PROSPECT MEDICAL

Quality Service ~ Quality Care

2025 PROVIDER REFERENCE GUIDE

ADULT QUALITY MEASURES

This reference guide can help you better understand the specifications for quality measures used to address care opportunities, as well as how to report data and what billing codes to use.

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Description: Improving a patient's ability to get needed care is a way that we can help a member's experience when seeking care, tests, or treatment. Each year health plans send Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to gather feedback from consumers about their experience when seeking care. The results are used to gauge patient experience across the network and practice. The feedback will help improve quality of care and the member's overall experience

Line of Business (LOB): ☑**Medicare** ☑ **Medicaid** ☑ **Commercial**

Here are the types of questions your patients will be asked about on the CAHPS survey or Prospect's Member Experience Survey and ideas to help improve:

Questions about getting needed care:

- How often was it easy to get the care, tests, or treatment you needed?
- How often did you get an appointment to see a specialist as soon as you needed?

Ideas to help Improve Patient's Experience with Getting Needed Care:

- Submit required prior authorizations request within 2 days of members appointment.
- Provide multiple services during a members visit.

Example: Is there anything else we can do for you while you're here?

- Offer to help schedule your patients follow-up appointment before they leave the office appointment.
- Offer to help assist with the patients specialist appointment if they are unfamiliar with the authorization process.
- Consider using extended office hours.

We're Here to Help

To learn more about the ways you can improve the patient experience, contact the performance programs department at Prospectquality@prospectmedical.com

Improving Getting Appointments and Care Quickly (CAHPS)

Description: Improving a patient's ability to get appointments and care quickly is one way that we can help a member's experience when accessing care. Each year health plans send Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to gather feedback from consumers about their experience when seeking care. The results are used to gauge patient experience across the network and practice. The feedback will help improve quality of care and the member's overall experience.

Line of Business (LOB): ☑Medicare ☑ Medicaid ☑ Commercial

Here are the types of questions your patients will be asked about on the CAHPS survey or Prospect's Member Experience Survey and ideas to help improve:

Questions about Getting Appointments and Care Quickly:

- How often did you see the person you came to see within 15 minutes of your appointment time? (Wait time included time spent in the waiting room and exam room)
- When you needed care right away, how often did you get care as soon as you need it?
- How often did you get an appointment for a checkup or routine care with your doctor as soon as you needed?

Ideas to help Improve Patient's Experience with Getting Appointments & Care Quickly:

- Acknowledge the patient upon arrival to their appointment.
- Set wait times and expectations.

  Example: "Thank you for being patient, the doctor will be with you within 15 minutes. I'll keep you updated if it will be any longer."

  If the patient is waiting longer than 15 minutes, ensure you acknowledge the member and let them know of the wait time.
- Reserve time for urgent appointments. The members ability to schedule an appointment timely is important for this CAHPS measure question.
- Follow access standards set forth by Department of Managed Health Care

We're Here to Help

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Improving Care Coordination (CAHPS)

Description: Improving a patient's ability to get appointments and care quickly is one way that we can help a member's experience when accessing care. Each year health plans send Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to gather feedback from consumers about their experience when seeking care. The results are used to gauge patient experience across the network and practice. The feedback will help improve quality of care and the member's overall experience.

Line of Business (LOB): ☑Medicare ☑ Medicaid ☑ Commercial

Here are the types of questions your patients will be asked about on the CAHPS survey or Prospect's Member Experience Survey and ideas to help improve:

Questions about Care Coordination:

- How often did your personal doctor seem to informed and up-to-date about the care you got from other doctors or healthcare provider?
- How often did your personal doctor talk to you about all the prescription medicines you are taking?
- When your doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?

Ideas to Improve Patient's Experience with Care Coordination:

- Remind patients to share your contact information to other care providers including specialists that they see.
- Make sure test results are shared between primary care and specialist providers.
- Review your patient's medical records with them.

  Example: "To provide the best care, I will take a minute to review you medical records for new information." Review all the prescription medications your patients are taking during each visit.
- Always follow up with patients after they have completed lab tests or other tests to discuss results of those tests.

We're Here to Help

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Adults' Access to Preventive/Ambulatory Health Services (AAP)

Description: Percentage of patients 20 years old and older who had an ambulatory or preventive care visit during the measurement year

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

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:
- Please be sure to have members come in for an ambulatory or preventive care visit annually

Measure Best Practices:
- Request monthly or bi-monthly AAP gaps in care lists for your group. Provider rosters can change throughout the year and newly assigned members need to have care initiated
- Make reminder calls to patients who have appointments to decrease no-show rates
- Try other appointment scheduling methods (i.e. email or online portals). Long wait times on the phone may cause patients to seek care elsewhere
- Keep a few open appointment slots each day to see patients the day they call
- Offer evening and weekend hours to accommodate all patient schedules

Exclusions:
- Patients in hospice
- Patients who died during measurement year

For applicable coding: AAP (page 41)

Advance Care Planning (ACP)

Description: The percentage of adults 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- An advance care plan with a dated notation in the medical record in 2024
- Discussion about advance care planning in 2025 with a dated notation in the patient's medical record
- Documentation that the patient previously executed an advance care plan with a dated notation in the patient's medical record in 2025

Important Note:

- Advance care planning is an administrative measure for measurement year 2025

Measure Best Practices:

- Complete the COA assessment form annually with eligible patients. Then submitting proper ACP codes on visit note claim.
- Discuss the following types of advance care plans with your patients during visits and include a dated notation in their medical record document along with proper coding on visit note claim:
  – Advance directive or living will
  – Power of attorney
  – Health care proxy
  – Actionable medical or surrogate decision-maker

Exclusions:

- Patients in hospice
- Patients who died during measurement year

For applicable coding: (ACP page 52)

Asthma Medication Ratio (AMR)

Description: The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year

Line of Business (LOB): ☐ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- The number of members who have a medication ratio of 0.50 or greater during the measurement year
- The ratio is between the units of Asthma controller medication given during 2025 sum and units of Asthma reliever medication given during 2025 sum
- Ratio = Units of Controller Medications /Units of Total Asthma Medications

Examples of Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral

Examples of Asthma Controller Medications continued

Description	Prescriptions	Medication Lists	Route
Long-acting beta2-adrenergic agonist (LABA)	Fluticasone furoate-umeclidinium-vilanterol	Fluticasone Furoate Umeclidinium Vilanterol Medications List	Inhalation
Long-acting beta2-adrenergic agonist (LABA)	Salmeterol	Salmeterol Medications List	Inhalation
Long-acting muscarinic antagonists (LAMA)	Tiotropium	Tiotropium Medications List	Inhalation
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Examples of Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Exclusions:

- Patients who had a diagnosis that requires a different treatment approach than members with asthma any time during the measurement year
- Patients who had no asthma controller or reliever medications dispensed during the measurement year
- Patients in hospice
- Patients who died during measurement year

Breast Cancer Screening (BCS-E)

Description: Percentage of women 50-74 years old who had a mammogram to screen for breast cancer in the past two years

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- Mammogram between October 1, 2023—December 31, 2025
- All types and methods of mammograms including digital breast tomosynthesis

Important Note:

- Biopsies, breast ultrasounds, or MRIs will not meet measure compliance

Measure Best Practices:

- Due to the unique 27–month measurement period, physician practices may want to consider ordering a mammogram every two years for their patients beginning at 50 years old, or sooner when risk factors such as family history exist
- Educate patients about the importance of early screenings and encourage testing
- Schedule a mammogram for the patient
- Engage patients to discuss their fears about mammograms and let them know that the test is more comfortable and uses less radiation than it did in the past
- Provide patients with a list of facilities that provide mammograms
- Document date of service (at minimum month and year) of most recent mammogram in the medical record — along with the results (i.e., normal vs. abnormal)
- Document mastectomy status (unilateral vs. bilateral) and date of service (minimum year performed) in the medical record

Exclusions:

- Patients who have had a bilateral mastectomy or who have had both a unilateral left and right mastectomy
  - — A single unilateral mastectomy does **not** count as a full exclusion
- Patients in hospice or using hospice services
- Patients 66-74 years old who:
  - — Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) **AND/OR** have frailty and advanced illness
- Patients who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the patient's history through the end of the measurement period
- Patients who died during measurement year

For applicable coding: BCS (page 51)

Cervical Cancer Screening (CCS-E)

Description: Percentage of women 21—64 years of age who were screened for cervical cancer

Line of Business (LOB): ☐ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- Women age 21–64 who had cervical cytology performed within the last 3 years
- Women age: 30–64 who had cervical high-risk human papillomavirus (hrHPV) performed within the last 5 years
- Women age 30–64 who had cervical cytology/high-risk human papillomavirus (hrHPV) performed within the last 5 years

Measure Best Practices:

- Make sure to document specific dates for year of service
- Women aged 21-29 should have a Pap test every 3 years
- Women aged 30-65 should have a hrHPV test every 5 years
- Women who have had a TOTAL hysterectomy and do not have history of high-grade precancerous lesion (CIN 2 or 3) or cervical cancer are NOT recommended to be screened
- Those of high risk of cervical cancer may need to be screened more often, if they have any of the following risk factors:
  – prior diagnosis of a high-grade precancerous cervical lesion or cervical cancer
  – suppressed immune system (HIV infection, organ transplant, long-term steroid use)
  – exposed to DES in utero

Exclusions:

- Evidence of a TOTAL hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix
- Documentation of complete, total or radical abdominal or vaginal hysterectomy
- Documentation of vaginal pap in conjunction w/ documentation of hysterectomy
- Documentation of hysterectomy in combination w/ documentation that the patient no longer needs pap testing
- Patients in Hospice
- Members with Sex Assigned at Birth of Male at any time during the patient's history
- Patients who died during measurement year

For applicable coding: CCS (page 57)

Chlamydia Screening (CHL)

Description: Percentage of members ages 16–24 who were recommended for routine chlamydia screening, were identified as sexually active and had a least one test for chlamydia during measurement year

Line of Business (LOB): ☐ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- Test to screen for chlamydia among women 16–24 years as of December 31, 2025. Report two age stratifications and a total rate:
  – 16–20 years
  – 21–24 years
  – Total

Measure Best Practices:

- For all those on birth control pills, make chlamydia screening a standard lab
- Remember that chlamydia screening can be performed through a simple urine test; offer this as an option for your patients
- Diagnosis is easy and non-invasive; pelvic exam is NOT needed for diagnosis
- Chlamydia screening can be performed through a simple urine test; offer this as an option for your patients
- Offer chlamydia or STD patient educational resources to all sexually active females ages 16-24
- Explain the complications of undiagnosed and untreated sexually transmitted infections (STIs)
- Review gaps in care list to identify patients that meet the criteria and need a screening
- Make discussion of this screening a standard part of any discussion of every visit
- Use all medical visits, including well visits, sick visits, and sports physicals as an opportunity to update needed screenings

Exclusions:

- Patients in hospice
- Sex Assigned at Birth: (LOINC code 76689-9) Male (LOINC code LA2-8) any time in the member's history
- Optional Exclusion: If a member qualified for the measure from a pregnancy test alone, they'll be excluded if they **additionally** have one of the following:
  – A prescription for isotretinoin
  – An X-ray
- Patients who died during the measurement year

For applicable coding: CHL (page 60)

Colorectal Cancer Screening (COL-E)

Description: Percentage of patients 45–75 years old who had an appropriate screening for colorectal cancer

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance (any one of the following):

- Fecal occult blood test (FOBT) during 2025 (one year)
- Cologuard (FIT-DNA) test from 2023 to 2025 (three years)
- Flexible sigmoidoscopy or computed tomographic (CT) colonography from 2021 to 2025 (five years)
- Colonoscopy from 2016 to 2025 (10 years)
- Report two age stratifications and a total rate:
  - 46-49 years
  - 50-75 years
  - Total.

Important Notes:

- Partial colectomy and digital rectal exam (DRE) **do not** count as an exclusion
- Result is required for FOBT and FIT-DNA; include if result is positive/negative

Measure Best Practices:

- Clearly document administered screenings, total colectomy or colorectal cancer in patient's medical record, including date of service
- Ask patients if they've had a colorectal cancer screening and update patient history annually
- Encourage patients resistant to having a colonoscopy to perform and return at-home stool tests (FOBT)
- If testing of the patient's sample has unfavorable results, further diagnostic testing such as a colonoscopy is recommended

Exclusions:

- Patients in hospice or using hospice services
- Members ages 66 and older as of Dec. 31, 2025 who had a diagnosis of frailty and advanced illness.* Advanced illness is indicated by one of the following:
  - — Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness
  - — One or more acute inpatient encounters with a diagnosis of advanced illness
  - — One or more acute inpatient discharges with a diagnosis of advanced illness on the discharge claim
  - — Dispensed a dementia medication: Donepezil, galantamine, rivastigmine or memantine
- Medicare members ages 66 and older as of Dec. 31, 2025 who are either:
  - – Enrolled in an Institutional Special Needs Plan (I-SNP)
  - – Living long term in an institution*
- Patients who have had a total colectomy or colorectal cancer at any time during the patient's history through Dec. 31, 2025
- Patients who expired during the measurement period

*** Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions**

For applicable coding: COL (page 70)

Controlling High Blood Pressure (CBP)

Description: Percentage of hypertensive patients 18–85 years old whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- BP reading during 2025 on or after the second diagnosis of hypertension
- Most recent reading in 2025 must have a representative systolic BP < 140 mm Hg and a representative diastolic BP of < 90 mm Hg to be measure compliant
- The adequately controlled result must be documented and reported administratively

Important Notes:

- BP readings taken in the following situations will **not** count toward compliance:
  – During an acute inpatient stay or an emergency department visit
  – On the same day as a diagnostic test, or diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the day of the test or procedure – with the exception of a fasting blood test. Examples include, but are not limited to:
    - Colonoscopy
    - Dialysis, infusions and chemotherapy
    - Nebulizer treatment with albuterol

Measure Best Practices:

- If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. Do not round BP values. If using an automated machine, record exact values
- Review hypertensive medication history and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure, as needed
- If blood pressure is out of target range, have the patient return in three months
- Document blood pressure readings at each visit
- Ensure submitted claims or encounters include the appropriate CPT Category II codes for BP readings

Exclusions:

- Patients in hospice or using hospice services or with end-stage renal disease (ESRD)
- Patients 66–85 years old living long-term in an institutional setting or who are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years old with frailty and advanced Illness
- Patients 81 years and older with frailty
- Patients who died during measurement year

Optional Exclusion:

– Female members who are pregnant
– Members on dialysis
– Members who have had a kidney transplant
– Members who have had a nephrectomy

For applicable coding: CBP (page 74)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Description: The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED during the measurement year

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:
A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Report two age stratifications and a total rate:

- 18-64 years
- 65 years and older
- Total

The following meet criteria for follow-up:

- An outpatient visit
- A telephone visit
- Transitional care management services
- Case management visits
- Complex Care Management Services
- An outpatient or telehealth behavioral health visit
- An outpatient or telehealth behavioral health visit
- An intensive outpatient encounter or partial hospitalization
- An intensive outpatient encounter or partial hospitalization
- A community mental health center visit
- Electroconvulsive therapy
- A telehealth visit
- A substance use disorder service
- An e-visit or virtual check-in

Exclusions:

- Members in hospice or using hospice services anytime during the measurement year are a required exclusion
- Exclude nonacute inpatient stays
- Exclude ED visits that result in an inpatient stay
- Members who died during the measurement year

For applicable coding: FMC (page 78)

Osteoporosis Management in Women (OMW)

Description: Percentage of women ages 67–85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within six months (180 days) of the fracture (does not include fractures to the finger, toe, face or skull)

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance (any one of the following):

- Within six months of fracture date or date of discharge (if hospitalized for fracture):
  – A BMD test including test administered during inpatient stay for fracture
  – Osteoporosis therapy including any long-acting therapy provided during inpatient stay for fracture
    - A dispensed medication to treat or prevent osteoporosis

Important Notes:

- Osteoporosis medication must be dispensed within six months of the fracture
- Documentation that the medications aren't tolerated is **not** an exclusion for this measure

Measure Best Practices:

- For activity before the fracture, submit supplemental data (i.e., medical record) for BMD test performed within 24 months
- For osteoporosis medication given to the patient in a clinical setting within the 12 months prior to the fracture, document in the medical record the medication name, the date that it was dispensed, its dosage/strength and administration route. This documentation can then be submitted as supplemental data
- Humana pays for a BMD test every two years for qualified patients—generally women older than 65 who are at risk of losing bone mass or are at risk for osteoporosis; and post-menopausal women older than 50 based on risk factors. Please encourage your at risk patients to have a screening before a fracture occurs
- Claims for BMD test should be submitted with an ICD-10 diagnosis code that indicates risk factors exist for osteoporosis. Claims submitted with screening diagnosis codes, such as Z13.820, may cause the claim to deny
- Prescribe medication to treat osteoporosis. Use of calcium supplements will not meet criteria for measure
- Promote the use of remote/mobile dual-energy X-ray absorptiometry (DEXA) scans
- Collaborate with our designated team of nurses to conduct outreach calls to your Humana-covered patients who have recently sustained a fracture. During the call, a nurse will inform patients about osteoporosis risks, encourage preventive screenings and offer the scheduling of any needed bone density tests

Exclusions:

- Patients in hospice
- Patients 67–85 years old living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 67–80 years old with frailty and advanced illness
- Patients 81 years and older with frailty
- Patients who died during the measurement year

For applicable coding: OMW (page 76)

Plan All-Cause Readmissions (PCR)

Description: For members ages 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission (a lower rate indicates a better score for this measure)

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- No particular service is needed. However, practices can identify patients who have been discharged from acute facilities using daily discharge reporting. Outreaches to these patients to schedule follow-up care and medication reconciliation could reduce the risk of readmission.

