

HEDIS Benchmarks and Coding Guidelines for Quality Care

Electronic Clinical Data Systems (ECDS)



Table of contents

Electronic Clinical Data Systems	3
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	4
Adult Immunization Status (AIS-E)	6
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	7
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)	8
Breast Cancer Screening (BCS-E)	10
Cervical Cancer Screening (CCS-E).....	11
Childhood Immunization Status (CIS-E)	12
Colorectal Cancer Screening (COL-E).....	14
Utilization of the <i>PHQ-9</i> to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)	14
Depression Remission or Response for Adolescents and Adults (DRR-E)	16
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E).....	17
Immunizations for Adolescents (IMA-E)	20
Postpartum Depression Screening and Follow-Up (PDS-E).....	21
Prenatal Depression Screening and Follow-up (PND-E)	22
Prenatal Immunization Status (PRS-E).....	26
Social Need Screening and Intervention (SNS-E)	27
Appendix	30
Coding for ECDS measures	31
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	31
Adult Immunization Status (AIS-E)	33
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E).....	38
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)	46
Breast Cancer Screening (BCS-E)	51
Childhood Immunization Status (CIS-E).....	60
Colorectal Cancer Screening (COL-E)	80
Utilization of the <i>PHQ-9</i> to Monitor Depression Symptoms for Adolescents and Adults (DMS-E) E).....	83

<https://provider.healthybluenc.com>

Healthy Blue is a Medicaid plan offered by Blue Cross and Blue Shield of North Carolina. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross Blue Shield Association. ® Marks of the Blue Cross Blue Shield Association. All other marks are the property of their respective owners.

NCHB-CD-046863-23-CPN46796 February 2024

Depression Remission or Response for Adolescents and Adults (DRR-E)	86
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	89
Immunizations for Adolescents (IMA-E)	90
Postpartum Depression Screening and Follow-Up (PDS-E)	92
Prenatal Depression Screening and Follow-up (PND-E).....	94
Prenatal Immunization Status (PRS-E)	97
Social Need Screening and Intervention (SNS-E)	99

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Electronic Clinical Data Systems

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

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

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

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Helpful tips:

- Utilize this booklet as a reference to understand the ECDS measures and the coding associated with electronic data transmission.
- Contact your health plan representative to establish an electronic data transfer with the plan if your organization does not already have one.
- Make full use of CPT II codes to submit care quality findings, many HEDIS gaps could be closed via claims if CPT II codes were fully utilized.
- Ensure the EMR systems are set up to link the clinical and behavior health entries to LOINC codes and SNOMED codes:
 - Ensure that the extracts are inclusive of LOINC codes for BH screenings among other things and SNOMED codes.

Our Supplemental Data team is here to help. For additional support in submitting supplemental data for ECDS measures, send inquiries to supplementaldata@healthybluenc.com.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

Two rates are reported:

Initiation phase: the percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase

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

Record your efforts

When prescribing a new ADHD medication:

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

Exclusions

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members with a diagnosis of narcolepsy any time during the member's history through the end of the measurement period.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Adult Immunization Status (AIS-E)

This measure looks at the percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster and pneumococcal during the measurement year.

Record your efforts

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

- Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period
- Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period

or

- Members with a history of at least one of the following contraindications any time before or during the measurement period:
 - Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine.
 - Encephalitis due to the diphtheria, tetanus, or pertussis vaccine.
- Members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the measurement period
- Members who were administered the 23-valent pneumococcal polysaccharide vaccine on or after the member's 60th birthday and before or during the measurement period

Exclusion:

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

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

Record your efforts:

- Members who received at least one test for blood glucose or HbA1c
- Members who received at least one test for LDL-C or cholesterol
- Members who received both of the following on the same or different dates:
 - At least one test for blood glucose or HbA1c
 - At least one test for LDL-C or cholesterol

Exclusions:

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

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

Record your efforts

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

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members with alcohol use disorder that starts during the year prior to the measurement period.
- Members with history of dementia any time during the member's history through the end of the measurement period.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Breast Cancer Screening (BCS-E)

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

Record your efforts

Include documentation of all types and methods of mammograms including:

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

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

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

- Breast ultrasounds
- MRIs
- Biopsies

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period.
- Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet **BOTH** frailty and advanced illness criteria to be excluded.
- Members who die any time during the measurement year

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

- Members receiving palliative care any time during the measurement year.
- Members who had an encounter for palliative anytime during the measurement year.

Cervical Cancer Screening (CCS-E)

This measure looks at the percentage of members 21-64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members 21 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Record your efforts

Make sure your medical records reflect:

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

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year
- Cervical agenesis or acquired absence of cervix any time during the member's history through the end of the measurement period.
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care any time during the measurement period.
- Members with Sex Assigned at Birth of Male at any time during the patient's history.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Childhood Immunization Status (CIS-E)

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

- 4 diphtheria, tetanus, and acellular pertussis, **DTaP** vaccine
- 3 polio, **IPV** vaccine
- 1 measles, mumps and rubella, **MMR** vaccine (can only be given on or between first and second birthday to close the gap)
- 3 haemophilus influenza type B, **Hib** vaccine
- 3 hepatitis B, **HepB** vaccine (One of the three vaccinations can be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth.)
- 1 chicken pox, **VZV** vaccine (can only be given on or between first and second birthday to close the gap)
- 4 pneumococcal conjugate, **PCV** vaccine
- 1 hepatitis A, **HepA** vaccine (can only be given on or between first and second birthday to close the gap)
- 2 two-dose rotavirus, **RV** vaccine, or 3 three-dose rotavirus (RV) (Or one two-dose and two three-dose RV combination)
- 2 influenza, **Flu** vaccine (influenza cannot be given until infant is 6 months of age — One of the two vaccinations for influenza can be an LAIV administered on the child's second birthday).

Record your efforts

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

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Exclusions:

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Colorectal Cancer Screening (COL-E)

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

Record your efforts:

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

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded.
- Members receiving palliative care any time during the measurement year.
- Members who had an encounter for palliative care any time during the measurement year.
- Members who had colorectal cancer any time during the member's history through December 31 of the measurement year.
- Members who had a total colectomy any time during the member's history through December 31 of the measurement period.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

Record your efforts

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

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

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

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

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

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

Exclusions:

- Members with any of the following at any time during member's history through the end measurement period:
 - Bipolar disorder
 - Personality disorder
 - Psychotic disorder
 - Pervasive developmental disorder
- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement year.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

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

Record your efforts

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

- May 1 of the year prior to the measurement period through December 31 of the measurement period
- May 1 of the year prior to the measurement period through April 30 of the measurement period
- The 120- to 240-day period after the index episode start date.
- Index episode start date: The earliest date during the intake period where a member has a diagnosis of major depression or dysthymia **and** a *PHQ-9* total score > 9 documented.

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

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

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

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members with any of the following any time during the member's history through the end of the measurement period:

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

- Bipolar disorder
- Personality disorder
- Psychotic disorder
- Pervasive developmental disorder

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

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

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

Record your efforts

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

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

Depression screening instrument:

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

Instruments for adolescents (≤ 17 years)	Total Score LOINC Codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire Modified for Teens (PHQ- 9M)</i> [®]	89204-2	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Instruments for adolescents (≤ 17 years)	Total Score LOINC Codes	Positive finding
<i>Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	71354-5	Total score ≥ 10
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60

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

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

Instruments for adults (18+ years)	Total Score LOINC Codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Beck Depression Inventory (BDI-II)</i>	89209-1	Total score ≥ 20
<i>Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Duke Anxiety-Depression Scale (DUKE-AD)</i> ^{®2}	90853-3	Total score ≥ 30
<i>Geriatric Depression Scale Short Form (GDS)</i> ¹	48545-8	Total score ≥ 5
<i>Geriatric Depression Scale Long Form (GDS)</i>	48544-1	Total score ≥ 10
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	48544-1	Total score ≥ 10
<i>My Mood Monitor (M-3)</i> [®]	71777-7	Total score ≥ 5
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
<i>Clinically Useful Depression Outcome Scale (CUDOS)</i>	90221-3	Total score ≥ 31

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

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members with a history of bipolar 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 year prior to the measurement period.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunizations for Adolescents (IMA-E)

This measure reviews members 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Vaccines administered on or before their 13th birthday:

- One MCV/meningococcal vaccine on or between 11th and 13th birthdays, and one Tdap or one Td vaccine on or between their 10th and 13th birthdays
- At least two doses of HPV vaccine with DOS at 146 days apart on or between the 9th and 13th birthdays:
 - Or at least three HPV vaccines with different dates of service on or between the 9th and 13th birthdays

Record your efforts

Immunization information obtained from the medical record:

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

Two-dose HPV vaccination series:

- There must be at least 146 days between the first and second dose of the HPV vaccine.

Meningococcal:

- **Do not count** meningococcal recombinant (serogroup B) (MenB) vaccines.

Exclusions:

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

- **Depression Screening** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (7–84 days following the delivery date).
- **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding (31 total days).

Record your efforts

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

- The delivery date through 60 days following the date of delivery

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

Instruments for adolescents (≤ 17 years)	Total Score LOINC Codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire Modified for Teens (PHQ-9M)</i> [®]	89204-2	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	71354-5	Total score ≥ 10
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Instruments for adults (18+ years)	Total Score LOINC Codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Beck Depression Inventory (BDI-II)</i>	89209-1	Total score ≥ 20
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Duke Anxiety-Depression Scale (DUKE-AD)</i> ^{®2}	90853-3	Total score ≥ 30
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	71354-5	Total score ≥ 10
<i>My Mood Monitor (M-3)</i> [®]	71777-7	Total score ≥ 5
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
<i>Clinically Useful Depression Outcome Scale (CUDOS)</i>	90221-3	Total score ≥ 31

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

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

Exclusions:

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

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

Record your efforts

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

- 28 days prior to the delivery date through the delivery date
- A pregnancy episode in which the delivery date occurs during the measurement period

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

Instruments for adolescents (≤ 17 years)	Total Score LOINC Codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire Modified for Teens (PHQ-9M)</i> [®]	89204-2	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	71354-5	Total score ≥ 10
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Instruments for adults (18+ years)	Total Score LOINC Codes	Positive finding
<i>Patient Health Questionnaire (PHQ-9)</i> [®]	44261-6	Total score ≥ 10
<i>Patient Health Questionnaire-2 (PHQ-2)</i> ^{®1}	55758-7	Total score ≥ 3
<i>Beck Depression Inventory-Fast Screen (BDI-FS)</i> ^{®1,2}	89208-3	Total score ≥ 8
<i>Beck Depression Inventory (BDI-II)</i>	89209-1	Total score ≥ 20
<i>Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)</i>	89205-9	Total score ≥ 17
<i>Duke Anxiety-Depression Scale (DUKE-AD)</i> ^{®2}	90853-3	Total score ≥ 30
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>	71354-5	Total score ≥ 10
<i>My Mood Monitor (M-3)</i> [®]	71777-7	Total score ≥ 5
<i>PROMIS Depression</i>	71965-8	Total score (T score) ≥ 60
<i>Clinically Useful Depression Outcome Scale (CUDOS)</i>	90221-3	Total score ≥ 31

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

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

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Deliveries that occurred at less than 37 weeks gestation.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Prenatal Immunization Status (PRS-E)

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

Record your efforts

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

- 28 days prior to the delivery date through the delivery date
- A pregnancy episode in which the delivery date occurs during the measurement period

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Deliveries that occurred at less than 37 weeks gestation

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Social Need Screening and Intervention (SNS-E)

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

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

Record your efforts:

- **Food insecurity:** Uncertain, limited, or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways.
- **Housing instability:** Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.
- **Homelessness:** Currently living in an environment that is not meant for permanent human habitation (for example, cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.
- **Housing inadequacy:** Housing does not meet habitability standards.
- **Transportation insecurity:** Uncertain, limited or no access to safe, reliable, accessible, affordable, and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being, or livelihood.

Eligible screening instruments with thresholds for positive findings include:

Food insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
	88122-7	LA28397-0 LA6729-3

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Food insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	88123-5	LA28397-0 LA6729-3
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
<i>Health Leads Screening Panel®1</i>	95251-5	LA33-6
<i>Hunger Vital Sign™ 1 (HVS)</i>	88124-3	LA19952-3
<i>Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1</i>	93031-3	LA30125-1
<i>Safe Environment for Every Kid (SEEK)®1</i>	95400-8	LA33-6
	95399-2	LA33-6
<i>U.S. Household Food Security Survey (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6
<i>U.S. Adult Food Security Survey (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6
<i>U.S. Child Food Security Survey (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6
<i>U.S. Household Food Security Survey–Six-Item Short Form (U.S. FSS)</i>	95264-8	LA30985-8 LA30986-6
<i>We Care Survey</i>	96434-6	LA32-8
<i>WellRx Questionnaire</i>	93668-2	LA33-6

Housing instability and homelessness instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	71802-3	LA31994-9 LA31995-6
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	99550-6	LA33-6

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

Housing inadequacy instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2

Transportation insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</i>	93030-5	LA33-6

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Transportation insecurity instruments	Screening item LOINC codes	Positive finding LOINC codes
<i>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</i>	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	99594-4	LA33093-8 LA30134-3
<i>Comprehensive Universal Behavior Screen (CUBS)</i>	89569-8	LA29232-8 LA29233-6 LA29234-4
<i>Health Leads Screening Panel</i> ^{®1}	99553-0	LA33-6
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)—version 4.0 [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Discharge from Agency [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Resumption of Care [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Start of Care [CMS Assessment]	93030-5	LA30133-5 LA30134-3
<i>Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)</i> ^{®1}	93030-5	LA30133-5 LA30134-3
<i>PROMIS</i> ^{®1}	92358-1	LA30024-6 LA30026-1 LA30027-9
<i>WellRx Questionnaire</i>	93671-6	LA33-6

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

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

Exclusions:

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Appendix

Coding for ECDS measures

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

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

Description	CPT/HCPCS/POS/SNOMED CT
Outpatient POS	POS 03: School 05: Indian Health Service Free-standing Facility 07: Facility 09: Tribal 638 Free-standing Facility 11: Office 12: Home 13: Assisted Living Facility 14: Group Home 15: Mobile Unit 16: Temporary Lodging 17: Walk-in Retail Clinic 18: Place of Employment-Worksite 19: Off Campus-Outpatient Hospital 20: Urgent Care Facility 22: On-Campus Outpatient Hospital 33: Custodial Care Facility 49: Independent Clinic 50: Federally Qualified Health Center 71: Public Health Clinic 72: Rural Health Clinic
Health and Behavioral Assessment or Intervention	CPT 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
Online Assessments	CPT 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99457, 99458 HCPCS G0071: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCP/POS/SNOMED CT
	<p>recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only</p> <p>G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment</p> <p>G2012: Brief communication technology-based service, e.g. 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 e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion</p> <p>G2250: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment</p> <p>G2251: Brief communication technology-based service, e.g., virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion</p> <p>G2252: Brief communication technology-based service, e.g. 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 e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion</p>
Telephone Visits	<p>CPT 98966, 98967, 98968, 99441, 99442, 99443</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/POS/SNOMED CT
Telehealth POS	POS 02: Telehealth Provided Other than in Patient's Home 10: Telehealth Provided in Patient's Home
Visit Setting Unspecified	CPT 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99252, 99253, 99254, 99255

