ADULT
HEDIS® CODING GUIDE INDIANA MEDICAID 2022-2023

This guide provides HEDIS coding information only, not necessarily payment guidance. Refer to CMS guidance for payment details and telehealth regulations.

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Access/Availability of Care			
Adults' Access to Preventive/ Ambulatory Health Services (AAP) 20 years and over	Adults who had an ambulatory or preventive care visit.	This measure looks at whether adult patients receive preventive and ambulatory services. To qualify, the patient must receive an evaluation and management care during an ambulatory visit with a medical professional. Care received in an Emergency Department or inpatient setting does **not** qualify. Telehealth option available for this measure.	**CPT®:** 99201-5, 99211-5, 99241-5, 99341-2, 99343-5, 99347-50, 99381-7, 99391-7, 99401, 99429, 99483, 92002, 92004, 92012, 92014, 99304-10, 99315-6, 99318, 99324-8, 99334-7 **HCPCS:** G0463, T1015 **ICD10:** Z00.00-01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0-6, Z02.71, Z02.79, Z02.81-3, Z02.89, Z02.9, Z76.1, Z76.2
Prenatal and Postpartum Care: Prenatal Care (PPC) All Ages	The measure assesses the following facets of prenatal care: **Timeliness of Prenatal Care** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	A qualified prenatal care visit with an OB/GYN or other prenatal care practitioner or PMP. Documentation must include the date the visit occurred and include at least one of the following: • Auscultation for fetal heart tones • Pelvic exam with OB observations (a pap test alone does **not** count) • Measurement of fundal height • Basic OB visit that includes one of the following prenatal procedures: – Complete OB lab panel – TORCH antibody panel – Rubella antibody with Rh incompatibility blood typing – Ultrasound of pregnant uterus	**Stand-Alone Prenatal Visit** **CPT:** 99500 **CPT II:** 0500F, 0501F, 0502F ***– OR –*** **Prenatal Bundled Services** **CPT:** 59425-6 ***– OR –*** Any of the following **WITH** an appropriate pregnancy diagnosis: **Prenatal Visit** **CPT:** 99201-5, 99211-5, 99241-5, 99483 **HCPCS:** G0463, T1015 *Note: CPT II codes are for quality reporting purposes only, not for payment.*

CareSource®

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Access/Availability of Care			
Prenatal and Postpartum Care: Prenatal Care (PPC) All Ages	Services provided via telephone, e-visit, or virtual check-in **are** eligible for both PPC measures.	• Documentation indicating pregnancy which includes: – Standardized prenatal flow sheet – LMP or EDD or gestational age – Prenatal risk assessment and counseling/education – A complete obstetrical history – Gravidity and parity – Positive pregnancy test result • Visits with a PMP or other family practitioner must follow the same guidelines but also include a documented diagnosis of pregnancy	
Prenatal and Postpartum Care: Postpartum Care (PPC) All Ages	The measure assesses the following facets of postpartum care: **Postpartum Care** The percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery. Services provided via telephone, e-visit, or virtual check-in **are** eligible for both PPC measures.	A qualified postpartum visit must include a note indicating the date the visit occurred and include at least one of the following: • Notation of postpartum care • Pelvic exam • Evaluation of weight, blood pressure, breasts, and abdomen (must have all four components) • Perineal or cesarean incision/ wound check • Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders • Glucose screening for women with gestational diabetes • Documentation of infant care or breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity, or attainment of healthy weight	**Postpartum Visit** **CPT:** 57170, 58300, 59430, 99501 **CPT II:** 0503F **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 **Cervical Cytology** **CPT:** 88141-3, 88147-8, 88150, 88152-3, 88164-7, 88174-5 **HCPCS:** G0123-4, G0141, G0143, G0147-8, Q0091 *Note: CPT II codes are for quality reporting purposes only, not for payment.*
Prevention and Screening			
Breast Cancer Screening (BCS)* Females 50-74 years	Women 50-74 years of age who had a mammogram to screen for breast cancer once every 27 months.	Biopsies, breast ultrasounds, or MRIs do not count towards this measure.	**CPT:** 77061-3, 77065-7 *Potential exclusion for* **Bilateral/Unilateral Mastectomy** *in patient history* **ICD-10:** Z90.11, Z90.12, Z90.13

