HEDIS Coding Reference Guide: Adult Measures

MEASUREMENT YEAR 2026

QUESTIONS?
Email the MVP HEDIS Operations team: **MVPGapClosures@mvphealthcare.com**

MEASURE	AGE RANGE	FREQUENCY	CODES	LINE OF BUSINESS	CLAIM SUBMITTER	DOCUMENTATION REQUIREMENTS	RECOMMENDATIONS
Annual Wellness Visit (AWV) ****Not a HEDIS Measure****	65+ yrs	Annually	**HCPCS:** G0402 (Welcome to Medicare) G0438 (Initial AWV) G0439 (Subsequent AWV)	Medicare	Primary Care Provider	AWV forms for paper chart and EMR are available in your MVP Provider Online Account/Resources (highlights priority measures impacting Medicare Members).	Although the AWV is not a HEDIS measure itself, it is an important gateway to improved health outcomes. • Utilize the AWV form to guide care and screening needs of Member • Diabetes, HTN, statins, asthma medication management • Behavioral health screenings i.e. depression screening • Submit completed AWV form to your MVP Provider Online Account • Schedule the next AWV appointment before the Member leaves practice • Set reminder calls
Eye Exam for Patients with Diabetes (EED)	18-75 yrs	**Positive for retinopathy:** Annually **Negative for retinopathy:** Every two years	**Diabetes ICD-10:** E10, E11, E13 **Positive Retinal Eye Exam Reviewed:** CPTII: 2022F, 2024F, 2026F **Negative Retinal Eye Exam Reviewed:** CPTII: 2023F, 2025F, 2033F CPTII: 3072F (Negative retinopathy prior year)	Medicare Medicaid Commercial	Optometrist or Ophthal-mologist or Primary Care Provider	Document the type of eye exam performed including findings. Documentation of only the order or statement that test was performed is not sufficient. Please clarify if the result is Positive or Negative for diabetic retinopathy.	• Refer Members with a diagnosis of diabetes (Type 1 or Type 2) to optometrist or ophthalmologist for dilated retinal eye exam • Follow up and discuss the results and findings with the Member

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 **Colorectal Cancer Screening (COL-E)**	45-75 yrs	**FOBT:** Annually **FIT DNA test:** every three years **CT Colonography:** Every five years **Flexible Sigmoidoscopy:** Every five years **Colonoscopy:** Every ten years	**Colonoscopy/ CT Colonography/ Sigmoidoscopy:** Upload report if gap exists **iFOBT/FIT DNA:** Codes submitted by laboratories **Exclusions Colorectal Cancer:** ICD-10: C18.0-C18.9, C19, C20, Z85.038, Z85.048 Colectomy: CPT: 44150–44158, 44210–44212	Medicare Medicaid Commercial	Lab	Document the date, type, and result of colorectal cancer screening clearly. Member reported colonoscopy is acceptable by documenting the date and as much detail as the Member can offer.	• Educate Members about the importance of colorectal cancer screening • Discuss different screening options if the Member is hesitant • Provide at-home FOBT kits if refused other options • Create referral and/or standing order to share with the Member • Provide a list of locations where colorectal cancer screening can be performed based on the recommendations and the Member's preference • Follow up and discuss the results and findings with the Member
 **Blood Pressure Control for Patients with Diabetes (BPD)**	18-75 yrs	Annually	**Systolic BP:** < 130 mmHg – CPTII: 3074F 130-139 mmHg – CPTII: 3075F **Diastolic BP:** < 80 mmHg – CPTII: 3078F 80-89 mmHg – CPTII: 3079F	Medicare Medicaid Commercial	Primary Care Provider	Record the Member's blood pressure at every office visit. If multiple readings were recorded for a single date, use the lowest systolic and diastolic BP on that date. Submit one systolic CPTII and one diastolic CPTII with an office visit code on the claim/encounter. BP equal to or above 140/90 is considered non-compliant.	**High priority measure!** • Educate Members to report blood pressure readings via telehealth encounters if they have digital monitors • Encourage and educate Members to take blood pressure at home, keep a log, and report back to the provider at their next in-person visit or telehealth visit • Reassess Member for compliance and medication regimen while stressing the importance of healthy diet, exercise, and medication intake if blood pressure readings are compromised
 **Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**	12+ yrs	Annually	**PHQ-2 LOINC:** 55758–7 **PHQ-9 LOINC:** 44261–6 **PHQ-9M (Teens) LOINC:** 89204–2	Medicare Medicaid Commercial	Primary Care Provider	Utilize validated tools PHQ9/PHQ2 and ensure that the total score is written clearly on the form with date of service (DOS). Please upload your completed assessment forms of PHQ9/PHQ2 to your MVP Provider Online Account. Record notation of Member refusal on medical record.	• Screen for depression and mood changes at every visit using validated tools (i.e., PHQ9/PHQ2) • Educate the Member on the importance of follow-up and adherence to treatment recommendations • Schedule the next DSF appointment before the Member leaves practice and set reminder calls • Refer to provider who is qualified to diagnose and treat depression, as needed

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Chlamydia Screening (CHL)	16-24 yrs	Annually for Members within the age range identified as sexually active	CPT: 87110, 87270, 87320, 87490-87492, 87810	Medicaid Commercial	Lab	Document the date and findings of the most recent screening.	• Educate Members on the importance of CHL • Conduct chlamydia screening via urine test as part of the annual physical exam • Parental consent is not required • Follow up and discuss the results and findings with the Member
Glycemic Status Assessment for Patients with Diabetes (GSD)	18-75 yrs	Annually	HbA1c <8.0% ; HbA1c ≤9.0% E10, E11, E13 CPTII: HbA1c <7.0% – 3044F ≥7.0% – <8.0% – 3051F ≥8.0% – ≤9.0% – 3052F >9.0% – 3046F	Medicare Medicaid Commercial	Lab or Primary Care Provider	Document medical records with the date and result. Please note that a result of 8% or higher is considered non-compliant for Medicaid and Commercial and a result higher than 9% is considered non-compliant for Medicare.	**High priority measure!** • For Medicaid and Commercial Members, obtain at least one HbA1c value <8% • For Medicare Members, obtain at least one value ≤9% • Follow up results and findings with the Member • Double weighted for Medicaid and Commercial • Triple weighted for Medicare Member
Controlling High Blood Pressure (CBP)	18-65 yrs	Annually	**Systolic BP:** < 130 mmHg – CPTII: 3074F 130-139 mmHg – CPTII: 3075F ≥140 mmHg – CPTII: 3077F **Diastolic BP:** < 80 mmHg – CPTII: 3078F 80-89 mmHg – CPTII: 3079F	Medicare Medicaid Commercial	Primary Care Provider	Record the Member's blood pressure at every office visit. If multiple readings were recorded for a single date, use the lowest systolic and diastolic BP on that date. Submit one systolic CPTII and one diastolic CPTII with an office visit code on the claim/encounter. Blood pressure equal to or above 140/90 is considered non-compliant.	**High priority measure!** • Educate Members to report blood pressure readings via telehealth encounters if they have digital monitors • Encourage and educate members to take blood pressure at home, keep a log and report back to the provider at their next in-person visit or telehealth visit • Reassess Member for compliance and medication regimen while stressing the importance of healthy diet, exercise, and medication intake if blood pressure readings are compromised • Double weighted for Medicaid and Commercial • Triple weighted for Medicare Members

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 **Osteoporosis Management in Women who had a Fracture (OMW)**	67-85 yrs	180 days (six months) after the fracture	**BMD Test** CPT: 77078 (CT), 77080 (DEXA) **Osteoporosis Medications** HCPCSII: J0897, J1740, J3110–J3111, J3489, Q5136	Medicare	Primary Care Provider or Orthopedic Specialist or Endocrinologist / Rheumatologist or Pharmacy / Prescribing Provider	Documentation should include Bone Mineral Density (BMD) testing on the day of fracture or within 180 days (six months) after the fracture. Inpatient BMD test is acceptable. Or prescribe medication to treat osteoporosis on the day of fracture or within 180 days (six months) of fracture.	• Discuss osteoporosis prevention tips with the female Members within the age range • Ask if the Member had any recent fractures or falls that the provider is not aware of
 **Breast Cancer Screening (BCS-E)**	40-74 yrs	Every two years	**Mammography** CPT: 77065–77067 **Digital Breast Tomosynthesis** CPT: 77061–77063 **Exclusions History of Bilateral** Mastectomy – ICD-10: Z90.13	Medicare Medicaid Commercial	Radiology Imaging Center	This measure should be collected and reported through the E-clinical data system. Document the month and year of the most recent mammogram with the result and/or mastectomy status in the medical record. Member reported mammograms are acceptable by documenting the date. BI-RADS screening, regardless of the result, can close gaps. Biopsies, breast ultrasounds, or MRIs do not count towards this measure.	• Educate Members on the importance of early detection and encourage screening • Discuss possible fears the Member might have about mammograms and advise them that the present available testing methods are less uncomfortable and require less radiation • Create referral and/or standing order to share with the Member • Provide a list of locations where mammogram screening can be performed • Follow up and discuss the results and findings with the Member
 **Transition of Care (TRC)**	18+ yrs	Within 30 days of every inpatient discharge	**Patient Engagement after Inpatient Discharge** CPT: 99211–99215, 99395–99397 **Medication Reconciliation Post-Discharge** CPTII: 1111F	Medicare	Primary Care Provider	Documentation of Member engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. Member engagement that takes place on the day of discharge is not measure compliant. Documentation of medication reconciliation of the current and newly prescribed medications.	**Time sensitive measure!** • Schedule the Member for a post-discharge visit once you are notified that the Member is admitted • This appointment should be made within seven days of hospital discharge • Outpatient visits, including office or home visits • Utilize telehealth visits when possible • If the Member is unable to communicate, the provider can interact with the caregiver • Review discharge summaries and work with the hospital to obtain access to the electronic medical records for the Member • Identify all TRC visits within the measurement year, if a Member has multiple hospital admissions

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 **Cervical Cancer Screening (CCS-E)**	21-64 yrs	**Members 21-64** years of age who had cervical cytology in the measurement year or two years prior. **Members 30-64** years of age who had cervical high-risk human Papillomavirus (hrHPV) testing performed in the measurement year or four years prior. **Members 30-64** years of age who had cervical cytology and human papillomavirus (hrHPV) co-testing performed in the measurement year or four years prior.	**Pap Smear / Cytology** HCPCS: G0123 **HPV Test** HCPCS: G0476 **Exclusions: Acquired absence of cervix** ICD-10: Z90.712 (w/uterus) and ICD-10: Z90.710 (w/o uterus) **Total abdominal hysterectomy** CPT: 58150	Medicaid Commercial	Lab or Gynecologist or Primary Care Provider	Document the date when cervical cancer screening was performed with specific test names and results in the medical record. The cervical cytology and HPV test must be from the same data source. Request to have the results of pap tests sent over if completed by OB/GYN.	• Educate Members about the importance of cervical cancer screening • Create referral and/or standing order to share with the Member • Provide a list of locations where cervical cancer screening can be performed • Follow up and discuss the results and findings with the Member
 **Care for Older Adults (COA)**	66+ yrs	Annually	**Functional Status Assessment** CPTII: 1170F **Medication Review** CPTII: 1159F (list) and CPTII: 1160F (review)	Medicare (Only for Dual Eligible Special Needs)	Primary Care Provider	Functional assessment was conducted to evaluate the Member's ability to independently perform activities of daily living (ADLs)-bathing, dressing, eating, toileting, transferring and instrumental activities of daily living (IADL)-transportation, cooking, managing medication, finances, housekeeping, and related activities. Comprehensive medication review was conducted to evaluate the appropriateness, safety, and efficacy of the medication regimen for the Member. Documentation of the current medications, medication reconciliation to identify discrepancies of current and past list. Any adverse drug reactions, allergies, medication compliance and adherence, Member education and follow-up care.	• Educate Members on their condition and the importance of taking medication as prescribed • Encourage medication compliance and adherence • Timely medication pick-up • Discuss follow-up care assessment, medication assessment and adjustment when applicable

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 **Kidney Health Evaluation for Patients with Diabetes (KED)**	18-85 yrs	Annually	**ICD-10 Diabetes:** E10, E11, E13 **Estimated Blood Glomerular Filtration Rate (eGFR):** 80047, 80048, 80050, 80053, 80069, 82565 **Urine Albumin-Creatinine Ratio (uACR):** 82043, 82570	Medicare Medicaid Commercial	Lab	At least one estimated Blood glomerular filtration Rate (eGFR) AND Quantitative urine albumin test AND a urine creatinine test four or less days apart OR Urine and Albumin-Creatinine Ratio (uACR) BOTH eGFR and uACR must be performed in the measurement year to be compliant.	• Refer Members with diagnosis of diabetes (Type 1 or Type 2) to lab to receive a kidney health evaluation during the measurement year • Follow up with Members who have not completed tests • Schedule regular follow-ups with Members to monitor changes, discuss lab results, and educate on how diabetes can affect the kidneys by offering tips for prevention and diet • Follow up and discuss the results and findings with the Member
 **Prenatal and Postpartum Care (PPC)**	All Ages	**Pre-Frequency:** First trimester or within 42 days after enrollment. **Post-Frequency:** On or between 7-84 days (1-12 weeks after delivery)	**Timeliness of Prenatal Care ICD-10:** Z34.90 CPTII: 0500F (initial), 0502F (subsequent) **Postpartum Care ICD-10:** Z01.411 CPTII: 0503F	Medicaid Commercial	OB/GYN or Primary Care Provider	Prenatal document must include the date of visit and indicate at least one of the following: fetal heart tone auscultation; pelvic exam with OB observations; fundal height measurement. Postpartum document must include the date of visit and at least one of the following: pelvic exam, evaluation of weight, blood pressure, breasts and abdomen; notation of postpartum care; depression screening; C/S incision or wound check and follow up, evidence of pap testing; glucose testing for women with gestational diabetes.	• Encourage and stress the importance of prenatal visits • Refer the Member to an OB/GYN for continued prenatal care • Schedule the next visit before the Member leaves the office • Utilize telehealth visits if the Member cannot make it to the office • Encourage a postpartum visit between 7-84 days of delivery
 **Follow-Up after Emergency Department (ED) Visit (FMC)**	18+ yrs	Within seven days of every ED discharge	**Multiple CPT codes:** Requires reviewing codes and provider workflow to meet claims submission requirement. **Outpatient and Telehealth Visits CPT:** 98966-98981, 99202- 99205, 99211-99215, 99242-99245 **Transitional Care Management CPT:** 99495, 99496	Medicare	Primary Care Provider	Document visit within seven days of discharge (eight total days) with the reason and outcome of the hospitalization along with the reconciliation of any changes to medication due to the ED visit. Visits on the day of ED visits are measure compliant. ED visits resulting in inpatient care are excluded. If the Member has more than one ED visit within an 8-day period, include only the first eligible visit.	**Time sensitive measure!** • Follow up post ED visit for people with two or more chronic conditions prior to the ED visit, within seven days of discharge (eight total days) • Outpatient office or telehealth visits • Identify all ED visits within the measurement year, if a Member had multiple ED visits