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

Adult Immunization Status (AIS-E)

Immunization	CPT/HCPCS/CVX/SNOMED CT
Adult Influenza Vaccine procedure	CPT 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90882, 90686, 90688, 90689, 90694, 90756 SNOMED CT 86198006: Administration of vaccine product containing only Influenza virus antigen (procedure)
Adult Influenza Immunization	CVX 88: influenza virus vaccine, unspecified formulation 135: influenza, high dose seasonal, preservative-free 140: Influenza, seasonal, injectable, preservative free 141: Influenza, seasonal, injectable 144: seasonal influenza, intradermal, preservative free 150: Influenza, injectable, quadrivalent, preservative free 153: Influenza, injectable, Madin Darby Canine Kidney, preservative free 155: Seasonal, trivalent, recombinant, injectable influenza vaccine, preservative free 158: influenza, injectable, quadrivalent, contains preservative 166: influenza, intradermal, quadrivalent, preservative free, injectable 168: Seasonal trivalent influenza vaccine, adjuvanted, preservative free 171: Influenza, injectable, Madin Darby Canine Kidney, preservative free, quadrivalent 185: Seasonal, quadrivalent, recombinant, injectable influenza vaccine, preservative free 186: Influenza, injectable, Madin Darby Canine Kidney, quadrivalent with preservative

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CT
	<p>197: influenza, high-dose seasonal, quadrivalent, 0.7mL dose, preservative free</p> <p>205: influenza, seasonal vaccine, quadrivalent, adjuvanted, 0.5mL dose, preservative free</p>
Adult Pneumococcal Immunization	<p>CVX</p> <p>33: pneumococcal polysaccharide vaccine, 23 valent</p> <p>109: pneumococcal vaccine, unspecified formulation</p> <p>133: pneumococcal conjugate vaccine, 13 valent</p> <p>152: Pneumococcal Conjugate, unspecified formulation</p> <p>215: Pneumococcal conjugate vaccine 15-valent (PCV15), polysaccharide CRM197 conjugate, adjuvant, preservative free</p> <p>216: Pneumococcal conjugate vaccine 20-valent (PCV20), polysaccharide CRM197 conjugate, adjuvant, preservative free</p>
Adult Pneumococcal Vaccine Procedure	<p>CPT 90670, 90671, 90677, 90732</p> <p>HCPCS G0009: Administration of pneumococcal vaccine</p> <p>SNOMED CT</p> <p>12866006: Administration of vaccine product containing only Streptococcus pneumoniae antigen (procedure)</p> <p>394678003: Administration of booster dose of vaccine product containing only Streptococcus pneumoniae antigen (procedure)</p> <p>871833000: Subcutaneous injection of pneumococcal vaccine (procedure)</p> <p>1119366009: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, and 23F capsular polysaccharide antigens (procedure)</p> <p>1119367000: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 11A, 12F, 14, 15B, 17F, 18C, 19A, 19F, 20, 22F, 23F, and 33F capsular polysaccharide antigens (procedure)</p> <p>1119368005: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 4, 6B, 9V, 14, 18C, 19F, and 23F capsular polysaccharide antigens conjugated (procedure)</p> <p>434751000124102: Pneumococcal conjugate vaccination (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CT
Influenza Virus LAIV Vaccine Procedure	CPT 90660, 90672 SNOMED CT 787016008: Administration of vaccine product containing only Influenza virus antigen in nasal dose form (procedure)
Influenza Virus LAIV Immunization	CVX 111: influenza virus vaccine, live, attenuated, for intranasal use 149: influenza, live, intranasal, quadrivalent
Td Vaccine Procedure	CPT 90714 SNOMED CT 73152006: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 312869001: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 395178008: Administration of first dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure) 395179000: Administration of second dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure) 395180002: Administration of third dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure) 395181003: Administration of booster dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae antigens (procedure) 414619005: Administration of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure) 416144004: Administration of third dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure) 416591003: Administration of first dose of vaccine product containing only Clostridium tetani and low dose

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Immunization	CPT/HCPCS/CVX/SNOMED CT
	<p>Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure) 417211006: Administration of first booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure) 417384007: Administration of second booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure) 417615007: Administration of second dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure) 866161006: Administration of booster dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 866184004: Administration of second dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 866185003: Administration of first dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 866186002: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 866227002: Administration of booster dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868266002: Administration of second dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868267006: Administration of first dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868268001: Administration of third dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

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

Description	CPT/CAT II/LOINC/SNOMED CT
Cholesterol Lab Test	<p>CPT 82465, 83718, 83722, 84478</p> <p>LOINC 2085-9: Cholesterol in HDL [Mass/volume] in Serum or Plasma</p> <p>2093-3: Cholesterol [Mass/volume] in Serum or Plasma</p> <p>2571-8: Triglyceride [Mass/volume] in Serum or Plasma</p> <p>3043-7: Triglyceride [Mass/volume] in Blood</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CT
	<p>314035000: Plasma high density lipoprotein cholesterol measurement (procedure) 315017003: Fasting cholesterol level (procedure) 390956002: Plasma total cholesterol level (procedure) 412808005: Serum total cholesterol measurement (procedure) 412827004: Fluid sample triglyceride measurement (procedure) 443915001: Measurement of total cholesterol and triglycerides (procedure)</p>
Cholesterol Test Result or Finding	<p>SNOMED CT 166830008: Serum cholesterol above reference range (finding) 166848004: Serum triglycerides above reference range (finding) 259557002: High density lipoprotein triglyceride (substance) 365793008: Finding of cholesterol level (finding) 365794002: Finding of serum cholesterol level (finding) 365795001: Finding of triglyceride level (finding) 365796000: Finding of serum triglyceride levels (finding) 439953004: Cholesterol/high density lipoprotein ratio above reference range (finding) 707122004: Triglyceride in high density lipoprotein subfraction 2 (substance) 707123009: Triglyceride in high density lipoprotein subfraction 3 (substance) 1162800007: Cholesterol esters within reference range (finding) 1172655006: Low density lipoprotein cholesterol below reference range (finding) 1172656007: Low density lipoprotein cholesterol within reference range (finding) 67991000119104: Serum cholesterol outside reference range (finding)</p>
Glucose Lab Test	<p>CPT 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 LOINC 10450-5: Glucose [Mass/volume] in Serum or Plasma --10 hours fasting 1492-8: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 0.5 g/kg glucose IV</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CT
	<p>1494-4: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 100 g glucose PO</p> <p>1496-9: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post 75 g glucose PO</p> <p>1499-3: Glucose [Mass/volume] in Serum or Plasma --1 hour post 0.5 g/kg glucose IV</p> <p>1501-6: Glucose [Mass/volume] in Serum or Plasma --1 hour post 100 g glucose PO</p> <p>1504-0: Glucose [Mass/volume] in Serum or Plasma --1 hour post 50 g glucose PO</p> <p>1507-3: Glucose [Mass/volume] in Serum or Plasma --1 hour post 75 g glucose PO</p> <p>1514-9: Glucose [Mass/volume] in Serum or Plasma --2 hours post 100 g glucose PO</p> <p>1518-0: Glucose [Mass/volume] in Serum or Plasma --2 hours post 75 g glucose PO</p> <p>1530-5: Glucose [Mass/volume] in Serum or Plasma --3 hours post 100 g glucose PO</p> <p>1533-9: Glucose [Mass/volume] in Serum or Plasma --3 hours post 75 g glucose PO</p> <p>1554-5: Glucose [Mass/volume] in Serum or Plasma --12 hours fasting</p> <p>1557-8: Fasting glucose [Mass/volume] in Venous blood</p> <p>1558-6: Fasting glucose [Mass/volume] in Serum or Plasma</p> <p>17865-7: Glucose [Mass/volume] in Serum or Plasma --8 hours fasting</p> <p>20436-2: Glucose [Mass/volume] in Serum or Plasma --2 hours post dose glucose</p> <p>20437-0: Glucose [Mass/volume] in Serum or Plasma --3 hours post dose glucose</p> <p>20438-8: Glucose [Mass/volume] in Serum or Plasma --1 hour post dose glucose</p> <p>20440-4: Glucose [Mass/volume] in Serum or Plasma --1.5 hours post dose glucose</p> <p>2345-7: Glucose [Mass/volume] in Serum or Plasma</p> <p>26554-6: Glucose [Mass/volume] in Serum or Plasma --2.5 hours post dose glucose</p> <p>41024-1: Glucose [Mass/volume] in Serum or Plasma --2 hours post 50 g glucose PO</p> <p>49134-0: Glucose [Mass/volume] in Blood --2 hours post dose glucose</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CT
	<p>6749-6: Glucose [Mass/volume] in Serum or Plasma --2.5 hours post 75 g glucose PO</p> <p>9375-7: Glucose [Mass/volume] in Serum or Plasma --2.5 hours post 100 g glucose PO</p> <p>SNOMED CT</p> <p>22569008: Glucose measurement, serum (procedure)</p> <p>33747003: Glucose measurement, blood (procedure)</p> <p>52302001: Glucose measurement, fasting (procedure)</p> <p>72191006: Glucose measurement, plasma (procedure)</p> <p>73128004: Glucose measurement, random (procedure)</p> <p>88856000: Glucose measurement, 2 hour post prandial (procedure)</p> <p>104686004: Glucose measurement, blood, test strip (procedure)</p> <p>167086002: Serum random glucose measurement (procedure)</p> <p>167087006: Serum fasting glucose measurement (procedure)</p> <p>167088001: Serum 2-hr post-prandial glucose measurement (procedure)</p> <p>167095005: Plasma random glucose measurement (procedure)</p> <p>167096006: Plasma fasting glucose measurement (procedure)</p> <p>167097002: Plasma 2-hr post-prandial glucose measurement (procedure)</p> <p>250417005: Glucose concentration, test strip measurement (procedure)</p> <p>271061004: Random blood glucose measurement (procedure)</p> <p>271062006: Fasting blood glucose measurement (procedure)</p> <p>271063001: Lunch time blood sugar measurement (procedure)</p> <p>271064007: Supper time blood sugar measurement (procedure)</p> <p>271065008: Bedtime blood sugar measurement (procedure)</p> <p>275810004: BM stix glucose measurement (procedure)</p> <p>302788006: Post-prandial blood glucose measurement (procedure)</p> <p>302789003: Capillary blood glucose measurement (procedure)</p> <p>308113006: Self-monitoring of blood glucose (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CT
	<p>313474007: 60-minute blood glucose measurement (procedure)</p> <p>313545000: 120-minute blood glucose measurement (procedure)</p> <p>313546004: 90-minute blood glucose measurement (procedure)</p> <p>313624000: 150-minute blood glucose measurement (procedure)</p> <p>313626003: 60-minute plasma glucose measurement (procedure)</p> <p>313627007: 120-minute plasma glucose measurement (procedure)</p> <p>313628002: 150-minute plasma glucose measurement (procedure)</p> <p>313630000: 60-minute serum glucose measurement (procedure)</p> <p>313631001: 120-minute serum glucose measurement (procedure)</p> <p>313697000: 90-minute plasma glucose measurement (procedure)</p> <p>313698005: 90-minute serum glucose measurement (procedure)</p> <p>313810002: 150-minute serum glucose measurement (procedure)</p> <p>412928005: Blood glucose series (procedure)</p> <p>440576000: 240-minute plasma glucose measurement (procedure)</p> <p>443780009: Quantitative measurement of mass concentration of glucose in serum or plasma specimen 120 minutes after 75-gram oral glucose challenge (procedure)</p> <p>444008003: Quantitative measurement of mass concentration of glucose in serum or plasma specimen 6 hours after glucose challenge (procedure)</p> <p>444127006: Quantitative measurement of mass concentration of glucose in postcalorie fasting serum or plasma specimen (procedure)</p>
Glucose Test Result or Finding	<p>SNOMED CT</p> <p>166890005: Random blood glucose within reference range (finding)</p> <p>166891009: Random blood sugar below reference range (finding)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CT
	<p>166892002: Random blood sugar above reference range (finding) 166914001: Blood glucose 0-1.4 mmol/L (finding) 166915000: Blood glucose 1.5-2.4 mmol/L (finding) 166916004: Blood glucose 2.5-4.9 mmol/L (finding) 166917008: Blood glucose 5-6.9 mmol/L (finding) 166918003: Blood glucose 7-9.9 mmol/L (finding) 166919006: Blood glucose 10-13.9 mmol/L (finding) 166921001: Blood glucose within reference range (finding) 166922008: Blood glucose outside reference range (finding) 166923003: Blood glucose 14+ mmol/L (finding) 442545002: Random blood glucose outside reference range (finding) 444780001: Glucose in blood specimen above reference range (finding) 1179458001: Blood glucose below reference range (finding)</p>
HbA1c Lab Test	<p>CPT 83036, 83037 LOINC 17855-8: Hemoglobin A1c/Hemoglobin. Total in Blood by calculation 17856-6: Hemoglobin A1c/Hemoglobin. Total in Blood by HPLC 4548-4: Hemoglobin A1c/Hemoglobin. Total in Blood 4549-2: Hemoglobin A1c/Hemoglobin. Total in Blood by Electrophoresis 96595-4: Hemoglobin A1c/Hemoglobin. Total in DBS SNOMED CT 43396009: Hemoglobin A1c measurement (procedure) 313835008: Hemoglobin A1c measurement aligned to the Diabetes Control and Complications Trial (procedure)</p>
HbA1c Test Result or Finding	<p>CPT 83036, 83037 CAT II 3044F: Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM) 3046F: Most recent hemoglobin A1c level greater than 9.0% (DM) 3051F: Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CT
	<p>3052F: Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)</p> <p>SNOMED CT</p> <p>451051000124101: Hemoglobin A1c less than 7 percent indicating good diabetic control (finding)</p> <p>451061000124104: Hemoglobin A1c greater than nine percent indicating poor diabetic control (finding)</p>
LDL-C Lab Test	<p>CPT 80061, 83700, 83701, 83704, 83721</p> <p>LOINC</p> <p>12773-8: Cholesterol in LDL [Units/volume] in Serum or Plasma by Electrophoresis</p> <p>13457-7: Cholesterol in LDL [Mass/volume] in Serum or Plasma by calculation</p> <p>18261-8: Cholesterol in LDL [Mass/volume] in Serum or Plasma ultracentrifugate</p> <p>18262-6: Cholesterol in LDL [Mass/volume] in Serum or Plasma by Direct assay</p> <p>2089-1: Cholesterol in LDL [Mass/volume] in Serum or Plasma</p> <p>49132-4: Cholesterol in LDL [Mass/volume] in Serum or Plasma by Electrophoresis</p> <p>55440-2: Cholesterol.in LDL (real) [Mass/volume] in Serum or Plasma by VAP</p> <p>96259-7: Cholesterol in LDL [Mass/volume] in Serum or Plasma by Calculated by Martin-Hopkins</p> <p>SNOMED CT</p> <p>113079009: Low density lipoprotein cholesterol measurement (procedure)</p> <p>166833005: Serum low density lipoprotein cholesterol measurement (procedure)</p> <p>166840006: Serum fasting low density lipoprotein cholesterol measurement (procedure)</p> <p>166841005: Serum random low density lipoprotein cholesterol measurement (procedure)</p> <p>167074000: Plasma random low density lipoprotein cholesterol measurement (procedure)</p> <p>167075004: Plasma fasting low density lipoprotein cholesterol measurement (procedure)</p> <p>314036004: Plasma low density lipoprotein cholesterol measurement (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CAT II/LOINC/SNOMED CT
LDL-C Test Result or Finding	CAT II 3048F, 3049F, 3050F