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Prevention and Screening			
Cervical Cancer Screening (CCS)* Females 21-64 years	Women 21-64 years of age who were screened for cervical cancer using one of the following methods: • Women 21-61 years of age who had cervical cytology performed within the last three years • Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed during the measurement year or the four years prior, and who were 30 years or older as of the date of testing • Women 30-64 years of age who had cervical cytology/hrHPV co-testing during the measurement year or the four years prior	Cervical cytology during the measurement year or the two years prior Documentation must include **both**: • A note indicating the date when the cervical cytology was performed • The result or findings Documentation must include **both**: • A note indicating the date when the cervical cytology and/or the HPV test were performed; the cervical cytology and HPV test must be from the same data source • The results or findings	**High Risk HPV CPT:** 87624-5 **Cervical Cytology** **CPT:** 88141-3, 88147-8, 88150, 88152-3, 88164-7, 88174-5 **HCPCS:** G0124, G0141, G0143, G0147-8, Q0091 ***Potential exclusion from measure for Hysterectomy in patient history*** **ICD-10:** Q51.5, Z90.710, Z90.712 **CPT:** 51925, 57530-1, 57540, 57545, 57550, 57555-6, 58150, 58152, 58200, 58210, 58240, 58260, 58262-3, 58267, 58270, 58275, 58280, 58285, 58290-4, 58548, 58550, 58552-4, 58570-3, 58575, 58951, 58953-4, 58956, 59135
Chlamydia Screening in Women (CHL) Females 16-24 years	Women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Women are considered sexually active if there is evidence of the following: • Contraceptives are prescribed • Via medical coding	**CPT:** 87110, 87270, 87320, 87490-2, 87810
Colorectal Cancer Screening (COL)* 45-75 years	Adults 45-75 years of age who had appropriate screening for colorectal cancer. Any one or more of the following screenings for colorectal cancer meet criteria: • Fecal occult blood test **Yearly** • FIT sDNA test **Every 3 Years** • CT Colonography **Every 5 Years** • Flexible sigmoidoscopy **Every 5 years** • Colonoscopy **Every 10 Years**	Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present. This ensures that the screening was performed and not merely ordered.	**FOBT CPT:** 82270, 82274 **FIT – sDNA CPT:** 81528 **CT Colonography CPT:** 74263 **Flexible Sigmoidoscopy CPT:** 45330-5, 45337-8, 45340-2, 45346-7, 45349-50 **Colonoscopy CPT:** 44388-92, 44394, 44401-8, 45378-93, 45398 ***Potential exclusion from measure*** **Colorectal Cancer ICD-10:** Z85.038, Z85.048, C18.0-9, C19, C20, C21.2, C21.8, C78.5 **Total Colectomy CPT:** 44150-1, 44155-8, 44210-2

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Respiratory Conditions			
Asthma Medication Ratio (AMR) 5-64 years	The percentage of members 5-64 years with persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	• Medications given as oral, inhaler, or as an injection are counted. • Controller medication(s) should account for ≥ 0.50 of total asthma medications dispensed.	Compliance occurs only if patient fills prescription. Encourage patient to fill prescriptions on time and take medications as prescribed.
Appropriate Testing for Pharyngitis (CWP) 3 years and older	Those 3 years and older with a diagnosis of pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.	Documentation in the medical record must include **all** of the following: • Diagnosis of pharyngitis, • Antibiotic dispensed on or up to three days after date of service ***– AND –*** • Received group A strep test	Need evidence **of all three** components: • **Strep Test CPT:** 87070-1, 87081, 87430, 87650-2, 87880 ***– WITH –*** • **Pharyngitis Diagnostic ICD-10:** J02.0, J02.8-9, J03.00-1, J03.80-1, J03.90-1 ***– AND –*** • **Prescribed antibiotic is filled** by a pharmacy