Important Note:

- For Commercial and Medicaid, report only members 18-64 years of age

Measure Best Practices:

- Promote health plan services (e.g., transition of care, care coordination, home health, etc.)
- Be aware of the daily discharge census
- If possible, manage scheduling capacity to ensure discharged patients can be seen within seven days
- Conduct medication reconciliation during first post-discharge visit with patient
- Have a discussion with patients to determine if they have issues accessing the resources necessary to prevent a readmission
- Connect patient to community resources and/or health plan care management services to help remove barriers to care and/or access to resources

Exclusions:

- Pregnant members
- Patients in hospice
- Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 – Dec. 1, 2025
- For stays that included a direct transfer, exclude original admission's discharge date. Only the last discharge should be considered

COA Functional Status Assessment

Description: Percentage of adults 66 years and older who had a functional assessment during the measurement year

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- At least one complete functional status assessment performed in an outpatient setting in 2025 with dated notation in the patient's medical record, which may include:
  – Assessment of instrumental activities of daily living (IADL) or activities of daily living (ADL)
    - Results using a standardized functional assessment tool

Important Notes:

- A functional status assessment done in an acute inpatient setting will **not** meet compliance
- A functional status assessment limited to an acute or single condition, event or body system, such as lower back or leg, will **not** meet compliance

Measure Best Practices:

- Perform a comprehensive functional status assessment with Medicare patients as a part of annual wellness or physical exam
- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.

Exclusions:

- Patients in hospice
- Patients who died during measurement year

For applicable coding: FSA (page 53)

COA Medication Review

Description: Percentage of adults 66 years and older who had a medication review by a clinical pharmacist or prescribing practitioner and the presence of a medication list in the medical record during the measurement year

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- At least one medication review conducted by a prescribing practitioner or clinical pharmacist in 2025 with a medication list present in the patient's medical record with a dated notation
- Transitional care management services that include medication review administered during 2025

Important Notes:

- Medication review conducted in an acute inpatient setting **will not** meet compliance
- Documentation that the medications aren't tolerated **is not** an exclusion for this measure
- Medication list must be included in the medical record **and** medication review must be completed by a prescribing provider or clinical pharmacist
- Medicare SNP and MMP enrolled patients only

Measure Best Practices:

- If patient is not taking any medicine, creating a dated notation in the medical record will address the measure
- A medication review and medication list code must be billed simultaneously for a patient to be compliant. A review of side effects for a single medication at the time of prescription alone is not sufficient
- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data

Exclusions:

- Patients in hospice
- Patients who died during measurement year

For applicable coding: MDR (page 54)

COA Pain Assessment

Description: Percentage of adults 66 years and older who were assessed for pain during the measurement year

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- At least one pain assessment or screening performed in an outpatient setting in 2025 with a dated notation in the patient's medical record, which may include:

  —Documentation that the patient was assessed for pain

  - May include positive or negative findings for pain ("pain present" or "no pain present")
- Result of assessment using a standardized pain assessment tool (i.e., pain scale 0-10)

Important Notes:

- A pain assessment conducted in an acute inpatient setting will **not** meet compliance

Measure Best Practices:

- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data

Exclusions:

- Patients in hospice

For applicable coding: PNS (page 56)

Glycemic Status Assessment for Patients with Diabetes

Description: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0% (Control)
- Glycemic Status >9.0% (Poor Control)

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- At least one HbA1c test in 2025 for all eligible patients with the resulting level reported
- The most recent HbA1c test in 2025 must have a level of 8% or less to be measure compliant

Important Note:

- If multiple tests were performed in 2025, the result from the **last** test is used

Measure Best Practices:

- Review recommendations for diabetes care at each office visit
- Order labs prior to patient appointments
- When point-of-care HbA1c tests are completed in-office, bill for service with results
- Encourage patients to monitor their blood glucose levels between office visits using at-home tests or monitors
- Ensure documentation in the medical record includes the date when the HbA1c test was performed along with the result or finding
  - Finding must be in the format of a value (e.g., 7%); missing values or results recorded in format other than this example will result in noncompliance for the measure
- Adjust therapy to improve HbA1c and BP levels; follow up with patients to monitor changes
- If result is more than 9%, order and document follow-up HbA1c testing as appropriate
- Ensure submitted claims or encounters include the appropriate Current Procedural Terminology (CPT®) Category II codes for the most recent HbA1c level

Exclusions:

- Members who use hospice services or elect to use a hospice benefit, regardless of when the services began in the measurement year
- Members ages 66 and older as of Dec. 31, 2025 who had a diagnosis of frailty and advanced illness.* Advanced illness is indicated by one of the following:
  - Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness
  - One or more acute inpatient encounter(s) with a diagnosis of advanced illness
  - One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim
  - Dispensed a dementia medication: Donepezil, galantamine, rivastigmine or memantine
- Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:
  - Enrolled in an Institutional Special Needs Plan (I-SNP)
  - Living long term in an institution*
- Optional Exclusion: Members who have no diagnosis of diabetes in any setting **and** a diagnosis of gestational or steroid-induced diabetes between January 1 — December 31 , 2025 and 2024
- Members who died during the measurement year

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions**

For applicable coding: CDC HbA1c (page 61)

Kidney Health Evaluation for Patients With Diabetes

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

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- At least one eGFR
- At least one uACR identified by either of the following:
  - **both** a quantitative urine albumin test **and** a urine creatinine test with service dates four or less days apart
  - A uACR

Measure Best Practices:

- Review recommendations for diabetes care at each office visit
- Order a Complete Metabolic Panel and Urine Albumin/Creatinine ratio test prior to patient appointments
- Complete urine albumin and urine creatinine tests for (uACR) within 4 days of each other
- Ensure documentation in the medical record includes the date when eGFR and uACR test was performed along with the result or finding
- Screen members with comorbid hypertension
- Remind patients of the importance of having labs done annually

Exclusions:

- Members who use hospice services or elect to use a hospice benefit, regardless of when the services began in the measurement year
- Members ages 66-80 years of age as of Dec. 31, 2025 who had a diagnosis of frailty and advanced illness.
  * Advanced illness is indicated by one of the following:
  – Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness
  – One or more acute inpatient encounter(s) with a diagnosis of advanced illness
  – One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim
  – Dispensed a dementia medication: Donepezil, galantamine, rivastigmine or memantine
- Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:
  – Enrolled in an Institutional Special Needs Plan (I-SNP)
  – Living long term in an institution*
- Members with evidence of ESRD or dialysis
- Optional Exclusion: Members who have no diagnosis of diabetes in any setting **and** a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes between January 1 — December 31 , 2025 and 2024
- Members who died during the measurement year

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions**

For applicable coding: KED (page 69)

Blood Pressure Control in Person With Diabetes

Description: Percentage of members ages 18–75 with diabetes (Types 1 and 2) who have a blood pressure (BP) reading of <140/90 mmHg during the measurement year

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- BP reading of <140/90mmHg during an outpatient visit, nonacute inpatient event or digitally stored and transmitted from a remote monitoring device interpreted by the provider and logged in the member's medical record during 2025

Important Notes:

- BP reading must be performed within the measurement year – last BP result of the year is the one measured
- BP readings reported by and taken by a member are acceptable only if they're done using a remote monitoring device that digitally stores and transmits BP results to a care provider
- **Always list the date of service and BP reading together**
  – If BP is listed on the vital flow sheet, it must have a date of service

Measure Best Practices:

- It's critical to follow up with a member for a BP check after their initial diagnosis
  – Members who have an elevated BP during an office visit in August, September or October should be brought back in for a follow-up visit before Dec. 31, 2025
- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading
- Remind members who are NPO for a fasting lab they should continue to take their anti-hypertensive medications with a sip of water on the morning of their appointment
  – If your office uses manual blood pressure cuffs, don't round up the BP reading
    - For example: 138/89 mmHg rounded to 140/90 mmHg

Exclusions:

- Patients in hospice
- Members ages 66 and older as of Dec. 31, 2025 who had a diagnosis of frailty and advanced illness.* Advanced illness is indicated by one of the following:
  – Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness
  – One or more acute inpatient encounter(s) with a diagnosis of advanced illness
  – One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim
  – Dispensed a dementia medication: Donepezil, galantamine, rivastigmine or memantine
- Medicare members ages 66 and older as of Dec. 31, 2025 who are either:
  – Enrolled in an Institutional Special Needs Plan (I-SNP)
  – Living long term in an institution*
- Optional Exclusion: Members who have no diagnosis of diabetes in any setting **and** a diagnosis of gestational or steroid-induced diabetes between January 1 — December 31, 2025 and 2024

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions**

For applicable coding: CDC - BP Control (page 62)

Eye Exam For Patients With Diabetes

Description: Percentage of diabetic patients ages 18—75 who have received a screening or monitoring for diabetic retinal disease

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- A retinal or dilated eye exam by an optometrist or ophthalmologist during 2025
- A negative retinal or dilated eye exam (negative for diabetic retinopathy) by an eye-care professional (optometrist or ophthalmologist) in 2024 or 2025

Important Notes:

- Members **without retinopathy** should have an eye exam every two years
- Members **with retinopathy** should have an eye exam **every year**

Measure Best Practices:

- Review diabetes services needed at each office visit
- Encourage and/or refer patients to see an eye care professional for a comprehensive dilated or retinal eye exam during 2025
- Document the date of most recent diabetic eye exam with results and name of eye care provider in the medical record. Negative result must be documented to be compliant for two years
- Obtain the record of an eye exam performed in the prior measurement year by an ophthalmologist or optometrist. The eye exam must note "no evidence of retinopathy."
- Ensure submitted claims or encounters include the appropriate coding used for exam and results
- Consider using mobile eye-exam units. Fundus photography captures an image of the retina with a camera that can be operated by healthcare provider staff after brief training.

Exclusions:

- Patients in hospice
- Bilateral eye enucleation at any time during the patient's history in 2024 or 2025
- Members ages 66 and older as of Dec. 31, 2025 who had a diagnosis of frailty and advanced illness.* Advanced illness is indicated by one of the following:
  – Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness
  – One or more acute inpatient encounter(s) with a diagnosis of advanced illness
  – One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim
  – Dispensed a dementia medication: Donepezil, galantamine, rivastigmine or memantine
- Medicare members ages 66 and older as of Dec. 31, 2025 who are either:
  – Enrolled in an Institutional Special Needs Plan (I-SNP)
  – Living long term in an institution*
- Optional Exclusion: Members who have no diagnosis of diabetes in any setting **and** a diagnosis of gestational or steroid-induced diabetes between January 1 — December 31, 2025 and 2024

***Supplemental and medical record data may not be used for the frailty with advanced illness or institutional living exclusions**

For applicable coding: CDC - EYE (page 63)

Transitions of Care (TRC)

Description: The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- *Notification of Inpatient Admission*. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- *Receipt of Discharge Information.* Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- *Patient Engagement After Inpatient Discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Measure Best Practices:

Notification of Inpatient Admission

- Document patient hospital admission date in out patient medical record
- Patient's outpatient medical record must include documentation by PCP's practice that discharge information was received on the day of discharge or within the two following days.
- Discharge information may be included in:
  A discharge summary
  A summary of care record
  Structured fields in an electronic health record (EHR)
  Notification of admission by the patient or the patient's family to the PCP or ongoing care provider does not meet criteria.

Receipt of Discharge Information

- Retrieve The practitioner responsible for the member's care during the inpatient stay information
- Procedure or treatment provided
- Diagnoses at discharge
- Current medication list
- Testing results, or documentation pending tests or no test pending
- Instructions for patient care post discharge

Must have all 6 components and evidence of the date when the documentation was received for measure compliance.

Patient Engagement After Inpatient Discharge

- Communication via an outpatient visit, including office visits and home visits
- Communication via a telephone visit
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using
- audio and visual communication
- An e-visit or virtual check in (asynchronous telehealth where two-way interaction, which was not real time,
- occurred between the member and provider)

Any documentation without a time frame or date stamp does not meet criteria.

Medication Reconciliation Post–Discharge (MRP) (TRC)

Description: Percentage of discharges from Jan. 1 – Dec. 1, 2025 for members ages 18 or older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 days total)

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse (RN) on the day the patient is discharged from the hospital through 30 days after discharge
  -- A list of medications is required in the medical record
  – Licensed practical nurses (LPNs) and other non-licensed staff can perform the medication reconciliation, but it must be reviewed and approved by a physician, clinical pharmacist or RN
  – If a patient is directly transferred for another inpatient stay, reconciliation is not required based on initial discharge date

Measure Best Practices

- Be aware of patients' inpatient stays
- Obtain timely discharge summaries
- Review and reconcile discharge medications against existing outpatient medications
- See patients in the office as soon as possible after an acute discharge stay
- Upon completion of the medication reconciliation, include CPT II code 1111F on applicable claims submitted.
- Review all discharge summaries; document all medication reconciliations in outpatient medical records (which may be done on the discharge summary filed in the outpatient medical record). Any of these medical record notations will ensure measure compliance:
  – Current medications with a notation that clinician reconciled the current and discharge medications
  – Current medications with a notation that references the discharge medications
  – Patient's current medications with a notation that the discharge medications were reviewed
  – Current medication list, a discharge medication list and a notation that both lists were reviewed on the same date of service
  – Current medication list with documentation that patient was seen for post-discharge follow-up with medications reviewed or reconciled after hospitalization/discharge
  – Documentation in discharge summary that discharge medications were reconciled with most recent medication list in outpatient record. There must be evidence that the discharge summary was filed in outpatient record within 30 days after discharge
  – Notation that no medications were prescribed or ordered upon discharge
- Medication names are needed. While dose, route and frequency are not required, their inclusion is highly recommended
- The final reconciled medication list should be communicated to the patient by the physician or clinical office staff during an office or home visit. It can also be communicated telephonically or virtually

Exclusions:

- Patients in hospice

For applicable coding: MRP (page 75)

Medication Adherence for Cholesterol (MAC)

Description: Percentage of patients with Part D benefits with a prescription for cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- If a patient's proportion of days covered (PDC) is greater than or equal to 80% for their statin medication in the measurement period, the patient is deemed adherent

Measure Best Practices:

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers
- Reinforce patients' understanding of the role of diabetes, cholesterol and hypertension medications in their therapy and the expected duration of the therapy
- Ask if transportation to pharmacy is an issue. Retail 90-day fills may offer less frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery
- Encourage adherence by providing a 90-day prescription for maintenance drugs
- Provide an updated prescription to the pharmacy if the patient's medication dose has changed since the original prescription
- Refer patients to Humana.com/TakeMyMedicine for adherence tips and tools

Exclusions:

- Patients who use hospice services or elect to use a hospice benefit, regardless of when the services began during 2025
- Patients with end-stage renal disease (ESRD)

Medication Adherence for Hypertension (MAH)

Description: Percentage of members ages 18 or older who adhere to their hypertension (RAS antagonist) medication at least 80 percent of the time in 2025

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- Patients with Part D benefits with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
  – Blood pressure medication therapy programs for these renin angiotensin system (RAS) antagonists are included in this measure: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications

Measure Best Practices:

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers
- Reinforce patients' understanding of the role of diabetes, cholesterol and hypertension medications in their therapy and the expected duration of the therapy
- Ask if transportation to pharmacy is an issue. Retail 90-day fills may offer less frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery
- Encourage adherence by providing a 90-day prescription for maintenance drugs
- Provide an updated prescription to the pharmacy if the patient's medication dose has changed since the original prescription
- Refer patients to Humana.com/TakeMyMedicine for adherence tips and tools

Exclusions:

- Patients who use hospice services or elect to use a hospice benefit, regardless of when the services began during 2025
- Patients with end-stage renal disease (ESRD)
- Prescriptions filled for Entresto (sacubitril/valsartan)

Medication Adherence for Diabetes Medications (MAD)

Description: Percentage of members ages 18 or older who are adherent to their diabetes medications at least 80 percent of the time in 2025

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

- Patients with Part D benefits with a prescription for diabetes medication must fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
  – Drug therapy across these classes of diabetes medications are included in this measure: biguanides, sulfonylureas, thiazolidinediones, and dipeptidyl peptidase-4 (DPP-4) inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors

Measure Best Practices:

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers
- Reinforce patients' understanding of the role of diabetes, cholesterol and hypertension medications in their therapy and the expected duration of the therapy
- Ask if transportation to pharmacy is an issue. Retail 90-day fills may offer less frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery
- Encourage adherence by providing a 90-day prescription for maintenance drugs
- Provide an updated prescription to the pharmacy if the patient's medication dose has changed since the original prescription
- Refer patients to Humana.com/TakeMyMedicine for adherence tips and tools

Exclusions:

- Patients who use hospice services or elect to use a hospice benefit, regardless of when the services began during 2025
- Patients with end-stage renal disease (ESRD)
- Prescriptions filled for insulin

USE OF MULTIPLE ANTICHOLINERGIC MEDICATIONS IN OLDER ADULTS (POLY-ACH)

Description: Percentage of members ages 65 years or older with concurrent use of two or more unique ACH medications, each with two unique fills in 2025

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

-Ensure that the number of fills for each unique ACH drug is less than two or the number of overlapping days' supply is less than 30 cumulative days

Measure Best Practices:

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers
- Review medications each visit for polypharmacy or COB and consider removal or replacement with a clinical alternative

Exclusions:

- Patients who use hospice services or elect to use a hospice benefit, regardless of when the services began during 2025
- Patients with end-stage renal disease (ESRD)
- Patients with cancer, sickle cell disease, or palliative care during measurement year if there is at least one claim in the primary diagnosis

CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB)

Description: Percentage of members ages 18 years or older with concurrent use of opioids and benzodiazepines, each with two unique fills in 2025

Line of Business (LOB): ☑ **Medicare** ☐ **Medicaid** ☐ **Commercial**

Service Needed for Compliance:

-Ensure that the number of fills for each drug is less than two or the number of overlapping days' supply is less than 30 cumulative days

Measure Best Practices:

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers
- Patients taking opioids and benzodiazepines together for two weeks or longer should be tapered

Exclusions:

- Patients who use hospice services or elect to use a hospice benefit, regardless of when the services began during 2025
- Patients with end-stage renal disease (ESRD)
- Patients with cancer, sickle cell disease, or palliative care during measurement year if there is at least one claim in the primary diagnosis

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Description: This measure evaluates the percentage of males 21–75 years old and females 40–75 years old during 2024 who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during 2025

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- Percentage of males ages 21–75 and females ages 40–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:
  – **Received statin therapy** – Members who were dispensed at least one high- or moderate-intensity statin medication during 2025
  - **Statin adherence 80 percent** – Members who remained on a high- or moderate-intensity statin medication for at least 80 percent of the treatment period

Important Note:

- The treatment period is defined as the earliest prescription dispensing date in 2025 for any statin medication of at least moderate intensity through Dec. 31, 2025

To comply with this measure, one of the following medications must have been dispensed:

High-Intensity Statin Therapy	Moderate-Intensity Statin Therapy
Daily dose lowers LDL-C on average by at least 50%	Daily dose lowers LDL-C on average between 30% and 50%
• Atorvastatin 40—80 mg (Lipitor) † • Amlodipine-atorvastatin 40-80 mg • Rosuvastatin 20—40 mg (Crestor) • Simvastatin 80 mg (Zocor) ‡ • Ezetimibe-simvastatin 80 mg	• Atorvastatin 10—20 mg (Lipitor) • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5—10 mg (Crestor) • Simvastatin 20–40 mg (Zocor) • Ezetimibe-simvastatin 20-40 mg • Pravastatin 40—80 mg (Pravachol) • Lovastatin 40 mg (Mevacor) • Fluvastatin 40-80 mg (Lescol) • Pitavastatin 1—4 mg (Livalo)

† Evidence from one randomized controlled trial (RCT) only: down-titration if unable to tolerate atorvastatin 80 mg in incremental decrease in events through aggressive lipid lowering (IDEAL)
‡ Although simvastatin 80 mg was evaluated in RCTs, initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the Food and Drug Administration due to the increased risk of myopathy, including rhabdomyolysis

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Exclusions:	Timeframe:
• Patients in hospice • Patients who died • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis or caused by statin • Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution	Measurement year (2025)
• Members ages 66 and older as of Dec. 31 of the measurement year who had a diagnosis of frailty and advanced illness. Advanced illness is indicated by one of the following: – Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness – One or more acute inpatient encounter(s) with a diagnosis of advanced illness – One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim – Dispensed a dementia medication: Donepezil, galantamine, rivastigmine or memantine	**Frailty** diagnosis must be in measurement year (2025) **Advanced illness** diagnosis must be in measurement year (2025) or prior year (2024)
• Cirrhosis • Dialysis • Dispensed at least one prescription for clomiphene • End-stage renal disease (ESRD) • Patients who are pregnant • In vitro fertilization	Measurement year (2025) or prior year (2024)

Statin Therapy for Patients With Diabetes (SPD)

Description: This measure evaluates the percentage of members 40–75 years old during 2025 with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and received statin therapy and had statin adherence of at least 80 percent

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- Percentage of members ages 40–75 during 2025 with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria:
  - **Received statin therapy** – Members who were dispensed at least one statin medication of any intensity during 2024
  - **Statin adherence 80 percent** – Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period

Important Note: The treatment period is defined as the earliest prescription dispensing date in 2025 for any statin medication of at least moderate intensity through Dec. 31, 2025

To comply with this measure, one of the following medications must have been dispensed:

Drug Category	Medications	
High-intensity statin therapy	• Amlodipine-atorvastatin 40–80 mg • Atorvastatin 40–80 mg • Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20–40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10–20 mg • Atorvastatin 10–20 mg • Ezetimibe-simvastatin 20–40 mg • Fluvastatin 40-80 mg • Lovastatin 40 mg	• Pitavastatin 1–4 mg • Pravastatin 40–80 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg • Fluvastatin 20 mg • Lovastatin 10-20 mg	• Pravastatin 10–20 mg • Simvastatin 5-10 mg

Statin Therapy for Patients With Diabetes (SPD)

Exclusions:	Timeframe:
• Patients who died • Patients in hospice • Myalgia, myositis, myopathy or rhabdomyolysis diagnosis or caused by statin • Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution	Measurement year (2025)
• Members ages 66 and older as of Dec. 31 of the measurement year who had a diagnosis of frailty and advanced illness. Advanced illness is indicated by one of the following: – Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness – One or more acute inpatient encounter(s) with a diagnosis of advanced illness – One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim – Dispensed a dementia medication: Donepezil, galantamine, rivastigmine or memantine	**Frailty** diagnosis must be in the measurement year (2025) **Advanced illness** diagnosis must be in the measurement year (2025) or year prior to the measurement year (2024)
• Cirrhosis, dispensed at least one prescription for clomiphene, end-stage renal disease (ESRD) or dialysis, pregnant members, in vitro fertilization, diagnosis of Polycystic Ovarian Syndrome, gestational diabetes or steroid-induced diabetes	Measurement year (2025) or prior year (2024)
• Coronary artery bypass grafting (CABG), myocardial infarction, other revascularization procedure, percutaneous coronary intervention (PCI)	Year prior to measurement year (2025)
• One or more acute inpatient or outpatient visits with a diagnosis of ischemic vascular disease (IVD)	2025 & 2024 (must be in both years)

For applicable coding: SPD (page 85)

Acute Hospital Utilization (AHU)

Description: For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.

Line of Business (LOB): ☑ **Medicare** ☑**Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- Identify and categorize acute inpatient and observation stay discharges and the discharge date for the stay
- For discharges with one or more direct transfers, use the last discharge
- For remaining observation and inpatient discharges, exclude inpatient and observation discharges with any of the following on the discharge claim:
    - Diagnosis of mental health or chemical dependency
    - Diagnosis of live born infant, maternity or maternity stay
    - Planned hospital stay
    - Inpatient and observation stays with a discharge for death
- For the remaining observation and inpatient discharges, remove discharges for outlier members and report these members as outliers
    - *Outlier:* Medicare members with four or more inpatient or observation stay discharges during the measurement year. Medicaid members with six or more inpatient or observation stay discharges during the measurement year. Commercial members with three or more inpatient or observation stay discharges during the measurement year
    - *Nonoutlier:* Medicare members with three or less inpatient or observation stay discharges during the measurement year. Medicaid members with five or less inpatient or observation stay discharges during the measurement year. Commercial members with two or less inpatient or observation stay discharges during the measurement year
- Calculate the total using all discharges identified

Measure Best Practices:

- Ensure the member has a scheduled follow-up visit with their PCP

Exclusions:

- Members in hospice anytime during the measurement year

Use of Opioids at High Dosage (HDO)

Description: The percentage of members 18 years of age or older who received prescription opioids at a high dosage for ≥15 days during the measurement year.

** Measure does not include the following opioid medication: injectables, opioid cough and cold products, Methadone for treatment of opioid use disorder, Ionsys (fentanyl transdermal patch)*

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- Identify members who met both of the following criteria during the measurement year:
  - Two or more opioid dispensing events on different dates of service
  - ≥15 total days covered by opioids

Measure Best Practices:

- Review the members medication list before their visit and identify opioids prescriptions at high dosages for ≥15 days
- If possible, prescribe a low dosage for a shorter period of time
- If members shows signs of opioid use disorder, refer them to an appropriate substance use provider
- If possible, improve utilization of non-narcotic and non-pharmacologic measures to control pain as part of a comprehensive pain management plan
- Provide member with educational resources

Exclusions:

- Members with the following diagnoses: Cancer, Sickle Cell Anemia
- Members receiving palliative care
- Members in hospice
- Members who died during the measurement year

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

Description: 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.