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

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

Description	CPT/HCPCS/ICD10CM
Alcohol Counseling or Other Follow Up Care	<p>CPT 99408, 99409</p> <p>HCPCS G0396: Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, DAST), and brief intervention 15 to 30 minutes G0397: Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, DAST), and intervention, greater than 30 minutes G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes G2011: Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, DAST), and brief intervention, 5-14 minutes H0005: Alcohol and/or drug services; group counseling by a clinician H0007: Alcohol and/or drug services; crisis intervention (outpatient) H0015: Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education H0016: Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting) H0022: Alcohol and/or drug intervention service (planned facilitation) H0050: Alcohol and/or drug services, brief intervention, per 15 minutes H2035: Alcohol and/or other drug treatment program, per hour H2036: Alcohol and/or other drug treatment program, per diem</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM
	<p>T1006: Alcohol and/or substance abuse services, family/couple counseling</p> <p>T1012: Alcohol and/or substance abuse services, skills development</p> <p>SNOMED CT</p> <p>20093000: Alcohol rehabilitation and detoxification (regime/therapy)</p> <p>23915005: Combined alcohol and drug rehabilitation and detoxification (regime/therapy)</p> <p>24165007: Alcoholism counseling (procedure)</p> <p>64297001: Detoxication psychiatric therapy for alcoholism (regime/therapy)</p> <p>386449006: Substance use treatment: alcohol withdrawal (regime/therapy)</p> <p>408945004: Alcohol abuse prevention (procedure)</p> <p>408947007: Alcohol abuse prevention education (procedure)</p> <p>408948002: Alcohol abuse prevention management (procedure)</p> <p>413473000: Counseling about alcohol consumption (procedure)</p> <p>707166002: Alcohol reduction program (regime/therapy)</p> <p>429291000124102: Alcohol brief intervention (procedure)</p>
Alcohol Use Disorder	<p>ICD10CM</p> <p>F10.10: Alcohol abuse, uncomplicated</p> <p>F10.120: Alcohol abuse with intoxication, uncomplicated</p> <p>F10.121: Alcohol abuse with intoxication delirium</p> <p>F10.129: Alcohol abuse with intoxication, unspecified</p> <p>F10.130: Alcohol abuse with withdrawal, uncomplicated</p> <p>F10.131: Alcohol abuse with withdrawal delirium</p> <p>F10.132: Alcohol abuse with withdrawal with perceptual disturbance</p> <p>F10.139: Alcohol abuse with withdrawal, unspecified</p> <p>F10.14: Alcohol abuse with alcohol-induced mood disorder</p> <p>F10.150: Alcohol abuse with alcohol-induced psychotic disorder with delusions</p> <p>F10.151: Alcohol abuse with alcohol-induced psychotic disorder with hallucinations</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM
	<p>F10.159: Alcohol abuse with alcohol-induced psychotic disorder, unspecified</p> <p>F10.180: Alcohol abuse with alcohol-induced anxiety disorder</p> <p>F10.181: Alcohol abuse with alcohol-induced sexual dysfunction</p> <p>F10.182: Alcohol abuse with alcohol-induced sleep disorder</p> <p>F10.188: Alcohol abuse with other alcohol-induced disorder</p> <p>F10.20: Alcohol dependence, uncomplicated</p> <p>F10.220: Alcohol dependence with intoxication, uncomplicated</p> <p>F10.221: Alcohol dependence with intoxication delirium</p> <p>F10.229: Alcohol dependence with intoxication, unspecified</p> <p>F10.230: Alcohol dependence with withdrawal, uncomplicated</p> <p>F10.231: Alcohol dependence with withdrawal delirium</p> <p>F10.232: Alcohol dependence with withdrawal with perceptual disturbance</p> <p>F10.239: Alcohol dependence with withdrawal, unspecified</p> <p>F10.24: Alcohol dependence with alcohol-induced mood disorder</p> <p>F10.250: Alcohol dependence with alcohol-induced psychotic disorder with delusions</p> <p>F10.251: Alcohol dependence with alcohol-induced psychotic disorder with hallucinations</p> <p>F10.259: Alcohol dependence with alcohol-induced psychotic disorder, unspecified</p> <p>F10.26: Alcohol dependence with alcohol-induced persisting amnesic disorder</p> <p>F10.27: Alcohol dependence with alcohol-induced persisting dementia</p> <p>F10.280: Alcohol dependence with alcohol-induced anxiety disorder</p> <p>F10.281: Alcohol dependence with alcohol-induced sexual dysfunction</p> <p>F10.282: Alcohol dependence with alcohol-induced sleep disorder</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM
	<p>F10.288: Alcohol dependence with other alcohol-induced disorder</p> <p>F10.29: Alcohol dependence with unspecified alcohol-induced disorder</p> <p>F10.90: Alcohol use, unspecified, uncomplicated</p> <p>F10.920: Alcohol use, unspecified with intoxication, uncomplicated</p> <p>F10.921: Alcohol use, unspecified with intoxication delirium</p> <p>F10.929: Alcohol use, unspecified with intoxication, unspecified</p> <p>F10.930: Alcohol use, unspecified with withdrawal, uncomplicated</p> <p>F10.931: Alcohol use, unspecified with withdrawal delirium</p> <p>F10.932: Alcohol use, unspecified with withdrawal with perceptual disturbance</p> <p>F10.939: Alcohol use, unspecified with withdrawal, unspecified</p> <p>F10.94: Alcohol use, unspecified with alcohol-induced mood disorder</p> <p>F10.950: Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions</p> <p>F10.951: Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations</p> <p>F10.959: Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified</p> <p>F10.96: Alcohol use, unspecified with alcohol-induced persisting amnestic disorder</p> <p>F10.97: Alcohol use, unspecified with alcohol-induced persisting dementia</p> <p>F10.980: Alcohol use, unspecified with alcohol-induced anxiety disorder</p> <p>F10.981: Alcohol use, unspecified with alcohol-induced sexual dysfunction</p> <p>F10.982: Alcohol use, unspecified with alcohol-induced sleep disorder</p> <p>F10.988: Alcohol use, unspecified with other alcohol-induced disorder</p> <p>F10.99: Alcohol use, unspecified with unspecified alcohol-induced disorder</p> <p>K29.20: Alcoholic gastritis without bleeding</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM
	<p>K29.21: Alcoholic gastritis with bleeding K70.10: Alcoholic hepatitis without ascites K70.11: Alcoholic hepatitis with ascites SNOMED CT 281004: Dementia associated with alcoholism (disorder) 7052005: Alcohol hallucinosis (disorder) 7200002: Alcoholism (disorder) 8635005: Alcohol withdrawal delirium (disorder) 15167005: Alcohol abuse (disorder) 18653004: Alcohol intoxication delirium (disorder) 29212009: Organic mental disorder caused by ingestible alcohol (disorder) 34938008: Anxiety disorder caused by alcohol (disorder) 41083005: Sleep disorder caused by ingestible alcohol (disorder) 42344001: Psychosis caused by ingestible alcohol (disorder) 53936005: Mood disorder caused by ingestible alcohol (disorder) 61144001: Alcohol-induced psychotic disorder with delusions (disorder) 66590003: Alcohol dependence (disorder) 69482004: Korsakoff's psychosis (disorder) 73097000: Alcohol amnestic disorder (disorder) 78524005: Alcohol-induced sexual dysfunction (finding) 85561006: Alcohol withdrawal syndrome without complication (disorder) 87810006: Megaloblastic anemia due to alcoholism (disorder) 191471000: Korsakov's alcoholic psychosis with peripheral neuritis (disorder) 191475009: Chronic alcoholic brain syndrome (disorder) 191476005: Alcohol withdrawal hallucinosis (disorder) 191478006: Alcoholic paranoia (disorder) 191480000: Alcohol withdrawal syndrome (disorder) 191811004: Continuous chronic alcoholism (disorder) 191812006: Episodic chronic alcoholism (disorder) 191813001: Chronic alcoholism in remission (disorder)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/ICD10CM
	191882002: Nondependent alcohol abuse, continuous (disorder)
	191883007: Nondependent alcohol abuse, episodic (disorder)
	191884001: Nondependent alcohol abuse in remission (disorder)
	231467000: Absinthe addiction (disorder)
	268645007: Nondependent alcohol abuse (disorder)
	284591009: Persistent alcohol abuse (disorder)
	713583005: Mild alcohol dependence (disorder)
	713862009: Severe alcohol dependence (disorder)
	714829008: Moderate alcohol dependence (disorder)
	723926008: Perceptual disturbances and seizures co-occurrent and due to alcohol withdrawal (disorder)
	723927004: Psychotic disorder caused by alcohol with schizophreniform symptoms (disorder)
	723928009: Mood disorder with depressive symptoms caused by alcohol (disorder)
	723929001: Mood disorder with manic symptoms caused by alcohol (disorder)
	723930006: Mood disorder with mixed manic and depressive symptoms caused by alcohol (disorder)
	97571000119109: Thrombocytopenia co-occurrent and due to alcoholism (disorder)
	135311000119100: Insomnia caused by alcohol (disorder)
	288031000119105: Alcohol induced disorder co-occurrent and due to alcohol dependence (disorder)
	10741871000119101: Alcohol dependence in pregnancy (disorder)
	10755041000119100: Alcohol dependence in childbirth (disorder)

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

Breast Cancer Screening (BCS-E)

Description	CPT/LOINC/SNOMED CT
Mammography	CPT 77061, 77062, 77063, 77065, 77066, 77067 LOINC 24604-1: MG Breast Diagnostic Limited Views 24605-8: MG Breast Diagnostic

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/LOINC/SNOMED CT
	24606-6: MG Breast Screening
	24610-8: MG Breast Limited Views
	26175-0: MG Breast - bilateral Screening
	26176-8: MG Breast - left Screening
	26177-6: MG Breast - right Screening
	26287-3: MG Breast - bilateral Limited Views
	26289-9: MG Breast - left Limited Views
	26291-5: MG Breast - right Limited Views
	26346-7: MG Breast - bilateral Diagnostic
	26347-5: MG Breast - left Diagnostic
	26348-3: MG Breast - right Diagnostic
	26349-1: MG Breast - bilateral Diagnostic Limited Views
	26350-9: MG Breast - left Diagnostic Limited Views
	26351-7: MG Breast - right Diagnostic Limited Views
	36319-2: MG Breast 4 Views
	36625-2: MG Breast Views
	36626-0: MG Breast - bilateral Views
	36627-8: MG Breast - left Views
	36642-7: MG Breast - left 2 Views
	36962-9: MG Breast Axillary
	37005-6: MG Breast - left Magnification
	37006-4: MG Breast - bilateral MLO
	37016-3: MG Breast - bilateral Rolled Views
	37017-1: MG Breast - left Rolled Views
	37028-8: MG Breast Tangential
	37029-6: MG Breast - bilateral Tangential
	37030-4: MG Breast - left Tangential
	37037-9: MG Breast True lateral
	37038-7: MG Breast - bilateral True lateral
	37052-8: MG Breast - bilateral XCCL
	37053-6: MG Breast - left XCCL
	37539-4: MG Breast Grid Views
	37542-8: MG Breast Magnification Views
	37543-6: MG Breast - bilateral Magnification Views
	37551-9: MG Breast Spot Views
	37552-7: MG Breast - bilateral Spot Views
	37553-5: MG Breast - left Spot Views compression
	37554-3: MG Breast - bilateral Magnification and Spot
	37768-9: MG Breast - right 2 Views
	37769-7: MG Breast - right Magnification and Spot
	37770-5: MG Breast - right Tangential
	37771-3: MG Breast - right True lateral

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/LOINC/SNOMED CT
	37772-1: MG Breast - right XCCL
	37773-9: MG Breast - right Magnification
	37774-7: MG Breast - right Views
	37775-4: MG Breast - right Rolled Views
	38070-9: MG Breast Views for implant
	38071-7: MG Breast - bilateral Views for implant
	38072-5: MG Breast - left Views for implant
	38090-7: MG Breast - bilateral Air gap Views
	38091-5: MG Breast - left Air gap Views
	38807-4: MG Breast - right Spot Views
	38820-7: MG Breast - right Views for implant
	38854-6: MG Breast - left Magnification and Spot
	38855-3: MG Breast - left True lateral
	39150-8: FFD mammogram Breast Views Post Localization
	39152-4: FFD mammogram Breast Diagnostic
	39153-2: FFD mammogram Breast Screening
	39154-0: FFD mammogram Breast - bilateral Diagnostic
	42168-5: FFD mammogram Breast - right Diagnostic
	42169-3: FFD mammogram Breast - left Diagnostic
	42174-3: FFD mammogram Breast - bilateral Screening
	42415-0: MG Breast - bilateral Views Post Wire Placement
	42416-8: MG Breast - left Views Post Wire Placement
	46335-6: MG Breast - bilateral Single view
	46336-4: MG Breast - left Single view
	46337-2: MG Breast - right Single view
	46338-0: MG Breast - unilateral Single view
	46339-8: MG Breast - unilateral Views
	46342-2: FFD mammogram Breast Views
	46350-5: MG Breast - unilateral Diagnostic
	46351-3: MG Breast - bilateral Displacement Views for Implant
	46354-7: FFD mammogram Breast - right Screening
	46355-4: FFD mammogram Breast - left Screening
	46356-2: MG Breast - unilateral Screening
	46380-2: MG Breast - unilateral Views for implant
	48475-8: MG Breast - bilateral Diagnostic for implant
	48492-3: MG Breast - bilateral Screening for implant
	69150-1: MG Breast - left Diagnostic for implant
	69251-7: MG Breast Views Post Wire Placement
	69259-0: MG Breast - right Diagnostic for implant
	72137-3: DBT Breast - right diagnostic
	72138-1: DBT Breast - left diagnostic
	72139-9: DBT Breast - bilateral diagnostic