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)* 18-85 years	Adults 18-85 years with a diagnosis of essential hypertension and whose BP was adequately controlled during the measurement year. Telephone visits, e-visits, and virtual check-ins are appropriate settings for BP readings. BPs can be taken by any digital device.	**Criteria for control** BP < 140/90 on or after the date of the second diagnosis of hypertension. **Exclusions:** • Patients with evident ESRD. • Diagnosis of pregnancy during the current year. • Patients who had an admission to a non-acute inpatient setting in the current year.	**Record Review** Notation of the **most recent BP** in the medical record. **Blood Pressure** **CPT II:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F ***– OR –*** Taken during **Outpatient, without Revenue Code** **CPT:** 99201-5, 99211-5, 99241-5, 99341-5, 99347-50, 99381-7, 99391-7, 99401-29, 99455-6, 99483 **HCPCS:** G0463, T1015 ***– OR –*** **Online Assessment** **CPT:** 98969-72, 99421-3, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061, G2062, G2063 *Note: CPT II codes are for quality reporting purposes only, not for payment.*
Statin Therapy for Patients With Cardiovascular Disease (SPC)* Males 21-75 years Females 40-75 years	Adults who were identified as having clinical ASCVD and met the following criteria: • Received statin therapy • Were adherent to therapy at least 80% of treatment period	Patients should be dispensed at least one high or moderate-intensity statin and stay on medication for at least 80% of treatment period. Include patients with a **discharge diagnosis** of MI. Patients with a diagnosis of CABG, PCI or any other revascularization process are automatically **included** in measure.	Compliance occurs only if patient fills prescription. Encourage patient to fill prescriptions on time and take medications as prescribed. Telehealth can be used to prescribe to eligible patients, if appropriate for the patient. **Exclusions** Frailty and advanced illness (must meet both), palliative care, ESRD, cirrhosis, pregnancy or IVF (current or prior year), and muscular pain or disease.*
Diabetes Care			
Statin Therapy for Patients With Diabetes (SPD)* 40-75 years	Adults who were identified as having diabetes and **DO NOT HAVE** clinical ASCVD, and met the following criteria: • Received statin therapy • Were adherent to therapy at least 80% of treatment period	Patients who were identified as having diabetes with diagnosis of MI, CABG, PCI, or any other revascularization process are automatically **excluded** in measure. Patients should be dispensed at least one high or moderate-intensity statin and stay on medication for at least 80% of treatment period.	Compliance occurs only if patient fills prescription. Encourage patient to fill prescriptions on time and take medications as prescribed. Telehealth can be used to prescribe to eligible patients, if appropriate for the patient.

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Diabetes Care			
Hemoglobin A1c Control for Patients With Diabetes (HBD)* 18-75 years with type 1 or type 2 diabetes	Adults whose hemoglobin A1c was at the following levels during the measurement year: • HbA1c control < 8% • HbA1c poor control ≥ 9%	Notation of the most recent HbA1c screening noting date performed and result performed in current year. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance when documented in the medical record.	**HbA1c CPT:** 83036-7 **CPT II:** 3044F, 3046F, 3051F, 3052F *Note: CPT II codes are for quality reporting purposes only, not for payment.*
Eye Exam for Patients With Diabetes (EED)* 18-75 years with type 1 or type 2 diabetes	Adults who had a screening or monitoring for diabetic retinal disease in the measurement year.	A retinal or dilated eye exam by an optometrist or ophthalmologist in current year. A negative retinal or dilated exam (negative for retinopathy) done by an optometrist or ophthalmologist in previous year.	**Eye Exam by Eye Care Professional** **CPT:** 67028, 67030-1, 67036, 67039-43, 67101, 67105, 67107-8, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220-1, 67227-8, 92002, 92004, 92012, 92014, 92018-9, 92134, 92201-2, 92227-8, 92230, 92235, 92240, 92250, 92260, 99203-5, 99213-5 **Eye Exam any Professional** **CPT:** 92229 (automated eye exam) **CPT II:** 2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F *Note: CPT II codes are for quality reporting purposes only, not for payment.*
Blood Pressure Control for Patients With Diabetes (BPD)* 18-75 years with type 1 or type 2 diabetes	Adults with diabetes whose blood pressure was adequately controlled (< 140/90 mm Hg) during the measurement year.	Notation of the most recent BP in the medical record.	**Blood Pressure CPT II:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F **Taken During Outpatient** **CPT:** 99201-5, 99211-5, 99241-5, 99341-5, 99347-50, 99381-7, 99391-7, 99401-29, 99455-6, 99483 **HCPCS:** G0463, T1015 Blood Pressure **CPT II:** 3074F, 3075F, 3077F, 3078F, 3079F, 3080F *Note: CPT II codes are for quality reporting purposes only, not for payment.*
Kidney Health Evaluation for Patients With Diabetes (KED)* 18-85 years with type 1 or type 2 diabetes	Percentage of adults with diabetes (type 1 and type 2) who received a kidney health evaluation during the measurement year.	Defined by an estimated glomerular filtration rate (eGFR) AND a urine albumin-creatinine ratio (uACR; both quantitative urine albumin test and urine creatinine test with service dates four or less days apart). **Exclusion:** ESRD or dialysis at any time during patients history.	**eGFR CPT:** 80047-8, 80050, 80053, 80069, 82565 **With Urine Albumin Creatinine Ratio Lab Test (uACR)** ***– OR –*** **Quantitative Urine Albumin CPT:** 82043 **With Urine Creatinine CPT:** 82570