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

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

Depression Screening

- Documented result for depression screening using age appropriate standardized instruments (see tables below) performed between Jan. 1– Dec. 1 of measurement period

Follow-Up on Positive Screen

- Members should have documented follow-up care within 30 days of the first positive depression screen
  - Outpatient, telephone or e-visit with a diagnosis of depression or other behavioral health condition
  - Depression case management encounter with documentation of symptoms or diagnosis of depression or other behavioral health condition
  - Behavioral health encounter, including assessment, therapy, collaborative care or medication management
  - Dispensed antidepressant medication
  - Documentation of additional depression screening using full length instrument indicating either no depression or no symptoms that require follow-up on the same day as a positive screen on a brief screening instrument

Instruments for Adolescents (≤17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
PROMIS Depression	Total score (T Score) ≥60

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

Instruments for Adults (18+ years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Beck Depression Inventory (BDI-II)	Total score ≥20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
My Mood Monitor (M-3)®	Total score ≥5
PROMIS Depression	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥31

Exclusions:

- Members with a history of bipolar depression any time during the member's history through the end of the year prior to the measurement period
- Members with depression that starts during the measurement year prior to the measurement period
- Members in hospice or using hospice services any time during the measurement period
- Members who die in measurement period

For applicable coding: DSF-E (page 86)

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

Description: 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 4–8 months of the elevated score.

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

Line of Business (LOB): ☑ **Medicare** ☑ **Medicaid** ☑ **Commercial**

Service Needed for Compliance:

- A PHQ-9 total score in the member's record during the depression follow-up period

Measure Best Practices:

- Educate member on the member on the importance of adherence for follow-up care
- Schedule follow-up appointments for members with recent discharges
- Refer the member to a mental health provider
- If you use an EMR, set up tracking for members who need follow up care

Exclusions:

- Members with any of the following any time during the member's history through the end of the measurement period: Bipolar Disorder, Personality Disorder, Psychotic Disorder, Pervasive Development Disorder
- Members in hospice

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Ambulatory Visits		
99202	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
99203	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99204	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
99205	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
99211	CPT	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
99212	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded
99213	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99214	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Ambulatory Visits (Cont.)		
99215	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99242	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99243	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99244	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99245	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded
99347	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99348	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Ambulatory Visits (Cont.)		
99349	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99350	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
99381	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Ambulatory Visits (Cont.)		
99387	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient
99391	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Ambulatory Visits (Cont.)		
99397	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99404	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99411	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99429	CPT	Unlisted preventive medicine service; Report code 99429 only when a more specific preventive medicine service code does not exist
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home
G0402	HCPCS	Initial Preventive Physical Examination; face-to-face visit, services limited to a new patient during the first 12 months of Medicare enrollment
G0438	HCPCS	Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit
G0439	HCPCS	Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Ambulatory Visits (Cont.)		
T1015	HCPCS	Clinic visit/encounter, all-inclusive
Z00.00	ICD-10	Encounter for general adult medical examination without abnormal findings
Z00.01	ICD-10	Encounter for general adult medical examination with abnormal findings
Z00.121	ICD-10	Encounter for routine child health examination with abnormal findings
Z00.129	ICD-10	Encounter for routine child health examination without abnormal findings
Z00.3	ICD-10	Encounter for examination for adolescent development state
Z00.5	ICD-10	Encounter for examination of potential donor of organ and tissue
Z00.8	ICD-10	Encounter for other general examination
Z02.0	ICD-10	Encounter for exam for admission to educational institution
Z02.1	ICD-10	Encounter for pre-employment examination
Z02.2	ICD-10	Encounter for examination for admission to residential institution
Z02.3	ICD-10	Encounter for examination for recruitment to armed forces
Z02.4	ICD-10	Encounter for examination for driving license
Z02.5	ICD-10	Encounter for examination for participation in sport
Z02.6	ICD-10	Encounter for examination for insurance purposes
Z02.71	ICD-10	Encounter for disability determination
Z02.79	ICD-10	Encounter for issue of other medical certificate
Z02.81	ICD-10	Encounter for paternity testing
Z02.82	ICD-10	Encounter for adoption services
Z02.83	ICD-10	Encounter for blood-alcohol and blood-drug test
Z02.89	ICD-10	Encounter for other administrative examinations
Z02.9	ICD-10	Encounter for administrative examinations, unspecified
Z76.1	ICD-10	Encounter for health supervision and care of foundling
Z76.2	ICD-10	Encounter for health supervision and care of other healthy infant and child

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Other Ambulatory Visits		
92002	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	CPT	Ophthalmological services: medical examination and evaluation, comprehensive, established patient
99304	CPT	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded
99305	CPT	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded
99306	CPT	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded
99307	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Other Ambulatory Visits		
99308	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99309	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99310	CPT	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
99315	CPT	Nursing facility discharge day management; 30 minutes or less
99316	CPT	Nursing facility discharge day management; more than 30 minutes
S0620	HCPCS	Routine ophthalmological examination including refraction; new patient
S0621	HCPCS	Routine ophthalmological examination including refraction; established patient
Telephone Visits		
98966	CPT	Telephone evaluation and management service by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Telephone Visits		
98967	CPT	Telephone evaluation and management service by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 11-12 minutes of medical discussion
98968	CPT	Telephone evaluation and management service by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
98008	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
98009	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
98010	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
98011	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Telephone Visits (cont)		
98012	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded
98013	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
98014	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
98015	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
98016	CPT	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

Breast Cancer Screening (BCS)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
77061	CPT	Diagnostic digital breast tomosynthesis; unilateral
77062	CPT	Tomosynthesis bilateral
77063	CPT	Screening digital breast tomosynthesis, bilateral
77065	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	CPT	Screening mammography, bilateral (two-view study of each breast), including computer -aided detection (CAD) when performed
EXCLUSIONS		
Z90.13	ICD-10-CM	History of bilateral mastectomy; acquired absence of breasts, bilateral
0HTV0ZZ	ICD-10-PCS	Resection of Bilateral Breast, Open Approach

COA Advance Care Planning

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99497	CPT	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
1123F	CPT	Advance care planning discussed; advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)
1124F	CPT	Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)
1157F	CPT	Advance care plan or similar legal document present in the medical record
1158F	CPT	Advance care planning discussion documented in the medical record
S0257	HCPCS	Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
Z66	ICD-10 CM	Do not resuscitate

COA Functional Status Assessment

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
99483	CPT	Assessment of and care planning for a patient with cognitive impairment
1170F	CPT II	Functional status assessed
G0438	HCPCS	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439	HCPCS	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

COA Medication Review

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99495	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit within 14 calendar days of discharge
99496	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge
99605	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, new patient
99606	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, established patient
1159F	CPT	Medication list documented in medical record

COA Medication Review

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
1160F	CPT	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
G8427	HCPCS	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

COA Pain Assessment

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
1125F	CPT II	Pain severity quantified; pain present
1126F	CPT II	Pain severity quantified; no pain present

Cervical Cancer Screening (CCS)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Cervical Cytology		
88141	CPT	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88142	CPT	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	CPT	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	CPT	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	CPT	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	CPT	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	CPT	Cytopathology, slides, cervical or vaginal; with manual screening and computer assisted rescreening under physician supervision
88153	CPT	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88164	CPT	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	CPT	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166	CPT	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167	CPT	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

Cervical Cancer Screening (CCS)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
88174	CPT	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	CPT	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
G0123	HCPCS	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
G0124	HCPCS	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician
G0141	HCPCS	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician
G0143	HCPCS	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision
G0144	HCPCS	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision
G0145	HCPCS	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
G0147	HCPCS	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148	HCPCS	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening
P3000	HCPCS	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision

Cervical Cancer Screening (CCS)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
P3001	HCPCS	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician
Q0091	HCPCS	Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory
19764-0	LOINC	Statement of adequacy [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain
High Risk HPV Test		
87623	CPT	Infectious agent detection by nucleic acid (DNA or RNA)
87624	CPT	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68. 87625: Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed
87625	CPT	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed
G0476	HCPCS	Infectious agent detection by nucleic acid (dna or rna); human papillomavirus (hpv), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test
69002-4	LOINC	Human papilloma virus E6+E7 mRNA [Presence] in Cervix by NAA with probe detection