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/LOINC/SNOMED CT
	72140-7: DBT Breast - right screening 72141-5: DBT Breast - left screening 72142-3: DBT Breast - bilateral screening 86462-9: DBT Breast - unilateral 86463-7: DBT Breast - bilateral 91517-3: DBT Breast - right diagnostic for implant 91518-1: DBT Breast - left diagnostic for implant 91519-9: DBT Breast - bilateral diagnostic for implant 91520-7: DBT Breast - right screen for implant 91521-5: DBT Breast - left screen for implant 91522-3: DBT Breast - bilateral screen for implant SNOMED CT 12389009: Xeromammography (procedure) 24623002: Screening mammography (procedure) 43204002: Mammography of bilateral breasts (procedure) 71651007: Mammography (procedure) 241055006: Mammogram - symptomatic (procedure) 241057003: Mammogram coned (procedure) 241058008: Mammogram magnification (procedure) 258172002: Stereotactic mammography (procedure) 439324009: Mammogram in compression view (procedure) 450566007: Digital breast tomosynthesis (procedure) 709657006: Fluoroscopy of breast (procedure) 723778004: Digital tomosynthesis of right breast (procedure) 723779007: Digital tomosynthesis of left breast (procedure) 723780005: Digital tomosynthesis of bilateral breasts (procedure) 726551006: Contrast enhanced spectral mammography (procedure) 833310007: Contrast enhanced dual energy spectral mammography (procedure) 866234000: Mammography of breast implant (procedure) 866235004: Mammography of bilateral breast implants (procedure) 866236003: Mammography of left breast implant (procedure) 866237007: Mammography of right breast implant (procedure) 384151000119104: Screening mammography of bilateral breasts (procedure) 392521000119107: Screening mammography of right breast (procedure) 392531000119105: Screening mammography of left breast (procedure) 566571000119105: Mammography of right breast (procedure) 572701000119102: Mammography of left breast (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Cervical Cancer Screening (CCS-E)

Description	CPT/HCPCS/LOINC/SNOWMED CT
Cervical Cytology Lab Test	<p>CPT 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175</p> <p>HCPCS G0123: Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision G0124: Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician G0141: Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician G0143: 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: 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: 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: Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision G0148: Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening P3000: Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision P3001: Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician Q0091: Screening papanicolaou smear; obtaining, preparing</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CT
	<p>LOINC</p> <p>10524-7: Microscopic observation [Identifier] in Cervix by Cyto stain</p> <p>18500-9: Microscopic observation [Identifier] in Cervix by Cyto stain. Thin prep</p> <p>19762-4: General categories [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain</p> <p>19764-0: Statement of adequacy [Interpretation] of Cervical or vaginal smear or scraping by Cyto stain</p> <p>19765-7: Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain</p> <p>19766-5: Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain Narrative</p> <p>19774-9: Cytology study comment Cervical or vaginal smear or scraping Cyto stain</p> <p>33717-0: Cervical AndOr vaginal cytology study</p> <p>47527-7: Cytology report of Cervical or vaginal smear or scraping Cyto stain. Thin prep</p> <p>47528-5: Cytology report of Cervical or vaginal smear or scraping Cyto stain</p> <p>SNOMED CT</p> <p>171149006: Screening for malignant neoplasm of cervix (procedure)</p> <p>416107004: Cervical cytology test (procedure)</p> <p>417036008: Liquid based cervical cytology screening (procedure)</p>
Cervical Cytology Result or Finding	<p>SNOMED CT</p> <p>168406009: Severe dyskaryosis on cervical smear cannot exclude invasive carcinoma (finding)</p> <p>168407000: Cannot exclude glandular neoplasia on cervical smear (finding)</p> <p>168408005: Cervical smear - atrophic changes (finding)</p> <p>168410007: Cervical smear - borderline changes (finding)</p> <p>168414003: Cervical smear - inflammatory change (finding)</p> <p>168415002: Cervical smear - no inflammation (finding)</p> <p>168416001: Cervical smear - severe inflammation (finding)</p> <p>168424006: Cervical smear - koilocytosis (finding)</p> <p>250538001: Dyskaryosis on cervical smear (finding)</p> <p>269957009: Cervical smear result (finding)</p> <p>269958004: Cervical smear - negative (finding)</p> <p>269959007: Cervical smear - mild dyskaryosis (finding)</p> <p>269960002: Cervical smear - severe dyskaryosis (finding)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOWMED CT
	<p>275805003: Viral changes on cervical smear (finding) 281101005: Smear: no abnormality detected - no endocervical cells (finding) 309081009: Abnormal cervical smear (finding) 310841002: Cervical smear - mild inflammation (finding) 310842009: Cervical smear - moderate inflammation (finding) 416030007: Cervicovaginal cytology: Low grade squamous intraepithelial lesion (finding) 416032004: Cervicovaginal cytology normal or benign (finding) 416033009: Cervicovaginal cytology: High grade squamous intraepithelial lesion or carcinoma (finding) 439074000: Dysplasia on cervical smear (finding) 439776006: Cervical Papanicolaou smear positive for malignant neoplasm (finding) 439888000: Abnormal cervical Papanicolaou smear (finding) 441087007: Atypical squamous cells of undetermined significance on cervical Papanicolaou smear (finding) 441088002: Atypical squamous cells on cervical Papanicolaou smear cannot exclude high grade squamous intraepithelial lesion (finding) 441094005: Atypical endocervical cells on cervical Papanicolaou smear (finding) 441219009: Atypical glandular cells on cervical Papanicolaou smear (finding) 441667007: Abnormal cervical Papanicolaou smear with positive human papillomavirus deoxyribonucleic acid test (finding) 700399008: Cervical smear - borderline change in squamous cells (finding) 700400001: Cervical smear - borderline change in endocervical cells (finding) 1155766001: Nuclear abnormality in cervical smear (finding) 62051000119105: Low grade squamous intraepithelial lesion on cervical Papanicolaou smear (finding)</p>
High Risk HPV Lab Test	<p>CPT 87624, 87625 HCPCS G0476: 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</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

<p>21440-3: Human papilloma virus 16+18+31+33+35+45+51+52+56 DNA [Presence] in Cervix by Probe</p> <p>30167-1: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification</p> <p>38372-9: Human papilloma virus 6+11+16+18+31+33+35+39+42+43+44+45+51+52+56+58+59+68 DNA [Presence] in Cervix by Probe with signal amplification</p> <p>59263-4: Human papilloma virus 16 DNA [Presence] in Cervix by Probe with signal amplification</p> <p>59264-2: Human papilloma virus 18 DNA [Presence] in Cervix by Probe with signal amplification</p> <p>59420-0: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by Probe with signal amplification</p> <p>69002-4: Human papilloma virus E6+E7 mRNA [Presence] in Cervix by NAA with probe detection</p> <p>71431-1: Human papilloma virus 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection</p> <p>75694-0: Human papilloma virus 18+45 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection</p> <p>77379-6: Human papilloma virus 16 and 18 and 31+33+35+39+45+51+52+56+58+59+66+68 DNA [Interpretation] in Cervix</p> <p>77399-4: Human papilloma virus 16 DNA [Presence] in Cervix by NAA with probe detection</p> <p>77400-0: Human papilloma virus 18 DNA [Presence] in Cervix by NAA with probe detection</p> <p>82354-2: Human papilloma virus 16 and 18+45 E6+E7 mRNA [Identifier] in Cervix by NAA with probe detection</p> <p>82456-5: Human papilloma virus 16 E6+E7 mRNA [Presence] in Cervix by NAA with probe detection</p> <p>82675-0: Human papilloma virus 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection</p> <p>95539-3: Human papilloma virus 31 DNA [Presence] in Cervix by NAA with probe detection</p> <p>SNOMED CT 35904009: Human papillomavirus deoxyribonucleic acid detection (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

Childhood Immunization Status (CIS-E)

Codes to identify immunizations:

Description	CPT/HCPCS/SNOMED/CVX
DTaP Immunization	CVX 20: diphtheria, tetanus toxoids and acellular pertussis vaccine 50: DTaP-Haemophilus influenzae type b conjugate vaccine 106: diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens 107: diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified formulation 110: DTaP-hepatitis B and poliovirus vaccine 120: diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) 146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.
DTaP Vaccine Procedure	CPT 90697, 90698, 90700, 90723 SNOMED CT 310306005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure) 310307001: Administration of second dose of vaccine product containing only Bordetella pertussis and

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>310308006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>312870000: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>313383003: Administration of fourth dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>390846000: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>390865008: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>399014008: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>412755006: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>412756007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>412757003: Administration of third dose of vaccine product containing only acellular Bordetella pertussis</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>412762002: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>412763007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>412764001: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>414001002: Administration of vaccine product containing only five component acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>414259000: Administration of first dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>414620004: Administration of vaccine product containing only acellular Bordetella pertussis five component and Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)</p> <p>415507003: Administration of second dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>415712004: Administration of third dose of vaccine product containing only five component acellular</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>770608009: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>770616000: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>770617009: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>770618004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>787436003: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b antigens (procedure)</p> <p>866158005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>866159002: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>866226006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p> <p>868273007: Administration of vaccine product containing only Bordetella pertussis and Clostridium</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868274001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868276004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868277008: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 1162640003 Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus and inactivated Human poliovirus antigens (procedure) 428251000124104: Tetanus, diphtheria, and acellular pertussis vaccination (procedure) 571571000119105: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 572561000119108: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure) 16290681000119103 : Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)</p>
Haemophilus Influenzae Type B (HiB) Immunization	<p>CVX 17: Haemophilus influenzae type b vaccine, conjugate unspecified formulation 46: Haemophilus influenzae type b vaccine, PRP-D conjugate</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>47: Haemophilus influenzae type b vaccine, HbOC conjugate</p> <p>48: Haemophilus influenzae type b vaccine, PRP-T conjugate</p> <p>49: Haemophilus influenzae type b vaccine, PRP-OMP conjugate</p> <p>50: DTaP-Haemophilus influenzae type b conjugate vaccine</p> <p>51: Haemophilus influenzae type b conjugate and Hepatitis B vaccine</p> <p>120: diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV)</p> <p>146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.</p> <p>148: Meningococcal Groups C and Y and Haemophilus b Tetanus Toxoid Conjugate Vaccine</p>
Haemophilus Influenzae Type B (HiB) Vaccine Procedure	<p>CPT 90644, 90647, 90648, 90697, 90698, 90748</p> <p>SNOMED CT</p> <p>127787002: Administration of vaccine product containing only Haemophilus influenzae type b antigen (procedure)</p> <p>170343007: Administration of first dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure)</p> <p>170344001: Administration of second dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure)</p> <p>170345000: Administration of third dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure)</p> <p>170346004: Administration of booster dose of vaccine product containing only Haemophilus influenzae type b antigen (procedure)</p> <p>310306005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>310307001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>310308006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>312869001: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>312870000: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>313383003: Administration of fourth dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>414001002: Administration of vaccine product containing only five component acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>414259000: Administration of first dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>415507003: Administration of second dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>786846001: Administration of vaccine product containing only Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>787436003: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b antigens (procedure)</p> <p>1119364007: Administration of vaccine product containing only Haemophilus influenzae type b and Neisseria meningitidis serogroup C and Y antigens (procedure)</p> <p>1162640003: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus and inactivated Human poliovirus antigens (procedure)</p> <p>16292241000119109: Administration of booster dose of vaccine product containing only Haemophilus influenzae type b capsular polysaccharide polyribosylribitol phosphate conjugated to Clostridium tetani toxoid protein (procedure)</p>
Hepatitis A Immunization	<p>CVX</p> <p>31: hepatitis A vaccine, pediatric dosage, unspecified formulation</p> <p>83: hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule</p> <p>85: hepatitis A vaccine, unspecified formulation</p>
Hepatitis A Vaccine Procedure	<p>CPT</p> <p>90633</p> <p>SNOMED CT</p> <p>17037+D909+D90971:E185331: Administration of first dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>170379004: Administration of second dose of vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>170380001: Administration of third dose of vaccine product containing only Hepatitis A virus antigen (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>170381002: Administration of booster dose of vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>170434002: Administration of first dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>170435001: Administration of second dose of vaccine product containing only Hepatitis A and B virus antigens (procedure)</p> <p>170436000: Administration of third dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>170437009: Administration of booster dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>243789007: Administration of vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>312868009: Administration of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>314177003: Administration of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)</p> <p>314178008: Administration of first dose of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)</p> <p>314179000: Administration of second dose of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)</p> <p>394691002: Administration of booster dose of vaccine product containing only Hepatitis A virus and Salmonella enterica subspecies enterica serovar Typhi antigens (procedure)</p> <p>871752004: Administration of second dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>871753009: Administration of third dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>871754003: Administration of booster dose of pediatric vaccine product containing only Hepatitis A virus antigen (procedure)</p> <p>571511000119102: Administration of adult vaccine product containing only Hepatitis A virus antigen (procedure)</p>
Hepatitis B Immunization	<p>CVX</p> <p>08: hepatitis B vaccine, pediatric or pediatric/adolescent dosage</p> <p>44: hepatitis B vaccine, dialysis patient dosage</p> <p>45: hepatitis B vaccine, unspecified formulation</p> <p>51: Haemophilus influenzae type b conjugate and Hepatitis B vaccine</p> <p>110: DTaP-hepatitis B and poliovirus vaccine</p> <p>146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.</p>
Hepatitis B Vaccine Procedure	<p>CPT 90697, 90723, 90740, 90744, 90747, 90748</p> <p>HCPCS G0010: Administration of hepatitis b vaccine</p> <p>SNOMED CT 16584000: Administration of vaccine product containing only Hepatitis B virus antigen (procedure)</p> <p>170370000: Administration of first dose of vaccine product containing only Hepatitis B virus antigen (procedure)</p> <p>170371001: Administration of second dose of vaccine product containing only Hepatitis B virus antigen (procedure)</p> <p>170372008: Administration of third dose of vaccine product containing only Hepatitis B virus antigen (procedure)</p> <p>170373003: Administration of booster dose of vaccine product containing only Hepatitis B virus antigen (procedure)</p> <p>170374009: Administration of fourth dose of vaccine product containing only Hepatitis B virus antigen (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>170375005: Administration of fifth dose of vaccine product containing only Hepatitis B virus antigen (procedure)</p> <p>170434002: Administration of first dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>170435001: Administration of second dose of vaccine product containing only Hepatitis A and B virus antigens (procedure)</p> <p>170436000: Administration of third dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>170437009: Administration of booster dose of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>312868009: Administration of vaccine product containing only Hepatitis A and Hepatitis B virus antigens (procedure)</p> <p>396456003: Administration of vaccine product containing only acellular Bordetella pertussis and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure)</p> <p>416923003: Administration of sixth dose of vaccine product containing only Hepatitis B virus antigen (procedure)</p> <p>770608009: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>770616000: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>770617009: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>770618004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>786846001: Administration of vaccine product containing only Haemophilus influenzae type b and Hepatitis B virus antigens (procedure)</p> <p>1162640003: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Hepatitis B virus and inactivated Human poliovirus antigens (procedure)</p> <p>572561000119108: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure)</p>
<p>Inactivated polio vaccine (IPV) immunization</p>	<p>CVX</p> <p>10: poliovirus vaccine, inactivated</p> <p>89: poliovirus vaccine, unspecified formulation</p> <p>110: DTaP-hepatitis B and poliovirus vaccine</p> <p>120: diphtheria, tetanus toxoids and acellular pertussis vaccine, Haemophilus influenzae type b conjugate, and poliovirus vaccine, inactivated (DTaP-Hib-IPV)</p> <p>146: Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.</p>
<p>Inactivated polio vaccine (IPV) procedure</p>	<p>CPT</p> <p>90697, 90698, 90713, 90723</p> <p>SNOMED CT</p> <p>310306005: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>310307001: Administration of second dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>310308006: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>312869001: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>312870000: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>313383003: Administration of fourth dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and Human poliovirus antigens (procedure)</p> <p>390865008: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>396456003: Administration of vaccine product containing only acellular Bordetella pertussis and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure)</p> <p>412762002: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>412763007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>412764001: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>414001002: Administration of vaccine product containing only five component acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>414259000: Administration of first dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>414619005: Administration of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)</p> <p>414620004: Administration of vaccine product containing only acellular Bordetella pertussis five component and Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)</p> <p>415507003: Administration of second dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>415712004: Administration of third dose of vaccine product containing only five component acellular Bordetella pertussis, Clostridium tetani, Corynebacterium diphtheriae, Haemophilus influenzae type b and inactivated whole Human poliovirus antigens (procedure)</p> <p>416144004: Administration of third dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>416591003: Administration of first dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)</p> <p>417211006: Administration of first booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)</p> <p>417384007: Administration of second booster of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)</p> <p>417615007: Administration of second dose of vaccine product containing only Clostridium tetani and low dose Corynebacterium diphtheriae and inactivated Human poliovirus antigens (procedure)</p> <p>866186002: Administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>866227002: Administration of booster dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>868266002: Administration of second dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>868267006: Administration of first dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>868268001: Administration of third dose of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>868273007: Administration of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure)</p> <p>868274001: Administration of second dose of vaccine product containing only Bordetella pertussis and</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868276004: Administration of third dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 868277008: Administration of first dose of vaccine product containing only Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 870670004: Preschool administration of vaccine product containing only Clostridium tetani and Corynebacterium diphtheriae and Human poliovirus antigens (procedure) 572561000119108: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and Hepatitis B virus and inactivated whole Human poliovirus antigens (procedure) 16290681000119103 : Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae and inactivated whole Human poliovirus antigens (procedure)</p>
Influenza Immunization	<p>CVX 88: influenza virus vaccine, unspecified formulation 140: Influenza, seasonal, injectable, preservative free 141: Influenza, seasonal, injectable 150: Influenza, injectable, quadrivalent, preservative free 153: Influenza, injectable, Madin Darby Canine Kidney, preservative free 155: Seasonal, trivalent, recombinant, injectable influenza vaccine, preservative free 158: influenza, injectable, quadrivalent, contains preservative 161: Influenza, injectable, quadrivalent, preservative free, pediatric 171: Influenza, injectable, Madin Darby Canine Kidney, preservative free, quadrivalent</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	186: Influenza, injectable, Madin Darby Canine Kidney, quadrivalent with preservative88, 140, 141, 150, 153, 155, 158, 161
Influenza Vaccine Procedure	CPT 90655, 90657, 90661, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756 HCPCS G0008: Administration of influenza virus vaccine SNOMED CT 86198006: Administration of vaccine product containing only Influenza virus antigen (procedure)
Influenza Virus LAIV Immunization	CVX 111: influenza virus vaccine, live, attenuated, for intranasal use 149: influenza, live, intranasal, quadrivalent
Influenza Virus LAIV Vaccine Procedure	CPT 90660, 90672 SNOMED CT 787016008: Administration of vaccine product containing only Influenza virus antigen in nasal dose form (procedure)
Measles, Mumps and Rubella (MMR) Immunization	CVX: 03, 94
Measles, Mumps and Rubella (MMR) Vaccine Procedure	CPT: 90707, 90710 SNOMED: 38598009, 170433008, 432636005, 433733003, 150971000119104, 571591000119106, 572511000119105
Pneumococcal Conjugate Immunization	CVX 109: pneumococcal vaccine, unspecified formulation 133: pneumococcal conjugate vaccine, 13 valent 152: Pneumococcal Conjugate, unspecified formulation 215: Pneumococcal conjugate vaccine 15-valent (PCV15), polysaccharide CRM197 conjugate, adjuvant, preservative free
Pneumococcal Conjugate Vaccine Procedure	CPT 90670, 90671 HCPCS G0009: Administration of pneumococcal vaccine SNOMED CT

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	1119368005: Administration of vaccine product containing only Streptococcus pneumoniae Danish serotype 4, 6B, 9V, 14, 18C, 19F, and 23F capsular polysaccharide antigens conjugated (procedure) 434751000124102: Pneumococcal conjugate vaccination (procedure)
Rotavirus (3 Dose Schedule) Immunization	CVX 116: rotavirus, live, pentavalent vaccine 122: rotavirus vaccine, unspecified formulation
Rotavirus Vaccine (2 Dose Schedule) Procedure	CPT 90681 SNOMED CT 434741000124104: Rotavirus vaccination, 2 dose schedule (procedure)
Rotavirus Vaccine (3 Dose Schedule) Procedure	CPT 90680 SNOMED CT 434731000124109: Rotavirus vaccination, 3 dose schedule (procedure)
Varicella zoster (VZV) immunization	CVX 21: varicella virus vaccine 94: measles, mumps, rubella, and varicella virus vaccine
Varicella zoster (VZV) vaccine procedure	CPT 90710, 90716 SNOMED CT 425897001: Administration of first dose of vaccine product containing only Human alphaherpesvirus 3 antigen for chickenpox (procedure) 428502009: Administration of second dose of vaccine product containing only Human alphaherpesvirus 3 antigen for chickenpox (procedure) 432636005: Administration of vaccine product containing only Human alphaherpesvirus 3 and Measles morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (procedure) 433733003: Administration of second dose of vaccine product containing only Human alphaherpesvirus 3 and Measles morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (procedure)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED/CVX
	<p>737081007: Administration of vaccine product containing only Human alphaherpesvirus 3 antigen for chickenpox (procedure)</p> <p>871898007: Administration of vaccine product containing only live attenuated Human alphaherpesvirus 3 antigen (procedure)</p> <p>871899004: Administration of vaccine product containing only live attenuated Human alphaherpesvirus 3 antigen via subcutaneous route (procedure)</p> <p>871909005: Administration of first dose of vaccine product containing only Human alphaherpesvirus 3 and Measles morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (procedure)</p> <p>572511000119105: Administration of vaccine product containing only live attenuated Measles morbillivirus and Mumps orthorubulavirus and Rubella virus and Human alphaherpesvirus 3 antigens (procedure)</p>
CDC Race and Ethnicity	<p>1002-5: American Indian or Alaska Native</p> <p>2028-9: Asian</p> <p>2054-5: Black or African American</p> <p>2076-8: Native Hawaiian or Other Pacific Islander</p> <p>2106-3: White</p> <p>2135-2: Hispanic or Latino</p> <p>2186-5: Not Hispanic or Latino</p>

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Colorectal Cancer Screening (COL-E)

Description	CPT/HCPCS/LOINC/SNOMED CT
Colonoscopy	<p>CPT 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398</p> <p>HCPCS G0105: Colorectal cancer screening; colonoscopy on individual at high risk G0121: Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk</p> <p>SNOMED CT 8180007: Fiberoptic colonoscopy through colostomy (procedure) 12350003: Colonoscopy with rigid sigmoidoscope through colotomy (procedure) 25732003: Fiberoptic colonoscopy with biopsy (procedure) 34264006: Intraoperative colonoscopy (procedure) 73761001: Colonoscopy (procedure) 174158000: Open colonoscopy (procedure) 174185007: Diagnostic fiberoptic endoscopic examination of colon and biopsy of lesion of colon (procedure) 235150006: Total colonoscopy (procedure) 235151005: Limited colonoscopy (procedure) 275251008: Diagnostic endoscopic examination of colon using fiberoptic sigmoidoscope (procedure) 302052009: Endoscopic biopsy of lesion of colon (procedure) 367535003: Fiberoptic colonoscopy (procedure) [367535003] 443998000: Colonoscopy through colostomy with endoscopic biopsy of colon (procedure) 444783004: Screening colonoscopy (procedure) 446521004: Colonoscopy and excision of mucosa of colon (procedure) 446745002: Colonoscopy and biopsy of colon (procedure) 447021001: Colonoscopy and tattooing (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CT
	<p>709421007: Colonoscopy and dilatation of stricture of colon (procedure) 710293001: Colonoscopy using fluoroscopic guidance (procedure) 711307001: Colonoscopy using X-ray guidance (procedure) 789778002: Colonoscopy and fecal microbiota transplantation (procedure) 1209098000: Fiberoptic colonoscopy with biopsy of lesion of colon (procedure)</p>
CT Colonography	<p>CPT 74261, 74262, 74263 LOINC 60515-4: CT Colon and Rectum W air contrast PR 72531-7: CT Colon and Rectum W contrast IV and W air contrast PR 79069-1: CT Colon and Rectum for screening WO contrast IV and W air contrast PR 79071-7: CT Colon and Rectum WO contrast IV and W air contrast PR 79101-2: CT Colon and Rectum for screening W air contrast PR 82688-3: CT Colon and Rectum WO and W contrast IV and W air contrast PR SNOMED CT 418714002: Virtual computed tomography colonoscopy (procedure)</p>
Flexible sigmoidoscopy	<p>CPT 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350 HCPCS G0104: Colorectal cancer screening; flexible sigmoidoscopy SNOMED CT 44441009: Flexible fiberoptic sigmoidoscopy (procedure) 396226005: Flexible fiberoptic sigmoidoscopy with biopsy (procedure) 425634007: Diagnostic endoscopic examination of lower bowel and sampling for bacterial overgrowth using fiberoptic sigmoidoscope (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CT
FOBT Lab Test	<p>CPT 82270, 82274</p> <p>HCPCS G0328: Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous</p> <p>LOINC 12503-9:Hemoglobin.gastrointestinal [Presence] in Stool --4th specimen 12504-7: Hemoglobin. Gastrointestinal [Presence] in Stool --5th specimen 14563-1: Hemoglobin. Gastrointestinal [Presence] in Stool --1st specimen 14564-9: Hemoglobin. Gastrointestinal [Presence] in Stool --2nd specimen 14565-6: Hemoglobin. Gastrointestinal [Presence] in Stool --3rd specimen 2335-8: Hemoglobin. Gastrointestinal [Presence] in Stool 27396-1: Hemoglobin. Gastrointestinal [Mass/mass] in Stool 27401-9: Hemoglobin. Gastrointestinal [Presence] in Stool --6th specimen 27925-7: Hemoglobin. Gastrointestinal [Presence] in Stool --7th specimen 27926-5: Hemoglobin. Gastrointestinal [Presence] in Stool --8th specimen 29771-3: Hemoglobin. Gastrointestinal. Lower [Presence] in Stool by Immunoassay 56490-6: Hemoglobin. Gastrointestinal. Lower [Presence] in Stool by Immunoassay --2nd specimen 56491-4: Hemoglobin. Gastrointestinal. Lower [Presence] in Stool by Immunoassay --3rd specimen 57905-2: Hemoglobin. Gastrointestinal. Lower [Presence] in Stool by Immunoassay --1st specimen 58453-2: Hemoglobin. Gastrointestinal. Lower [Mass/volume] in Stool by Immunoassay 80372-6: Hemoglobin. Gastrointestinal [Presence] in Stool by Rapid immunoassay</p> <p>SNOMED CT 104435004: Screening for occult blood in feces (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

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

Description	ICD10CM/SNOMED CT
Major Depression or Dysthymia	ICD10MC F32.0: Major depressive disorder, single episode, mild F32.1: Major depressive disorder, single episode, moderate F32.2: Major depressive disorder, single episode, severe without psychotic features F32.3: Major depressive disorder, single episode, severe with psychotic features

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	ICD10CM/SNOMED CT
	<p>F32.4: Major depressive disorder, single episode, in partial remission</p> <p>F32.5: Major depressive disorder, single episode, in full remission</p> <p>F32.9: Major depressive disorder, single episode, unspecified</p> <p>F33.0: Major depressive disorder, recurrent, mild</p> <p>F33.1: Major depressive disorder, recurrent, moderate</p> <p>F33.2: Major depressive disorder, recurrent severe without psychotic features</p> <p>F33.3: Major depressive disorder, recurrent, severe with psychotic symptoms</p> <p>F33.40: Major depressive disorder, recurrent, in remission, unspecified</p> <p>F33.41: Major depressive disorder, recurrent, in partial remission</p> <p>F33.42: Major depressive disorder, recurrent, in full remission</p> <p>F33.9: Major depressive disorder, recurrent, unspecified</p> <p>F34.1: Dysthymic disorder</p> <p>SNOMED CT</p> <p>832007: Moderate major depression (disorder)</p> <p>2506003: Early onset dysthymia (disorder)</p> <p>2618002: Chronic recurrent major depressive disorder (disorder)</p> <p>3109008: Secondary dysthymia early onset (disorder)</p> <p>14183003: Chronic major depressive disorder, single episode (disorder)</p> <p>15193003: Severe recurrent major depression with psychotic features, mood-incongruent (disorder)</p> <p>15639000: Moderate major depression, single episode (disorder)</p> <p>18818009: Moderate recurrent major depression (disorder)</p> <p>19527009: Single episode of major depression in full remission (disorder)</p> <p>19694002: Late onset dysthymia (disorder)</p> <p>20250007: Severe major depression, single episode, with psychotic features, mood-incongruent (disorder)</p> <p>25922000: Major depressive disorder, single episode with postpartum onset (disorder)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	ICD10CM/SNOMED CT
	<p>28475009: Severe recurrent major depression with psychotic features (disorder)</p> <p>30605009: Major depression in partial remission (disorder)</p> <p>33078009: Severe recurrent major depression with psychotic features, mood-congruent (disorder)</p> <p>33135002: Recurrent major depression in partial remission (disorder)</p> <p>33736005: Severe major depression with psychotic features, mood-congruent (disorder)</p> <p>36170009: Secondary dysthymia late onset (disorder)</p> <p>36474008: Severe recurrent major depression without psychotic features (disorder)</p> <p>36923009: Major depression, single episode (disorder)</p> <p>38451003: Primary dysthymia early onset (disorder)</p> <p>38694004: Recurrent major depressive disorder with atypical features (disorder)</p> <p>39809009: Recurrent major depressive disorder with catatonic features (disorder)</p> <p>40379007: Mild recurrent major depression (disorder)</p> <p>42810003: Major depression in remission (disorder)</p> <p>42925002: Major depressive disorder, single episode with atypical features (disorder)</p> <p>46244001: Recurrent major depression in full remission (disorder)</p> <p>60099002: Severe major depression with psychotic features, mood-incongruent (disorder)</p> <p>63412003: Major depression in full remission (disorder)</p> <p>63778009: Major depressive disorder, single episode with melancholic features (disorder)</p> <p>66344007: Recurrent major depression (disorder)</p> <p>67711008: Primary dysthymia late onset (disorder)</p> <p>69392006: Major depressive disorder, single episode with catatonic features (disorder)</p> <p>70747007: Major depression single episode, in partial remission (disorder)</p> <p>71336009: Recurrent major depressive disorder with postpartum onset (disorder)</p> <p>73867007: Severe major depression with psychotic features (disorder)</p> <p>75084000: Severe major depression without psychotic features (disorder)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	ICD10CM/SNOMED CT
	<p>76441001: Severe major depression, single episode, without psychotic features (disorder) 77911002: Severe major depression, single episode, with psychotic features, mood-congruent (disorder) 78667006: Dysthymia (disorder) 79298009: Mild major depression, single episode (disorder) 83176005: Primary dysthymia (disorder) 85080004: Secondary dysthymia (disorder) 87512008: Mild major depression (disorder) 191604000: Single major depressive episode, severe, with psychosis (disorder) 191610000: Recurrent major depressive episodes, mild (disorder) 191611001: Recurrent major depressive episodes, moderate (disorder) 191613003: Recurrent major depressive episodes, severe, with psychosis (disorder) 231499006: Endogenous depression first episode (disorder) 268621008: Recurrent major depressive episodes (disorder) 274948002: Endogenous depression - recurrent (disorder) 300706003: Endogenous depression (disorder) 319768000: Recurrent major depressive disorder with melancholic features (disorder) 320751009: Major depression, melancholic type (disorder) 370143000: Major depressive disorder (disorder) 430852001: Severe major depression, single episode, with psychotic features (disorder)</p>