MEASURE	DESCRIPTION OF MEASURE	DOCUMENTATION TIPS	COMPLIANCE CODES & MEASURE TIPS
Overuse/Appropriateness			
Use of Opioids at High Dosage (HDO)* 18 years and over	The proportion of members 18 years and older receiving prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90mg) for ≥ 15 days during the measurement year.	Reduce the number of adults prescribed high dose opioids for ≥15 days. A lower rate indicates better performance. Increasing total MME dose of opioids is related to increased risk of overdose and adverse events. Necessity of use of high doses should be clear. Patients with cancer, sickle cell disease, or members receiving palliative care are excluded from this measure.	Patients are considered out of compliance if their prescription average MME was ≥ 90mg during the treatment period. This measure **does not include** the following opioid medications: • Injectables • Opioid cough and cold products • Ionsys® (fentanyl transdermal patch) • Methadone for the treatment of opioid use disorder
Use of Opioids from Multiple Providers (UOP) 18 years and over	The proportion of members 18 years and older, receiving prescription opioids for ≥ 15 days during the measurement year who received opioids from multiple providers. Three rates are reported: **Multiple Prescribers** Patients receiving prescriptions for opioids from four or more different prescribers during the calendar year. **Multiple Pharmacies** Patients receiving prescriptions for opioids from four or more different pharmacies during the current calendar year. **Multiple Prescribers and Multiple Pharmacies** Patients receiving prescriptions for opioids from four or more different prescribers **and** four or more different pharmacies during the calendar year.	Reduce the number of adults prescribed opioids for ≥ 15 days by multiple providers. A lower rate indicates better performance for all three rates. Member use of increasing number of prescribers or pharmacies may signal risk for uncoordinated care. Clinical correlation is encouraged so that providers can evaluate for risk of diversion, misuse, or a substance use disorder. Providers are encouraged to communicate with each other for ideal management of member.	**Multiple Prescribers** Patients are considered out of compliance if they received prescription opioids from four or more different prescribers. **Multiple Pharmacies** Patients are considered out of compliance if they received prescription opioids from four or more different pharmacies. **Multiple Prescribers and Multiple Pharmacies** Patients are considered out of compliance if they received prescription opioids from four or more different prescribers **and** four or more different pharmacies. The following opioid medications are excluded from this measure: • Injectables • Opioid cough and cold products • Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder • Ionsys® (fentanyl transdermal patch) • Methadone for the treatment of opioid use disorder

*Palliative Care is a required exclusion for this measure.

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

Please Note: The codes in this document are derived from the NCQA HEDIS Volume 2 Technical Specifications for Health Plans. These codes are examples of codes typically billed for this type of service and are subject to change. Billing these codes does not guarantee payment. CPT II codes are for quality reporting purposes only. Submitting claims using these codes helps improve reporting of quality measure performance.

IN-MED-P-406013a; First Use: 2/2/2023 | OMPP Approved: 2/2/2023