Chlamydia Screening (CHL)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
87110	CPT	Culture for chlamydia
87270	CPT	Infectious agent antigen detection by immunofluorescent technique
87320	CPT	Infectious agent antigen detection by EIA, qualitative or semi-quantitative
87490	CPT	Infectious agent detection by nucleic acid direct probe
87491	CPT	Infectious agent detection by nucleic acid amplified direct probe
87492	CPT	Infectious agent detection by nucleic acid quantification
87810	CPT	Infectious agent detection by immunoassay with direct optical observation
14467-5	LOINC	Chlamydia trachomatis [Presence] in Urine sediment by Organism specific culture
14463-4	LOINC	Chlamydia trachomatis [Presence] in Cervix by Organism specific culture
14464-2	LOINC	Chlamydia trachomatis [Presence] in Vaginal fluid by Organism specific culture

Glycemic Status Assessment for Patients with Diabetes (GSD)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
83036	CPT	Hemoglobin; glycosylated (A1c)
83037	CPT	Hemoglobin; glycosylated (A1c) by device cleared by FDA for home use
3044F	CPT	Most recent hemoglobin A1c level less than 7%
3046F	CPT	Most recent hemoglobin A1c level greater than 9%
3051F	CPT	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
3052F	CPT	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
4548-4	LOINC	Hemoglobin A1c/Hemoglobin.total in Blood

CDC — Blood Pressure Controlled

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
3074F	CPT	Most recent systolic blood pressure < 130 mm Hg
3075F	CPT	Most recent systolic blood pressure < 130 - 139 mm Hg
3078F	CPT	Most recent diastolic blood pressure < 80 mm Hg
3079F	CPT	Most recent diastolic blood pressure < 80 - 90 mm Hg

Comprehensive Diabetes Care (CDC) — Eye Exam

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
65091	CPT	Evisceration of ocular contents; without implant
65093	CPT	Evisceration of ocular contents; with implant
65101	CPT	Enucleation of eye; without implant
65103	CPT	Enucleation of eye; with implant, muscles not attached to implant
65105	CPT	Enucleation of eye; with implant, muscles attached to implant
65110	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; only
65112	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone
65114	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap
67028	CPT	Intravitreal injection of a pharmacologic agent (separate procedure)
67030	CPT	Discussion of vitreous strands (without removal), pars plana approach
67031	CPT	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036	CPT	Vitrectomy, mechanical, pars plana approach
67039	CPT	Vitrectomy, mechanical, pars plana approach, with focal endolaser photocoagulation
67040	CPT	Vitrectomy, mechanical, pars plana approach, with endolaser panretinal photocoagulation
67041	CPT	Vitrectomy, mechanical, pars plana approach, with removal of preretinal cellular membrane (e.g., macular pucker)
67042	CPT	Vitrectomy, mechanical, pars plana approach, with removal of internal limiting membrane of retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil)
67043	CPT	Vitrectomy, mechanical, pars plana approach, with removal of subretinal membrane (e.g., choroidal neovascularization), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil) and laser photocoagulation
67101	CPT	Repair of retinal detachment, one or more sessions, cryotherapy or diathermy, with or without drainage of subretinal fluid

Comprehensive Diabetes Care (CDC) — Eye Exam

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
67105	CPT	Repair of retinal detachment, one or more sessions, photocoagulation, with or without drainage of subretinal fluid
67107	CPT	Repair of retinal detachment, scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation and drainage of subretinal fluid
67108	CPT	Repair of retinal detachment, with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling and/or removal of lens by same technique
67110	CPT	Repair of retinal detachment, by injection of air or other gas (e.g., pneumatic retinopexy)
67113	CPT	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling and/or removal of lens
67121	CPT	Removal of implanted material, posterior segment, intraocular
67141	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, cryotherapy, diathermy
67145	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, photocoagulation (laser or xenon arc)
67208	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, cryotherapy, diathermy
67210	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, photocoagulation
67218	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, radiation by implantation of source (includes removal of source)
67220	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photocoagulation (e.g., laser), one or more sessions

Comprehensive Diabetes Care (CDC) — Eye Exam

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
67221	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photodynamic therapy (includes intravenous infusion)
67227	CPT	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions, cryotherapy, diathermy
67228	CPT	Treatment of extensive or progressive retinopathy, one or more sessions (e.g., diabetic retinopathy), photocoagulation
92002	CPT	Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program, intermediate, new patient
92004	CPT	Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program, comprehensive, new patient, one or more visits
92012	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, intermediate, established patient
92014	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, comprehensive, established patient, one or more visits
92018	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, complete
92019	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, limited
92134	CPT	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina
92227	CPT	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes), with analysis and report under physician supervision, unilateral or bilateral
92228	CPT	Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy), with physician review, interpretation and report, unilateral or bilateral
92230	CPT	Fluorescein angioscopy with interpretation and report

Comprehensive Diabetes Care (CDC) — Eye Exam

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
92235	CPT	Fluorescein angiography (includes multiframe imaging), with interpretation and report
92240	CPT	Indocyanine green angiography, with interpretation and report
92250	CPT	Fundus photography, with interpretation and report
92260	CPT	Ophthalmodynamometry
99203	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99204	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
99205	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
99213	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99214	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99215	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99242	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99243	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99244	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99245	CPT	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded

Comprehensive Diabetes Care (CDC) — Eye Exam

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
2022F	CPT	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
2023F	CPT	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	CPT	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
2025F	CPT	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	CPT	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy
2033F	CPT	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3072F	CPT	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)
S0620	HCPCS	Routine ophthalmological examination including refraction, new patient
S0621	HCPCS	Routine ophthalmological examination including refraction, established patient
S3000	HCPCS	Diabetic indicator, retinal eye exam, dilated, bilateral

Comprehensive Diabetes Care (CDC) — Eye Exam

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
08B00ZX	ICD-10-PCS	Excision of right eye, open approach, diagnostic
08B00ZZ	ICD-10-PCS	Excision of right eye, open approach
08B03ZX	ICD-10-PCS	Excision of right eye, percutaneous approach, diagnostic
08B03ZZ	ICD-10-PCS	Excision of right eye, percutaneous approach
08B0XZX	ICD-10-PCS	Excision of right eye, external approach, diagnostic
08B0XZZ	ICD-10-PCS	Excision of right eye, external approach
08B10ZX	ICD-10-PCS	Excision of left eye, open approach, diagnostic
08B10ZZ	ICD-10-PCS	Excision of left eye, open approach
08B13ZX	ICD-10-PCS	Excision of left eye, percutaneous approach, diagnostic
08B13ZZ	ICD-10-PCS	Excision of left eye, percutaneous approach
08B1XZX	ICD-10-PCS	Excision of left eye, external approach, diagnostic
08B1XZZ	ICD-10-PCS	Excision of left eye, external approach

Kidney Health Evaluation for Patients With Diabetes (KED)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
Estimated Glomerular Filtration Rate Lab Test		
80047	CPT	Basic metabolic panel (Calcium Ionized)
80048	CPT	Basic metabolic panel (Calcium Total)
80050	CPT	General health panel (includes Comprehensive metabolic panel)
80053	CPT	Comprehensive metabolic panel
80069	CPT	Renal function panel
82565	CPT	Creatinine; blood
69405-9	LOINC	Glomerular filtration rate/1.73 sq M.predicted [Volume Rate/Area] in Serum, Plasma or Blood
Quantitative Urine Albumin Lab Test		
82043	CPT	Albumin; serum, plasma, or whole blood
1754-1	LOINC	Albumin [Mass/volume] in Urine
Urine Creatinine Lab Test		
82570	CPT	Creatinine; other source
2161-8	LOINC	Creatinine [Mass/volume] in Urine

Colorectal Cancer Screening (COL)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
Fecal Occult Blood Test (FOBT)		
82270	CPT	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, one determination
82274	CPT	Blood, occult, by fecal hemoglobin, qualitative, one to three simultaneous determinations
G0328	HCPCS	Colorectal cancer screening, fecal occult blood test, immunoassay, one to three simultaneous determinations
2335-8	LOINC	Blood, occult, by fecal hemoglobin
Flexible Sigmoidoscopy		
45330	CPT	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	CPT	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	CPT	Sigmoidoscopy, flexible; with removal of foreign body
45333	CPT	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	CPT	Sigmoidoscopy, flexible; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	CPT	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	CPT	Sigmoidoscopy, flexible; with decompression (for pathological distention) (e.g., volvulus, megacolon) including placement of decompression tube, when performed
45338	CPT	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45340	CPT	Sigmoidoscopy, flexible; with transendoscopic balloon dilation
45341	CPT	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	CPT	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45346	CPT	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guidewire passage, when performed)