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

Description	CPT/ICD10CM/LOINC/SNOMED CT
Major Depression or Dysthymia	<p>SNOMED CT 832007: Moderate major depression (disorder) 2506003: Early onset dysthymia (disorder) 2618002: Chronic recurrent major depressive disorder (disorder) 3109008: Secondary dysthymia early onset (disorder)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ICD10CM/LOINC/SNOMED CT
	<p>14183003: Chronic major depressive disorder, single episode (disorder)</p> <p>15193003: Severe recurrent major depression with psychotic features, mood-incongruent (disorder)</p> <p>15639000: Moderate major depression, single episode (disorder)</p> <p>18818009: Moderate recurrent major depression (disorder)</p> <p>19527009: Single episode of major depression in full remission (disorder)</p> <p>19694002: Late onset dysthymia (disorder)</p> <p>20250007: Severe major depression, single episode, with psychotic features, mood-incongruent (disorder)</p> <p>25922000: Major depressive disorder, single episode with postpartum onset (disorder)</p> <p>28475009: Severe recurrent major depression with psychotic features (disorder)</p> <p>30605009: Major depression in partial remission (disorder)</p> <p>33078009: Severe recurrent major depression with psychotic features, mood-congruent (disorder)</p> <p>33135002: Recurrent major depression in partial remission (disorder)</p> <p>33736005: Severe major depression with psychotic features, mood-congruent (disorder)</p> <p>36170009: Secondary dysthymia late onset (disorder)</p> <p>36474008: Severe recurrent major depression without psychotic features (disorder)</p> <p>36923009: Major depression, single episode (disorder)</p> <p>38451003: Primary dysthymia early onset (disorder)</p> <p>38694004: Recurrent major depressive disorder with atypical features (disorder)</p> <p>39809009: Recurrent major depressive disorder with catatonic features (disorder)</p> <p>40379007: Mild recurrent major depression (disorder)</p> <p>42810003: Major depression in remission (disorder)</p> <p>42925002: Major depressive disorder, single episode with atypical features (disorder)</p> <p>46244001: Recurrent major depression in full remission (disorder)</p> <p>60099002: Severe major depression with psychotic features, mood-incongruent (disorder)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ICD10CM/LOINC/SNOMED CT
	<p>320751009: Major depression, melancholic type (disorder)</p> <p>370143000: Major depressive disorder (disorder)</p> <p>430852001: Severe major depression, single episode, with psychotic features (disorder)</p>

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

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

Description	CPT/HCPCS/LOINC/SNOMED CT
Depression Case Management Encounter	<p>CPT 99366, 99492, 99493, 99494</p> <p>HCPCS G0512: Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month T1016: Case management, each 15 minutes T1017: Targeted case management, each 15 minutes T2022: Case management, per month T2023: Targeted case management; per month</p> <p>SNOMED CT 182832007: Procedure related to management of drug administration (procedure) 225333008: Behavior management (regime/therapy) 385828006: Health promotion management (procedure) 386230005: Case management (procedure) 409022004: Dispensing medication management (procedure) 410216003: Communication care management (procedure) 410219005: Personal care management (procedure) 410328009: Coping skills case management (procedure) 410335001: Exercises case management (procedure) 410346003: Medication action/side effects case management (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/LOINC/SNOMED CT
	<p>410347007: Medication set-up case management (procedure) 410351009: Relaxation/breathing techniques case management (procedure) 410352002: Rest/sleep case management (procedure) 410353007: Safety case management (procedure) 410354001: Screening case management (procedure) 410356004: Signs/symptoms-mental/emotional case management (procedure) 410360001: Spiritual care case management (procedure) 410363004: Support group case management (procedure) 410364005: Support system case management (procedure) 410366007: Wellness case management (procedure) 416341003: Case management started (situation) 416584001: Case management ended (situation) 424490002: Medication prescription case management (procedure) 425604002: Case management follow up (procedure) 737850002: Day care case management (procedure) 621561000124106: Psychiatric case management (procedure) 661051000124109: Education about Department of Veterans Affairs Military2VA Case Management Program (procedure) 662081000124106: Assistance with application for Department of Veterans Affairs Military2VA Case Management Program (procedure) 662541000124107: Evaluation of eligibility for Department of Veterans Affairs Military2VA Case Management Program (procedure)</p>
Symptoms of Depression	<p>SNOMED CT 394924000: Symptoms of depression (finding) 788976000: Leaden paralysis (finding)</p>

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

Immunizations for Adolescents (IMA-E)

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CT
Meningococcal Immunization	<p>CVX 32: meningococcal polysaccharide vaccine (MPSV4) 108: meningococcal ACWY vaccine, unspecified formulation 114: meningococcal polysaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4P) 136: meningococcal oligosaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4O) 147: Meningococcal, MCV4, unspecified conjugate formulation(groups A, C, Y and W-135) 167: meningococcal vaccine of unknown formulation and unknown serogroups 203: meningococcal polysaccharide (groups A, C, Y, W-135) tetanus toxoid conjugate vaccine 0.5mL dose, preservative free</p>
Meningococcal Vaccine Procedure	<p>CPT 90619, 90733, 90734 SNOMED CT 871874000: Administration of vaccine product containing only Neisseria meningitidis serogroup A, C, W135 and Y antigens (procedure) 428271000124109: Meningococcal conjugate vaccination (procedure) 16298691000119102: Administration of vaccine product containing only Neisseria meningitidis serogroup A, C, W135 and Y capsular oligosaccharide conjugated antigens (procedure)</p>
Tdap Vaccine Procedure	<p>CPT 90715 SNOMED CT 390846000: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412755006: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412756007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412757003: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 428251000124104: Tetanus, diphtheria, and acellular pertussis vaccination (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

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

Description	CPT/ HCPCS/SNOMED/ICD10PCS
Depression Case Management Encounter	CPT 99366, 99492, 99493, 99494 HCPCS

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ HCPCS/SNOMED/ICD10PCS
	<p>T1016: Case management, each 15 minutes T1017: Targeted case management, each 15 minutes T2022: Case management, per month T2023: Targeted case management; per month SNOMED CT 182832007: Procedure related to management of drug administration (procedure) 225333008: Behavior management (regime/therapy) 385828006: Health promotion management (procedure) 386230005: Case management (procedure) 409022004: Dispensing medication management (procedure) 410216003: Communication care management (procedure) 410219005: Personal care management (procedure) 410328009: Coping skills case management (procedure) 410335001: Exercises case management (procedure) 410346003: Medication action/side effects case management (procedure) 410347007: Medication set-up case management (procedure) 410351009: Relaxation/breathing techniques case management (procedure) 410352002: Rest/sleep case management (procedure) 410353007: Safety case management (procedure) 410354001: Screening case management (procedure) 410356004: Signs/symptoms-mental/emotional case management (procedure) 410360001: Spiritual care case management (procedure) 410363004: Support group case management (procedure) 410364005: Support system case management (procedure) 410366007: Wellness case management (procedure) 416341003: Case management started (situation) 416584001: Case management ended (situation) 424490002: Medication prescription case management (procedure) 425604002: Case management follow up (procedure) 737850002: Day care case management (procedure) 621561000124106: Psychiatric case management (procedure) 661051000124109: Education about Department of Veterans Affairs Military2VA Case Management Program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ HCPCS/SNOMED/ICD10PCS
	<p>662081000124106: Assistance with application for Department of Veterans Affairs Military2VA Case Management Program (procedure)</p> <p>662541000124107: Evaluation of eligibility for Department of Veterans Affairs Military2VA Case Management Program (procedure)</p>
Symptoms of Depression	<p>SNOMED CT</p> <p>394924000: Symptoms of depression (finding)</p> <p>788976000: Lethargy (finding)</p>
CDC Race and Ethnicity	<p>1002-5: American Indian or Alaska Native</p> <p>2028-9: Asian</p> <p>2054-5: Black or African American</p> <p>2076-8: Native Hawaiian or Other Pacific Islander</p> <p>2106-3: White</p> <p>2135-2: Hispanic or Latino</p> <p>2186-5: Not Hispanic or Latino</p>

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

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

Description	CPT/ HCPCS/SNOMED CT
37 weeks gestation	<p>SNOMED CT</p> <p>43697006: Gestation period, 37 weeks (finding)</p>
38 weeks gestation	<p>SNOMED CT</p> <p>13798002: Gestation period, 38 weeks (finding)</p>
39 weeks gestation	<p>SNOMED CT</p> <p>80487005: Gestation period, 39 weeks (finding)</p>
40 weeks gestation	<p>SNOMED CT</p> <p>46230007: Gestation period, 40 weeks (finding)</p>
41 weeks gestation	<p>SNOMED CT</p> <p>63503002: Gestation period, 41 weeks (finding)</p>
42 weeks gestation	<p>SNOMED CT</p> <p>36428009: Gestation period, 42 weeks (finding)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/ HCPCS/SNOMED CT
Depression Case Management Encounter	<p>CPT 99366, 99492, 99493, 99494</p> <p>HCPCS T1016: Case management, each 15 minutes T1017: Targeted case management, each 15 minutes T2022: Case management, per month T2023: Targeted case management; per month</p> <p>SNOMED CT 182832007: Procedure related to management of drug administration (procedure) 225333008: Behavior management (regime/therapy) 385828006: Health promotion management (procedure) 386230005: Case management (procedure) 409022004: Dispensing medication management (procedure) 410216003: Communication care management (procedure) 410219005: Personal care management (procedure) 410328009: Coping skills case management (procedure) 410335001: Exercises case management (procedure) 410346003: Medication action/side effects case management (procedure) 410347007: Medication set-up case management (procedure) 410351009: Relaxation/breathing techniques case management (procedure) 410352002: Rest/sleep case management (procedure) 410353007: Safety case management (procedure) 410354001: Screening case management (procedure) 410356004: Signs/symptoms-mental/emotional case management (procedure) 410360001: Spiritual care case management (procedure) 410363004: Support group case management (procedure) 410364005: Support system case management (procedure) 410366007: Wellness case management (procedure) 416341003: Case management started (situation) 416584001: Case management ended (situation) 424490002: Medication prescription case management (procedure) 425604002: Case management follow up (procedure) 737850002: Day care case management (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

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

Prenatal Immunization Status (PRS-E)

Description	CPT/CVX/SNOMED CT
37 Weeks Gestation	SNOMED CT 43697006: Gestation period, 37 weeks (finding)
38 Weeks Gestation	SNOMED CT 13798002: Gestation period, 38 weeks (finding)
39 Weeks Gestation	SNOMED CT 80487005: Gestation period, 39 weeks (finding)
40 Weeks Gestation	SNOMED CT 46230007: Gestation period, 40 weeks (finding)
41 Weeks Gestation	SNOMED CT 63503002: Gestation period, 41 weeks (finding)
42 Weeks Gestation	SNOMED CT 36428009: Gestation period, 42 weeks (finding)
Adult Influenza Immunization	CVX 88: influenza virus vaccine, unspecified formulation 135: influenza, high dose seasonal, preservative-free

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CT
	<p>140: Influenza, seasonal, injectable, preservative free 141: Influenza, seasonal, injectable 144: seasonal influenza, intradermal, preservative free 150: Influenza, injectable, quadrivalent, preservative free 153: Influenza, injectable, Madin Darby Canine Kidney, preservative free 155: Seasonal, trivalent, recombinant, injectable influenza vaccine, preservative free 158: influenza, injectable, quadrivalent, contains preservative 166: influenza, intradermal, quadrivalent, preservative free, injectable 168: Seasonal trivalent influenza vaccine, adjuvanted, preservative free 171: Influenza, injectable, Madin Darby Canine Kidney, preservative free, quadrivalent 185: Seasonal, quadrivalent, recombinant, injectable influenza vaccine, preservative free 186: Influenza, injectable, Madin Darby Canine Kidney, quadrivalent with preservative 197: influenza, high-dose seasonal, quadrivalent, 0.7mL dose, preservative free 205: influenza, seasonal vaccine, quadrivalent, adjuvanted, 0.5mL dose, preservative free</p>
Adult Influenza Vaccine Procedure	<p>CPT 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756 SNOMED CT 86198006: Administration of vaccine product containing only Influenza virus antigen (procedure)</p>
Tdap Vaccine Procedure	<p>CPT 90715 SNOMED CT 390846000: Administration of booster dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412755006: Administration of first dose of vaccine product containing only acellular Bordetella pertussis and</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/CVX/SNOMED CT
	<p>Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412756007: Administration of second dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 412757003: Administration of third dose of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure) 428251000124104: Tetanus, diphtheria, and acellular pertussis vaccination (procedure) 571571000119105: Administration of vaccine product containing only acellular Bordetella pertussis and Clostridium tetani and Corynebacterium diphtheriae antigens (procedure)</p>
CDC Race and Ethnicity	<p>1002-5: American Indian or Alaska Native 2028-9: Asian 2054-5: Black or African American 2076-8: Native Hawaiian or Other Pacific Islander 2106-3: White 2135-2: Hispanic or Latino 2186-5: Not Hispanic or Latino</p>

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

Social Need Screening and Intervention (SNS-E)

Description	CPT/HCPCS/SNOWMED CT
Food insecurity procedures	<p>CPT 96156, 96160, 96161, 97802, 97803, 97804 HCPCS S5170: Home delivered meals, including preparation; per meal S9470: Nutritional counseling, dietitian visit SNOWMED CT 1759002: Assessment of nutritional status (procedure) 61310001: Nutrition education (procedure) 103699006: Patient referral to dietitian (procedure) 308440001: Referral to social worker (procedure) 385767005: Meals on wheels provision education (procedure) 710824005: Assessment of health and social care needs (procedure) 710925007: Provision of food (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>711069006: Coordination of care plan (procedure) 713109004: Referral to community meals service (procedure) 1002223009: Assessment of progress toward goals to achieve food security (procedure) 1002224003: Assessment for food insecurity (procedure) 1002225002: Assessment of barriers in food insecurity care plan (procedure) 1004109000: Assessment of goals to achieve food security (procedure) 1004110005: Coordination of resources to address food insecurity (procedure) 1148446004: Education about legal aid (procedure) 1162436000: Referral to legal aid (procedure) 1230338004: Referral to charitable organization (procedure) 441041000124100: Counseling about nutrition (regime/therapy) 441201000124108: Counseling about nutrition using cognitive behavioral theoretical approach (regime/therapy) 441231000124100: Counseling about nutrition using health belief model (regime/therapy) 441241000124105: Counseling about nutrition using social learning theory approach (regime/therapy) 441251000124107: Counseling about nutrition using transtheoretical model and stages of change approach (regime/therapy) 441261000124109: Counseling about nutrition using motivational interviewing technique (regime/therapy) 441271000124102: Counseling about nutrition using goal setting strategy (regime/therapy) 441281000124104: Counseling about nutrition using self-monitoring strategy (regime/therapy) 441291000124101: Counseling about nutrition using problem solving strategy (regime/therapy) 441301000124100: Counseling about nutrition using social support strategy (regime/therapy) 441311000124102: Counseling about nutrition using stress management strategy (regime/therapy) 441321000124105: Counseling about nutrition using stimulus control strategy (regime/therapy) 441331000124108: Counseling about nutrition using cognitive restructuring strategy (regime/therapy) 441341000124103: Counseling about nutrition using relapse prevention strategy (regime/therapy)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>441351000124101: Counseling about nutrition using rewards and contingency management strategy (regime/therapy)</p> <p>445291000124103: Nutrition-related skill education (procedure)</p> <p>445301000124102: Content-related nutrition education (procedure)</p> <p>445641000124105: Technical nutrition education (procedure)</p> <p>461481000124109: Referral to peer support (procedure)</p> <p>462481000124102: Referral to Community Action Agency program (procedure)</p> <p>462491000124104: Referral to benefits enrollment assistance program (procedure)</p> <p>464001000124109: Referral to case manager (procedure)</p> <p>464011000124107: Referral to care manager (procedure)</p> <p>464021000124104: Referral to care navigator (procedure)</p> <p>464031000124101: Referral to food pantry program (procedure)</p> <p>464041000124106: Referral to Child and Adult Care Food Program (procedure)</p> <p>464051000124108: Referral to Gus Schumacher Nutrition Incentive Program (procedure)</p> <p>464061000124105: Referral to food prescription program (procedure)</p> <p>464071000124103: Referral to garden program (procedure)</p> <p>464081000124100: Referral to home-delivered meals program (procedure)</p> <p>464091000124102: Referral to medically tailored meal program (procedure)</p> <p>464101000124108: Referral to Supplemental Nutrition Assistance Program (procedure)</p> <p>464111000124106: Referral to Special Supplemental Nutrition Program for Women, Infants and Children (procedure)</p> <p>464121000124103: Referral to Summer Food Service Program (procedure)</p> <p>464131000124100: Referral to community health worker (procedure)</p> <p>464141000124105: Referral to Meals on Wheels Program (procedure)</p> <p>464151000124107: Referral to congregate meal program (procedure)</p> <p>464161000124109: Referral to community resource network program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>464171000124102: Referral to Senior Farmers' Market Nutrition Program (procedure)</p> <p>464181000124104: Referral to Farmers' Market Nutrition Program for Women, Infants and Children (procedure)</p> <p>464191000124101: Referral to Food Distribution Program on Indian Reservations (procedure)</p> <p>464201000124103: Education about Child and Adult Care Food Program (procedure)</p> <p>464211000124100: Education about Community Meals Program (procedure)</p> <p>464221000124108: Education about Gus Schumacher Nutrition Incentive Program (procedure)</p> <p>464231000124106: Education about food pantry program (procedure)</p> <p>464241000124101: Education about food prescription program (procedure)</p> <p>464251000124104: Education about garden program (procedure)</p> <p>464261000124102: Education about home-delivered meals program (procedure)</p> <p>464271000124109: Education about medically tailored meal program (procedure)</p> <p>464281000124107: Education about Special Supplement Nutrition Program for Women, Infants and Children (procedure)</p> <p>464291000124105: Education about community resource network program (procedure)</p> <p>464301000124106: Education about benefits enrollment assistance program (procedure)</p> <p>464311000124109: Education about Community Action Agency program (procedure)</p> <p>464321000124101: Education about Food Distribution Program on Indian Reservations (procedure)</p> <p>464331000124103: Education about Farmers' Market Nutrition Program for Women, Infants and Children (procedure)</p> <p>464341000124108: Education about Senior Farmers' Market Nutrition Program (procedure)</p> <p>464351000124105: Education about congregate meal program (procedure)</p> <p>464361000124107: Education about Supplemental Nutrition Assistance Program (procedure)</p> <p>464371000124100: Education about Summer Food Service Program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>464381000124102: Provision of prescription for infant formula (procedure)</p> <p>464401000124102: Provision of fresh fruit and vegetable voucher (procedure)</p> <p>464411000124104: Provision of food voucher (procedure)</p> <p>464421000124107: Provision of home-delivered meals (procedure)</p> <p>464431000124105: Provision of medically tailored meals (procedure)</p> <p>464611000124102: Coordination of care team (procedure)</p> <p>464621000124105: Evaluation of eligibility for home-delivered meals program (procedure)</p> <p>464631000124108: Evaluation of eligibility for Meals on Wheels program (procedure)</p> <p>464641000124103: Evaluation of eligibility for medically tailored meals program (procedure)</p> <p>464651000124101: Evaluation of eligibility for Senior Farmers' Market Nutrition Program (procedure)</p> <p>464661000124104: Evaluation of eligibility for Special Supplemental Nutrition Program for Women, Infants and Children (procedure)</p> <p>464671000124106: Counseling for readiness to implement food insecurity care plan (procedure)</p> <p>464681000124109: Counseling for food insecurity care plan participation barriers (procedure)</p> <p>464691000124107: Counseling for barriers to achieving food security (procedure)</p> <p>464701000124107: Counseling for readiness to achieve food security goals (procedure)</p> <p>464721000124102: Provision of food prescription (procedure)</p> <p>467591000124102: Evaluation of eligibility for food pantry program (procedure)</p> <p>467601000124105: Evaluation of eligibility for Food Distribution Program on Indian Reservations (procedure)</p> <p>467611000124108: Evaluation of eligibility for Farmers' Market Nutrition Program for Women, Infants and Children (procedure)</p> <p>467621000124100: Evaluation of eligibility for Supplemental Nutrition Assistance Program (procedure)</p> <p>467631000124102: Evaluation of eligibility for Summer Food Service Program (procedure)</p> <p>467641000124107: Evaluation of eligibility for Gus Schumacher Nutrition Incentive funded program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>467651000124109: Evaluation of eligibility for garden program (procedure)</p> <p>467661000124106: Evaluation of eligibility for Community Meal Program (procedure)</p> <p>467671000124104: Evaluation of eligibility for Child and Adult Care Food Program (procedure)</p> <p>467681000124101: Assistance with application for Summer Food Service Program (procedure)</p> <p>467691000124103: Assistance with application for Special Supplemental Nutrition Program for Women, Infants and Children (procedure)</p> <p>467711000124100: Assistance with application for Senior Farmers' Market Nutrition Program (procedure)</p> <p>467721000124108: Assistance with application for Medically Tailored Meals Program (procedure)</p> <p>467731000124106: Assistance with application for Home-Delivered Meals Program (procedure)</p> <p>467741000124101: Assistance with Application for Gus Schumacher Nutrition Incentive Program (procedure)</p> <p>467751000124104: Assistance with application for garden program (procedure)</p> <p>467761000124102: Assistance with application for food prescription program (procedure)</p> <p>467771000124109: Assistance with application for food pantry program (procedure)</p> <p>467781000124107: Assistance with application for Child and Adult Care Food Program (procedure)</p> <p>467791000124105: Assistance with application for Food Distribution Program on Indian Reservations (procedure)</p> <p>467801000124106: Assistance with application for Community Meal Program (procedure)</p> <p>467811000124109: Assistance with application for Farmers' Market Nutrition Program for Women, Infants and Children (procedure)</p> <p>467821000124101: Assistance with application for Supplemental Nutrition Assistance Program (procedure)</p> <p>468401000124109: Evaluation of eligibility for food prescription program (procedure)</p> <p>470231000124107: Counseling for social determinant of health risk (procedure)</p> <p>470241000124102: Assistance with application for national school lunch program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>470261000124103: Assistance with application for school breakfast program (procedure) 470281000124108: Evaluation of eligibility for school breakfast program (procedure) 470291000124106: Referral to national school lunch program (procedure) 470301000124107: Referral to school breakfast program (procedure) 470311000124105: Education about national school lunch program (procedure) 470321000124102: Education about school breakfast program (procedure) 470591000124109: Education about community development financial institution (procedure) 470601000124101: Education about community development corporation (procedure) 470611000124103: Education about area agency on aging program (procedure) 471111000124101: Referral to community development financial institution (procedure) 471121000124109: Referral to community development corporation (procedure) 471131000124107: Referral to area agency on aging (procedure) 472151000124109: Referral to medical legal partnership program (procedure) 472331000124100: Education about medical legal partnership program (procedure) 551101000124107: Referral to lawyer (procedure)</p>
Homelessness Procedures	<p>CPT 96156, 96160, 96161 SNOWMED CT 308440001: Referral to social worker (procedure) 710824005: Assessment of health and social care needs (procedure) 711069006: Coordination of care plan (procedure) 1148446004: Education about legal aid (procedure) 1148447008: Assessment for housing insecurity (procedure) 1148812007: Assessment of progress toward goals to achieve housing security (procedure) 1148814008: Assessment of goals to achieve housing security (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>1148817001: Assessment of barriers in housing insecurity care plan (procedure)</p> <p>1148818006: Coordination of services to assist with maintaining housing security (procedure)</p> <p>1162436000: Referral to legal aid (procedure)</p> <p>1162437009: Coordination of resources to address housing instability (procedure)</p> <p>1230338004: Referral to charitable organization (procedure)</p> <p>461481000124109: Referral to peer support (procedure)</p> <p>462481000124102: Referral to Community Action Agency program (procedure)</p> <p>462491000124104: Referral to benefits enrollment assistance program (procedure)</p> <p>464001000124109: Referral to case manager (procedure)</p> <p>464011000124107: Referral to care manager (procedure)</p> <p>464021000124104: Referral to care navigator (procedure)</p> <p>464131000124100: Referral to community health worker (procedure)</p> <p>464161000124109: Referral to community resource network program (procedure)</p> <p>464291000124105: Education about community resource network program (procedure)</p> <p>464301000124106: Education about benefits enrollment assistance program (procedure)</p> <p>464311000124109: Education about Community Action Agency program (procedure)</p> <p>464611000124102: Coordination of care team (procedure)</p> <p>470231000124107: Counseling for social determinant of health risk (procedure)</p> <p>470471000124109: Assistance with application for rental assistance program (procedure)</p> <p>470481000124107: Assistance with application for subsidized housing program (procedure)</p> <p>470491000124105: Evaluation of eligibility for subsidized housing program (procedure)</p> <p>470501000124102: Education about subsidized housing program (procedure)</p> <p>470581000124106: Education about healthcare for the homeless program (procedure)</p> <p>470591000124109: Education about community development financial institution (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>470601000124101: Education about community development corporation (procedure)</p> <p>470611000124103: Education about area agency on aging program (procedure)</p> <p>470781000124104: Evaluation of eligibility for permanent supportive housing program (procedure)</p> <p>470791000124101: Assistance with application for permanent supportive housing program (procedure)</p> <p>470801000124100: Education about permanent supportive housing program (procedure)</p> <p>470811000124102: Evaluation of eligibility for transitional housing program (procedure)</p> <p>470821000124105: Education about transitional housing program (procedure)</p> <p>470831000124108: Assistance with application for transitional housing program (procedure)</p> <p>470841000124103: Referral to healthcare for the homeless program (procedure)</p> <p>471021000124108: Referral to street outreach program (procedure)</p> <p>471031000124106: Education about street outreach program (procedure)</p> <p>471041000124101: Referral to rental assistance program (procedure)</p> <p>471071000124109: Referral to fair housing assistance program (procedure)</p> <p>471081000124107: Referral to Day Shelter program (procedure)</p> <p>471091000124105: Referral to Emergency Shelter program (procedure)</p> <p>471101000124104: Referral to coordinated entry program (procedure)</p> <p>471111000124101: Referral to community development financial institution (procedure)</p> <p>471121000124109: Referral to community development corporation (procedure)</p> <p>471131000124107: Referral to area agency on aging (procedure)</p> <p>472031000124103: Evaluation of eligibility for Safe Haven Program (procedure)</p> <p>472041000124108: Referral to subsidized housing service (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>472051000124105: Education about Safe Haven program (procedure)</p> <p>472081000124102: Education about rental assistance program (procedure)</p> <p>472091000124104: Evaluation of eligibility for rental assistance program (procedure)</p> <p>472101000124105: Evaluation of eligibility for Rapid Re-housing program (procedure)</p> <p>472111000124108: Education about Rapid Re-housing program (procedure)</p> <p>472121000124100: Assistance with application for Rapid Re-housing program (procedure)</p> <p>472131000124102: Provision of rental assistance voucher (procedure)</p> <p>472141000124107: Referral to medical respite for homeless program (procedure)</p> <p>472151000124109: Referral to medical legal partnership program (procedure)</p> <p>472161000124106: Referral to housing support program (procedure)</p> <p>472191000124103: Counseling for readiness to achieve housing security goals (procedure)</p> <p>472221000124105: Counseling for readiness to implement housing insecurity care plan (procedure)</p> <p>472241000124103: Counseling for barriers to achieve housing security (procedure)</p> <p>472261000124104: Counseling for housing insecurity care plan participation barriers (procedure)</p> <p>472301000124108: Evaluation of eligibility for medical respite for homeless program (procedure)</p> <p>472311000124106: Education about medical respite for homeless program (procedure)</p> <p>472321000124103: Assistance with application for medical respite for homeless program (procedure)</p> <p>472331000124100: Education about medical legal partnership program (procedure)</p> <p>472341000124105: Evaluation of eligibility for Housing with Services program (procedure)</p> <p>472351000124107: Assistance with application for Housing with Services (procedure)</p> <p>472361000124109: Education about Housing with Services program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>480791000124106: Evaluation of eligibility for Street Outreach program (procedure)</p> <p>480801000124107: Assistance with application for Safe Haven program (procedure)</p> <p>480811000124105: Evaluation of eligibility for Housing Only program (procedure)</p> <p>480821000124102: Education about Housing Only program (procedure)</p> <p>480831000124104: Assistance with application for Housing Only program (procedure)</p> <p>480871000124101: Evaluation of eligibility for healthcare for homeless program (procedure)</p> <p>480901000124101: Education about fair housing assistance program (procedure)</p> <p>480921000124106: Assistance with application to Emergency Shelter program (procedure)</p> <p>480931000124109: Evaluation of eligibility for Emergency Shelter program (procedure)</p> <p>480941000124104: Education about Emergency Shelter program (procedure)</p> <p>480961000124100: Education about Day Shelter program (procedure)</p> <p>480971000124107: Education about Coordinated Entry program (procedure)</p> <p>480981000124105: Assistance with application for Day Shelter program (procedure)</p> <p>551101000124107: Referral to lawyer (procedure)</p>
Housing Instability Procedures	<p>CPT 96156, 96160, 96161</p> <p>SNOWMED CT 308440001: Referral to social worker (procedure) 710824005: Assessment of health and social care needs (procedure) 711069006: Coordination of care plan (procedure) 1148446004: Education about legal aid (procedure) 1148447008: Assessment for housing insecurity (procedure) 1148812007: Assessment of progress toward goals to achieve housing security (procedure) 1148814008: Assessment of goals to achieve housing security (procedure) 1148817001: Assessment of barriers in housing insecurity care plan (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>1148818006: Coordination of services to assist with maintaining housing security (procedure)</p> <p>1156869006: Education about tenant rights organization (procedure)</p> <p>1162436000: Referral to legal aid (procedure)</p> <p>1162437009: Coordination of resources to address housing instability (procedure)</p> <p>1230338004: Referral to charitable organization (procedure)</p> <p>461481000124109: Referral to peer support (procedure)</p> <p>462481000124102: Referral to Community Action Agency program (procedure)</p> <p>462491000124104: Referral to benefits enrollment assistance program (procedure)</p> <p>464001000124109: Referral to case manager (procedure)</p> <p>464011000124107: Referral to care manager (procedure)</p> <p>464021000124104: Referral to care navigator (procedure)</p> <p>464131000124100: Referral to community health worker (procedure)</p> <p>464161000124109: Referral to community resource network program (procedure)</p> <p>464291000124105: Education about community resource network program (procedure)</p> <p>464301000124106: Education about benefits enrollment assistance program (procedure)</p> <p>464311000124109: Education about Community Action Agency program (procedure)</p> <p>464611000124102: Coordination of care team (procedure)</p> <p>470231000124107: Counseling for social determinant of health risk (procedure)</p> <p>470471000124109: Assistance with application for rental assistance program (procedure)</p> <p>470481000124107: Assistance with application for subsidized housing program (procedure)</p> <p>470491000124105: Evaluation of eligibility for subsidized housing program (procedure)</p> <p>470501000124102: Education about subsidized housing program (procedure)</p> <p>470591000124109: Education about community development financial institution (procedure)</p> <p>470601000124101: Education about community development corporation (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>470611000124103: Education about area agency on aging program (procedure)</p> <p>471041000124101: Referral to rental assistance program (procedure)</p> <p>471051000124104: Referral to Homelessness Prevention program (procedure)</p> <p>471061000124102: Referral to mortgage assistance program (procedure)</p> <p>471071000124109: Referral to fair housing assistance program (procedure)</p> <p>471111000124101: Referral to community development financial institution (procedure)</p> <p>471121000124109: Referral to community development corporation (procedure)</p> <p>471131000124107: Referral to area agency on aging (procedure)</p> <p>472021000124101: Referral to tenants' rights organization program (procedure)</p> <p>472041000124108: Referral to subsidized housing service (procedure)</p> <p>472081000124102: Education about rental assistance program (procedure)</p> <p>472091000124104: Evaluation of eligibility for rental assistance program (procedure)</p> <p>472131000124102: Provision of rental assistance voucher (procedure)</p> <p>472151000124109: Referral to medical legal partnership program (procedure)</p> <p>472161000124106: Referral to housing support program (procedure)</p> <p>472191000124103: Counseling for readiness to achieve housing security goals (procedure)</p> <p>472221000124105: Counseling for readiness to implement housing insecurity care plan (procedure)</p> <p>472241000124103: Counseling for barriers to achieve housing security (procedure)</p> <p>472261000124104: Counseling for housing insecurity care plan participation barriers (procedure)</p> <p>472271000124106: Provision of mortgage assistance voucher (procedure)</p> <p>472281000124109: Evaluation of eligibility for mortgage assistance program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>472291000124107: Education about mortgage assistance program (procedure) 472331000124100: Education about medical legal partnership program (procedure) 472381000124104: Provision of emergency housing fund voucher (procedure) 480841000124109: Education about Homelessness Prevention program (procedure) 480851000124106: Evaluation of eligibility for Homelessness Prevention program (procedure) 480861000124108: Assistance with application to Homelessness Prevention program (procedure) 480901000124101: Education about fair housing assistance program (procedure) 551091000124101: Referral to emergency housing fund program (procedure) 551101000124107: Referral to lawyer (procedure)</p>
<p>Inadequate Housing Procedures</p>	<p>CPT 96156, 96160, 96161 SNOWMED CT 49919000: Home safety education (procedure) 308440001: Referral to social worker (procedure) 710824005: Assessment of health and social care needs (procedure) 711069006: Coordination of care plan (procedure) 1148446004: Education about legal aid (procedure) 1148813002: Assessment of barriers in inadequate housing care plan (procedure) 1148815009: Assessment of goals to achieve adequate housing (procedure) 1148823006: Assessment of progress toward goals to achieve adequate housing (procedure) 1162436000: Referral to legal aid (procedure) 1230338004: Referral to charitable organization (procedure) 461481000124109: Referral to peer support (procedure) 462481000124102: Referral to Community Action Agency program (procedure) 462491000124104: Referral to benefits enrollment assistance program (procedure) 464001000124109: Referral to case manager (procedure) 464011000124107: Referral to care manager (procedure) 464021000124104: Referral to care navigator (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>464131000124100: Referral to community health worker (procedure)</p> <p>464161000124109: Referral to community resource network program (procedure)</p> <p>464291000124105: Education about community resource network program (procedure)</p> <p>464301000124106: Education about benefits enrollment assistance program (procedure)</p> <p>464311000124109: Education about Community Action Agency program (procedure)</p> <p>464611000124102: Coordination of care team (procedure)</p> <p>470231000124107: Counseling for social determinant of health risk (procedure)</p> <p>470431000124106: Referral to weatherization assistance program (procedure)</p> <p>470441000124101: Evaluation of eligibility for weatherization assistance program (procedure)</p> <p>470451000124104: Education about weatherization assistance program (procedure)</p> <p>470461000124102: Assistance with application for weatherization assistance program (procedure)</p> <p>470591000124109: Education about community development financial institution (procedure)</p> <p>470601000124101: Education about community development corporation (procedure)</p> <p>470611000124103: Education about area agency on aging program (procedure)</p> <p>471111000124101: Referral to community development financial institution (procedure)</p> <p>471121000124109: Referral to community development corporation (procedure)</p> <p>471131000124107: Referral to area agency on aging (procedure)</p> <p>472151000124109: Referral to medical legal partnership program (procedure)</p> <p>472201000124100: Counseling for readiness to achieve adequate housing goals (procedure)</p> <p>472211000124102: Counseling for readiness to implement inadequate housing care plan (procedure)</p> <p>472231000124108: Counseling for barriers to achieve adequate housing (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>472251000124101: Counseling for inadequate housing care plan participation barriers (procedure)</p> <p>472331000124100: Education about medical legal partnership program (procedure)</p> <p>472371000124102: Provision of voucher for repair of place of residence (procedure)</p> <p>480881000124103: Referral to environmental hazard testing of residence program (procedure)</p> <p>480891000124100: Evaluation of eligibility for environmental hazard testing of residence program (procedure)</p> <p>480911000124103: Education about environmental hazard testing of residence program (procedure)</p> <p>480951000124102: Assistance with application for environmental hazard testing of residence program (procedure)</p> <p>551041000124105: Referral to housing repair program (procedure)</p> <p>551051000124107: Referral for housing repair assessment program (procedure)</p> <p>551061000124109: Evaluation of eligibility for housing repair program (procedure)</p> <p>551071000124102: Education about housing repair program (procedure)</p> <p>551081000124104: Assistance with application for housing repair program (procedure)</p> <p>551101000124107: Referral to lawyer (procedure)</p>
Transportation Insecurity Procedures	<p>CPT 96156, 96160, 96161</p> <p>SNOWMED CT</p> <p>308440001: Referral to social worker (procedure)</p> <p>710824005: Assessment of health and social care needs (procedure)</p> <p>711069006: Coordination of care plan (procedure)</p> <p>1148446004: Education about legal aid (procedure)</p> <p>1162436000: Referral to legal aid (procedure)</p> <p>1230338004: Referral to charitable organization (procedure)</p> <p>461481000124109: Referral to peer support (procedure)</p> <p>462481000124102: Referral to Community Action Agency program (procedure)</p> <p>462491000124104: Referral to benefits enrollment assistance program (procedure)</p> <p>464001000124109: Referral to case manager (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

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

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOWMED CT
	<p>551201000124102: Referral to fuel voucher program (procedure)</p> <p>551211000124104: Evaluation of eligibility for a fuel voucher program (procedure)</p> <p>551221000124107: Education about fuel voucher program (procedure)</p> <p>551231000124105: Referral to vehicle donation program (procedure)</p> <p>551241000124100: Assistance with application for fuel voucher program (procedure)</p> <p>551251000124103: Evaluation of eligibility for vehicle donation program (procedure)</p> <p>551261000124101: Education about vehicle donation program (procedure)</p> <p>551271000124108: Assistance with application for vehicle donation program (procedure)</p> <p>551281000124106: Referral to transportation network company program (procedure)</p> <p>551291000124109: Assistance with application for transportation network company program (procedure)</p> <p>551301000124105: Education about transportation network company program (procedure)</p> <p>551311000124108: Evaluation of eligibility for transportation network company program (procedure)</p> <p>551321000124100: Referral to volunteer driver program (procedure)</p> <p>551331000124102: Referral to rideshare program (procedure)</p> <p>551341000124107: Referral to public transportation voucher program (procedure)</p> <p>551351000124109: Referral to paratransit program (procedure)</p> <p>551361000124106: Referral to microtransit program (procedure)</p> <p>551371000124104: Referral to Non-Emergency Medical Transportation program (procedure)</p> <p>551381000124101: Referral to automobile share program (procedure)</p> <p>551401000124101: Referral to vehicle repair program (procedure)</p> <p>551421000124106: Assistance with application for bicycle share program (procedure)</p> <p>551431000124109: Referral to bicycle share program (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>610961000124100: Assistance with application for volunteer driver program (procedure)</p> <p>610971000124107: Assistance with application for rideshare program (procedure)</p> <p>610981000124105: Assistance with application for public transportation voucher program (procedure)</p> <p>610991000124108: Assistance with application for paratransit program (procedure)</p> <p>611001000124109: Assistance with application for microtransit program (procedure)</p> <p>611011000124107: Assistance with application for Non-Emergency Medical Transportation program (procedure)</p> <p>611021000124104: Assistance with application for automobile share program (procedure)</p> <p>611031000124101: Education about rideshare program (procedure)</p> <p>611041000124106: Education about volunteer driver program (procedure)</p> <p>611051000124108: Education about microtransit program (procedure)</p> <p>611061000124105: Education about public transportation voucher program (procedure)</p> <p>611071000124103: Education about paratransit program (procedure)</p> <p>611081000124100: Education about Non-Emergency Medical Transportation program (procedure)</p> <p>611101000124108: Education about vehicle repair program (procedure)</p> <p>611121000124103: Education about automobile share program (procedure)</p> <p>611281000124107: Counseling for readiness to achieve transportation security (procedure)</p> <p>611291000124105: Counseling for barriers to achieve transportation security (procedure)</p> <p>611301000124106: Counseling for readiness for engagement in transportation insecurity care plan (procedure)</p> <p>611311000124109: Counseling for barriers to engagement in transportation insecurity care plan (procedure)</p> <p>611321000124101: Assessment of progress toward goals to achieve transportation security (procedure)</p> <p>611331000124103: Assessment of goals to achieve transportation security (procedure)</p>

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

Description	CPT/HCPCS/SNOMED CT
	<p>611341000124108: Assessment of barriers in transportation insecurity care plan (procedure)</p> <p>611351000124105: Assessment for transportation insecurity (procedure)</p> <p>611361000124107: Evaluation of eligibility for rideshare program (procedure)</p> <p>611371000124100: Evaluation of eligibility for volunteer driver program (procedure)</p> <p>611381000124102: Provision of public transportation voucher (procedure)</p> <p>611391000124104: Evaluation of eligibility for public transportation voucher program (procedure)</p> <p>611401000124102: Evaluation of eligibility for paratransit program (procedure)</p> <p>611411000124104: Evaluation of eligibility for microtransit program (procedure)</p> <p>611421000124107: Evaluation of eligibility for automobile share program (procedure)</p> <p>611431000124105: Evaluation of eligibility for vehicle repair program (procedure)</p> <p>611441000124100: Evaluation of eligibility for Non-Emergency Medical Transportation program (procedure)</p>

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

Patient care opportunities

You can find patient care opportunities within the **Patient360** application located on Availity Essentials **Payer Spaces**. To access the **Patient360** application you must have the *Patient360* role assignment. From Availity's home page select **Payer Spaces**, then choose the health plan from the menu. Choose the **Patient360** tile from the **Payer Space Applications** menu and complete the required information on the screen. Gaps in care are located in the **Active Alerts** section of the *Member Summary*.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.



HealthyBlue®

<https://provider.healthybluenc.com>

Healthy Blue is a Medicaid plan offered by Blue Cross and Blue Shield of North Carolina. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross Blue Shield Association. © Marks of the Blue Cross Blue Shield Association. All other marks are the property of their respective owners.