05: Indian Health Service Free-standing Facility 07 - Tribal 638 Free-standing Facility 09 - Prison / Correctional Facility 11: Office 12: Home 13: Assisted Living Facility 14: Group Home 15: Mobile Unit 16: Temporary Lodging 17: Walk-in Retail Clinic 18: Place of Employment-Worksite 19: Off Campus-Outpatient Hospital 20: Urgent Care Facility 22: On-Campus Outpatient Hospital 33: Custodial Care Facility 49: Independent Clinic 50: Federally Qualified Health Center 71: Public Health Clinic 72: Rural Health Clinic
Health and Behavioral Assessment or Intervention	CPT 96156
Online Assessments	CPT 99422HCPCS G0071: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/POS
	patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only G2251: Brief communication technology-based service, e.g. for example, virtual check-in, by a qualified health carehealthcare professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion G2252: Brief communication technology-based service, e.g. for example virtual check-in, by a physician or other qualified health carehealthcare professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
Telehealth POS	POS 02: Telehealth Provided Other than in Patient’s Home 10: Telehealth Provided in Patient’s Home
Visit Setting Unspecified	CPT 90791, 90792, 90832, 90833, 90834, 90836, 90837, , 90839, 90840, , 90847, , 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Adult Immunization Status (AIS-E)

Immunization	CPT/HCPCS/CVX/SNOMED CTSNOMED CT
Adult Influenza Vaccine procedure	CPT 0, 90653, , , 90658, 90661, 90662, , 90674, , 90686, 90688, 90689, 90694, 90756 SNOMED CTSNOMED CT 86198006: Administration of vaccine product containing only Influenza virus antigen (procedure)
Adult Influenza Immunization	CVX 88: influenza virus vaccine, unspecified formulation 135: influenza, high dose seasonal, preservative-free 140: Influenza, seasonal, injectable, preservative free

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CTSNOMED CT
	141: Influenza, seasonal, injectable 144: seasonal influenza, intradermal, preservative free 150: Influenza, injectable, quadrivalent, preservative free 153: Influenza, injectable, Madin Darby Canine Kidney, preservative free 155: Seasonal, trivalent, recombinant, injectable influenza vaccine, preservative free 158: influenza, injectable, quadrivalent, contains preservative 166: influenza, intradermal, quadrivalent, preservative free, injectable 168: Seasonal trivalent influenza vaccine, adjuvanted, preservative free 171: Influenza, injectable, Madin Darby Canine Kidney, preservative free, quadrivalent 185: Seasonal, quadrivalent, recombinant, injectable influenza vaccine, preservative free 186: Influenza, injectable, Madin Darby Canine Kidney, quadrivalent with preservative 197: influenza, high-dose seasonal, quadrivalent, 0.7mL dose, preservative free 205: influenza, seasonal vaccine, quadrivalent, adjuvanted, 0.5mL dose, preservative free
Adult Pneumococcal Immunization	CVX 33: pneumococcal polysaccharide vaccine, 23 valent 109: pneumococcal vaccine, unspecified formulation 133: pneumococcal conjugate vaccine, 13 valent 152: Pneumococcal Conjugate, unspecified formulation 215: Pneumococcal conjugate vaccine 15-valent (PCV15), polysaccharide CRM197 conjugate, adjuvant, preservative free 216: Pneumococcal conjugate vaccine 20-valent (PCV20), polysaccharide CRM197 conjugate, adjuvant, preservative free
Adult Pneumococcal Vaccine Procedure	CPT 90670, 90671, 90677, 90732 HCPCS G0009: Administration of pneumococcal vaccine SNOMED CTSNOMED CT 12866006: Administration of vaccine product containing only Streptococcus pneumoniae antigen (procedure) 394678003: Administration of booster dose of vaccine product containing only Streptococcus pneumoniae antigen (procedure) 871833000: Subcutaneous injection of pneumococcal vaccine (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CTSNOMED CT
	1119366009: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, and 23F capsular polysaccharide antigens (procedure) 1119367000: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 11A, 12F, 14, 15B, 17F, 18C, 19A, 19F, 20, 22F, 23F, and 33F capsular polysaccharide antigens (procedure) 1119368005: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 4, 6B, 9V, 14, 18C, 19F, and 23F capsular polysaccharide antigens conjugated (procedure) 1296904008: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, and 23F capsular polysaccharide antigens conjugated (procedure) 434751000124102: Pneumococcal conjugate vaccination (procedure)
Influenza Virus LAIV Vaccine Procedure	CPT 90660, 90672 SNOMED CTSNOMED CT 787016008: Administration of vaccine product containing only Influenza virus antigen in nasal dose form (procedure)
Influenza Virus LAIV Immunization	CVX 111: influenza virus vaccine, live, attenuated, for intranasal use 149: influenza, live, intranasal, quadrivalent
Td Vaccine Procedure	CPT 90714 SNOMED CTSNOMED CT 73152006: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 312869001: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 395178008: Administration of first dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure) 395179000: Administration of second dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CTSNOMED CT
	395180002: Administration of third dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure)
	395181003: Administration of booster dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure)
	414619005: Administration of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	416144004: Administration of third dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	416591003: Administration of first dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	417211006: Administration of first booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	417384007: Administration of second booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	417615007: Administration of second dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	866161006: Administration of booster dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	866184004: Administration of second dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	866185003: Administration of first dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	866186002: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	866227002: Administration of booster dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	868266002: Administration of second dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CTSNOMED CT
	<p>868267006: Administration of first dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>868268001: Administration of third dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>870668008: Administration of third dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>870669000: Preschool administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>870670004: Preschool administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>871828004: Administration of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure)</p> <p>632481000119106: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens, less than 7 years of age (procedure)</p>
Td Immunization	<p>CVX</p> <p>09: tetanus and diphtheria toxoids, adsorbed, preservative free, for adult use (2 Lf of tetanus toxoid and 2 Lf of diphtheria toxoid)</p> <p>113: tetanus and diphtheria toxoids, adsorbed, preservative free, for adult use (5 Lf of tetanus toxoid and 2 Lf of diphtheria toxoid)</p> <p>115: tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine, adsorbed</p> <p>138: tetanus and diphtheria toxoids, not adsorbed, for adult use</p> <p>139: Td(adult) unspecified formulation</p>
Tdap Vaccine Procedure	<p>CPT</p> <p>90715</p> <p>SNOMED CTSNOMED CT</p> <p>390846000: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>412755006: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>412756007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CTSNOMED CT
	412757003: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 428251000124104: Tetanus, diphtheria, and acellular pertussis vaccination (procedure) 571571000119105: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
Herpes Zoster Live Vaccine Procedure	CPT 90736 SNOMED CTSNOMED CT 871898007: Administration of vaccine product containing only live attenuated Human alphaherpesvirus 3 antigen (procedure) 871899004: Administration of vaccine product containing only live attenuated Human alphaherpesvirus 3 antigen via subcutaneous route (procedure)
Herpes Zoster Recombinant Vaccine Procedure	CPT 90750 SNOMED CTSNOMED CT 722215002: Administration of vaccine product containing only Human alphaherpesvirus 3 antigen for shingles (procedure)
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

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

Description	CPT/CAT II/LOINC/SNOMED CTSNOMED CT
Cholesterol Lab Test	CPT 82465, 83718, , 84478 LOINC 2085-9: Cholesterol in HDL [Mass/volume] in Serum or Plasma 2093-3: Cholesterol [Mass/volume] in Serum or Plasma 2571-8: Triglyceride [Mass/volume] in Serum or Plasma 3043-7: Triglyceride [Mass/volume] in Blood

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CTSNOMED CT
	9830-1: Cholesterol. Total/Cholesterol in HDL [Mass Ratio] in Serum or Plasma SNOMED CTSNOMED CT
	14740000: Triglycerides measurement (procedure)
	28036006: High density lipoprotein cholesterol measurement (procedure)
	77068002: Cholesterol measurement (procedure)
	104583003: High density lipoprotein/total cholesterol ratio measurement (procedure)
	104584009: Intermediate density lipoprotein cholesterol measurement (procedure)
	104586006: Cholesterol/triglyceride ratio measurement (procedure)
	104784006: Lipids, triglycerides measurement (procedure)
	104990004: Triglyceride and ester in high density lipoprotein measurement (procedure)
	104991000: Triglyceride and ester in intermediate density lipoprotein measurement (procedure)
	121868005: Total cholesterol measurement (procedure)
	166832000: Serum high density lipoprotein cholesterol measurement (procedure)
	166838001: Serum fasting high density lipoprotein cholesterol measurement (procedure)
	166839009: Serum random high density lipoprotein cholesterol measurement (procedure)
	166849007: Serum fasting triglyceride measurement (procedure)
	166850007: Serum random triglyceride measurement (procedure)
	167072001: Plasma random high density lipoprotein cholesterol measurement (procedure)
	167073006: Plasma fasting high density lipoprotein cholesterol measurement (procedure)
	167082000: Plasma triglyceride measurement (procedure)
	167083005: Plasma random triglyceride measurement (procedure)
	167084004: Plasma fasting triglyceride measurement (procedure)
	271245006: Measurement of serum triglyceride level (procedure)
	275972003: Cholesterol screening (procedure)
	314035000: Plasma high density lipoprotein cholesterol measurement (procedure)
	315017003: Fasting cholesterol level (procedure)
	390956002: Plasma total cholesterol level (procedure)
	412808005: Serum total cholesterol measurement (procedure)
	412827004: Fluid sample triglyceride measurement (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CTSNOMED CT
	443915001: Measurement of total cholesterol and triglycerides (procedure)
Cholesterol Test Result or Finding	SNOMED CT 166830008: Serum cholesterol above reference range (finding) 166848004: Serum triglycerides above reference range (finding) 259557002: High density lipoprotein triglyceride (substance) 365793008: Finding of cholesterol level (finding) 365794002: Finding of serum cholesterol level (finding) 365795001: Finding of triglyceride level (finding) 365796000: Finding of serum triglyceride levels (finding) 439953004: Cholesterol/high density lipoprotein ratio above reference range (finding) 707122004: Triglyceride in high density lipoprotein subfraction 2 (substance) 707123009: Triglyceride in high density lipoprotein subfraction 3 (substance) 1162800007: Cholesterol esters within reference range (finding) 1172655006: Low density lipoprotein cholesterol below reference range (finding) 1172656007: Low density lipoprotein cholesterol within reference range (finding) 67991000119104: Serum cholesterol outside reference range (finding)
Glucose Lab Test	CPT 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 LOINC 10450-5: Glucose [Mass/volume] in Serum or Plasma --10 hours fasting 1492-8: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 0.5 g/kg glucose IV 1494-4: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 100 g glucose PO 1496-9: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 75 g glucose PO 1499-3: Glucose [Mass/volume] in Serum or Plasma --1 hour post 0.5 g/kg glucose IV 1501-6: Glucose [Mass/volume] in Serum or Plasma --1 hour post 100 g glucose PO 1504-0: Glucose [Mass/volume] in Serum or Plasma --1 hour post 50 g glucose PO 1507-3: Glucose [Mass/volume] in Serum or Plasma --1 hour post 75 g glucose PO 1514-9: Glucose [Mass/volume] in Serum or Plasma --2 hours post 100 g glucose PO

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CTSNOMED CT
	1518-0: Glucose [Mass/volume] in Serum or Plasma --2 hours post 75 g glucose PO
	1530-5: Glucose [Mass/volume] in Serum or Plasma --3 hours post 100 g glucose PO
	1533-9: Glucose [Mass/volume] in Serum or Plasma --3 hours post 75 g glucose PO
	1554-5: Glucose [Mass/volume] in Serum or Plasma --12 hours fasting
	1557-8: Fasting glucose [Mass/volume] in Venous blood
	1558-6: Fasting glucose [Mass/volume] in Serum or Plasma
	17865-7: Glucose [Mass/volume] in Serum or Plasma --8 hours fasting
	20436-2: Glucose [Mass/volume] in Serum or Plasma --2 hours post dose glucose
	20437-0: Glucose [Mass/volume] in Serum or Plasma --3 hours post dose glucose
	20438-8: Glucose [Mass/volume] in Serum or Plasma --1 hour post dose glucose
	20440-4: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post dose glucose
	2345-7: Glucose [Mass/volume] in Serum or Plasma
	26554-6: Glucose [Mass/volume] in Serum or Plasma --2.5 hours post dose glucose
	41024-1: Glucose [Mass/volume] in Serum or Plasma --2 hours post 50 g glucose PO
	49134-0: Glucose [Mass/volume] in Blood --2 hours post dose glucose
	6749-6: Glucose [Mass/volume] in Serum or Plasma --2.5 hours post 75 g glucose PO
	9375-7: Glucose [Mass/volume] in Serum or Plasma --2.5 hours post 100 g glucose PO
	SNOMED CTSNOMED CT
	22569008: Glucose measurement, serum (procedure)
	33747003: Glucose measurement, blood (procedure)
	52302001: Glucose measurement, fasting (procedure)
	72191006: Glucose measurement, plasma (procedure)
	73128004: Glucose measurement, random (procedure)
	88856000: Glucose measurement, 2 hour post prandial (procedure)
	104686004: Glucose measurement, blood, test strip (procedure)
	167086002: Serum random glucose measurement (procedure)
	167087006: Serum fasting glucose measurement (procedure)
	167088001: Serum 2-hr post-prandial glucose measurement (procedure)
	167095005: Plasma random glucose measurement (procedure)
	167096006: Plasma fasting glucose measurement (procedure)
	167097002: Plasma 2-hr post-prandial glucose measurement (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CTSNOMED CT
	250417005: Glucose concentration, test strip measurement (procedure)
	271061004: Random blood glucose measurement (procedure)
	271062006: Fasting blood glucose measurement (procedure)
	271063001: Lunch time blood sugar measurement (procedure)
	271064007: Supper time blood sugar measurement (procedure)
	271065008: Bedtime blood sugar measurement (procedure)
	275810004: BM stix glucose measurement (procedure)
	302788006: Post-prandial blood glucose measurement (procedure)
	302789003: Capillary blood glucose measurement (procedure)
	308113006: Self-monitoring of blood glucose (procedure)
	313474007: 60-minute blood glucose measurement (procedure)
	313545000: 120-minute blood glucose measurement (procedure)
	313546004: 90-minute blood glucose measurement (procedure)
	313624000: 150-minute blood glucose measurement (procedure)
	313626003: 60-minute plasma glucose measurement (procedure)
	313627007: 120-minute plasma glucose measurement (procedure)
	313628002: 150-minute plasma glucose measurement (procedure)
	313630000: 60-minute serum glucose measurement (procedure)
	313631001: 120-minute serum glucose measurement (procedure)
	313697000: 90-minute plasma glucose measurement (procedure)
	313698005: 90-minute serum glucose measurement (procedure)
	313810002: 150-minute serum glucose measurement (procedure)
	412928005: Blood glucose series (procedure)
	440576000: 240-minute plasma glucose measurement (procedure)
	443780009: Quantitative measurement of mass concentration of glucose in serum or plasma specimen 120 minutes after 75-gram oral glucose challenge (procedure)
	444008003: Quantitative measurement of mass concentration of glucose in serum or plasma specimen 6 hours after glucose challenge (procedure)
	444127006: Quantitative measurement of mass concentration of glucose in postcalorie fasting serum or plasma specimen (procedure)
Glucose Test Result or Finding	SNOMED CT 166890005: Random blood glucose within reference range (finding) 166891009: Random blood sugar below reference range (finding) 166892002: Random blood sugar above reference range (finding) 166914001: Blood glucose 0-1.4 mmol/L (finding) 166915000: Blood glucose 1.5-2.4 mmol/L (finding) 166916004: Blood glucose 2.5-4.9 mmol/L (finding) 166917008: Blood glucose 5-6.9 mmol/L (finding)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CTSNOMED CT
	166918003: Blood glucose 7-9.9 mmol/L (finding) 166919006: Blood glucose 10-13.9 mmol/L (finding) 166921001: Blood glucose within reference range (finding) 166922008: Blood glucose outside reference range (finding) 166923003: Blood glucose 14+ mmol/L (finding) 442545002: Random blood glucose outside reference range (finding) 444780001: Glucose in blood specimen above reference range (finding) 1179458001: Blood glucose below reference range (finding)
HbA1c Lab Test	CPT 83036, 83037 LOINC 17855-8: Hemoglobin A1c/Hemoglobin. Total in Blood by calculation 17856-6: Hemoglobin A1c/Hemoglobin. Total in Blood by HPLC 4548-4: Hemoglobin A1c/Hemoglobin. Total in Blood 4549-2: Hemoglobin A1c/Hemoglobin. Total in Blood by Electrophoresis 96595-4: Hemoglobin A1c/Hemoglobin. Total in DBS SNOMED CTSNOMED CT 43396009: Hemoglobin A1c measurement (procedure) 313835008: Hemoglobin A1c measurement aligned to the Diabetes Control and Complications Trial (procedure)
HbA1c Test Result or Finding	CPT 83036, 83037 CAT II 3044F: Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM) 3046F: Most recent hemoglobin A1c level greater than 9.0% (DM) 3051F: Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM) 3052F: Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM) SNOMED CTSNOMED CT 451051000124101: Hemoglobin A1c less than 77 percent % indicating good diabetic control (finding) 451061000124104: Hemoglobin A1c greater than nine percent indicating poor diabetic control (finding)
LDL-C Lab Test	CPT 80061, 83700, 83701, 83704, 83721 LOINC 12773-8: Cholesterol in LDL [Units/volume] in Serum or Plasma by Electrophoresis

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CTSNOMED CT
	13457-7: Cholesterol in LDL [Mass/volume] in Serum or Plasma by calculation
	18261-8: Cholesterol in LDL [Mass/volume] in Serum or Plasma ultracentrifugate
	18262-6: Cholesterol in LDL [Mass/volume] in Serum or Plasma by Direct assay
	2089-1: Cholesterol in LDL [Mass/volume] in Serum or Plasma
	49132-4: Cholesterol in LDL [Mass/volume] in Serum or Plasma by Electrophoresis
	55440-2: Cholesterol.in LDL (real) [Mass/volume] in Serum or Plasma by VAP
	96259-7: Cholesterol in LDL [Mass/volume] in Serum or Plasma by Calculated by Martin-Hopkins
	SNOMED CTSNOMED CT
	113079009: Low density lipoprotein cholesterol measurement (procedure)
	166833005: Serum low density lipoprotein cholesterol measurement (procedure)
	166840006: Serum fasting low density lipoprotein cholesterol measurement (procedure)
	166841005: Serum random low density lipoprotein cholesterol measurement (procedure)
	167074000: Plasma random low density lipoprotein cholesterol measurement (procedure)
	167075004: Plasma fasting low density lipoprotein cholesterol measurement (procedure)
	314036004: Plasma low density lipoprotein cholesterol measurement (procedure)

LDL-C Test Result or Finding CAT II
 3048F, 3049F, 3050F

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

Description	CPT/HCPCS/ICD10CM/ SNOMED CTSNOMED CT
Alcohol Counseling or Other Follow Up Care	CPT 99408, 99409
	HCPCS H0015: Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
	H0050: Alcohol and/or drug services, brief intervention, per 15 minutes
	H2036: Alcohol and/or other drug treatment program, per diem

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM/ SNOMED CTSNOMED CT
	SNOMED CTSNOMED CT
	20093000: Alcohol rehabilitation and detoxification (regime/therapy)
	23915005: Combined alcohol and drug rehabilitation and detoxification (regime/therapy)
	24165007: Alcoholism counseling (procedure)
	64297001: Detoxication psychiatric therapy for alcoholism (regime/therapy)
	386449006: Substance use treatment: alcohol withdrawal (regime/therapy)
	408945004: Alcohol abuse prevention (procedure)
	408947007: Alcohol abuse prevention education (procedure)
	408948002: Alcohol abuse prevention management (procedure)
	413473000: Counseling about alcohol consumption (procedure)
	707166002: Alcohol reduction program (regime/therapy)
	429291000124102: Alcohol brief intervention (procedure)

Alcohol Use Disorder	ICD10CM
	F10.10: Alcohol abuse, uncomplicated
	F10.120: Alcohol abuse with intoxication, uncomplicated
	F10.121: Alcohol abuse with intoxication delirium
	F10.129: Alcohol abuse with intoxication, unspecified
	F10.130: Alcohol abuse with withdrawal, uncomplicated
	F10.131: Alcohol abuse with withdrawal delirium
	F10.132: Alcohol abuse with withdrawal with perceptual disturbance
	F10.139: Alcohol abuse with withdrawal, unspecified
	F10.14: Alcohol abuse with alcohol-induced mood disorder
	F10.150: Alcohol abuse with alcohol-induced psychotic disorder with delusions
	F10.151: Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
	F10.159: Alcohol abuse with alcohol-induced psychotic disorder, unspecified
	F10.180: Alcohol abuse with alcohol-induced anxiety disorder
	F10.181: Alcohol abuse with alcohol-induced sexual dysfunction
	F10.182: Alcohol abuse with alcohol-induced sleep disorder
	F10.188: Alcohol abuse with other alcohol-induced disorder
	F10.20: Alcohol dependence, uncomplicated
	F10.220: Alcohol dependence with intoxication, uncomplicated
	F10.221: Alcohol dependence with intoxication delirium
	F10.229: Alcohol dependence with intoxication, unspecified
	F10.230: Alcohol dependence with withdrawal, uncomplicated
	F10.231: Alcohol dependence with withdrawal delirium
	F10.232: Alcohol dependence with withdrawal with perceptual disturbance
	F10.239: Alcohol dependence with withdrawal, unspecified

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM/ SNOMED CTSNOMED CT
	F10.24: Alcohol dependence with alcohol-induced mood disorder
	F10.250: Alcohol dependence with alcohol-induced psychotic disorder with delusions
	F10.251: Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
	F10.259: Alcohol dependence with alcohol-induced psychotic disorder, unspecified
	F10.26: Alcohol dependence with alcohol-induced persisting amnestic disorder
	F10.27: Alcohol dependence with alcohol-induced persisting dementia
	F10.280: Alcohol dependence with alcohol-induced anxiety disorder
	F10.281: Alcohol dependence with alcohol-induced sexual dysfunction
	F10.282: Alcohol dependence with alcohol-induced sleep disorder
	F10.288: Alcohol dependence with other alcohol-induced disorder
	F10.29: Alcohol dependence with unspecified alcohol-induced disorder
	F10.90: Alcohol use, unspecified, uncomplicated
	F10.920: Alcohol use, unspecified with intoxication, uncomplicated
	F10.921: Alcohol use, unspecified with intoxication delirium
	F10.929: Alcohol use, unspecified with intoxication, unspecified
	F10.930: Alcohol use, unspecified with withdrawal, uncomplicated
	F10.931: Alcohol use, unspecified with withdrawal delirium
	F10.932: Alcohol use, unspecified with withdrawal with perceptual disturbance
	F10.939: Alcohol use, unspecified with withdrawal, unspecified
	F10.94: Alcohol use, unspecified with alcohol-induced mood disorder
	F10.950: Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
	F10.951: Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
	F10.959: Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
	F10.96: Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
	F10.97: Alcohol use, unspecified with alcohol-induced persisting dementia
	F10.980: Alcohol use, unspecified with alcohol-induced anxiety disorder
	F10.981: Alcohol use, unspecified with alcohol-induced sexual dysfunction
	F10.982: Alcohol use, unspecified with alcohol-induced sleep disorder
	F10.988: Alcohol use, unspecified with other alcohol-induced disorder
	F10.99: Alcohol use, unspecified with unspecified alcohol-induced disorder
	K29.20: Alcoholic gastritis without bleeding
	K29.21: Alcoholic gastritis with bleeding

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM/ SNOMED CTSNOMED CT
	K70.10: Alcoholic hepatitis without ascites
	K70.11: Alcoholic hepatitis with ascites
	SNOMED CTSNOMED CT
	281004: Dementia associated with alcoholism (disorder)
	7052005: Alcohol hallucinosis (disorder)
	7200002: Alcoholism (disorder)
	8635005: Alcohol withdrawal delirium (disorder)
	15167005: Alcohol abuse (disorder)
	18653004: Alcohol intoxication delirium (disorder)
	29212009: Organic mental disorder caused by ingestible alcohol (disorder)
	34938008: Anxiety disorder caused by alcohol (disorder)
	41083005: Sleep disorder caused by ingestible alcohol (disorder)
	42344001: Psychosis caused by ingestible alcohol (disorder)
	53936005: Mood disorder caused by ingestible alcohol (disorder)
	61144001: Alcohol-induced psychotic disorder with delusions (disorder)
	66590003: Alcohol dependence (disorder)
	69482004: Korsakoff's psychosis (disorder)
	73097000: Alcohol amnestic disorder (disorder)
	78524005: Alcohol-induced sexual dysfunction (finding)
	85561006: Alcohol withdrawal syndrome without complication (disorder)
	87810006: Megaloblastic anemia due to alcoholism (disorder)
	191471000: Korsakov's alcoholic psychosis with peripheral neuritis (disorder)
	191475009: Chronic alcoholic brain syndrome (disorder)
	191476005: Alcohol withdrawal hallucinosis (disorder)
	191478006: Alcoholic paranoia (disorder)
	191480000: Alcohol withdrawal syndrome (disorder)
	191811004: Continuous chronic alcoholism (disorder)
	191812006: Episodic chronic alcoholism (disorder)
	191813001: Chronic alcoholism in remission (disorder)
	191882002: Nondependent alcohol abuse, continuous (disorder)
	191883007: Nondependent alcohol abuse, episodic (disorder)
	191884001: Nondependent alcohol abuse in remission (disorder)
	231467000: Absinthe addiction (disorder)
	268645007: Nondependent alcohol abuse (disorder)
	284591009: Persistent alcohol abuse (disorder)
	713583005: Mild alcohol dependence (disorder)
	713862009: Severe alcohol dependence (disorder)
	714829008: Moderate alcohol dependence (disorder)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM/ SNOMED CTSNOMED CT
	723926008: Perceptual disturbances and seizures co-occurrent and due to alcohol withdrawal (disorder)
	723927004: Psychotic disorder caused by alcohol with schizophreniform symptoms (disorder)
	723928009: Mood disorder with depressive symptoms caused by alcohol (disorder)
	723929001: Mood disorder with manic symptoms caused by alcohol (disorder)
	723930006: Mood disorder with mixed manic and depressive symptoms caused by alcohol (disorder)
	97571000119109: Thrombocytopenia co-occurrent and due to alcoholism (disorder)
	135311000119100: Insomnia caused by alcohol (disorder)
	288031000119105: Alcohol induced disorder co-occurrent and due to alcohol dependence (disorder)
	10741871000119101: Alcohol dependence in pregnancy (disorder)
	10755041000119100: Alcohol dependence in childbirth (disorder)

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Breast Cancer Screening (BCS-E)

Description	CPT/LOINC/SNOMED CTSNOMED CT
Mammography	CPT , , 77063, 77065, 77066, 77067 LOINC 24604-1: MG Breast Diagnostic Limited Views 24605-8: MG Breast Diagnostic 24606-6: MG Breast Screening 24610-8: MG Breast Limited Views 26175-0: MG Breast - bilateral Screening 26176-8: MG Breast - left Screening 26177-6: MG Breast - right Screening 26287-3: MG Breast - bilateral Limited Views 26289-9: MG Breast - left Limited Views 26291-5: MG Breast - right Limited Views 26346-7: MG Breast - bilateral Diagnostic 26347-5: MG Breast - left Diagnostic 26348-3: MG Breast - right Diagnostic 26349-1: MG Breast - bilateral Diagnostic Limited Views 26350-9: MG Breast - left Diagnostic Limited Views

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/LOINC/SNOMED CTSNOMED CT
	26351-7: MG Breast - right Diagnostic Limited Views
	36319-2: MG Breast 4 Views
	36625-2: MG Breast Views
	36626-0: MG Breast - bilateral Views
	36627-8: MG Breast - left Views
	36642-7: MG Breast - left 2 Views
	36962-9: MG Breast Axillary
	37005-6: MG Breast - left Magnification
	37006-4: MG Breast - bilateral MLO
	37016-3: MG Breast - bilateral Rolled Views
	37017-1: MG Breast - left Rolled Views
	37028-8: MG Breast Tangential
	37029-6: MG Breast - bilateral Tangential
	37030-4: MG Breast - left Tangential
	37037-9: MG Breast True lateral
	37038-7: MG Breast - bilateral True lateral
	37052-8: MG Breast - bilateral XCCL
	37053-6: MG Breast - left XCCL
	37539-4: MG Breast Grid Views
	37542-8: MG Breast Magnification Views
	37543-6: MG Breast - bilateral Magnification Views
	37551-9: MG Breast Spot Views
	37552-7: MG Breast - bilateral Spot Views
	37553-5: MG Breast - left Spot Views compression
	37554-3: MG Breast - bilateral Magnification and Spot
	37768-9: MG Breast - right 2 Views
	37769-7: MG Breast - right Magnification and Spot
	37770-5: MG Breast - right Tangential
	37771-3: MG Breast - right True lateral
	37772-1: MG Breast - right XCCL
	37773-9: MG Breast - right Magnification
	37774-7: MG Breast - right Views
	37775-4: MG Breast - right Rolled Views
	38070-9: MG Breast Views for implant
	38071-7: MG Breast - bilateral Views for implant
	38072-5: MG Breast - left Views for implant
	38090-7: MG Breast - bilateral Air gap Views
	38091-5: MG Breast - left Air gap Views
	38807-4: MG Breast - right Spot Views

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/LOINC/SNOMED CTSNOMED CT
	38820-7: MG Breast - right Views for implant
	38854-6: MG Breast - left Magnification and Spot
	38855-3: MG Breast - left True lateral
	39150-8: FFD mammogram Breast Views Post Localization
	39152-4: FFD mammogram Breast Diagnostic
	39153-2: FFD mammogram Breast Screening
	39154-0: FFD mammogram Breast - bilateral Diagnostic
	42168-5: FFD mammogram Breast - right Diagnostic
	42169-3: FFD mammogram Breast - left Diagnostic
	42174-3: FFD mammogram Breast - bilateral Screening
	42415-0: MG Breast - bilateral Views Post Wire Placement
	42416-8: MG Breast - left Views Post Wire Placement
	46335-6: MG Breast - bilateral Single view
	46336-4: MG Breast - left Single view
	46337-2: MG Breast - right Single view
	46338-0: MG Breast - unilateral Single view
	46339-8: MG Breast - unilateral Views
	46342-2: FFD mammogram Breast Views
	46350-5: MG Breast - unilateral Diagnostic
	46351-3: MG Breast - bilateral Displacement Views for Implant
	46354-7: FFD mammogram Breast - right Screening
	46355-4: FFD mammogram Breast - left Screening
	46356-2: MG Breast - unilateral Screening
	46380-2: MG Breast - unilateral Views for implant
	48475-8: MG Breast - bilateral Diagnostic for implant
	48492-3: MG Breast - bilateral Screening for implant
	69150-1: MG Breast - left Diagnostic for implant
	69251-7: MG Breast Views Post Wire Placement
	69259-0: MG Breast - right Diagnostic for implant
	72137-3: DBT Breast - right diagnostic
	72138-1: DBT Breast - left diagnostic
	72139-9: DBT Breast - bilateral diagnostic
	72140-7: DBT Breast - right screening
	72141-5: DBT Breast - left screening
	72142-3: DBT Breast - bilateral screening
	86462-9: DBT Breast - unilateral
	86463-7: DBT Breast - bilateral
	91517-3: DBT Breast - right diagnostic for implant
	91518-1: DBT Breast - left diagnostic for implant

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/LOINC/SNOMED CTSNOMED CT
	91519-9: DBT Breast - bilateral diagnostic for implant
	91520-7: DBT Breast - right screen for implant
	91521-5: DBT Breast - left screen for implant
	91522-3: DBT Breast - bilateral screen for implant
	103885-0: MG Breast - left Screening for implant
	103886-8: MG Breast - right Screening for implant
	103892-6: DBT Breast screening
	103893-4: MG Breast Screening for implant
	103894-2: MG Breast Diagnostic for implant
	SNOMED CTSNOMED CT
	12389009: Xeromammography (procedure)
	24623002: Screening mammography (procedure)
	43204002: Mammography of bilateral breasts (procedure)
	71651007: Mammography (procedure)
	241055006: Mammogram - symptomatic (procedure)
	241057003: Mammogram coned (procedure)
	241058008: Mammogram magnification (procedure)
	258172002: Stereotactic mammography (procedure)
	439324009: Mammogram in compression view (procedure)
	450566007: Digital breast tomosynthesis (procedure)
	709657006: Fluoroscopy of breast (procedure)
	723778004: Digital tomosynthesis of right breast (procedure)
	723779007: Digital tomosynthesis of left breast (procedure)
	723780005: Digital tomosynthesis of bilateral breasts (procedure)
	726551006: Contrast enhanced spectral mammography (procedure)
	833310007: Contrast enhanced dual energy spectral mammography (procedure)
	866234000: Mammography of breast implant (procedure)
	866235004: Mammography of bilateral breast implants (procedure)
	866236003: Mammography of left breast implant (procedure)
	866237007: Mammography of right breast implant (procedure)
	384151000119104: Screening mammography of bilateral breasts (procedure)
	392521000119107: Screening mammography of right breast (procedure)
	392531000119105: Screening mammography of left breast (procedure)
	566571000119105: Mammography of right breast (procedure)
	572701000119102: Mammography of left breast (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/LOINC/SNOMED CTSNOMED CT
CDC race and ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

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

Description	CPT/CVX/SNOMED CTSNOMED CT
Diastolic Blood Pressure	CAT II 3079F: Most recent diastolic blood pressure 80-89 mm Hg 3080F: Most recent diastolic blood pressure greater than or equal to 90 mm Hg 3078F: Most recent diastolic blood pressure less than 80 mm Hg LOINC 8514-2: Brachial artery - left Diastolic blood pressure 8515-9: Brachial artery - right Diastolic blood pressure 8496-2: Brachial artery Diastolic blood pressure 8462-4 : Diastolic blood pressure 75995-1: Diastolic blood pressure by Continuous non-invasive monitoring 89267-9: Diastolic blood pressure--lying in L-lateral position 8453-3: Diastolic blood pressure--sitting 8454-1: Diastolic blood pressure--standing 8455-8: Diastolic blood pressure--supine SNOMED CTSNOMED CT 271650006: Diastolic blood pressure (observable entity)

Diastolic Less Than 90	CAT II 3079F: Most recent diastolic blood pressure 80-89 mm Hg 3078F: Most recent diastolic blood pressure less than 80 mm Hg
------------------------	---

Systolic and Diastolic Result	CAT II 3079F: Most recent diastolic blood pressure 80-89 mm Hg 3080F: Most recent diastolic blood pressure greater than or equal to 90 mm Hg 3078F: Most recent diastolic blood pressure less than 80 mm Hg 3075F: Most recent systolic blood pressure 130-139 mm Hg 3077F: Most recent systolic blood pressure greater than or equal to 140 mm Hg
-------------------------------	---

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CTSNOMED CT
	3074F: Most recent systolic blood pressure less than 130 mm Hg
Systolic Blood Pressure	CAT II 3075F: Most recent systolic blood pressure 130-139 mm Hg 3077F: Most recent systolic blood pressure greater than or equal to 140 mm 3074F: Most recent systolic blood pressure less than 130 mm Hg LOINC 8546-4: Brachial artery - left Systolic blood pressure 8547-2: Brachial artery - right Systolic blood pressure 8508-4: Brachial artery Systolic blood pressure 8480-6: Systolic blood pressure 75997-7: Systolic blood pressure by Continuous non-invasive monitoring 89268-7: Systolic blood pressure--lying in L-lateral position 8459-0: Systolic blood pressure--sitting 8460-8: Systolic blood pressure--standing 8461-6: Systolic blood pressure--supine SNOMED CT 271649006: Systolic blood pressure (observable entity)
Systolic Less Than 140	CAT II 3075F: Most recent systolic blood pressure 130-139 mm Hg 3074F: Most recent systolic blood pressure less than 130 mm Hg
Essential Hypertension	ICD10CM I10: Essential (primary) hypertension SNOMED CTSNOMED CT 1201005: Benign essential hypertension (disorder) 71874008: Benign essential hypertension complicating AND/OR reason for care during childbirth (disorder) 23717007: Benign essential hypertension complicating AND/OR reason for care during pregnancy (disorder) 35303009: Benign essential hypertension complicating AND/OR reason for care during puerperium (disorder) 63287004: Benign essential hypertension in obstetric context (disorder) 59621000: Essential hypertension (disorder) 18416000: Essential hypertension complicating AND/OR reason for care during childbirth (disorder) 78808002: Essential hypertension complicating AND/OR reason for care during pregnancy (disorder)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CTSNOMED CT
	9901000: Essential hypertension complicating AND/OR reason for care during puerperium (disorder) 72022006: Essential hypertension in obstetric context (disorder) 19769006: High-renin essential hypertension (disorder) 371125006: Labile essential hypertension (disorder) 46481004: Low-renin essential hypertension (disorder) 78975002: Malignant essential hypertension (disorder) 40511000119107: Postpartum pre-existing essential hypertension (disorder) 429457004: Systolic essential hypertension (disorder)
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Cervical Cancer Screening (CCS-E)

Description	CPT/HCPCS/LOINC/SNOMED CTSNOMED CT
Cervical Cytology Lab Test	LOINC 10524-7: Microscopic observation [Identifier] in Cervix by Cyto stain 18500-9: Microscopic observation [Identifier] in Cervix by Cyto stain.thin prep 19762-4: General categories [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain 19764-0: Statement of adequacy [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain 19765-7: Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain 19766-5: Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain Narrative 19774-9: Cytology study comment Cervical or vaginal smear or scraping Cyto stain 33717-0 Cervical and/or vaginal cytology study 47527-7: Cytology report of Cervical or vaginal smear or scraping Cyto stain.thin prep 47528-5: Cytology report of Cervical or vaginal smear or scraping Cyto stain

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CTSNOMED CT
	SNOMED CTSNOMED CT
	171149006: Screening for malignant neoplasm of cervix (procedure)
	416107004: Cervical cytology test (procedure)
	417036008: Liquid based cervical cytology screening (procedure)
	440623000: Microscopic examination of cervical Papanicolaou smear (procedure)
	448651000124104: Microscopic examination of cervical Papanicolaou smear and Human papillomavirus deoxyribonucleic acid detection cotesting (procedure)
Cervical Cytology Result or Finding	SNOMED CT
	168406009: Severe dyskaryosis on cervical smear cannot exclude invasive carcinoma (finding)
	168407000: Cannot exclude glandular neoplasia on cervical smear (finding)
	168408005: Cervical smear - atrophic changes (finding)
	168410007: Cervical smear - borderline changes (finding)
	168414003: Cervical smear - inflammatory change (finding)
	168415002: Cervical smear - no inflammation (finding)
	168416001: Cervical smear - severe inflammation (finding)
	168424006: Cervical smear - koilocytosis (finding)
	250538001: Dyskaryosis on cervical smear (finding)
	269957009: Cervical smear result (finding)
	269958004: Cervical smear - negative (finding)
	269959007: Cervical smear - mild dyskaryosis (finding)
	269960002: Cervical smear - severe dyskaryosis (finding)
	269961003: Cervical smear - moderate dyskaryosis (finding)
	275805003: Viral changes on cervical smear (finding)
	281101005: Smear: no abnormality detected - no endocervical cells (finding)
	309081009: Abnormal cervical smear (finding)
	310841002: Cervical smear - mild inflammation (finding)
	310842009: Cervical smear - moderate inflammation (finding)
	416030007: Cervicovaginal cytology: Low grade squamous intraepithelial lesion (finding)
	416032004: Cervicovaginal cytology normal or benign (finding)
	416033009: Cervicovaginal cytology: High grade squamous intraepithelial lesion or carcinoma (finding)
	439074000: Dysplasia on cervical smear (finding)
	439776006: Cervical Papanicolaou smear positive for malignant neoplasm (finding)
	439888000: Abnormal cervical Papanicolaou smear (finding)
	441087007: Atypical squamous cells of undetermined significance on cervical Papanicolaou smear (finding)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CT SNOMED CT
	441088002: Atypical squamous cells on cervical Papanicolaou smear cannot exclude high grade squamous intraepithelial lesion (finding) 441094005: Atypical endocervical cells on cervical Papanicolaou smear (finding) 441219009: Atypical glandular cells on cervical Papanicolaou smear (finding) 441667007: Abnormal cervical Papanicolaou smear with positive human papillomavirus deoxyribonucleic acid test (finding) 700399008: Cervical smear - borderline change in squamous cells (finding) 700400001: Cervical smear - borderline change in endocervical cells (finding) 1155766001: Nuclear abnormality in cervical smear (finding) 62051000119105: Low grade squamous intraepithelial lesion on cervical Papanicolaou smear (finding) 62061000119107: High grade squamous intraepithelial lesion on cervical Papanicolaou smear (finding) 98791000119102: Cytological evidence of malignancy on cervical Papanicolaou smear (finding)
High Risk HPV Lab Test	CPT 87624, 87625 HCPCS
	LOINC 21440-3: Human papilloma virus 16+18+31+33+35+45+51+52+56 DNA [Presence] in Cervix by Probe 30167-1: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification 38372-9: Human papilloma virus 6+11+16+18+31+33+35+39+42+43+44+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification 59263-4: Human papilloma virus 16 DNA [Presence] in Cervix by Probe with signal amplification 59264-2: Human papilloma virus 18 DNA [Presence] in Cervix by Probe with signal amplification 59420-0: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by Probe with signal amplification 69002-4: Human papilloma virus E6+E7 mRNA [Presence] in Cervix by NAA with probe detection 71431-1: Human papilloma virus 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CT SNOMED CT
	75694-0: Human papilloma virus 18+45 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection
	77379-6 Human papilloma virus 16 and 18 and 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Interpretation] in Cervix
	77399-4: Human papilloma virus 16 DNA [Presence] in Cervix by NAA with probe detection
	77400-0: Human papilloma virus 18 DNA [Presence] in Cervix by NAA with probe detection
	82354-2: Human papilloma virus 16 and 18+45 E6+E7 mRNA [Identifier] in Cervix by NAA with probe detection
	82456-5: Human papilloma virus 16 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection
	82675-0: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection
	95539-3: Human papilloma virus 31 DNA [Presence] in Cervix by NAA with probe detection
	 SNOMED CT SNOMED CT
	35904009: Human papillomavirus deoxyribonucleic acid detection (procedure)
	44865100012410: Microscopic examination of cervical Papanicolaou smear and Human papillomavirus deoxyribonucleic acid detection cotesting (procedure)
	<hr/>
	104132-6: Human papilloma virus 16 and 18 and 31 and 45+33+52+58 and 35+39+51+56+59+66+68 DNA [Interpretation] in Cervix by NAA with probe detection
	104170-6: Human papilloma virus 31+33+52+58 DNA [Presence] in Cervix by NAA with probe detection
	<hr/>
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native
	2028-9: Asian
	2054-5: Black or African American
	2076-8: Native Hawaiian or Other Pacific Islander
	2106-3: White
	2135-2: Hispanic or Latino
	2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Childhood Immunization Status (CIS-E)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Codes to identify immunizations:

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
DTaP Immunization	CVX 20: diphtheria, tetanus toxoids and acellular pertussis vaccine 50: DTaP-Haemophilus influenzae type b conjugate vaccine 106: diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens 107: diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified formulation 110: DTaP-hepatitis B and poliovirus vaccine 120: diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) 146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine. 198: Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)
DTaP Vaccine Procedure	CPT , 90698, , 90723 SNOMED CTSNOMED CT 310306005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 310307001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 310308006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 312870000: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	313383003: Administration of fourth dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)
	390846000: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	390865008: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	399014008: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	412755006: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	412756007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	412757003: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	412762002: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	412763007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	412764001: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	414001002: Administration of vaccine product containing only five component acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	414259000: Administration of first dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	414620004: Administration of vaccine product containing only acellular Bordetella pertussis five component and Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)
	415507003: Administration of second dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	415712004: Administration of third dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	770608009: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770616000: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770617009: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770618004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	787436003: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	diphtheriae and Haemophilus influenzae type b antigens (procedure)
	866158005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	866159002: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	866226006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	868273007: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	868274001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	868276004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	868277008: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	1162640003: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus and inactivated Human poliovirus antigens (procedure)
	428251000124104: Tetanus, diphtheria, and acellular pertussis vaccination (procedure)
	571571000119105: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
	572561000119108: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	<p>Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure) 16290681000119103 : Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)</p>
<p>Haemophilus Influenzae Type B (HiB) Immunization</p>	<p>CVX 17: Haemophilus influenzae type b vaccine, conjugate unspecified formulation 46: Haemophilus influenzae type b vaccine, PRP-D conjugate 47: Haemophilus influenzae type b vaccine, HbOC conjugate 48: Haemophilus influenzae type b vaccine, PRP-T conjugate 49: Haemophilus influenzae type b vaccine, PRP-OMP conjugate 50: DTaP-Haemophilus influenzae type b conjugate vaccine 51: Haemophilus influenzae type b conjugate and Hepatitis B vaccine 120: diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) 146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine. 148: Meningococcal Groups C and Y and Haemophilus b Tetanus Toxoid Conjugate Vaccine 198: Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)</p>
<p>Haemophilus Influenzae Type B (HiB) Vaccine Procedure</p>	<p>CPT , 90647, 90648, , 90698, 90748 SNOMED CTSNOMED CT 127787002: Administration of vaccine product containing only Haemophilus influenzae type b antigen (procedure) 170343007: Administration of first dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure) 170344001: Administration of second dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	170345000: Administration of third dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure)
	170346004: Administration of booster dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure)
	310306005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)
	310307001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)
	310308006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)
	312869001: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)
	312870000: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)
	313383003: Administration of fourth dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)
	414001002: Administration of vaccine product containing only five component acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	414259000: Administration of first dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	415507003: Administration of second dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	415712004: Administration of third dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	428975001: Administration of vaccine product containing only Haemophilus influenzae type b and Neisseria meningitidis serogroup C antigens (procedure)
	712833000: Administration of second dose of vaccine product containing only Haemophilus influenzae type b and Neisseria meningitidis serogroup C antigens (procedure)
	712834006: Administration of first dose of vaccine product containing only Haemophilus influenzae type b and Neisseria meningitidis serogroup C antigens (procedure)
	770608009: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770616000: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770617009: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770618004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	<p>786846001: Administration of vaccine product containing only Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>787436003: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b antigens (procedure)</p> <p>1119364007: Administration of vaccine product containing only Haemophilus influenzae type b and Neisseria meningitidis serogroup C and Y antigens (procedure)</p> <p>1162640003: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus and inactivated Human poliovirus antigens (procedure)</p> <p>16292241000119109 : Administration of booster dose of vaccine product containing only Haemophilus influenzae type b capsular polysaccharide polyribosylribitol phosphate conjugated to Clostridium tetani toxoid protein (procedure)</p>
Hepatitis A Immunization	<p>CVX</p> <p>31: hepatitis A vaccine, pediatric dosage, unspecified formulation</p> <p>83: hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule</p> <p>85: hepatitis A vaccine, unspecified formulation</p>
Hepatitis A Vaccine Procedure	<p>CPT</p> <p>SNOMED CTSNOMED CT</p> <p>17037+D909+D90971:E185331: Administration of first dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>170379004: Administration of second dose of vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>170380001: Administration of third dose of vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>170381002: Administration of booster dose of vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>170434002: Administration of first dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	170435001: Administration of second dose of vaccine product containing only Hepatitis A and B virus antigens (procedure)
	170436000: Administration of third dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)
	170437009: Administration of booster dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)
	243789007: Administration of vaccine product containing only Hepatitis A virus antigen (procedure)
	312868009: Administration of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)
	314177003: Administration of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)
	314178008: Administration of first dose of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)
	314179000: Administration of second dose of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)
	394691002: Administration of booster dose of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)
	871752004: Administration of second dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)
	871753009: Administration of third dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)
	871754003: Administration of booster dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)
	571511000119102: Administration of adult vaccine product containing only Hepatitis A virus antigen (procedure)
Hepatitis B Immunization	CVX 08: hepatitis B vaccine, pediatric or pediatric/adolescent dosage 44: hepatitis B vaccine, dialysis patient dosage 45: hepatitis B vaccine, unspecified formulation 51: Haemophilus influenzae type b conjugate and Hepatitis B vaccine 110: DTaP-hepatitis B and poliovirus vaccine

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine. 198: Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)
Hepatitis B Vaccine Procedure	CPT 90723, 90740, 90744, 90747, 90748 HCPCS G0010: Administration of hepatitis b vaccine SNOMED CTSNOMED CT 16584000: Administration of vaccine product containing only Hepatitis B virus antigen (procedure) 170370000: Administration of first dose of vaccine product containing only Hepatitis B virus antigen (procedure) 170371001: Administration of second dose of vaccine product containing only Hepatitis B virus antigen (procedure) 170372008: Administration of third dose of vaccine product containing only Hepatitis B virus antigen (procedure) 170373003: Administration of booster dose of vaccine product containing only Hepatitis B virus antigen (procedure) 170374009: Administration of fourth dose of vaccine product containing only Hepatitis B virus antigen (procedure) 170375005: Administration of fifth dose of vaccine product containing only Hepatitis B virus antigen (procedure) 170434002: Administration of first dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure) 170435001: Administration of second dose of vaccine product containing only Hepatitis A and B virus antigens (procedure) 170436000: Administration of third dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure) 170437009: Administration of booster dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure) 312868009: Administration of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	396456003: Administration of vaccine product containing only acellular Bordetella pertussis and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure)
	416923003: Administration of sixth dose of vaccine product containing only Hepatitis B virus antigen (procedure)
	770608009: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770616000: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770617009: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	770618004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	786846001: Administration of vaccine product containing only Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)
	1162640003: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus and inactivated Human poliovirus antigens (procedure)
	572561000119108: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure)
Inactivated polio vaccine (IPV) immunization	CVX 10: poliovirus vaccine, inactivated 89: poliovirus vaccine, unspecified formulation 110: DTaP-hepatitis B and poliovirus vaccine

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	120: diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) 146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.
Inactivated polio vaccine (IPV) procedure	CPT , 90698, 90713, 90723 SNOMED CTSNOMED CT 310306005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 310307001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 310308006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 312869001: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 312870000: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 313383003: Administration of fourth dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 390865008: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	396456003: Administration of vaccine product containing only acellular Bordetella pertussis and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure)
	412762002: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	412763007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	412764001: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	414001002: Administration of vaccine product containing only five component acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	414259000: Administration of first dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	414619005: Administration of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	414620004: Administration of vaccine product containing only acellular Bordetella pertussis five component and Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)
	415507003: Administration of second dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	415712004: Administration of third dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)
	416144004: Administration of third dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	416591003: Administration of first dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	417211006: Administration of first booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	417384007: Administration of second booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	417615007: Administration of second dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)
	866186002: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	866227002: Administration of booster dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	868266002: Administration of second dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)
	868267006: Administration of first dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	868268001: Administration of third dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868273007: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868274001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868276004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868277008: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 870670004: Preschool administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 572561000119108: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure) 16290681000119103 : Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)
Influenza Immunization	CVX 88: influenza virus vaccine, unspecified formulation 140: Influenza, seasonal, injectable, preservative free 141: Influenza, seasonal, injectable 150: Influenza, injectable, quadrivalent, preservative free 153: Influenza, injectable, Madin Darby Canine Kidney, preservative free 155: Seasonal, trivalent, recombinant, injectable influenza vaccine, preservative free 158: influenza, injectable, quadrivalent, contains preservative

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	161: Influenza, injectable, quadrivalent, preservative free, pediatric 171: Influenza, injectable, Madin Darby Canine Kidney, preservative free, quadrivalent 186: Influenza, injectable, Madin Darby Canine Kidney, quadrivalent with preservative88, 140, 141, 150, 153, 155, 158, 161
Influenza Vaccine Procedure	CPT 90655, , 90661, , 90674, 90685, 90686, 90687, 90688, 90689, 90756 HCPCS SNOMED CTSNOMED CT 86198006: Administration of vaccine product containing only Influenza virus antigen (procedure)
Influenza Virus LAIV Immunization	CVX 111: influenza virus vaccine, live, attenuated, for intranasal use 149: influenza, live, intranasal, quadrivalent
Influenza Virus LAIV Vaccine Procedure	CPT 90660, 90672 SNOMED CTSNOMED CT 787016008: Administration of vaccine product containing only Influenza virus antigen in nasal dose form (procedure)
Measles, Mumps and Rubella (MMR) Immunization	CVX: 03, 94
Measles, Mumps and Rubella (MMR) Vaccine Procedure	CPT: 90707, 90710 SNOMEDSNOMED CT: 38598009, 170433008, 432636005, 433733003, 150971000119104, 571591000119106, 572511000119105
Pneumococcal Conjugate Immunization	CVX 109: pneumococcal vaccine, unspecified formulation 133: pneumococcal conjugate vaccine, 13 valent 152: Pneumococcal Conjugate, unspecified formulation 215: Pneumococcal conjugate vaccine 15-valent (PCV15), polysaccharide CRM197 conjugate, adjuvant, preservative free
Pneumococcal Conjugate Vaccine Procedure	CPT 90670, 90671 HCPCS SNOMED CTSNOMED CT

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	1119368005: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 4, 6B, 9V, 14, 18C, 19F, and 23F capsular polysaccharide antigens conjugated (procedure) 1296904008: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, and 23F capsular polysaccharide antigens conjugated (procedure) 434751000124102: Pneumococcal conjugate vaccination (procedure)
Rotavirus (3 Dose Schedule) Immunization	CVX 116: rotavirus, live, pentavalent vaccine 122: rotavirus vaccine, unspecified formulation
Rotavirus Vaccine (2 Dose Schedule) Procedure	CPT 90681 SNOMED CTSNOMED CT 434741000124104: Rotavirus vaccination, 2 dose schedule (procedure)
Rotavirus Vaccine (3 Dose Schedule) Procedure	CPT SNOMED CTSNOMED CT 434731000124109: Rotavirus vaccination, 3 dose schedule (procedure)
Varicella zoster (VZV) immunization	CVX 21: varicella virus vaccine 94: measles, mumps, rubella, and varicella virus vaccine
Varicella zoster (VZV) vaccine procedure	CPT 90710, 90716 SNOMED CTSNOMED CT 425897001: Administration of first dose of vaccine product containing only Human alphaherpesvirus 3 antigen for chickenpox (procedure) 428502009: Administration of second dose of vaccine product containing only Human alphaherpesvirus 3 antigen for chickenpox (procedure) 432636005: Administration of vaccine product containing only Human alphaherpesvirus 3 and Measles morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (procedure) 433733003: Administration of second dose of vaccine product containing only Human alphaherpesvirus 3 and Measles

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMEDSNOMED CT/CVX
	morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (procedure) 737081007: Administration of vaccine product containing only Human alphaherpesvirus 3 antigen for chickenpox (procedure) 871898007: Administration of vaccine product containing only live attenuated Human alphaherpesvirus 3 antigen (procedure) 871899004: Administration of vaccine product containing only live attenuated Human alphaherpesvirus 3 antigen via subcutaneous route (procedure) 871909005: Administration of first dose of vaccine product containing only Human alphaherpesvirus 3 and Measles morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (procedure) 572511000119105: Administration of vaccine product containing only live attenuated Measles morbillivirus and Mumps orthorubulavirus and Rubella virus and Human alphaherpesvirus 3 antigens (procedure)

CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino
------------------------	--

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Colorectal Cancer Screening (COL-E)

Description	CPT/HCPCS/LOINC/SNOMED CTSNOMED CT
Colonoscopy	CPT 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398 HCPCS G0105: Colorectal cancer screening; colonoscopy on individual at high risk : Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk SNOMED CTSNOMED CT

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CTSNOMED CT
	8180007: Fiberoptic colonoscopy through colostomy (procedure) 12350003: Colonoscopy with rigid sigmoidoscope through colotomy (procedure) 25732003: Fiberoptic colonoscopy with biopsy (procedure) 34264006: Intraoperative colonoscopy (procedure) 73761001: Colonoscopy (procedure) 174158000: Open colonoscopy (procedure) 174185007: Diagnostic fiberoptic endoscopic examination of colon and biopsy of lesion of colon (procedure) 235150006: Total colonoscopy (procedure) 235151005: Limited colonoscopy (procedure) 275251008: Diagnostic endoscopic examination of colon using fiberoptic sigmoidoscope (procedure) 302052009: Endoscopic biopsy of lesion of colon (procedure) 367535003: Fiberoptic colonoscopy (procedure) [367535003] 443998000: Colonoscopy through colostomy with endoscopic biopsy of colon (procedure) 444783004: Screening colonoscopy (procedure) 446521004: Colonoscopy and excision of mucosa of colon (procedure) 446745002: Colonoscopy and biopsy of colon (procedure) 447021001: Colonoscopy and tattooing (procedure) 709421007: Colonoscopy and dilatation of stricture of colon (procedure) 710293001: Colonoscopy using fluoroscopic guidance (procedure) 711307001: Colonoscopy using X-ray guidance (procedure) 789778002: Colonoscopy and fecal microbiota transplantation (procedure) 1209098000: Fiberoptic colonoscopy with biopsy of lesion of colon (procedure) 48021000087103: Colonoscopy using cecal retroflexion technique (procedure) 48031000087101: Colonoscopy using rectal retroflexion technique (procedure)
CT Colonography	CPT 74261, 74262, 74263 LOINC 60515-4: CT Colon and Rectum W air contrast PR 72531-7: CT Colon and Rectum W contrast IV and W air contrast PR 79069-1: CT Colon and Rectum for screening WO contrast IV and W air contrast PR 79071-7: CT Colon and Rectum WO contrast IV and W air contrast PR 79101-2: CT Colon and Rectum for screening W air contrast PR 82688-3: CT Colon and Rectum WO and W contrast IV and W air contrast PR SNOMED CTSNOMED CT 418714002: Virtual computed tomography colonoscopy (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CTSNOMED CT
Flexible sigmoidoscopy	CPT 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350 HCPCS G0104: Colorectal cancer screening; flexible sigmoidoscopy SNOMED CTSNOMED CT 44441009: Flexible fiberoptic sigmoidoscopy (procedure) 396226005: Flexible fiberoptic sigmoidoscopy with biopsy (procedure) 425634007: Diagnostic endoscopic examination of lower bowel and sampling for bacterial overgrowth using fiberoptic sigmoidoscope (procedure)
FOBT Lab Test	CPT 82270, 82274 HCPCS Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous LOINC 12503-9: Hemoglobin.gastrointestinal [Presence] in Stool --4th specimen 12504-7: Hemoglobin. Gastrointestinal [Presence] in Stool --5th specimen 14563-1: Hemoglobin. Gastrointestinal [Presence] in Stool --1st specimen 14564-9: Hemoglobin. Gastrointestinal [Presence] in Stool --2nd specimen 14565-6: Hemoglobin. Gastrointestinal [Presence] in Stool --3rd specimen 2335-8: Hemoglobin. Gastrointestinal [Presence] in Stool 27396-1: Hemoglobin. Gastrointestinal [Mass/mass] in Stool 27401-9: Hemoglobin. Gastrointestinal [Presence] in Stool --6th specimen 27925-7: Hemoglobin. Gastrointestinal [Presence] in Stool --7th specimen 27926-5: Hemoglobin. Gastrointestinal [Presence] in Stool --8th specimen 29771-3: Hemoglobin.gastrointestinal.lower [Presence] in Stool by Immunoassay 56490-6: Hemoglobin.gastrointestinal.lower [Presence] in Stool by Immunoassay --2nd specimen 56491-4: Hemoglobin.gastrointestinal.lower [Presence] in Stool by Immunoassay --3rd specimen 57905-2: Hemoglobin.gastrointestinal.lower [Presence] in Stool by Immunoassay --1st specimen 58453-2: Hemoglobin.gastrointestinal.lower [Mass/volume] in Stool by Immunoassay 80372-6: Hemoglobin. Gastrointestinal [Presence] in Stool by Rapid immunoassay SNOMED CTSNOMED CT 104435004: Screening for occult blood in feces (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CTSNOMED CT
	441579003: Measurement of occult blood in stool specimen using immunoassay (procedure) 442067009: Measurement of occult blood in two separate stool specimens (procedure) 442516004: Measurement of occult blood in three separate stool specimens (procedure) 442554004: Guaiac test for occult blood in feces specimen (procedure) 442563002: Measurement of occult blood in single stool specimen (procedure)
FOBT Test Result or Finding	SNOMED CT 59614000: Occult blood in stools (finding) 167667006: Fecal occult blood: negative (finding) 389076003: Fecal occult blood: trace (finding) 71711000112103: Occult blood detected in feces by immunoassay (finding)
sDNA FIT Lab Test	CPT 81528 LOINC 77353-1: Noninvasive colorectal cancer DNA and occult blood screening [Interpretation] in Stool Narrative 77354-9: Noninvasive colorectal cancer DNA and occult blood screening [Presence] in Stool
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Documented Assessment After Mammogram (DBM-E)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	SNOMED CT
BIRADS Assessment	397138000: Mammography assessment (Category 0) - Need additional imaging evaluation (finding) 397140005: Mammography assessment (Category 1) - Negative (finding) 397141009: Mammography assessment (Category 2) - Benign finding (finding) 397143007: Mammography assessment (Category 3) - Probably benign finding, short interval follow-up (finding) 397144001: Mammography assessment (Category 4) - Suspicious abnormality, biopsy should be considered (finding) 6121000179106: Mammography assessment (Category 4A) - Suspicious abnormality, biopsy should be considered, low suspicion of malignancy (finding) 6131000179108: Mammography assessment (Category 4B) - Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy (finding) 6141000179100: Mammography assessment (Category 4C) - Suspicious abnormality, biopsy should be considered, high suspicion of malignancy (finding) 397145000: Mammography assessment (Category 5) - Highly suggestive of malignancy (finding) 6111000179101: Mammography assessment (Category 6) - known biopsy, proven malignancy (finding)

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

Description	ICD10CM/SNOMED CTSNOMED CT
Major Depression or Dysthymia	ICD10CM F32.0: Major depressive disorder, single episode, mild F32.1: Major depressive disorder, single episode, moderate F32.2: Major depressive disorder, single episode, severe without psychotic features F32.3: Major depressive disorder, single episode, severe with psychotic features F32.4: Major depressive disorder, single episode, in partial remission F32.5: Major depressive disorder, single episode, in full remission F32.9: Major depressive disorder, single episode, unspecified F33.0: Major depressive disorder, recurrent, mild F33.1: Major depressive disorder, recurrent, moderate F33.2: Major depressive disorder, recurrent severe without psychotic features F33.3: Major depressive disorder, recurrent, severe with psychotic symptoms F33.40: Major depressive disorder, recurrent, in remission, unspecified F33.41: Major depressive disorder, recurrent, in partial remission

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	ICD10CM/SNOMED CT SNOMED CT
	F33.42: Major depressive disorder, recurrent, in full remission
	F33.9: Major depressive disorder, recurrent, unspecified
	F34.1: Dysthymic disorder
	SNOMED CT
	832007: Moderate major depression (disorder)
	2506003: Early onset dysthymia (disorder)
	2618002: Chronic recurrent major depressive disorder (disorder)
	3109008: Secondary dysthymia early onset (disorder)
	14183003: Chronic major depressive disorder, single episode (disorder)
	15193003: Severe recurrent major depression with psychotic features, mood-incongruent (disorder)
	15639000: Moderate major depression, single episode (disorder)
	18818009: Moderate recurrent major depression (disorder)
	19527009: Single episode of major depression in full remission (disorder)
	19694002: Late onset dysthymia (disorder)
	20250007: Severe major depression, single episode, with psychotic features, mood-incongruent (disorder)
	25922000: Major depressive disorder, single episode with postpartum onset (disorder)
	28475009: Severe recurrent major depression with psychotic features (disorder)
	30605009: Major depression in partial remission (disorder)
	33078009: Severe recurrent major depression with psychotic features, mood-congruent (disorder)
	33135002: Recurrent major depression in partial remission (disorder)
	33736005: Severe major depression with psychotic features, mood-congruent (disorder)
	36170009: Secondary dysthymia late onset (disorder)
	36474008: Severe recurrent major depression without psychotic features (disorder)
	36923009: Major depression, single episode (disorder)
	38451003: Primary dysthymia early onset (disorder)
	38694004: Recurrent major depressive disorder with atypical features (disorder)
	39809009: Recurrent major depressive disorder with catatonic features (disorder)
	40379007: Mild recurrent major depression (disorder)
	42810003: Major depression in remission (disorder)
	42925002: Major depressive disorder, single episode with atypical features (disorder)
	46244001: Recurrent major depression in full remission (disorder)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	ICD10CM/SNOMED CT/SNOMED CT
	60099002: Severe major depression with psychotic features, mood-incongruent (disorder)
	63412003: Major depression in full remission (disorder)
	63778009: Major depressive disorder, single episode with melancholic features (disorder)
	66344007: Recurrent major depression (disorder)
	67711008: Primary dysthymia late onset (disorder)
	69392006: Major depressive disorder, single episode with catatonic features (disorder)
	70747007: Major depression single episode, in partial remission (disorder)
	71336009: Recurrent major depressive disorder with postpartum onset (disorder)
	73867007: Severe major depression with psychotic features (disorder)
	75084000: Severe major depression without psychotic features (disorder)
	76441001: Severe major depression, single episode, without psychotic features (disorder)
	77911002: Severe major depression, single episode, with psychotic features, mood-congruent (disorder)
	78667006: Dysthymia (disorder)
	79298009: Mild major depression, single episode (disorder)
	83176005: Primary dysthymia (disorder)
	85080004: Secondary dysthymia (disorder)
	87512008: Mild major depression (disorder)
	191604000: Single major depressive episode, severe, with psychosis (disorder)
	191610000: Recurrent major depressive episodes, mild (disorder)
	191611001: Recurrent major depressive episodes, moderate (disorder)
	191613003: Recurrent major depressive episodes, severe, with psychosis (disorder)
	231499006: Endogenous depression first episode (disorder)
	268621008: Recurrent major depressive episodes (disorder)
	274948002: Endogenous depression - recurrent (disorder)
	300706003: Endogenous depression (disorder)
	319768000: Recurrent major depressive disorder with melancholic features (disorder)
	320751009: Major depression, melancholic type (disorder)
	370143000: Major depressive disorder (disorder)
	430852001: Severe major depression, single episode, with psychotic features (disorder)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Depression Remission or Response for Adolescents and Adults (DRR-E)

Description	SNOMED CT
Major Depression or Dysthymia	SNOMED CT
	832007: Moderate major depression (disorder)
	2506003: Early onset dysthymia (disorder)
	2618002: Chronic recurrent major depressive disorder (disorder)
	3109008: Secondary dysthymia early onset (disorder)
	14183003: Chronic major depressive disorder, single episode (disorder)
	15193003: Severe recurrent major depression with psychotic features, mood-incongruent (disorder)
	15639000: Moderate major depression, single episode (disorder)
	18818009: Moderate recurrent major depression (disorder)
	19527009: Single episode of major depression in full remission (disorder)
	19694002: Late onset dysthymia (disorder)
	20250007: Severe major depression, single episode, with psychotic features, mood-incongruent (disorder)
	25922000: Major depressive disorder, single episode with postpartum onset (disorder)
	28475009: Severe recurrent major depression with psychotic features (disorder)
	30605009: Major depression in partial remission (disorder)
	33078009: Severe recurrent major depression with psychotic features, mood-congruent (disorder)
	33135002: Recurrent major depression in partial remission (disorder)
	33736005: Severe major depression with psychotic features, mood-congruent (disorder)
	36170009: Secondary dysthymia late onset (disorder)
	36474008: Severe recurrent major depression without psychotic features (disorder)
	36923009: Major depression, single episode (disorder)
	38451003: Primary dysthymia early onset (disorder)
	38694004: Recurrent major depressive disorder with atypical features (disorder)
	39809009: Recurrent major depressive disorder with catatonic features (disorder)
	40379007: Mild recurrent major depression (disorder)
	42810003: Major depression in remission (disorder)
42925002: Major depressive disorder, single episode with atypical features (disorder)	
46244001: Recurrent major depression in full remission (disorder)	

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	SNOMED CT
	60099002: Severe major depression with psychotic features, mood-incongruent (disorder)
	63412003: Major depression in full remission (disorder)
	63778009: Major depressive disorder, single episode with melancholic features (disorder)
	66344007: Recurrent major depression (disorder)
	67711008: Primary dysthymia late onset (disorder)
	69392006: Major depressive disorder, single episode with catatonic features (disorder)
	70747007: Major depression single episode, in partial remission (disorder)
	71336009: Recurrent major depressive disorder with postpartum onset (disorder)
	73867007: Severe major depression with psychotic features (disorder)
	75084000: Severe major depression without psychotic features (disorder)
	76441001: Severe major depression, single episode, without psychotic features (disorder)
	77911002: Severe major depression, single episode, with psychotic features, mood-congruent (disorder)
	78667006: Dysthymia (disorder)
	79298009: Mild major depression, single episode (disorder)
	83176005: Primary dysthymia (disorder)
	85080004: Secondary dysthymia (disorder)
	87512008: Mild major depression (disorder)
	191604000: Single major depressive episode, severe, with psychosis (disorder)
	191610000: Recurrent major depressive episodes, mild (disorder)
	191611001: Recurrent major depressive episodes, moderate (disorder)
	191613003: Recurrent major depressive episodes, severe, with psychosis (disorder)
	231499006: Endogenous depression first episode (disorder)
	268621008: Recurrent major depressive episodes (disorder)
	274948002: Endogenous depression - recurrent (disorder)
	300706003: Endogenous depression (disorder)
	319768000: Recurrent major depressive disorder with melancholic features (disorder)
	320751009: Major depression, melancholic type (disorder)
	370143000: Major depressive disorder (disorder)
	430852001: Severe major depression, single episode, with psychotic features (disorder)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Description	CPT/HCPCS/SNOMED CTSNOMED CT
Depression Case Management Encounter	CPT , , , HCPCS : Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month T1016: Case Management, each 15 minutes T1017: Targeted Case Management, each 15 minutes : Case Management, per month : Targeted Case Management; per month SNOMED CTSNOMED CT 182832007: Procedure related to management of drug administration (procedure) 225333008: Behavior management (regime/therapy) 385828006: Health promotion management (procedure) 386230005: Case Management (procedure) 409022004: Dispensing medication management (procedure) 410216003: Communication care management (procedure) 410219005: Personal care management (procedure) 410328009: Coping skills Case Management (procedure) 410335001: Exercises Case Management (procedure) 410346003: Medication action/side effects Case Management (procedure) 410347007: Medication set-up Case Management (procedure) 410351009: Relaxation/breathing techniques Case Management (procedure) 410352002: Rest/sleep Case Management (procedure) 410353007: Safety Case Management (procedure) 410354001: Screening Case Management (procedure) 410356004: Signs/symptoms-mental/emotional Case Management (procedure) 410360001: Spiritual care Case Management (procedure) 410363004: Support group Case Management (procedure) 410364005: Support system Case Management (procedure) 410366007: Wellness Case Management (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT SNOMED CT
	416341003: Case Management started (situation)
	416584001: Case Management ended (situation)
	424490002: Medication prescription Case Management (procedure)
	425604002: Case Management follow up (procedure)
	737850002: Day care Case Management (procedure)
	621561000124106: Psychiatric Case Management (procedure)
	661051000124109: Education about Department of Veterans Affairs Military2VA Case Management Program (procedure)
	662081000124106: Assistance with application for Department of Veterans Affairs Military2VA Case Management Program (procedure)
	662541000124107: Evaluation of eligibility for Department of Veterans Affairs Military2VA Case Management Program (procedure)
	842901000000108: Multidisciplinary Case Management (procedure)

Symptoms of Depression	SNOMED CT 394924000: Symptoms of depression (finding) 788976000: Leaden paralysis (finding)
------------------------	---

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Follow-Up After Abnormal Mammogram Assessment (FMA-E)

Description	SNOMED CT
High Risk BIRADS	397144001: Mammography assessment (Category 4) - Suspicious abnormality, biopsy should be considered (finding) 6121000179106: Mammography assessment (Category 4A) - Suspicious abnormality, biopsy should be considered, low suspicion of malignancy (finding) 6131000179108: Mammography assessment (Category 4B) - Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy (finding) 6141000179100: Mammography assessment (Category 4C) - Suspicious abnormality, biopsy should be considered, high suspicion of malignancy (finding) 397145000: Mammography assessment (Category 5) - Highly suggestive of malignancy (finding)
Inconclusive BIRADS	397138000: Mammography assessment (Category 0) - Need additional imaging evaluation (finding)

Immunizations for Adolescents (IMA-E)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CTSNOMED CT
Meningococcal Immunization	CVX 32: meningococcal polysaccharide vaccine (MPSV4) 108: meningococcal ACWY vaccine, unspecified formulation 114: meningococcal polysaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4P) 136: meningococcal oligosaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4O) 147: Meningococcal, MCV4, unspecified conjugate formulation(groups A, C, Y and W-135) 167: meningococcal vaccine of unknown formulation and unknown serogroups 203: meningococcal polysaccharide (groups A, C, Y, W-135) tetanus toxoid conjugate vaccine 0.5mL dose, preservative free 316: Meningococcal polysaccharide (groups A, C, Y, W) tetanus toxoid conjugate, meningococcal B recombinant vaccine, 0.5mL, preservative free
Meningococcal Vaccine Procedure	CPT , 90733, 90734 SNOMED CTSNOMED CT 871874000: Administration of vaccine product containing only Neisseria meningitidis serogroup A, C, W135 and Y antigens (procedure) 428271000124109: Meningococcal conjugate vaccination (procedure) 16298691000119102: Administration of vaccine product containing only Neisseria meningitidis serogroup A, C, W135 and Y capsular oligosaccharide conjugated antigens (procedure)
Tdap Vaccine Procedure	CPT 90715 SNOMED CTSNOMED CT 390846000: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412755006: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412756007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412757003: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CTSNOMED CT
	428251000124104: Tetanus, diphtheria, and acellular pertussis vaccination (procedure) 571571000119105: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
HPV Immunization	CVX 62: Human papilloma virus vaccine, quadrivalent 118: Human papilloma virus vaccine, bivalent 137: HPV, unspecified formulation 165: Human Papillomavirus 9-valent vaccine
HPV Vaccine Procedure	CPT 90649, 90650, 90651 SNOMED CTSNOMED CT 428741008: Administration of first dose of vaccine product containing only Human papillomavirus antigen (procedure) 428931000: Administration of third dose of vaccine product containing only Human papillomavirus antigen (procedure) 429396009: Administration of second dose of vaccine product containing only Human papillomavirus antigen (procedure) 717953009: Administration of vaccine product containing only Human papillomavirus 16 and 18 antigens (procedure) 724332002: Administration of vaccine product containing only Human papillomavirus 9 antigen (procedure) 734152003: Administration of vaccine product containing only Human papillomavirus 6, 11, 16 and 18 antigens (procedure) 761841000: Administration of vaccine product containing only Human papillomavirus antigen (procedure) 1209198003: Administration of vaccine product containing only Human papillomavirus 6, 11, 16, 18, 31, 33, 45, 52 and 58 antigen (procedure)
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

Description	CPT/ HCPCS/SNOMEDSNOMED CT
Deliveries	CPT , 59409, 59410, , 59514, 59515, , 59612, 59614, , 59620, 59622 SNOMED CT 2321005: Delivery by Ritgen maneuver (procedure) 199771001: Piper forceps delivery by application to aftercoming head (procedure)
Depression Case Management Encounter	CPT HCPCS T1016: Case Management, each 15 minutes T1017: Targeted Case Management, each 15 minutes Case Management, per month Targeted Case Management; per month SNOMED CTSNOMED CT 182832007: Procedure related to management of drug administration (procedure) 225333008: Behavior management (regime/therapy) 385828006: Health promotion management (procedure) 386230005: Case Management (procedure) 409022004: Dispensing medication management (procedure) 410216003: Communication care management (procedure) 410219005: Personal care management (procedure) 410328009: Coping skills Case Management (procedure) 410335001: Exercises Case Management (procedure) 410346003: Medication action/side effects Case Management (procedure) 410347007: Medication set-up Case Management (procedure) 410351009: Relaxation/breathing techniques Case Management (procedure) 410352002: Rest/sleep Case Management (procedure) 410353007: Safety Case Management (procedure) 410354001: Screening Case Management (procedure) 410356004: Signs/symptoms-mental/emotional Case Management (procedure) 410360001: Spiritual care Case Management (procedure) 410363004: Support group Case Management (procedure) 410364005: Support system Case Management (procedure) 410366007: Wellness Case Management (procedure) 416341003: Case Management started (situation) 416584001: Case Management ended (situation) 424490002: Medication prescription Case Management (procedure) 425604002: Case Management follow up (procedure) 737850002: Day care Case Management (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ HCPCS/SNOMEDSNOMED CT
	621561000124106: Psychiatric Case Management (procedure) 661051000124109: Education about Department of Veterans Affairs Military2VA Case Management Program (procedure) 662081000124106: Assistance with application for Department of Veterans Affairs Military2VA Case Management Program (procedure) 662541000124107: Evaluation of eligibility for Department of Veterans Affairs Military2VA Case Management Program (procedure) 842901000000108: Multidisciplinary Case Management (procedure)
Symptoms of Depression	SNOMED CT 394924000: Symptoms of depression (finding) 788976000: Leaden paralysis (finding)
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

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

Description	CPT/ HCPCS/SNOMED CTSNOMED CT
Deliveries	CPT 59409, 59410, 59510, 59514, 59515, , 59612, 59614, , 59620, 59622 SNOMED CT 2321005: Delivery by Ritgen maneuver (procedure) 199771001: Piper forceps delivery by application to aftercoming head (procedure)
37 weeks gestation	SNOMED CT 43697006: Gestation period, 37 weeks (finding)
38 weeks gestation	SNOMED CT 13798002: Gestation period, 38 weeks (finding)
39 weeks gestation	SNOMED CT 80487005: Gestation period, 39 weeks (finding)
40 weeks gestation	SNOMED CT 46230007: Gestation period, 40 weeks (finding)
41 weeks gestation	SNOMED CT 63503002: Gestation period, 41 weeks (finding)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ HCPCS/SNOMED CT SNOMED CT
42 weeks gestation	36428009: Gestation period, 42 weeks (finding)
Weeks of Gestation Less Than 37	SNOMED CT 931004: Gestation period, 9 weeks (finding) 6678005: Gestation period, 15 weeks (finding) 15633004: Gestation period, 16 weeks (finding) 23464008: Gestation period, 20 weeks (finding) 25026004: Gestation period, 18 weeks (finding) 26690008: Gestation period, 8 weeks (finding) 37005007: Gestation period, 5 weeks (finding) 38039008: Gestation period, 10 weeks (finding) 41438001: Gestation period, 21 weeks (finding) 44398003: Gestation period, 4 weeks (finding) 46906003: Gestation period, 27 weeks (finding) 48688005: Gestation period, 26 weeks (finding) 50367001: Gestation period, 11 weeks (finding) 54318006: Gestation period, 19 weeks (finding) 57907009: Gestation period, 36 weeks (finding) 62333002: Gestation period, 13 weeks (finding) 63110000: Gestation period, 7 weeks (finding) 65035007: Gestation period, 22 weeks (finding) 65683006: Gestation period, 17 weeks (finding) 72544005: Gestation period, 25 weeks (finding) 72846000: Gestation period, 14 weeks (finding) 74952004: Gestation period, 3 weeks (finding) 79992004: Gestation period, 12 weeks (finding) 82118009: Gestation period, 2 weeks (finding) 86801005: Gestation period, 6 weeks (finding) 86883006: Gestation period, 23 weeks (finding) 87178007: Gestation period, 1 week (finding) 313178001: Gestation less than 24 weeks (finding) 313179009: Gestation period, 24 weeks (finding) 428058009: Gestation less than 9 weeks (finding) 428566005: Gestation less than 20 weeks (finding) 428567001: Gestation 14 - 20 weeks (finding) 428930004: Gestation 9- 13 weeks (finding)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ HCPCS/SNOMED CTSNOMED CT
Depression Case Management Encounter	<p>CPT</p> <p>HCPCS</p> <p>T1016: Case Management, each 15 minutes</p> <p>T1017: Targeted Case Management, each 15 minutes</p> <p>Case Management, per month</p> <p>Targeted Case Management; per month</p> <p>SNOMED CTSNOMED CT</p> <p>182832007: Procedure related to management of drug administration (procedure)</p> <p>225333008: Behavior management (regime/therapy)</p> <p>385828006: Health promotion management (procedure)</p> <p>386230005: Case Management (procedure)</p> <p>409022004: Dispensing medication management (procedure)</p> <p>410216003: Communication care management (procedure)</p> <p>410219005: Personal care management (procedure)</p> <p>410328009: Coping skills Case Management (procedure)</p> <p>410335001: Exercises Case Management (procedure)</p> <p>410346003: Medication action/side effects Case Management (procedure)</p> <p>410347007: Medication set-up Case Management (procedure)</p> <p>410351009: Relaxation/breathing techniques Case Management (procedure)</p> <p>410352002: Rest/sleep Case Management (procedure)</p> <p>410353007: Safety Case Management (procedure)</p> <p>410354001: Screening Case Management (procedure)</p> <p>410356004: Signs/symptoms-mental/emotional Case Management (procedure)</p> <p>410360001: Spiritual care Case Management (procedure)</p> <p>410363004: Support group Case Management (procedure)</p> <p>410364005: Support system Case Management (procedure)</p> <p>410366007: Wellness Case Management (procedure)</p> <p>416341003: Case Management started (situation)</p> <p>416584001: Case Management ended (situation)</p> <p>424490002: Medication prescription Case Management (procedure)</p> <p>425604002: Case Management follow up (procedure)</p> <p>737850002: Day care Case Management (procedure)</p> <p>621561000124106: Psychiatric Case Management (procedure)</p> <p>661051000124109: Education about Department of Veterans Affairs Military2VA Case Management Program (procedure)</p> <p>662081000124106: Assistance with application for Department of Veterans Affairs Military2VA Case Management Program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ HCPCS/SNOMED CTSNOMED CT
	662541000124107: Evaluation of eligibility for Department of Veterans Affairs Military2VA Case Management Program (procedure) 842901000000108: Multidisciplinary Case Management (procedure)
Symptoms of Depression	SNOMED CT 394924000: Symptoms of depression (finding) 788976000: Leaden paralysis (finding)
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Prenatal Immunization Status (PRS-E)

Description	CPT/CVX/SNOMED CTSNOMED CT
Deliveries	CPT 59409, 59410, , 59514, 59515, , 59612, 59614, , 59620, 59622 SNOMED CT 2321005: Delivery by Ritgen maneuver (procedure) 199771001: Piper forceps delivery by application to aftercoming head (procedure)
37 Weeks Gestation	SNOMED CT 43697006: Gestation period, 37 weeks (finding)
38 Weeks Gestation	SNOMED CT 13798002: Gestation period, 38 weeks (finding)
39 Weeks Gestation	SNOMED CT 80487005: Gestation period, 39 weeks (finding)
40 Weeks Gestation	SNOMED CT 46230007: Gestation period, 40 weeks (finding)
41 Weeks Gestation	SNOMED CT 63503002: Gestation period, 41 weeks (finding)
42 Weeks Gestation	SNOMED CT 36428009: Gestation period, 42 weeks (finding)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CTSNOMED CT
Adult Influenza Immunization	CVX 88: influenza virus vaccine, unspecified formulation 135: influenza, high dose seasonal, preservative-free 140: Influenza, seasonal, injectable, preservative free 141: Influenza, seasonal, injectable 144: seasonal influenza, intradermal, preservative free 150: Influenza, injectable, quadrivalent, preservative free 153: Influenza, injectable, Madin Darby Canine Kidney, preservative free 155: Seasonal, trivalent, recombinant, injectable influenza vaccine, preservative free 158: influenza, injectable, quadrivalent, contains preservative 166: influenza, intradermal, quadrivalent, preservative free, injectable 168: Seasonal trivalent influenza vaccine, adjuvanted, preservative free 171: Influenza, injectable, Madin Darby Canine Kidney, preservative free, quadrivalent 185: Seasonal, quadrivalent, recombinant, injectable influenza vaccine, preservative free 186: Influenza, injectable, Madin Darby Canine Kidney, quadrivalent with preservative 197: influenza, high-dose seasonal, quadrivalent, 0.7mL dose, preservative free 205: influenza, seasonal vaccine, quadrivalent, adjuvanted, 0.5mL dose, preservative free
Adult Influenza Vaccine Procedure	CPT 90653,90658, 90661, 90662, 90674, 90682, 90686, 90688, 90689, 90694, 90756 SNOMED CTSNOMED CT 86198006: Administration of vaccine product containing only Influenza virus antigen (procedure)
Tdap Vaccine Procedure	CPT 90715 SNOMED CTSNOMED CT 390846000: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412755006: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412756007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CT SNOMED CT
	412757003: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 428251000124104: Tetanus, diphtheria, and acellular pertussis vaccination (procedure) 571571000119105: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)
CDC Race and Ethnicity	1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino

Additional codes

Description	CPT/CAT II/HCPCS
Prenatal Bundled Services	CPT HCPCS Prenatal care, at-risk enhanced service package (includes h1001-h1004)
Prenatal Visits	CPT 99202-99205, 99211-99215, , HCPCS Hospital outpatient clinic visit for assessment and management of a patient T1015: Clinic visit/encounter, all-inclusive
Stand-Alone Prenatal Visits	CPT CAT II Initial prenatal care visit (report at first prenatal encounter with a health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal) Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/HCPCS
	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (e.g. for example, an upper respiratory infection; patients seen for consultation only, not for continuing care)] HCPCS H1000: Prenatal care, at-risk assessment Prenatal care, at-risk enhanced service; antepartum management Prenatal care, at risk enhanced service; care coordination Prenatal care, at-risk enhanced service; education Prenatal care, at-risk enhanced service; follow-up home visit SNOMED CT 169600002: Antenatal care assessment (procedure) 169602005: Antenatal care: 10 years plus since last pregnancy (regime/therapy) 169603000: Antenatal care: primiparous, under 17 years (regime/therapy)
Postpartum Bundles Services	CPT 59410, 59515, 59614, 59622
Home Visit Prenatal Monitoring	CPT
Postpartum Visit	CPT 57170, 58300, 59430, CAT II Postpartum care visit HCPCS Cervical or vaginal cancer screening; pelvic and clinical breast examination (G0101)
Online Assessments	CPT 99422 HCPCS Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only Remote evaluation of recorded video and/or images submitted by an established patient (e.g. for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment Brief communication technology-based service, e.g. for example virtual check-in, by a physician or other qualified health care/healthcare professional who can report

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/HCP/PCS
	<p>evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion</p> <p>Brief communication technology-based service, e.g. for example, virtual check-in, by a qualified health care/healthcare professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion</p> <p>Brief communication technology-based service, e.g. for example virtual check-in, by a physician or other qualified health care/healthcare professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion</p>

Note: The codes listed are informational only; this information does not guarantee reimbursement.

Social Need Screening and Intervention (SNS-E)

Description	CPT/HCP/PCS/SNOMED CT/SNOMED CT
Food insecurity procedures	<p>441311000124102: Counseling about nutrition using stress management strategy (regime/therapy)</p> <p>441321000124105: Counseling about nutrition using stimulus control strategy (regime/therapy)</p> <p>441331000124108: Counseling about nutrition using cognitive restructuring strategy (regime/therapy)</p> <p>441341000124103: Counseling about nutrition using relapse prevention strategy (regime/therapy)</p> <p>441351000124101: Counseling about nutrition using rewards and contingency management strategy (regime/therapy)</p> <p>445291000124103: Nutrition-related skill education (procedure)</p> <p>445301000124102: Content-related nutrition education (procedure)</p> <p>445641000124105: Technical nutrition education (procedure)</p> <p>461481000124109: Referral to peer support (procedure)</p> <p>462481000124102: Referral to Community Action Agency program (procedure)</p> <p>462491000124104: Referral to benefits enrollment assistance program (procedure)</p> <p>464001000124109: Referral to case manager (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	464011000124107: Referral to care manager (procedure)
	464021000124104: Referral to care navigator (procedure)
	464031000124101: Referral to food pantry program (procedure)
	464041000124106: Referral to Child and Adult Care Food Program (procedure)
	464051000124108: Referral to Gus Schumacher Nutrition Incentive Program (procedure)
	464061000124105: Referral to food prescription program (procedure)
	464071000124103: Referral to garden program (procedure)
	464081000124100: Referral to home-delivered meals program (procedure)
	464091000124102: Referral to medically tailored meal program (procedure)
	464101000124108: Referral to Supplemental Nutrition Assistance Program (procedure)
	464111000124106: Referral to Special Supplemental Nutrition Program for Women, Infants and Children (procedure)
	464121000124103: Referral to Summer Food Service Program (procedure)
	464131000124100: Referral to community health worker (procedure)
	464141000124105: Referral to Meals on Wheels Program (procedure)
	464151000124107: Referral to congregate meal program (procedure)
	464161000124109: Referral to community resource network program (procedure)
	464171000124102: Referral to Senior Farmers' Market Nutrition Program (procedure)
	464181000124104: Referral to Farmers' Market Nutrition Program for Women, Infants and Children (procedure)
	464191000124101: Referral to Food Distribution Program on Indian Reservations (procedure)
	464201000124103: Education about Child and Adult Care Food Program (procedure)
	464211000124100: Education about Community Meals Program (procedure)
	464221000124108: Education about Gus Schumacher Nutrition Incentive Program (procedure)
	464231000124106: Education about food pantry program (procedure)
	464241000124101: Education about food prescription program (procedure)
	464251000124104: Education about garden program (procedure)
	464261000124102: Education about home-delivered meals program (procedure)
	464271000124109: Education about medically tailored meal program (procedure)
	464281000124107: Education about Special Supplement Nutrition Program for Women, Infants and Children (procedure)
	464291000124105: Education about community resource network program (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT SNOMED CT
	464301000124106: Education about benefits enrollment assistance program (procedure)
	464311000124109: Education about Community Action Agency program (procedure)
	464321000124101: Education about Food Distribution Program on Indian Reservations (procedure)
	464331000124103: Education about Farmers' Market Nutrition Program for Women, Infants and Children (procedure)
	464341000124108: Education about Senior Farmers' Market Nutrition Program (procedure)
	464351000124105: Education about congregate meal program (procedure)
	464361000124107: Education about Supplemental Nutrition Assistance Program (procedure)
	464371000124100: Education about Summer Food Service Program (procedure)
	464381000124102: Provision of prescription for infant formula (procedure)
	464401000124102: Provision of fresh fruit and vegetable voucher (procedure)
	464411000124104: Provision of food voucher (procedure)
	464421000124107: Provision of home-delivered meals (procedure)
	464431000124105: Provision of medically tailored meals (procedure)
	464611000124102: Coordination of care team (procedure)
	464621000124105: Evaluation of eligibility for home-delivered meals program (procedure)
	464631000124108: Evaluation of eligibility for Meals on Wheels program (procedure)
	464641000124103: Evaluation of eligibility for medically tailored meals program (procedure)
	464651000124101: Evaluation of eligibility for Senior Farmers' Market Nutrition Program (procedure)
	464661000124104: Evaluation of eligibility for Special Supplemental Nutrition Program for Women, Infants and Children (procedure)
	464671000124106: Counseling for readiness to implement food insecurity care plan (procedure)
	464681000124109: Counseling for food insecurity care plan participation barriers (procedure)
	464691000124107: Counseling for barriers to achieving food security (procedure)
	464701000124107: Counseling for readiness to achieve food security goals (procedure)
	464721000124102: Provision of food prescription (procedure)
	467591000124102: Evaluation of eligibility for food pantry program (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT SNOMED CT
	467601000124105: Evaluation of eligibility for Food Distribution Program on Indian Reservations (procedure)
	467611000124108: Evaluation of eligibility for Farmers' Market Nutrition Program for Women, Infants and Children (procedure)
	467621000124100: Evaluation of eligibility for Supplemental Nutrition Assistance Program (procedure)
	467631000124102: Evaluation of eligibility for Summer Food Service Program (procedure)
	467641000124107: Evaluation of eligibility for Gus Schumacher Nutrition Incentive funded program (procedure)
	467651000124109: Evaluation of eligibility for garden program (procedure)
	467661000124106: Evaluation of eligibility for Community Meal Program (procedure)
	467671000124104: Evaluation of eligibility for Child and Adult Care Food Program (procedure)
	467681000124101: Assistance with application for Summer Food Service Program (procedure)
	467691000124103: Assistance with application for Special Supplemental Nutrition Program for Women, Infants and Children (procedure)
	467711000124100: Assistance with application for Senior Farmers' Market Nutrition Program (procedure)
	467721000124108: Assistance with application for Medically Tailored Meals Program (procedure)
	467731000124106: Assistance with application for Home-Delivered Meals Program (procedure)
	467741000124101: Assistance with Application for Gus Schumacher Nutrition Incentive Program (procedure)
	467751000124104: Assistance with application for garden program (procedure)
	467761000124102: Assistance with application for food prescription program (procedure)
	467771000124109: Assistance with application for food pantry program (procedure)
	467781000124107: Assistance with application for Child and Adult Care Food Program (procedure)
	467791000124105: Assistance with application for Food Distribution Program on Indian Reservations (procedure)
	467801000124106: Assistance with application for Community Meal Program (procedure)
	467811000124109: Assistance with application for Farmers' Market Nutrition Program for Women, Infants and Children (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	467821000124101: Assistance with application for Supplemental Nutrition Assistance Program (procedure)
	468401000124109: Evaluation of eligibility for food prescription program (procedure)
	470231000124107: Counseling for social determinant of health risk (procedure)
	470241000124102: Assistance with application for national school lunch program (procedure)
	470261000124103: Assistance with application for school breakfast program (procedure)
	470281000124108: Evaluation of eligibility for school breakfast program (procedure)
	470291000124106: Referral to national school lunch program (procedure)
	470301000124107: Referral to school breakfast program (procedure)
	470311000124105: Education about national school lunch program (procedure)
	470321000124102: Education about school breakfast program (procedure)
	470591000124109: Education about community development financial institution (procedure)
	470601000124101: Education about community development corporation (procedure)
	470611000124103: Education about area agency on aging program (procedure)
	471111000124101: Referral to community development financial institution (procedure)
	471121000124109: Referral to community development corporation (procedure)
	471131000124107: Referral to area agency on aging (procedure)
	472151000124109: Referral to medical legal partnership program (procedure)
	472331000124100: Education about medical legal partnership program (procedure)
	551101000124107: Referral to lawyer (procedure)
Homelessness Procedures	CPT 96156, 96160, 96161 SNOMED CTSNOMED CT 308440001: Referral to social worker (procedure) 710824005: Assessment of health and social care needs (procedure) 711069006: Coordination of care plan (procedure) 1148446004: Education about legal aid (procedure) 1148447008: Assessment for housing insecurity (procedure) 1148812007: Assessment of progress toward goals to achieve housing security (procedure) 1148814008: Assessment of goals to achieve housing security (procedure) 1148817001: Assessment of barriers in housing insecurity care plan (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	1148818006: Coordination of services to assist with maintaining housing security (procedure)
	1162436000: Referral to legal aid (procedure)
	1162437009: Coordination of resources to address housing instability (procedure)
	1230338004: Referral to charitable organization (procedure)
	461481000124109: Referral to peer support (procedure)
	462481000124102: Referral to Community Action Agency program (procedure)
	462491000124104: Referral to benefits enrollment assistance program (procedure)
	464001000124109: Referral to case manager (procedure)
	464011000124107: Referral to care manager (procedure)
	464021000124104: Referral to care navigator (procedure)
	464131000124100: Referral to community health worker (procedure)
	464161000124109: Referral to community resource network program (procedure)
	464291000124105: Education about community resource network program (procedure)
	464301000124106: Education about benefits enrollment assistance program (procedure)
	464311000124109: Education about Community Action Agency program (procedure)
	464611000124102: Coordination of care team (procedure)
	470231000124107: Counseling for social determinant of health risk (procedure)
	470471000124109: Assistance with application for rental assistance program (procedure)
	470481000124107: Assistance with application for subsidized housing program (procedure)
	470491000124105: Evaluation of eligibility for subsidized housing program (procedure)
	470501000124102: Education about subsidized housing program (procedure)
	470581000124106: Education about healthcare for the homeless program (procedure)
	470591000124109: Education about community development financial institution (procedure)
	470601000124101: Education about community development corporation (procedure)
	470611000124103: Education about area agency on aging program (procedure)
	470781000124104: Evaluation of eligibility for permanent supportive housing program (procedure)
	470791000124101: Assistance with application for permanent supportive housing program (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT SNOMED CT
	470801000124100: Education about permanent supportive housing program (procedure)
	470811000124102: Evaluation of eligibility for transitional housing program (procedure)
	470821000124105: Education about transitional housing program (procedure)
	470831000124108: Assistance with application for transitional housing program (procedure)
	470841000124103: Referral to healthcare for the homeless program (procedure)
	471021000124108: Referral to street outreach program (procedure)
	471031000124106: Education about street outreach program (procedure)
	471041000124101: Referral to rental assistance program (procedure)
	471071000124109: Referral to fair housing assistance program (procedure)
	471081000124107: Referral to Day Shelter program (procedure)
	471091000124105: Referral to Emergency Shelter program (procedure)
	471101000124104: Referral to coordinated entry program (procedure)
	471111000124101: Referral to community development financial institution (procedure)
	471121000124109: Referral to community development corporation (procedure)
	471131000124107: Referral to area agency on aging (procedure)
	472031000124103: Evaluation of eligibility for Safe Haven Program (procedure)
	472041000124108: Referral to subsidized housing service (procedure)
	472051000124105: Education about Safe Haven program (procedure)
	472081000124102: Education about rental assistance program (procedure)
	472091000124104: Evaluation of eligibility for rental assistance program (procedure)
	472101000124105: Evaluation of eligibility for Rapid Re-housing program (procedure)
	472111000124108: Education about Rapid Re-housing program (procedure)
	472121000124100: Assistance with application for Rapid Re-housing program (procedure)
	472131000124102: Provision of rental assistance voucher (procedure)
	472141000124107: Referral to medical respite for homeless program (procedure)
	472151000124109: Referral to medical legal partnership program (procedure)
	472161000124106: Referral to housing support program (procedure)
	472191000124103: Counseling for readiness to achieve housing security goals (procedure)
	472221000124105: Counseling for readiness to implement housing insecurity care plan (procedure)
	472241000124103: Counseling for barriers to achieve housing security (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	472261000124104: Counseling for housing insecurity care plan participation barriers (procedure)
	472301000124108: Evaluation of eligibility for medical respite for homeless program (procedure)
	472311000124106: Education about medical respite for homeless program (procedure)
	472321000124103: Assistance with application for medical respite for homeless program (procedure)
	472331000124100: Education about medical legal partnership program (procedure)
	472341000124105: Evaluation of eligibility for Housing with Services program (procedure)
	472351000124107: Assistance with application for Housing with Services (procedure)
	472361000124109: Education about Housing with Services program (procedure)
	480791000124106: Evaluation of eligibility for Street Outreach program (procedure)
	480801000124107: Assistance with application for Safe Haven program (procedure)
	480811000124105: Evaluation of eligibility for Housing Only program (procedure)
	480821000124102: Education about Housing Only program (procedure)
	480831000124104: Assistance with application for Housing Only program (procedure)
	480871000124101: Evaluation of eligibility for healthcare for homeless program (procedure)
	480901000124101: Education about fair housing assistance program (procedure)
	480921000124106: Assistance with application to Emergency Shelter program (procedure)
	480931000124109: Evaluation of eligibility for Emergency Shelter program (procedure)
	480941000124104: Education about Emergency Shelter program (procedure)
	480961000124100: Education about Day Shelter program (procedure)
	480971000124107: Education about Coordinated Entry program (procedure)
	480981000124105: Assistance with application for Day Shelter program (procedure)
	551101000124107: Referral to lawyer (procedure)
Housing Instability Procedures	CPT 96156, 96160, 96161 SNOMED CTSNOMED CT 308440001: Referral to social worker (procedure) 710824005: Assessment of health and social care needs (procedure) 711069006: Coordination of care plan (procedure) 1148446004: Education about legal aid (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	1148447008: Assessment for housing insecurity (procedure)
	1148812007: Assessment of progress toward goals to achieve housing security (procedure)
	1148814008: Assessment of goals to achieve housing security (procedure)
	1148817001: Assessment of barriers in housing insecurity care plan (procedure)
	1148818006: Coordination of services to assist with maintaining housing security (procedure)
	1156869006: Education about tenant rights organization (procedure)
	1162436000: Referral to legal aid (procedure)
	1162437009: Coordination of resources to address housing instability (procedure)
	1230338004: Referral to charitable organization (procedure)
	461481000124109: Referral to peer support (procedure)
	462481000124102: Referral to Community Action Agency program (procedure)
	462491000124104: Referral to benefits enrollment assistance program (procedure)
	464001000124109: Referral to case manager (procedure)
	464011000124107: Referral to care manager (procedure)
	464021000124104: Referral to care navigator (procedure)
	464131000124100: Referral to community health worker (procedure)
	464161000124109: Referral to community resource network program (procedure)
	464291000124105: Education about community resource network program (procedure)
	464301000124106: Education about benefits enrollment assistance program (procedure)
	464311000124109: Education about Community Action Agency program (procedure)
	464611000124102: Coordination of care team (procedure)
	470231000124107: Counseling for social determinant of health risk (procedure)
	470471000124109: Assistance with application for rental assistance program (procedure)
	470481000124107: Assistance with application for subsidized housing program (procedure)
	470491000124105: Evaluation of eligibility for subsidized housing program (procedure)
	470501000124102: Education about subsidized housing program (procedure)
	470591000124109: Education about community development financial institution (procedure)
	470601000124101: Education about community development corporation (procedure)
	470611000124103: Education about area agency on aging program (procedure)
	471041000124101: Referral to rental assistance program (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	471051000124104: Referral to Homelessness Prevention program (procedure)
	471061000124102: Referral to mortgage assistance program (procedure)
	471071000124109: Referral to fair housing assistance program (procedure)
	471111000124101: Referral to community development financial institution (procedure)
	471121000124109: Referral to community development corporation (procedure)
	471131000124107: Referral to area agency on aging (procedure)
	472021000124101: Referral to tenants’ rights organization program (procedure)
	472041000124108: Referral to subsidized housing service (procedure)
	472081000124102: Education about rental assistance program (procedure)
	472091000124104: Evaluation of eligibility for rental assistance program (procedure)
	472131000124102: Provision of rental assistance voucher (procedure)
	472151000124109: Referral to medical legal partnership program (procedure)
	472161000124106: Referral to housing support program (procedure)
	472191000124103: Counseling for readiness to achieve housing security goals (procedure)
	472221000124105: Counseling for readiness to implement housing insecurity care plan (procedure)
	472241000124103: Counseling for barriers to achieve housing security (procedure)
	472261000124104: Counseling for housing insecurity care plan participation barriers (procedure)
	472271000124106: Provision of mortgage assistance voucher (procedure)
	472281000124109: Evaluation of eligibility for mortgage assistance program (procedure)
	472291000124107: Education about mortgage assistance program (procedure)
	472331000124100: Education about medical legal partnership program (procedure)
	472381000124104: Provision of emergency housing fund voucher (procedure)
	480841000124109: Education about Homelessness Prevention program (procedure)
	480851000124106: Evaluation of eligibility for Homelessness Prevention program (procedure)
	480861000124108: Assistance with application to Homelessness Prevention program (procedure)
	480901000124101: Education about fair housing assistance program (procedure)
	551091000124101: Referral to emergency housing fund program (procedure)
	551101000124107: Referral to lawyer (procedure)
Inadequate Housing Procedures	CPT 96156, 96160, 96161 SNOMED CTSNOMED CT 49919000: Home safety education (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT SNOMED CT
	308440001: Referral to social worker (procedure)
	710824005: Assessment of health and social care needs (procedure)
	711069006: Coordination of care plan (procedure)
	1148446004: Education about legal aid (procedure)
	1148813002: Assessment of barriers in inadequate housing care plan (procedure)
	1148815009: Assessment of goals to achieve adequate housing (procedure)
	1148823006: Assessment of progress toward goals to achieve adequate housing (procedure)
	1162436000: Referral to legal aid (procedure)
	1230338004: Referral to charitable organization (procedure)
	461481000124109: Referral to peer support (procedure)
	462481000124102: Referral to Community Action Agency program (procedure)
	462491000124104: Referral to benefits enrollment assistance program (procedure)
	464001000124109: Referral to case manager (procedure)
	464011000124107: Referral to care manager (procedure)
	464021000124104: Referral to care navigator (procedure)
	464131000124100: Referral to community health worker (procedure)
	464161000124109: Referral to community resource network program (procedure)
	464291000124105: Education about community resource network program (procedure)
	464301000124106: Education about benefits enrollment assistance program (procedure)
	464311000124109: Education about Community Action Agency program (procedure)
	464611000124102: Coordination of care team (procedure)
	470231000124107: Counseling for social determinant of health risk (procedure)
	470431000124106: Referral to weatherization assistance program (procedure)
	470441000124101: Evaluation of eligibility for weatherization assistance program (procedure)
	470451000124104: Education about weatherization assistance program (procedure)
	470461000124102: Assistance with application for weatherization assistance program (procedure)
	470591000124109: Education about community development financial institution (procedure)
	470601000124101: Education about community development corporation (procedure)
	470611000124103: Education about area agency on aging program (procedure)
	471111000124101: Referral to community development financial institution (procedure)
	471121000124109: Referral to community development corporation (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	471131000124107: Referral to area agency on aging (procedure)
	472151000124109: Referral to medical legal partnership program (procedure)
	472201000124100: Counseling for readiness to achieve adequate housing goals (procedure)
	472211000124102: Counseling for readiness to implement inadequate housing care plan (procedure)
	472231000124108: Counseling for barriers to achieve adequate housing (procedure)
	472251000124101: Counseling for inadequate housing care plan participation barriers (procedure)
	472331000124100: Education about medical legal partnership program (procedure)
	472371000124102: Provision of voucher for repair of place of residence (procedure)
	480881000124103: Referral to environmental hazard testing of residence program (procedure)
	480891000124100: Evaluation of eligibility for environmental hazard testing of residence program (procedure)
	480911000124103: Education about environmental hazard testing of residence program (procedure)
	480951000124102: Assistance with application for environmental hazard testing of residence program (procedure)
	551041000124105: Referral to housing repair program (procedure)
	551051000124107: Referral for housing repair assessment program (procedure)
	551061000124109: Evaluation of eligibility for housing repair program (procedure)
	551071000124102: Education about housing repair program (procedure)
	551081000124104: Assistance with application for housing repair program (procedure)
	551101000124107: Referral to lawyer (procedure)

Transportation	CPT
Insecurity Procedures	96156, 96160, 96161
	SNOMED CTSNOMED CT
	308440001: Referral to social worker (procedure)
	710824005: Assessment of health and social care needs (procedure)
	711069006: Coordination of care plan (procedure)
	1148446004: Education about legal aid (procedure)
	1162436000: Referral to legal aid (procedure)
	1230338004: Referral to charitable organization (procedure)
	461481000124109: Referral to peer support (procedure)
	462481000124102: Referral to Community Action Agency program (procedure)
	462491000124104: Referral to benefits enrollment assistance program (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CTSNOMED CT
	464001000124109: Referral to case manager (procedure)
	464011000124107: Referral to care manager (procedure)
	464021000124104: Referral to care navigator (procedure)
	464131000124100: Referral to community health worker (procedure)
	464161000124109: Referral to community resource network program (procedure)
	464291000124105: Education about community resource network program (procedure)
	464301000124106: Education about benefits enrollment assistance program (procedure)
	464311000124109: Education about Community Action Agency program (procedure)
	464611000124102: Coordination of care team (procedure)
	470231000124107: Counseling for social determinant of health risk (procedure)
	470591000124109: Education about community development financial institution (procedure)
	470601000124101: Education about community development corporation (procedure)
	470611000124103: Education about area agency on aging program (procedure)
	471111000124101: Referral to community development financial institution (procedure)
	471121000124109: Referral to community development corporation (procedure)
	471131000124107: Referral to area agency on aging (procedure)
	472151000124109: Referral to medical legal partnership program (procedure)
	472331000124100: Education about medical legal partnership program (procedure)
	551101000124107: Referral to lawyer (procedure)
	551111000124105: Provision of taxi voucher (procedure)
	551121000124102: Referral to taxi voucher program (procedure)
	551141000124109: Evaluation of eligibility for taxi voucher program (procedure)
	551161000124108: Education about taxi voucher program (procedure)
	551191000124100: Assistance with application for taxi voucher program (procedure)
	551201000124102: Referral to fuel voucher program (procedure)
	551211000124104: Evaluation of eligibility for a fuel voucher program (procedure)
	551221000124107: Education about fuel voucher program (procedure)
	551231000124105: Referral to vehicle donation program (procedure)
	551241000124100: Assistance with application for fuel voucher program (procedure)
	551251000124103: Evaluation of eligibility for vehicle donation program (procedure)
	551261000124101: Education about vehicle donation program (procedure)
	551271000124108 Assistance with application for vehicle donation program (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT SNOMED CT
	551281000124106: Referral to transportation network company program (procedure)
	551291000124109: Assistance with application for transportation network company program (procedure)
	551301000124105: Education about transportation network company program (procedure)
	551311000124108: Evaluation of eligibility for transportation network company program (procedure)
	551321000124100: Referral to volunteer driver program (procedure)
	551331000124102: Referral to rideshare program (procedure)
	551341000124107: Referral to public transportation voucher program (procedure)
	551351000124109: Referral to paratransit program (procedure)
	551361000124106: Referral to microtransit program (procedure)
	551371000124104: Referral to Non-Emergency Medical Transportation program (procedure)
	551381000124101: Referral to automobile share program (procedure)
	551401000124101: Referral to vehicle repair program (procedure)
	551421000124106: Assistance with application for bicycle share program (procedure)
	551431000124109: Referral to bicycle share program (procedure)
	610961000124100: Assistance with application for volunteer driver program (procedure)
	610971000124107: Assistance with application for rideshare program (procedure)
	610981000124105: Assistance with application for public transportation voucher program (procedure)
	610991000124108: Assistance with application for paratransit program (procedure)
	611001000124109: Assistance with application for microtransit program (procedure)
	611011000124107: Assistance with application for Non-Emergency Medical Transportation program (procedure)
	611021000124104: Assistance with application for automobile share program (procedure)
	611031000124101: Education about rideshare program (procedure)
	611041000124106: Education about volunteer driver program (procedure)
	611051000124108: Education about microtransit program (procedure)
	611061000124105: Education about public transportation voucher program (procedure)
	611071000124103: Education about paratransit program (procedure)
	611081000124100: Education about Non-Emergency Medical Transportation program (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT/SNOMED CT
	611101000124108: Education about vehicle repair program (procedure)
	611121000124103: Education about automobile share program (procedure)
	611281000124107: Counseling for readiness to achieve transportation security (procedure)
	611291000124105: Counseling for barriers to achieve transportation security (procedure)
	611301000124106: Counseling for readiness for engagement in transportation insecurity care plan (procedure)
	611311000124109: Counseling for barriers to engagement in transportation insecurity care plan (procedure)
	611321000124101: Assessment of progress toward goals to achieve transportation security (procedure)
	611331000124103: Assessment of goals to achieve transportation security (procedure)
	611341000124108: Assessment of barriers in transportation insecurity care plan (procedure)
	611351000124105: Assessment for transportation insecurity (procedure)
	611361000124107: Evaluation of eligibility for rideshare program (procedure)
	611371000124100: Evaluation of eligibility for volunteer driver program (procedure)
	611381000124102: Provision of public transportation voucher (procedure)
	611391000124104: Evaluation of eligibility for public transportation voucher program (procedure)
	611401000124102: Evaluation of eligibility for paratransit program (procedure)
	611411000124104: Evaluation of eligibility for microtransit program (procedure)
	611421000124107: Evaluation of eligibility for automobile share program (procedure)
	611431000124105: Evaluation of eligibility for vehicle repair program (procedure)
	611441000124100: Evaluation of eligibility for Non-Emergency Medical Transportation program (procedure)

Note: The codes listed are informational only; this information does not guarantee reimbursement.

To help make it as easy as possible to keep up with annual changes to HEDIS documentation, we have created a library of HEDIS content for you. You'll find tip sheets with coding information and more for many HEDIS measures and other documentation to help ensure accurate claims coding, which helps ensure accurate reimbursement. Go to *Provider News* to view all communications in the Optimizing HEDIS & STARS category.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Please visit [My Diverse Patients](#) for additional information about eLearning experiences on provider cultural competency and health equity.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2025 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