Colorectal Cancer Screening (COL)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
45347	CPT	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45349	CPT	Sigmoidoscopy, flexible; with endoscopic mucosal resection
45350	CPT	Sigmoidoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0104	HCPCS	Colorectal cancer screening; flexible sigmoidoscopy
Colonoscopy		
44388	CPT	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	CPT	Colonoscopy through stoma; with biopsy, single or multiple
44390	CPT	Colonoscopy through stoma; with removal of foreign body
44391	CPT	Colonoscopy through stoma; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	CPT	Colonoscopy through stoma; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps
44401	CPT	Colonoscopy through stoma; with ablation of tumor(s), polyp(s) or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
44402	CPT	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
44403	CPT	Colonoscopy through stoma; with endoscopic mucosal resection
44404		Colonoscopy through stoma; with directed submucosal injection(s), any substance
44405	CPT	Colonoscopy through stoma; with transendoscopic balloon dilation
44406	CPT	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407	CPT	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures

Colorectal Cancer Screening (COL)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
44408	CPT	Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45378	CPT	Colonoscopy, flexible diagnostic; including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	CPT	Colonoscopy, flexible; proximal to splenic flexure, with removal of foreign body
45380	CPT	Colonoscopy, flexible; proximal to splenic flexure, with biopsy, single or multiple
45381	CPT	Colonoscopy, flexible; proximal to splenic flexure, with directed submucosal injection(s), any substance
45382	CPT	Colonoscopy, flexible; proximal to splenic flexure, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45384	CPT	Colonoscopy, flexible; proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	CPT	Colonoscopy, flexible; proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45386	CPT	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	CPT	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45389	CPT	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guidewire passage, when performed)
45390	CPT	Colonoscopy, flexible; with endoscopic mucosal resection
45391	CPT	Colonoscopy, flexible; proximal to splenic flexure, with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45392	CPT	Colonoscopy, flexible; proximal to splenic flexure, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

Colorectal Cancer Screening (COL)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure

Code	Code Type	Description
45393	CPT	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45398	CPT	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0105	HCPCS	Colorectal cancer screening; colonoscopy on individual at high risk
G0121	HCPCS	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
CT Colonography		
74261	CPT	Computed tomographic (CT) colonography, diagnostic, including image post-processing; without contrast material
74262	CPT	Computed tomographic (CT) colonography, diagnostic, including image post-processing; with contrast material(s) including non-contrast images, if performed
74263	CPT	Computed tomographic (CT) colonography, screening, including image post-processing
Cologuard Test		
81528	CPT	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
G0464	HCPCS	Colorectal cancer screening; stool based DNA & fecal occult hemoglobin (FIT)
77353-1	LOINC	Noninvasive colorectal cancer DNA and occult blood screening [Interpretation] in Stool Narrative
77354-9	LOINC	Noninvasive colorectal cancer DNA and occult blood screening [Presence] in Stool
EXCLUSIONS		
44155	CPT	Colectomy, total abdominal; w/proctectomy, w/ileostomy
C18.9	ICD-10-PCS	Malignant neoplasm of colon; unspecified

Controlling Blood Pressure (CBP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
I10	ICD-10	Essential (primary) hypertension
3074F	CPT	Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD)
3075F	CPT	Most recent systolic blood pressure 130–139 mm Hg (DM)
3077F	CPT	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	CPT	Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
3079F	CPT	Most recent diastolic blood pressure 80–89 mm Hg (HTN, CKD, CAD) (DM)
3080F	CPT	Most recent diastolic blood pressure greater than or equal to 90 mm Hg
93784	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report
93788	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report
93790	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; review with interpretation and report
99091	CPT	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or qualified healthcare professional, qualified by education & training
99453	CPT	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry), initial; set-up and patient education on use of equipment
99454	CPT	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	CPT	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Medication Reconciliation Post–Discharge (MRP)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99495	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge
99496	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge medical decision making of high complexity during the service period face-to-face visit, within seven calendar days of discharge
1111F	CPT	Discharge medications reconciled with the current medication list in outpatient medical record

Osteoporosis Management in Women (OMW)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
76977	CPT	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77078	CPT	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77080	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	CPT	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
J0897	HCPCS	Injection, denosumab, 1 mg
J1740	HCPCS	Injection, ibandronate sodium, 1 mg
J3110	HCPCS	Injection, teriparatide, 10 mcg
J3489	HCPCS	Injection, zoledronic acid, 1 mg
BP48ZZ1	ICD-10 PCS	Ultrasonography of right shoulder, densitometry
BP49ZZ1	ICD-10 PCS	Ultrasonography of left shoulder, densitometry
BP4GZZ1	ICD-10 PCS	Ultrasonography of right elbow, densitometry
BP4HZZ1	ICD-10 PCS	Ultrasonography of left elbow, densitometry
BP4LZZ1	ICD-10 PCS	Ultrasonography of right wrist, densitometry
BP4MZZ1	ICD-10 PCS	Ultrasonography of left wrist, densitometry
BP4NZZ1	ICD-10 PCS	Ultrasonography of right hand, densitometry
BP4PZZ1	ICD-10 PCS	Ultrasonography of left hand, densitometry
BQ00ZZ1	ICD-10 PCS	Plain radiography of right hip, densitometry
BQ01ZZ1	ICD-10 PCS	Plain radiography of left hip, densitometry
BQ03ZZ1	ICD-10 PCS	Plain radiography of right femur, densitometry
BQ04ZZ1	ICD-10 PCS	Plain radiography of left femur, densitometry
BR00ZZ1	ICD-10 PCS	Plain radiography of cervical spine, densitometry

Osteoporosis Management in Women (OMW)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
BR07ZZ1	ICD-10 PCS	Plain radiography of thoracic spine, densitometry
BR09ZZ1	ICD-10 PCS	Plain radiography of lumbar spine, densitometry
BR0GZZ1	ICD-10 PCS	Plain radiography of whole spine, densitometry

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
99202	CPT	Outpatient Visit
99203	CPT	Outpatient Visit
99204	CPT	Outpatient Visit
99205	CPT	Outpatient Visit
99211	CPT	Outpatient Visit
99212	CPT	Outpatient Visit
99213	CPT	Outpatient Visit
99214	CPT	Outpatient Visit
99215	CPT	Outpatient Visit
99242	CPT	Outpatient Visit
99243	CPT	Outpatient Visit
99244	CPT	Outpatient Visit
99245	CPT	Outpatient Visit
99341	CPT	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
99342	CPT	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99344	CPT	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
99345	CPT	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded
99347	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
99348	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99349	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99350	CPT	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
99381	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	CPT	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
99392	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	CPT	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99411	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99429	CPT	Unlisted preventive medicine service

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The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
99455	CPT	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
99456	CPT	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
99483	CPT	Outpatient Visit
99238	CPT	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
99239	CPT	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
99221	CPT	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99222	CPT	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded
99223	CPT	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
99408	CPT	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
98970	CPT	Online Assessments
98971	CPT	Online Assessments
98972	CPT	Online Assessments
99421	CPT	Online digital evaluation and management service, for an established patient, for up to 7
99422	CPT	Online digital evaluation and management service, for an established patient, for up to 7
99423	CPT	Online digital evaluation and management service, for an established patient, for up to 7
99457	CPT	Online Assessments
98966	CPT	Telephone Visits
98967	CPT	Telephone Visits
99495	CPT	Transitional Care Management Services
99496	CPT	Transitional Care Management Services
99408	CPT	Substance Use Disorder Services
99409	CPT	Substance Use Disorder Services
90791	CPT	Psychiatric diagnostic evaluation
90792	CPT	Psychiatric diagnostic evaluation with medical services
90832	CPT	Psychotherapy, 30 minutes with patient
90833	CPT	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	CPT	Psychotherapy, 45 minutes with patient
90836	CPT	Psychotherapy, 45 minutes with patient when performed with an evaluation and manage-

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
98008	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
98009	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
98010	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
98011	CPT	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
98012	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded
98013	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
98014	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
98015	CPT	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
98016	CPT	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

Statin Therapy for Patients with Diabetes (SPD)

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
G9664	HCPCS	Patients who are currently statin therapy users or received an order (prescription) for statin therapy
EXCLUSIONS		

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

The table below outlines applicable coding that indicate the services necessary to be compliant for the measure.

Code	Code Type	Description
90791, 90792, 90832, 90833, 90834, 90836, 90837-90839, 90845-90847, 90849, 90853, 90865, 90867-90870, 90875, 90876, 90880, 90887	CPT	Behavioral Health Screening
99366	CPT	Depression Case Management Encounter Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
98960-98962, 99078, 99201-99205, 99211 – 99215, 99217-99220, 99241 – 99245, 99341 – 99345, 99347 -99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412	CPT	Follow-Up Visit
99441-99443, 98966-98968, 99444, 99212-99215, 99201-99205	CPT	Telephonic and Telehealth Visits
96127	CPT	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument