

UnitedHealthcare[®] Quality Reference Guide

2026 HEDIS[®], CMS Part D, CAHPS[®] and HOS Measures

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Information contained in this guide is based on NCQA HEDIS technical specifications.
For more details, please visit [ncqa.org](https://www.ncqa.org).

PCA-1-26-00810-E&I-QRG_05062026
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We have the same goal:

To help improve your patients' health outcomes by identifying and addressing open care opportunities.

Like you, we want your patients, who are UnitedHealthcare plan members, to be as healthy as possible. And a big part of that is making sure they get the preventive care and chronic care management they need. To help identify care opportunities, our PATH program provides information specific to UnitedHealthcare members who are due or overdue for specific services.

This reference guide can help you better understand the specifications for many of the quality measurement programs and tools used to address care opportunities, as well as how to report data and related billing codes.

For additional PATH resources or to access this guide online, please visit UHCprovider.com/path.

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By working together, we can achieve our shared goals.

HEDIS measures

HEDIS is a National Committee for Quality Assurance (NCQA) tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

- **HEDIS measures are reported as administrative or hybrid and are collected and reported annually by health plans**
- **The data collection cycle, which includes gathering medical record information from care providers, generally happens in the first half of each year**
- **The data is then used to evaluate quality of care, which is determined by dividing the measure numerator by the measure denominator**

HEDIS-related terms are explained in the glossary.

CMS measures

Centers for Medicare & Medicaid Services (CMS) Part D medication adherence measures are used to help increase the number of Medicare members taking their cholesterol (statin), diabetes and/or hypertension (RAS antagonist) medications as prescribed. Members are eligible for a measure if their medication appears on a targeted list provided by the Pharmacy Quality Alliance (PQA). Their adherence is then evaluated using the proportion of days covered (PDC), which is defined in the Glossary.

- CMS considers Medicare members adherent if their PDC is 80% or more at the end of the measurement period
- Member eligibility and performance within the Part D medication adherence measures is based entirely on prescription claims processed at the pharmacy under the Part D benefit
- Supplemental data from medical records or patient assessments can't be used to affect these measures.

CAHPS® measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that asks consumers and members to report on and evaluate their experiences with health care. The CAHPS® survey is governed by CMS and NCQA.

- The survey is given annually between February and June to adults ages 18 and older who have been enrolled in a health plan during a continuous 6-month period for Medicare and Medicaid, or a 12-month period for commercial. For Medicaid only, guardians of children ages 17 and younger are also given the survey if they've been enrolled in a plan for a continuous 6-month period.
- Respondents are asked a core set of questions determined by NCQA and CMS, in addition to a series of optional supplemental questions crafted by a health plan and approved by NCQA and CMS
- Members are given the option to complete the survey by mail, phone or online
- Results are calculated and released between July and October

HOS measures

Health Outcomes Survey (HOS) is a health plan member survey by CMS that gathers health status data specific to the Medicare Advantage program. Respondents are given a baseline survey between late July to November and then asked to complete a follow-up survey 2 years later between late July and November.

Baseline survey results are calculated and released in May of the following year, while results for the follow-up survey are provided during the summer of the following year.

By working together, we can achieve our shared goals. (cont.)

QHP Enrollee Experience Survey

QHP Enrollee Experience Survey measures satisfaction with care received, physicians and ease of access for the Exchange/Marketplace plans.

The Patient Protection and Affordable Care Act (ACA) necessitated the development of a quality rating and enrollee satisfaction with each QHP offered through the Health Insurance Marketplaces. CMS requires that QHP issuers submit QHP Enrollee

Survey response data and QRS clinical measure data for their respective QHPs in accordance with CMS guidelines. The QHP Enrollee Survey is largely based on items from the CAHPS Surveys. The survey runs from February through May via mail, email, telephone or web/online.

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Measurement year

In most cases, the 12-month time frame between which a service was rendered – generally Jan.1 – Dec. 31. Data collected from this time frame is reported during the reporting year.

Reporting year

The time frame when data is collected and reported. The service dates are from the measurement year, which is usually the year prior. In some cases, the service dates may go back more than one year.

Example: The 2026 reporting year would include data from services rendered during the measurement year, which would be 2025 and/or any time prior. Results from the 2026 reporting year would likely be released in June 2026, depending on the quality program.

Denominator

The number of members who qualify for the measure criteria, based on NCQA technical specifications.

Numerator

The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment or service.

Medical record data

The information taken directly from a member's medical record to validate services rendered that weren't captured through medical or pharmacy claims, encounters or supplemental data.

Collection and reporting method

- Administrative – Measures reported as administrative use the total eligible population for the denominator. Medical, pharmacy and encounter claims count toward the numerator. In some instances, health plans use approved supplemental data for the numerator.
- Hybrid – Measures reported as hybrid use a random sample of 411 members from a health plan's total eligible population for the denominator. The numerator includes medical and pharmacy claims, encounters and medical record data. In some cases, health plans use auditor-approved supplemental data for the numerator.
- Supplemental data – Standardized process in which clinical data is collected by health plans for purposes of HEDIS improvement. Supplemental clinical data is additional data beyond claims data.
- Electronic Clinical Data Systems (ECDS) – Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to:
 - Administrative claims
 - Member eligibility files
 - Electronic health records
 - Clinical registries
 - Health information exchanges
 - Administrative claims systems
 - Disease/case management registries

Required exclusion

Members are excluded from a measure denominator based on a diagnosis and/or procedure captured in their Claim/encounter/ Pharmacy data. If applicable, the required exclusion is applied after the claims data is processed within certified HEDIS software while the measure denominator is being created.

For example: Members with end-stage renal disease (ESRD) during the measurement year or year prior will be excluded from the statin therapy for patients with cardiovascular disease (SPC) measure denominator.

- Members with a claim for hospice services during the measurement year will be excluded from all applicable measures.

Proportion of days covered (PDC)

According to the Pharmacy Quality Alliance (PQA), the PDC is the percent of days in the measurement period covered by prescription claims for the same medication or another in its therapeutic category.



We're always looking for ways to make your job easier and give you more time to do what matters most – care for patients.

The following digital solutions, tools and education are designed to help you quickly complete claim tasks, share data, identify members due for tests and screenings, and more.

Our digital solutions

Application programming interface (API)
API is a free digital solution that allows health care professionals to automate administrative transactions. This is a great alternative to Document Library for organizations with medium-to-high claim volume that have the technical resources to program API or the ability to outsource implementation. API interacts between multiple applications and allows you to get detailed data on claims status and payment, documents, eligibility and benefits, reconsiderations and appeals, and referrals.

Learn more at UHCprovider.com/apistart.

Electronic Data Interchange (EDI)

EDI is an electronic method of securely exchanging between systems via a standard transaction set. Transactions are generated from your practice management system (PMS) or hospital information system (HIS), and then routed to a clearinghouse for submission to UnitedHealthcare. It enables the submission and receipt of batch transactions for multiple members and payers, reducing the need for manual data entry, phone calls and numerous logins for payer websites. Information we send back to you for these transactions is automatically loaded back into your system.

Learn more at UHCProvider.com/edi.

UnitedHealthcare Provider Portal

Our **secure, provider portal** is where you go to get work done electronically 24/7. The portal includes an ever-expanding list of tools to help you:

- **Verify member eligibility and confirm benefits**
- **Check status of and submit prior authorizations**
- **Estimate, manage and take action on claims and payments**
- **Verify, submit and search referral requests**
- **Manage prescriptions**
- Manage your communication preferences
- Verify, update and attest to provider demographic data in the portal using **My Practice Profile**
 - Several **attestation options** available
- View your workflow at a glance and take action with TrackIt
- Access documents online through **Document Library**
- Get **credentialing and contracting** help
- Additional tools and resources, including:
 - **Practice Assist:** Manage patient care opportunities and suspect medical conditions across multiple health plans. Access Practice Assist on the **provider portal** under Clinical & Pharmacy.
 - **Chat:** Get real-time answers to your questions on claims, eligibility and benefits, prior authorization and advance notification, credentialing and technical support. Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**. For additional contact information, visit our **Contact us** page.

See UHCprovider.com/portal for additional information.

To access the portal:

- From any page on [UHCprovider.com](#) > Sign In
- Enter your One Healthcare ID and password

New user? Get started at [UHCprovider.com/access](#).

Other tools, resources and education

Patient Care Opportunity Report (PCOR) and Practice Assist

Check who may be due for screenings and tests, and who may be at risk for non-adherence to their medications. The PCOR is compiled monthly from medical and pharmacy claims and supplemental data. You can check it daily to view care opportunities tied to the following measure types:

- CMS Star Ratings
- HEDIS
- Pharmacy compliance
- Value-based contracting

Practice Assist is a workflow management tool that enables health care professionals to manage patient care opportunities and suspect medical conditions across multiple health plans.

Access your PCOR within Practice Assist under Provider Reports. Learn more at [UHCprovider.com/portal](#).

Point of Care Assist®

Compatible with Athena, Allscripts, eClinicalWorks and NextGen EMR systems Point of Care Assist integrates patient's UnitedHealthcare medical records with electronic medical records (EMRs) to provide real-time insights – clinical, labs, prior authorizations, cost transparency – making it easier for you to understand a patient's needs

at the time of care. This helps providers deliver more immediate value to patients and achieve better results for their practice with reliable, up-to-date information. It may also save significant money and administrative hours by reducing the need to call UnitedHealthcare Customer Service or log into another platform.

Learn more at [UHCprovider.com/POCA](#).

UnitedHealthcare Data Exchange Program

Share important member Enterprise Clinical Data and Platforms (ECDP) team to help us:

- Identify and address care opportunities
- Report accurate data to CMS and NCQA
- Reach our goal of improving health care outcomes while lowering health care costs

Email ecdiops@uhc.com for more information.

UnitedHealthcare education and training

We provide a full range of training resources including self-paced courses and instructor-led sessions.

The courses include:

- Featured courses
- CME credit courses
- Clinical tools
- Coding Corner
- Delegated providers
- Digital solutions
- Instructor-led learning events
- Plans and products
- Smart Edits
- State specific training
- Veterans Affairs Community Care Network (VA CCN)

Get started at [UHCprovider.com/training](#).

Tools You Can Use (cont.)

OptumHealth Education

OptumHealth Education, a UnitedHealth Group company, offers credit-based continuing education classes for several physical and mental health conditions. The courses are designed to help improve patient care delivery. Learn more at optumhealtheducation.com.

UnitedHealthcare Social Drivers of Health (SDoH) Protocol

Improving the lives of the members we serve

Tools and resources helpful in addressing SDoH are available at [UHCprovider.com](#) > Resource Library > Patient Health and Safety > Social Drivers of Health

- Studies estimate that social drivers of health (SDoH) have a bigger influence on health than clinical care, finding 60% of a person's health is driven by social, behavioral and environmental factors like their education, income and race/ethnicity
- Health care professionals can help patients overcome SDoH barriers by gaining a better understanding of the scope of factors influencing the treatment process

The value of using Z codes

Screening patients raises awareness of member specific SDoH needs. Through the use and documentation of ICD-10 Z codes, UnitedHealthcare can closely align with patients' needs and develop innovative solutions.

The UnitedHealthcare SDoH Protocol strongly encourages providers to document SDoH by using ICD-10 diagnostic code(s) (or successor diagnostic codes) in the member's medical record.

Unless prohibited by federal or state law, this protocol applies to all UnitedHealthcare's members, including UnitedHealthcare Medicare Advantage, Medicaid and Individual Group Market (Exchange) plans.

SDoH are non-clinical societal and environmental conditions, such as lack of access to adequate food and health care, housing, transportation and education, along with unsafe environment, lack of adequate social support, employment and behavioral stability support that prevent individuals from accessing health care they need.

Common codes for reporting SDoH

ICD-10

- Z55 - Z65: Should also be reported as part of an office visit using (E/M) codes
- Entire list of ICD-10 codes is at [UHCprovider.com](#) > Resource Library > Patient Health and Safety > [Social Drivers of Health](#)

CPT®

- SDoH should be reported as part of an office visit using (E/M) codes such as 99204/99214 (Moderate Complexity) and 99205/99215 (High Complexity)
- 96160: Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal)
- 96161: Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient

Read the full UnitedHealthcare Protocol

Reference the full UnitedHealthcare SDoH Protocol as well as our self-paced training, tools and SDoH resources for more information.

We encourage all health care professionals to remain current on SDoH ICD-10 codes, as they may be updated from time to time through expansion efforts supported by the Gravity Project.

¹ Schroeder, SA. NEJM 2007; 357: 1221-1228.

UnitedHealthcare Social Drivers of Health (SDoH) Protocol (cont.)



Calls to action

- Routinely screen, document and submit the appropriate ICD-10 code(s) when a patient is impacted by SDoH
- If you're not sure which screening tool to use, the **PRAPARE Screening Tool** is nationally recognized and can be used for reference
- Focus on 3 key domains:
 - Food insecurity: Z59.41
 - Transportation insecurity: Z59.82
 - Housing instability: Z59.8

¹ Schroeder, SA. NEJM 2007; 357: 1221-1228.

Electronic Clinical Data Systems Measures



HEDIS Electronic Clinical Data Systems (ECDS) measures are designed for payer or health system reporting. These measures use digital clinical data sources containing member information and allows for this information to be used to close gaps in care.

Why is ECDS important?

The National Committee for Quality Assurance (NCQA) implemented ECDS to help move measures towards a more digital future. There is potential for traditional reporting to transition to ECDS reporting, which may impact rates and incentives. That's why it's important for you to connect with your UnitedHealthcare representative if you're currently not sharing clinical data electronically. UnitedHealthcare prefers CCD files that comply with the most current HL7 standards.

What's the difference between traditional HEDIS measures and ECDS measures?

ECDS is a streamlined approach to closing care gaps to help reduce the administrative burden and resources traditional reporting requires of providers and UnitedHealthcare.

Although these measures can be closed via administrative claims, this reporting category encourages pursuing clinical data often found in electronic medical record systems. The goal is to promote the integration of clinical information by automatically transferring needed data for gap closure. ECDS measures allow for plans to view quality care prospectively as opposed to reviewing quality care retrospectively.

What type of data gets collected for ECDS?

Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to:

- Administrative claims
- Member eligibility files
- Electronic health records
- Clinical registries
- Health information exchanges
- Administrative claims systems
- Disease/case management registries

What are the requirements to report ECDS?

Per NCQA, to qualify for HEDIS ECDS reporting, practitioners or practitioner groups that are accountable for clinical services provided to members must not be prevented from accessing any data used by a health plan for quality measure reporting, regardless of the initial Source System of Record (SSoR). Each SSoR is a database where, through integrity testing, the data structure is standardized so it can be electronically extracted for HEDIS ECDS reporting.

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

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Electronic Clinical Data Systems Measures

The sources are prioritized into 4 categories:

- Electronic health record (EHR)/personal health record (PHR) (the system of data origin such as laboratory, pharmacy, pathology, radiology)
- Health information exchange (HIE)/clinical registry
- Case management registry
- Administrative

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

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Our mission is to help people live healthier lives and make the health system work better for everyone. To fulfill this mission, it's essential an organization of our size and reach defines health equity in a way that reflects our unique role and responsibility. We recognize not everyone experiences health care the same way and our definition acknowledges the social drivers that influence health.

UnitedHealth Group's definition of health equity: "Health equity is a state in which all people are able to live their healthiest lives. We work with communities, providers and partners to address the barriers that result from the circumstances in which people are born, live, learn, work and age, enabling the health system to work better for everyone."

Why Is sharing socio-demographic data important?

- Helps identify and address health inequities that may exist amongst the populations we serve
- Helps meet regulatory, compliance and quality organization requirements (e.g., NCQA, CMS, state and federal agencies)
- Self-reported (direct data) is the most accurate reflection of the population
- Helps to identify resources and needs at the community level to build consumer trust and increase engagement

How you can help?

- Survey your patients at least annually for socio-demographic data and social drivers of health (e.g., housing, transportation, food insecurities)
- Give members the option to choose not to answer, instead of leaving blank
- Avoid allowing for an option of unknown
- Include a disclaimer on how the data will be protected and used

Advancing Health Equity (cont.)

Race	White, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, Middle Eastern or Northern African, some other race, two or more races, prefer not to answer
Ethnicity	Hispanic or Latino, Not Hispanic Latino, prefer not to answer
Spoken	English, non- English, Prefer not to answer Recommend: English, Spanish, American Sign Language, Arabic, Farsi, Chinese, Cantonese, French, German, Harian Creole, Hindi, Italian, Korean, Mandarin, Portuguese, Russian, Tagalog, Vietnamese, Some other Language, Prefer Not to Answer
Written	English, non-English, prefer not to answer Recommend: English, Spanish, Arabic, Braille, Farsi, Chinese, Cantonese, French, German, Harian Creole, Hindi, Italian, Korean, Mandarin, Portuguese, Russian, Tagalog, Vietnamese, some other language, prefer not to answer
Sexual orientation	Lesbian or gay, straight or heterosexual, bisexual, queer, pansexual, two spirit, don't know, other, prefer not to answer
Gender identity	Female/woman/girl, male/man/boy, nonbinary, genderqueer or not exclusively female or male, transgender female/woman/girl, transgender male/man/boy, two spirit, another gender, don't know, prefer not to answer
Sex assigned at birth	Female, male, other, prefer not to answer
Pronouns	She/her/hers, he/him/his, they/them/ theirs, ze/zir/zir, co/co/cos, xie/hir/ here, en/en/ens, ey/em/eir, yo/yo/yos, ve/vis/ver, don't know, other, prefer not to answer
Disability status	Difficulty seeing/wear glasses, difficulty hearing/use hearing aids, difficulty walking/ climbing steps, difficulty remembering/ concentrating, difficulty with self-care (washing/ dressing), difficulty communicating/understanding

Advancing Health Equity (cont.)

Veteran status (Armed Forces, Reserves, National Guard)	Never served in the military, only on active duty for training in the, Reserves or National Guard, now on active duty, on active duty in the past, but not now, prefer not to answer
Social Drivers of Health	Questions including, but not limited to, insecurities related to food, transportation and housing

Language Diversity of Membership (LDM)

New for 2026

- No applicable changes to this measure

Definition

Percentage of all members enrolled at any time during the measurement year by preferred written and spoken languages.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare • Exchange/Market Place 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings 	<ul style="list-style-type: none"> • Direct member collection

International Organization for Standardization (ISO)

ISO is used for the representation of the world’s languages and language groups.

ISO language codes are the standard for linguistic codification worldwide. The standard sets are **ISO 639: Subsets ISO 639-1, ISO 639-2, ISO 639-3 for language codes.**

	ISO 639-1	ISO 639-2	ISO 639-3
Macro languages			X
Collection of languages	X	X	
Living languages	X	X	X
Extinct languages		X	X
Historical languages		X	X
Ancient languages	X	X	X
Constructed languages		X	X

Required exclusion(s)

Exclusion

There are no exclusions for this measure.

Language Diversity of Membership (LDM) (cont.)

Tips and best practices for collecting demographic data

- Collecting language preference information directly from patients or their caregivers is an important practice in healthcare organizations.
 - It is important to collect all of the following in regard to language:
 - o **English proficiency**
 - Tip: Responses should include very well, well, not well, not at all
 - o **Preferred spoken language for health care**
 - Tip: Avoid using "preferred language," instead ensure the question denotes it is seeking the patients preferred "spoken" language
 - Example: "What is your preferred spoken language for health care?"
 - Tip: Ensure sign language is included as an option
 - o **Preferred written language for health care**
 - Tip: Avoid using "preferred language," instead ensure the question denotes it is seeking the patients preferred "written" language
 - Example: "What is your preferred written language for health care?"
 - Tip: Ensure Braille is included as an option
 - o **Other languages spoken**
 - To the best of your ability, collect language preferences at the most granular level possible.
- Storing this information in an electronic format is also recommended whenever possible
- Providing this information should always be voluntary, and staff should be attentive to patients and give members the option to choose not to answer
- Key components to consider:
 - Collect data directly from the patient or their designated representative
 - Provide a clear rationale or reason for collecting this information
 - o Research shows patients are most comfortable providing this information when told why it is being collected and how it will be used

Race and Ethnicity Diversity of Membership (RDM)

New for 2026

- No applicable changes to this measure

Definition

Percentage of all members enrolled at any time during the measurement year by race and ethnicity.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare • Exchange/Market Place 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings 	<ul style="list-style-type: none"> • Direct member collection

Data collection

We encourage you to collect race and ethnicity at the granular level to better understand the health needs of the population you serve.

Examples of data collection categories are posted below.

Please note: This list is not inclusive of all races/ethnicity selections. Granular or detailed data collection is preferred when possible.

- Allow the patient to select multiple values for instances where a patient belongs to 2 or more races
- Include a write-in option, for instances where a patient may select “some other race”
- Avoid using “unknown” as a selection

Race	Ethnicity	
American Indian or Alaska Native	Not Hispanic or Latino	
Chinese	Hispanic or Latino	
Vietnamese	• Chilean	• Nicaraguan
Asian Indian	• Costa Rican	• Puerto Rican
Korean	• Cuban	• Salvadoran
Japanese	• Dominican	• Spanish
Black or African American	• Guatemalan	• Venezuelan
Middle Eastern or North African	• Honduran	• Other
Native Hawaiian or Other Pacific Islander	• Mexican	- Write-in option
White	Prefer not to answer or decline	
Other race		
• Write-in option		
Prefer not to answer or decline		

Race and Ethnicity Diversity of Membership (RDM)

Required exclusion(s)

Exclusion

There are no exclusions for this measure. Health Plans and providers are expected to collect this information on all members/patients.

Tips and best practices for collecting demographic data

- Collecting race and ethnicity information directly from patients or their caregivers is an important practice in health care organizations
- Storing this information in an electronic format is recommended whenever possible
- Providing this information should always be voluntary, and staff should be attentive to patients and give members the option to choose not to answer
- Key components to consider:
 - Collect data directly from the patient or their designated representative
 - Provide a clear rationale or reason for collecting this information
- Research shows patients are most comfortable providing this information when told why it is being collected and how it will be used
 - Determine whether your organization will use broad or granular categories based on its capacity. If using predefined categories, decide whether you will use the minimum required categories, such as those defined by the Office of Management and Budget (OMB) or if you will provide more detailed options.

Disability Description of Membership (DDM)

New Measure for 2026

Definition

Percentage of all members enrolled at any time during the measurement year by disability status.

Plans(s) affected	Collection and reporting method
<ul style="list-style-type: none">• Commercial• Medicaid• Medicare• Exchange/Market Place	<ul style="list-style-type: none">• Direct Member Collection

Data collection

Disability Description of Membership (DDM) can be collected utilizing self-reported questionnaires such as:

- American Community Survey Six-item (ACS-6) Disability Questions
- Washington Group Short Set (WG-SS) on Disability

Disability status may include, but is not limited to, the following:

- Hearing.
- Seeing (including when wearing glasses).
- Concentrating, remembering or making decisions.
- Walking or climbing stairs.
- Dressing or bathing.
- Completing errands alone.
- Communicating.
- Other difficulties when doing activities throughout your day, please describe:
- Don't know.
- Prefer Not to Answer

Required exclusion(s)

Exclusion

There are no exclusions for this measure.


Tips and best practices for collecting demographic data

- Providing information should always be voluntary, and staff should be attentive to patients and give members the option to choose not to answer.

Advanced Care Planning (ACP)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

Percentage of adults ages 66 to 80 with advanced illness, an indication of frailty or who are receiving palliative care, and adults ages 81 and older who had evidence of Advance care planning in the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
• Medicare	• None	Administrative • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Advance care planning	
CPT®/CPT II	99483, 99497, 1123F, 1124F, 1157F, 1158F
HCPCS	S0257
ICD-10 Diagnosis	Z66
SNOMED	310305009, 425392003, 425396000, 425397009, 425393008, 3041000175100, 425394002, 3021000175108, 3011000175104, 425395001, 4921000175109, 713603004, 310302007, 310303002, 3061000175101, 3031000175106, 310301000, 713600001, 87691000119105, 713662007, 714361002, 713665009, 713602009, 713058002, 423606002, 699388000, 714748000, 719239007, 719238004, 719240009, 713580008

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Advanced Care Planning (ACP) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

Test, service or procedure to close care opportunity

Measurement year


- Advanced directive, actionable medical orders, living will, surrogate decision maker are all examples of advance care planning
- Telehealth visits are acceptable to meet this numerator

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Care for Older Adults (COA) – Functional status assessment

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

Percentage of adults 66 and older who had evidence of a Functional status assessment in the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare Special Needs Plans (SNP) 	<ul style="list-style-type: none"> • CMS Star Ratings 	<p>Hybrid</p> <ul style="list-style-type: none"> • Claim/encounter data • Medical record documentation

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Functional status assessment	
CPT®/CPT II	1170F, 99483
HCPCS	G0438, G0439
SNOMED	304492001, 3585880002

Required exclusions(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who died 	Any time during the measurement year

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Care for Older Adults (COA) – Functional status assessment (cont.)



Important notes

	Test, service or procedure to close Care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • Functional status assessment must occur within the measurement year • Functional status assessment conducted in an acute inpatient setting will not meet compliance • Telehealth visits are acceptable to meet this numerator 	Standardized functional status assessment tool and results	<ul style="list-style-type: none"> • Functional status assessment forms • Health history and physical • Home health records • Occupational therapy notes • Physical therapy notes • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes
	Assessment of Instrumental Activities of Daily Living (IADL) or at least 4 of the following assessed: <ul style="list-style-type: none"> • Chores, such as laundry • Cleaning/housework • Cooking/meal prep • Driving or using public transportation • Grocery shopping • Home repair • Paying bills or other financial tasks • Taking prescribed medications • Using a phone 	
	Activities of Daily Living (ADLs) or at least 5 of the following assessed: <ul style="list-style-type: none"> • Bathing • Dressing • Eating meals/snacks • Getting up and down from sitting or lying position • Using the restroom • Walking 	

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Care for Older Adults (COA) – Functional status assessment (cont.)

Tips and best practices to help close this care opportunity


- **Always clearly document the date of service of the Functional status assessment**
- A functional status assessment done in an acute inpatient setting will **not** meet compliance
- A functional status assessment limited to an acute or single condition, event or body system, such as lower back or leg, will **not** meet compliance
- The following notations will **not** meet compliance:
 - “Functional status reviewed” doesn’t indicate that a complete Functional status assessment was performed
- Documentation of “normal motor/sensory” during an exam or a checked box next to “normal motor/sensory” on a neurological exam isn’t enough evidence for a functional status assessment
- A functional status assessment may be conducted with the member in various manners (phone, in person, virtually, etc.) and is not limited to being completed by clinicians
- Functional status assessments can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Care for Older Adults (COA) – Medication review

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

Percentage of adults ages 66 and older who had a Medication review by a clinical pharmacist or prescribing practitioner and the presence of a Medication list in the medical record or Transitional care management services in the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare Special Needs Plans (SNP) 	<ul style="list-style-type: none"> • CMS Star Ratings 	Hybrid <ul style="list-style-type: none"> • Claim/encounter data • Medical record documentation

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Medication list	
CPT®/CPT II	1159F This code (Medication list documented) must be submitted with 1160F (review of all medications by a prescribing practitioner or clinical pharmacist documented) on the same date of service.
HCPCS	G8427
SNOMED	428191000124101, 432311000124109 Submission of either code must also be submitted with one of the SNOMED codes listed for medication review on the same date of service

Medication review	
CPT®/CPT II	99605, 99606, 90863, 99483, 1160F (This code (1160F - review of all medications by a prescribing practitioner or clinical pharmacist documented) must also be submitted with 1159F (Medication list documented) on the same date of service)
SNOMED	719327002, 719328007, 719329004 Submission of codes must also be submitted with one of the SNOMED codes for medication list on the same date of service

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Care for Older Adults (COA) – Medication review (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Transitional care management

CPT®/CPT II	99495, 99496
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Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

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Care for Older Adults (COA) – Medication review (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> Medication list must be included in the medical record and Medication review must be completed by a prescribing provider or clinical pharmacist A medication list, signed and dated during the measurement year by the appropriate practitioner type – prescribing practitioner or clinical pharmacist – meets compliance A notation within the record that the medications were reviewed. If a notation is included, the signature is not needed. Documentation that the medications aren't tolerated isn't an exclusion for this measure A review of side effects for a single medication at the time of prescription alone does not meet compliance. Medication review conducted in an acute inpatient setting will not meet compliance Practitioner is not required to be the member's primary or ongoing care provider; any provider meeting the requirement of prescribing practitioner or clinical pharmacist can complete the medication review 	<p>Medication list and medication review or dated clinician's note that says the member is not taking medications</p>	<ul style="list-style-type: none"> Health history and physical Medication list Progress notes SOAP notes

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Care for Older Adults (COA) – Medication review (cont.)

Tips and best practices to help close this care opportunity

- **Always clearly document the date of service of the medication review or notation of no medications**
- A medication review conducted in an acute inpatient setting will **not** meet compliance
- A medication review may be conducted with a member over the phone if the clinician is a prescriber or clinical pharmacist. A registered nurse can collect the list of current medications from the member during the call, but there must be evidence that the appropriate practitioner reviewed the list.
 - For example: An electronic signature with credentials on the medication list
- The medication review must include all of the member's medications, including prescription and over-the-counter medications and herbal or supplemental therapies
- A medication list signed and dated within the measurement year by the prescribing practitioner or clinical pharmacist meets the criteria
 - The practitioner's signature along with a medication list in the member's chart is considered evidence that the medications were reviewed
 - A review of side effects for a single medication at the time of prescription alone will not meet compliance
- Medication reviews and the presence of a medication list can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Oral Evaluation, Dental Services (OED)

Definition

The percentage of members aged 20 and younger who received a periodic or comprehensive oral evaluation with a dental provider during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> Medicaid 	<ul style="list-style-type: none"> Medicaid P4P program 	Administrative <ul style="list-style-type: none"> Claim/encounter data

Codes

The following codes can be used to close numerator gaps in care for the screening part of the measure; they are not intended to be a directive of your billing practice.

Oral evaluation	
CDT	D0120, D0145, D0150

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

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Topical Fluoride for Children (TFC)

Definition

The percentage of members 1-4 years of age who received at least two fluoride varnish applications during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> Medicaid 	<ul style="list-style-type: none"> Medicaid P4P program 	Administrative <ul style="list-style-type: none"> Claim/encounter data

Codes

The following codes can be used to close numerator gaps in care for the screening part of the measure; they are not intended to be a directive of your billing practice.

Application of Fluoride Varnish	
CDT	D1206
CPT	99188
SNOMED	313042009

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

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Chlamydia Screening (CHL)

New for 2026

Removed

- Removed all SNOMED codes from Chlamydia screening test



Yes!
Supplemental
data accepted

Definition

Percentage of members recommended for routine Chlamydia screening ages 16–24 who were identified as sexually active and had at least 1 test to screen for chlamydia during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Chlamydia screening test	
CPT®/CPT II	87110, 87270, 87320, 87490, 87491, 87492, 87810
LOINC	14463-4, 14464-2, 14465-9, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 34710-4, 42931-6, 43304-5, 43404-3, 44806-8, 44807-6, 45068-4, 45069-2, 45072-6, 45073-4, 45075-9, 45084-1, 45089-0, 45090-8, 45091-6, 45093-2, 45095-7, 4993-2, 50387-0, 53925-4, 53926-2, 57287-5, 6353-7, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 80363-5, 80364-3, 80365-0, 80367-6, 82306-2, 87949-4, 87950-2, 88221-7, 89648-0, 91860-7, 91873-0

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Chlamydia Screening (CHL) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> Members with sex assigned at birth (LOINC code 76689-9) of male (LOINC code LA2-8) 	Any time in the member's history through Dec. 31 of the measurement year



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
Test must be performed within the measurement year	Chlamydia screening test	<ul style="list-style-type: none"> Consultation reports Health history and physical Lab reports

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Chlamydia Screening (CHL) (cont.)

Tips and best practices to help close this care opportunity

- Chlamydia screening may not be captured via claims if the service is performed and billed under prenatal and postpartum global billing. Chlamydia screening can be captured as supplemental lab data using our Data Exchange Program.
- The Centers for Disease Control and Prevention recommends self-obtained vaginal specimens for asymptomatic members
- Self-obtained vaginal specimens are cleared by the U.S. Food & Drug Administration (FDA) for collection in a clinical setting
- Additional information on chlamydia screening is available at brightfutures.aap.org
- In assessing sexually active members recommended for Chlamydia screening ages 16-24 years, consider standard orders for chlamydia urine testing as part of the office visit
- According to the American Academy of Pediatrics (AAP), pediatric patients should be assessed for risk of chlamydia infection
- Lab results for chlamydia screening can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Events that may qualify "persons as recommended for routine chlamydia screening" include:
 - Diagnoses or procedures indicative of sexual activity
 - Pregnancy test values
 - Contraceptive medications

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Chlamydia Screening (CHL) (cont.)

Additional measure resources

<ul style="list-style-type: none"> • Chlamydia and Gonorrhea: Screening United States Preventive Services Taskforce 	<p>Recommendation summary for screening for chlamydia in all sexually active women 24 years or younger.</p>
<ul style="list-style-type: none"> • Bright Futures Medical Screening Reference Tables 	<p>Adolescence Medical Screening Reference (MSR) Tables provides guidelines for health supervision of adolescents for well-child visits related to relevant history, risk assessment questions, and follow-up actions as appropriate.</p>
<ul style="list-style-type: none"> • CDC Sexually transmitted disease surveillance • CDC STI Screening Recommendations • CDC Chlamydial Infections - STI Treatment Guidelines 	<p>Screening recommendations and considerations on the CDC website. Evidence based information in support of self-collection screening in asymptomatic patients.</p>
<ul style="list-style-type: none"> • Medical-Care-of-Trans-and-Gender-Diverse-Adults Fenway Health • Standards of Care for the Health of Transgender and Gender Diverse People International Journal of Transgender Health 	<p>For information on medical care of trans and gender diverse adults related to chlamydia screening.</p>

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Osteoporosis Management in Women Who Had a Fracture (OMW)

New for 2026

- No applicable changes to this measure



Yes!
Supplemental data accepted

Definition

Percentage of women ages 67–85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within 6 months of the fracture (does not include fractures to the finger, toe, face or skull).

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	Administrative <ul style="list-style-type: none"> • Claim/encounter data • Pharmacy data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Bone mineral density tests	
CPT®/CPT II	76977, 77078, 77080, 77081, 77085, 77086
ICD-10 Procedure	BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BROGZZ1
LOINC	100225-2, 38268-9, 38269-7, 83012-5, 83013-3, 83014-1, 83051-3, 101804-3, 101805-0, 104938-6, 24701-5, 24890-6, 24966-4, 38261-4, 38262-2, 38263-0, 38264-8, 38265-5, 38266-3, 38267-1, 46278-8, 46279-6, 46383-6, 80932-7, 80933-5, 80934-3, 80935-0, 80936-8, 80937-6, 80938-4, 80939-2, 80940-0, 80941-8, 80942-6, 80943-4, 80944-2, 80945-9, 80946-7, 80947-5, 80948-3, 80949-1, 80950-9, 80951-7, 80952-5, 80953-3, 80954-1, 80955-8, 80956-6, 85385-3, 85386-1, 85387-9, 85388-7, 85389-5, 85390-3, 85391-1, 85392-9, 85393-7, 85394-5

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Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Osteoporosis medication therapy

HCPCS | J0897, J1740, J3110, J3111, J3489, Q5136, Q5157, Q5158, Q5159

Long-acting osteoporosis medications (during inpatient stay only)

HCPCS | J0897, J1740, J3489, Q5136, Q5157, Q5158, Q5159

Dispensed at least 1 of the following osteoporosis medications within 180 days of their discharge for a fracture:

Drug category	Medications
Bisphosphonates	<ul style="list-style-type: none"> • Alendronate • Alendronate-cholecalciferol • Ibandronate • Risedronate • Zoledronic acid
Other agents	<ul style="list-style-type: none"> • Abaloparatide • Denosumab • Raloxifene • Romosozumab • Teriparatide

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Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
Members receiving palliative care	During the intake period through the end of the measurement year
Members ages 81 and older as of Dec. 31 of the measurement year who had at least 2 diagnoses of frailty*	Frailty diagnoses must be on different dates of service during the intake period through last day of the measurement year
<ul style="list-style-type: none"> Members ages 67–80 as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> – Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). – Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication donepezil, donepezil-memantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be on 2 different dates of service during the intake period through the end of the measurement year Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
Medicare members ages 67 and older as of Dec. 31 of the measurement year who are either: <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution* 	Intake period through the last day of the measurement period

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Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> BMD test must take place within 6 months of the fracture If the fracture resulted in an inpatient stay, a BMD test administered during the stay will close the care opportunity 	BMD test	<ul style="list-style-type: none"> Medication list Progress notes
<ul style="list-style-type: none"> Osteoporosis medication must be dispensed within 6 months of the fracture Documentation that the medications aren't tolerated is <u>not</u> an exclusion for this measure 	Osteoporosis medications identified through pharmacy data	

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Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Tips and best practices to help close this care opportunity

- The post-fracture treatment period to close this care opportunity is only 6 months. Please see members for an office visit as soon as possible after an event occurs.
- Osteoporosis medication must be filled using a member's Part D prescription drug benefit
- Osteoporosis therapies are captured through medical claims
- To help prevent women from being included in this measure incorrectly, please check that fracture codes are used appropriately – and not before a fracture has been verified through diagnostic imaging. If a fracture code was submitted in error, please submit a corrected claim to fix the misdiagnosis and remove the member from this measure.
- A referral for a BMD will **not** close this care opportunity
- Women at risk for osteoporosis should be prescribed a bone density screening every 2 years. At-risk women include those who are:
 - At increased risk for falls or have a history of falls
 - Being monitored to assess their response to, or efficacy of, a Federal Drug Administration (FDA) -approved osteoporosis drug therapy regime
 - Diagnosed with primary hyperparathyroidism
 - Estrogen deficient
 - On long-term steroid therapy
- Bone density screening is a covered benefit for most benefit plans
- Best practice is to schedule a BMD at a time it is recommended and ordered, prior to the member leaving the clinic
- Bone mineral density testing codes can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)

Example

Fracture date: March 2, 2026

Important note: The index episode start date (IESD) is the date you begin counting for the appropriate testing or treatment – IESD plus 180 days.

Scenario 1: Inpatient hospital stay with no direct transfer

Admission date: March 2, 2026

Discharge date with no direct transfer: March 4, 2026, IESD

Scenario 2: Inpatient hospital stay with direct transfer

Admission date to second facility: March 3, 2026

Discharge date from second facility: March 8, 2026, IESD

Scenario 3: Outpatient or observation/emergency department (ED) visit

Visit date: March 6, 2026, IESD

Important note: This scenario assumes the member didn't go to a hospital on the day of their fall and/or wasn't admitted for inpatient stay.

Fracture date: March 2, 2026				
Fracture diagnosis setting	IESD	Bone mineral density test	Osteoporosis therapy	Dispensed Rx to treat osteoporosis
Scenario 1: Inpatient hospital stay with no direct transfer	Discharge date: March 4, 2026	During inpatient stay: March 2-4, 2026 On IESD or within 180 days after IESD: March 4-Aug. 31, 2026	During inpatient stay: March 2-4, 2026 (long-acting osteoporosis medications only)	On IESD or within 180 days after IESD: March 4-Aug. 31, 2026

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Osteoporosis Management in Women Who Had a Fracture (OMW) (cont.)


Fracture date: March 2, 2026				
Fracture diagnosis setting	IESD	Bone mineral density test	Osteoporosis therapy	Dispensed Rx to treat osteoporosis
Scenario 2: Inpatient hospital stay with direct transfer	Discharge date from second facility: March 8, 2026	During inpatient stay: March 2–8, 2026 On IESD or within 180 days after IESD: March 8–Sept. 4, 2026	During inpatient stay: March 2–8, 2026 (long-acting osteoporosis medications only)	On IESD or within 180 days after IESD: March 8–Sept. 4, 2026
Scenario 3: Outpatient or observation/ED visit	Visit date: March 6, 2026	On IESD or within 180 days after IESD: March 6–Sept. 2, 2026	On IESD or within 180 days after IESD: March 6–Sept. 2, 2026	On IESD or within 180 days after IESD: March 6–Sept. 2, 2026

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Prenatal and Postpartum Care (PPC)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

Percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. The measure includes the following 2 indicators:

- Timeliness of prenatal care – Percentage of women who had a live birth who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in a UnitedHealthcare health plan
- Postpartum care – Percentage of women who had a live birth who had a postpartum visit on or between 7–84 days after delivery

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings 	<p>Hybrid</p> <ul style="list-style-type: none"> • Claim/encounter data • Medical record documentation

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Prenatal bundled services	
CPT®/CPT II	59400, 59425, 59426, 59510, 59610, 59618
HCPCS	H1005

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Prenatal and Postpartum Care (PPC)

Stand-alone prenatal visits

CPT®/CPT II	99500, 0500F, 0501F, 0502F
HCPCS	H1000, H1001, H1002, H1003, H1004
SNOMED	169712008, 169713003, 169714009, 169715005, 169716006, 169717002, 169718007, 169719004, 169720005, 169721009, 169722002, 169723007, 169724001, 169725000, 169726004, 169727008, 424525001, 409010002, 169602005, 169603000, 169600002, 135892000, 713076009, 702396006, 386235000, 171058001, 440309009, 441839001, 440227005, 439165004, 440670004, 440047008, 440638004, 439908001, 440671000, 440536005, 440669000, 439733009, 439816006, 386322007, 58932009, 397931005, 406145006, 700256000, 171061000, 171060004, 171062007, 171064008, 66961001, 171057006, 171059009, 171054004, 171056002, 171063002, 171055003, 710970004, 17629007, 422808006, 18114009, 424441002, 424619006, 134435003, 702738006, 713386003, 702741002, 702743004, 702744005, 702742009, 713387007, 702737001, 713238008, 713235006, 713237003, 702736005, 713241004, 713234005, 702739003, 713233004, 702740001, 713239000, 713240003, 713242006, 717794008, 717795009

Prenatal visits with diagnosis of pregnancy

CPT®/CPT II	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483, 98979, 99470
HCPCS	G0463, T1015, G0071, G2010, G2012, G2250, G2251, G2252, G0544
SNOMED	77406008, 281036007, 185317003, 314849005, 386472008, 386473003, 401267002

Postpartum bundled services

CPT®/CPT II	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
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Prenatal and Postpartum Care (PPC) (cont.)

Postpartum care

CPT®/CPT II	57170, 58300, 59430, 99501, 0503F
HCPCS	G0101
SNOMED	408884008, 408883002, 408886005, 133907004, 384635005, 440085006, 431868002, 384636006, 169770008, 169771007, 169772000, 384634009, 169762003, 133906008, 409018009, 409019001, 717810008

Encounter for postpartum care

ICD-10 Diagnosis	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
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Cervical cytology

CPT®/CPT II	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001
LOINC	10524-7, 18500-9, 19762-4, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5, 104866-9
SNOMED	1155766001, 168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 62051000119105, 62061000119107, 700399008, 700400001, 98791000119102

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Prenatal and Postpartum Care (PPC) (cont.)

Acceptable provider types to render prenatal care services

- OB-GYN
- Physician

Any of the following who deliver prenatal care services under the direction of an OB-GYN or certified provider:

- Certified Nurse Midwife (CNM)
- Nurse Practitioner (NP)
- Physician’s Assistant (PA)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> • Pregnancy didn’t result in a live birth • Member wasn’t pregnant • Delivery wasn’t in date parameters 	Oct. 8 of the year prior to the measurement year through Oct. 7 of the measurement year

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Prenatal and Postpartum Care (PPC) (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • Prenatal care visit must take place in the first trimester, on or before the enrollment start date or within 42 days of enrollment with the health plan • First trimester is defined as 280-176 days prior to delivery/EDD • For prenatal visits with a primary care provider, a diagnosis of pregnancy must be included with any of the tests listed to the right • A Pap test does not count as a prenatal care visit and a colposcopy alone does not meet numerator compliance for prenatal 	<p>Prenatal care visit with an OB-GYN or prenatal care provider, which must include 1 of the following:</p> <ul style="list-style-type: none"> • A diagnosis of pregnancy or noted positive pregnancy test result • Auscultation for fetal heart tone • Documentation in a standard prenatal flowsheet • Documentation of last menstrual period (LMP), estimated date of delivery (EDD) or gestational age • Gravidity or parity • Complete obstetrical history • Prenatal risk assessment and counseling/education • Fundal height • Obstetric panel • Pelvic exam with obstetric observations • Prenatal lab results including hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing Rubella antibody test/ titer with an Rh incompatibility (ABO/ Rh) blood typing • TORCH antibody panel • Ultrasound of pregnant uterus 	<ul style="list-style-type: none"> • Consultation reports • Diagnostic reports <ul style="list-style-type: none"> - Lab result findings (cervical cytology) • Medical history • Prenatal flow sheets/ ACOG form • Progress notes • SOAP notes • Cervical cytology is indicative of pelvic exam and will close the postpartum care gap. • Documentation must have appropriate provider type signature; initials will not meet criteria.

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Prenatal and Postpartum Care (PPC) (cont.)



Important notes (cont.)

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
Documentation of care in an acute inpatient setting does not close the gap for postpartum care.	<p>Postpartum visit to an OB-GYN or other prenatal care provider, or PCP, which must include 1 of the following:</p> <ul style="list-style-type: none"> • Assessment of breasts or breast feeding, weight, blood pressure check and abdomen • Notation of postpartum care • Perineal or cesarean incision/wound check • Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders • Pelvic exam • Glucose screening for women with gestational diabetes • Documentation of infant care or breastfeeding • Documentation of resumption of intercourse, birth spacing or family planning • Documentation of sleep/fatigue • Documentation of resumption of physical activity or attainment of healthy weight 	<ul style="list-style-type: none"> • Consultation reports • Diagnostic reports • Hospital delivery report • Medical history • Prenatal flow sheets/ ACOG form • Progress notes • SOAP notes

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Prenatal and Postpartum Care (PPC) (cont.)

Tips and best practices to help close this care opportunity

- **When submitting a claim for bundled maternity services**, it is important to also submit separate claims for the pregnancy diagnosis office visit and postpartum visit with appropriate CPT® Category II Codes
 - Prenatal care: When submitting claim for initial pregnancy diagnosis visit (e.g., urine test, ultrasound), always include CPT® Category II 0500F as a no charge line item.
 - Postpartum care: When submitting claim for first office postpartum visit, always include CPT(R) Category II 0503F as a no charge line item
 - If your electronic medical record (EMR) system allows macros that auto-populate CPT® Category II Codes when submitting a claim for diagnostic tests (e.g., pregnancy urine test, ultrasound), please **add 0500F (prenatal) when individual E/M codes are used**
- Ultrasound and lab results alone aren't considered a visit. They must be linked to an office visit with an appropriate practitioner to count for this measure.
- A Pap test alone doesn't count as a prenatal care visit, but will count toward postpartum care as a pelvic exam
- A visit with a registered nurse will **not** meet compliance. See acceptable provider types above.
- When the prenatal care visit is with a PCP, the claim must include the prenatal visit, and a diagnosis of pregnancy
- The CDC, American College of Obstetricians and Gynecologists, American College of Nurse Midwives and American Academy of Family Physicians all recommend that pregnant women receive the following immunizations:
 - A flu shot during any trimester of their pregnancy to protect themselves and their newborn babies from flu
 - 1 dose of Tdap every pregnancy, preferably during early part of gestational weeks 27–36
 - Visit [cdc.gov/vaccines/pregnancy](https://www.cdc.gov/vaccines/pregnancy) for patient and provider resources

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Prenatal and Postpartum Care (PPC) (cont.)

- The American College of Obstetricians and Gynecologists (ACOG) recommends implementation of the following clinical workflows:
 - Screen patients for depression/anxiety at least once during the prenatal and postpartum visit, with additional frequency for higher risk women
 - Use a screening tool validated for use during pregnancy and the postpartum period to measure the level of risk, (i.e., Edinburgh Postnatal Depression Scale (EPDS) or Patient Health Questionnaire 9)
 - Train all care team members on the importance of depression screening and follow-up care
 - Establish a system to ensure follow-up for diagnosis and treatment for positive screenings
- Prenatal and postpartum codes can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Services provided during a telephone visit or online assessment (e-visit/virtual check-in) will meet the criteria for numerator compliance
- Provide education to members on importance of prenatal and postpartum care for them and their baby
- Identify members with ER visits who have a diagnosis of pregnancy and initiate timely follow-up
- Assess and address potential barriers to receiving care when pregnancy is confirmed
- Provide close monitoring and initiate relevant referrals for members who have had substance abuse or mental health diagnosis
- Ensure available appointments exist to allow for timely scheduling of members during their first trimester or postpartum period
- For members who do not show or schedule appointments, attempt to engage using a telephone or video visit to close the care gap

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Prenatal and Postpartum Care (PPC) (cont.)

Additional measure resources

<ul style="list-style-type: none"> NIH Prenatal Care NIH Postpartum Care of the New Mother - StatPearls - NCBI Bookshelf 	<p>Information on the importance of prenatal and postpartum care as emphasized by the National Institutes of Health (NIH).</p>
<ul style="list-style-type: none"> Tailored Prenatal Care Delivery for Pregnant Individuals ACOG Optimizing Postpartum Care ACOG 	<p>Evidence-based information from ACOG. Clinical consensus in support of early and timely prenatal care in addition to timely postpartum care following delivery. Recommendations on clinical workflows during prenatal and postpartum care visits for depression screening and follow-up.</p>
<ul style="list-style-type: none"> CPT Category II codes quick reference guide UHC 	<p>When submitting a claim for bundled maternity services, it is important to also submit separate claims for the pregnancy diagnosis office visit and postpartum visit with appropriate CPT® Category II Codes as a no charge line item. If your EMR system allows macros that auto-populate CPT II codes when submitting a claim for diagnostic tests (e.g., pregnancy urine test, ultrasound), it is important to add 0500F (prenatal) when individual E/M codes are used.</p>
<ul style="list-style-type: none"> Pregnancy and Vaccination Pregnancy & Vaccines CDC 	<p>Recommended vaccinations for women during pregnancy.</p>

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Blood Pressure Control for Patients With Diabetes (BPD and BPD-E)

 This measure is also an ECDS measure

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

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

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings • NCQA Health Plan Ratings 	<p>Hybrid</p> <ul style="list-style-type: none"> • Claim/encounter data • Medical record documentation

Codes

The following codes can be used to submit outcome results for this measure; they are not intended to be a directive of your billing practice.

Systolic blood pressure levels 130-139 mmHg

CPT®/CPT II | 3075F

Systolic blood pressure level <130 mmHg

CPT®/CPT II | 3074F

Systolic blood pressure level >=140 mmHg

CPT®/CPT II | 3077F

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Blood Pressure Control for Patients With Diabetes (BPD) (cont.)

Diastolic blood pressure level 80-89 mmHg	
CPT®/CPT II	3079F
Diastolic blood pressure level <80 mmHg	
CPT®/CPT II	3078F
Diastolic blood pressure level >/=90 mmHg	
CPT®/CPT II	3080F

***Please continue to code using CPT II codes for a blood pressure reading including a diastolic >90 and systolic >140, as it is important for tracking and addressing quality of care and health outcomes.**

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Blood Pressure Control for Patients With Diabetes (BPD) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members receiving palliative care Members who died 	<p>Any time during the measurement year</p>
<ul style="list-style-type: none"> Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> Frailty: At least 2 indications of frailty with different dates of service during the measurement year. Laboratory claims should not be used. Advanced Illness: Either of the following during the measurement year or the year prior to the measurement year: <ul style="list-style-type: none"> Advanced illness on at least 2 different dates of service. Laboratory claims should not be used. Dispensed dementia medication Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be in the measurement year on 2 different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<p>Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:</p> <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution 	<p>Any time during the measurement year</p>

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Blood Pressure Control for Patients With Diabetes (BPD) (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • BP reading must be performed within the measurement year – most recent BP result of the year is the one measured • BP readings taken on the same day the member receives a common low-intensity or preventive procedure can be used. Examples include, but aren't limited to: <ul style="list-style-type: none"> - Eye exam with dilating agents - Injections (e.g., allergy, Depo-Provera,® insulin, lidocaine, steroid, testosterone toradol or vitamin B-12) - Intrauterine device (IUD) insertion - Tuberculosis (TB) test - Vaccinations - Wart or mole removal 	<p>BP reading taken or reported and recorded during the measurement year via outpatient visits, telephone or telehealth visits, e-visits, virtual check-ins or non-acute inpatient visits.</p>	<ul style="list-style-type: none"> • Consultation reports • Diabetic flow sheets • Progress notes • Vitals sheet

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Blood Pressure Control for Patients With Diabetes (BPD) (cont.)



Important Notes (cont.)

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • BP readings taken in the following situations will not count toward compliance: <ul style="list-style-type: none"> - During an acute inpatient stay or an emergency department visit - On the same day as a diagnostic test, or diagnostic or therapeutic procedure that requires a change in diet or medication on or 1 day before the day of the test or procedure with the exception of a fasting blood test. Examples include, but are not limited to: <ul style="list-style-type: none"> • Colonoscopy • Dialysis, infusions and chemotherapy • Nebulizer treatment with albuterol • If the retrieval method is not mentioned (i.e., manual/digital), assume the method was digital and is acceptable 	<p>BP reading taken during the measurement year via:</p> <ul style="list-style-type: none"> - Outpatient visits - Telephone or telehealth visits - Virtual check-ins or e-visits - Non-acute inpatient visits <p>Member reported BP readings must be taken with a digital device, in any of these visit settings and documented in member's medical record. Does not require documentation that it was taken with a digital device.</p> <p>Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an average BP (e.g., average BP: 139/70) is eligible for use.</p> <p>Documentation of 'average BP' will meet the intent of the measure.</p> <p>If multiple BPs were taken on the same day, the lowest systolic and the lowest diastolic should represent the BP result for the date of service.</p>	<ul style="list-style-type: none"> • Consultation reports • Diabetic flow sheets • Progress notes • Vitals sheet

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Blood Pressure Control for Patients With Diabetes (BPD) (cont.)

Tips and best practices to help close this care opportunity

- **Always list the date of service and BP reading together**
 - If BP is listed on the vital flow sheet, it must have a date of service
- Members who have an elevated BP during an office visit in August, September or October should be brought back in for a follow-up visit before Dec. 31
- Talk with members about what a lower goal is for a healthy BP reading
 - For example: 130/80 mmHg
- Remind members who are NPO for a fasting lab they should continue to take their anti-hypertensive medications with a sip of water on the morning of their appointment
- If your office uses manual blood pressure cuffs, don't round up the BP reading
 - For example: 138/89 mmHg rounded to 140/90 mmHg
- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. Retake the member's BP after they've had time to rest.
 - For example: **If a member's first BP reading was 160/80 mmHg and the second reading was 120/90 mmHg, use the 120 systolic of the second reading and the 80 diastolic of the first reading to show a BP result of 120/80 mmHg**
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some chart review.
 - Adding CPT II modifier codes to a claim may result in the gap not closing
- BP readings can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Controlling High Blood Pressure (CBP)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
data accepted

Definition

Percentage of members ages 18–85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled at **<140/90 mmHg** during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Quality Rating System • CMS Star Ratings • NCQA Health Plan Ratings 	<p>Hybrid</p> <ul style="list-style-type: none"> • Claim/encounter data • Medical record documentation • Pharmacy data

Codes

The following codes can be used to submit outcome results for this measure; they are not intended to be a directive of your billing practice.

Systolic blood pressure levels 130-139 mm Hg	
CPT®/CPT II	3075F
Systolic blood pressure level <130 mmHg	
CPT®/CPT II	3074F
Systolic blood pressure level ≥140 mmHg	
CPT®/CPT II	3077F

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Controlling High Blood Pressure (CBP) (cont.)

Diastolic blood pressure level 80-89 mmHg

CPT®/CPT II	3079F
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Diastolic blood pressure level <80 mmHg

CPT®/CPT II	3078F
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Diastolic blood pressure level \geq 90 mmHg

CPT®/CPT II	3080F
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***Please continue to code using CPT II codes for a blood pressure reading including a diastolic \geq 90 and systolic \geq 140, as it is important for tracking and addressing quality of care and health outcomes.**

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Controlling High Blood Pressure (CBP) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members receiving palliative care Members who died Members with a diagnosis of pregnancy 	<p>Any time during the measurement year</p>
<p>Members ages 81 and older as of Dec.31 of the measurement year who had at least 2 diagnoses of frailty on different dates of service</p>	<p>Frailty diagnoses must be in the measurement year on different dates of service</p>
<p>Members 66-80 years of age as of Dec.31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion:</p> <ul style="list-style-type: none"> - Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). - Advanced illness: Indicated by 1 of the following: <ul style="list-style-type: none"> o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication: Donepezil, Donepezilmemantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> • Frailty diagnoses must be in the measurement year on different dates of service • Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<p>Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:</p> <ul style="list-style-type: none"> • Enrolled in an Institutional Special Needs Plan (I-SNP) • Living long term in an institution* 	<p>Any time during the measurement year on or before Dec. 31 of the measurement year</p>

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Controlling High Blood Pressure (CBP) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none">• Dialysis• End-stage renal disease (ESRD)• Kidney transplant• Nephrectomy	On or before Dec. 31 of the measurement year

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Controlling High Blood Pressure (CBP) (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • BP reading must be on or after the second hypertension diagnosis and must be the most recent blood pressure value performed within the measurement year • BP readings taken on the same day the member receives a common low-intensity or preventive procedure can be used. Examples include, but aren't limited to: <ul style="list-style-type: none"> - Eye exam with dilating agents - Injections (e.g., allergy, Depo-Provera®, insulin, lidocaine, steroid, testosterone toradol or vitamin B-12) - Intrauterine device (IUD) insertion - Tuberculosis (TB) test - Vaccinations - Wart or mole removal 	<ul style="list-style-type: none"> • BP reading taken during the measurement year via: <ul style="list-style-type: none"> - Outpatient visits - Telephone or telehealth visits - Virtual check-ins or e-visits - Non-acute inpatient visits • Member reported BP readings must be taken with a digital device and documented appropriately with the BP value (systolic and diastolic) and date of the BP reading in the member's medical record" • Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an average BP (e.g., average BP: 139/70) is eligible for use. • If multiple BPs were taken on the same day, the lowest systolic and the lowest diastolic should represent the BP result for the date of service 	<ul style="list-style-type: none"> • Consultation reports • Progress notes • Medical history • SOAP notes • Vitals sheet • CPT II codes on claims (preferred)

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Controlling High Blood Pressure (CBP) (cont.)



Important Notes (cont.)

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • BP readings taken in the following situations will <u>not</u> count toward compliance: <ul style="list-style-type: none"> - During an acute inpatient stay or an emergency department visit - On the same day as a diagnostic test, or diagnostic or therapeutic procedure that requires a change in diet or medication on or 1 day before the day of the test or procedure - with the exception of a fasting blood test. Examples include, but are not limited to: <ul style="list-style-type: none"> o Colonoscopy o Dialysis, infusions and chemotherapy o Nebulizer treatment with albuterol • If the retrieval method is not mentioned (i.e., manual/digital), assume the method was digital and is acceptable 		<ul style="list-style-type: none"> • Consultation reports • Progress notes • Medical history • SOAP notes • Vitals sheet

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Controlling High Blood Pressure (CBP) (cont.)

Tips and best practices to help close this care opportunity

- For additional resources on Blood Pressure rechecks, go to [UHCprovider.com](https://uhcprovider.com) > Resource Library > Healthcare Professional Education and Training > Clinical Tools
- It is important to document patient reported vitals in the official medical record when conducting telehealth, telephone or online assessment visits. Please encourage patients to use a digital device to track and report their BP during every visit.
- **Always list the date of service and BP reading together**
 - If BP is listed on the vital flow sheet, it must have a date of service
- It's critical to follow up with a member for a BP check after their initial diagnosis. Schedule member's follow-up visit prior to discharging from clinic.
 - Members who have an elevated BP during an office visit in August, September or October should be brought back in for a follow-up visit before Dec. 31
- Talk with members about what a lower goal BP reading is
 - For example: 130/80 mmHg
- Remind members who are NPO for a fasting lab they should continue to take their anti-hypertensive medications with a sip of water on the morning of their appointment
- If your office uses manual blood pressure cuffs, don't round up the BP reading
 - For example: 138/89 mmHg rounded to 140/90 mmHg
- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. Retake the member's BP after they've had time to rest.
 - For example: If a member's first BP reading was 160/80 mmHg and the second reading was 120/90 mmHg, use the 120 systolic of the second reading and the 80 diastolic of the first reading to show a BP result of 120/80 mmHg
 - Place a BP recheck reminder at exam room to recheck blood pressure if initial blood pressure was 140/90 or higher
- If member is seeing cardiologist for their hypertension please coordinate with the cardiologist to send all records to primary care provider's office.
- If a member is new to your office, please get their medical record from their previous care provider to properly document the transfer of care
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract

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Controlling High Blood Pressure (CBP) (cont.)


- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as systolic and diastolic BP readings. It can also reduce the need for some chart review.
- Recommendation is to submit blood pressures after each visit. Do not wait until end of year.
- BP readings can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Eye Exam for Patients With Diabetes (EED)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had a retinal eye exam.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings • CMS Quality Rating System • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data • Pharmacy data

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Eye Exam for Patients With Diabetes (EED) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice

Scenario 1: Eye exam with or without evidence of retinopathy billed by any provider type during the measurement year OR eye exam without evidence of retinopathy during prior year billed by any provider type

Diabetic eye exam without evidence of retinopathy

CPT®/CPT II	2023F, 2025F, 2033F
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Diabetic eye exam with evidence of retinopathy

CPT®/CPT II	2022F, 2024F, 2026F
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Scenario 2: Autonomous eye exam billed by any provider type during the measurement year

Autonomous eye exam (imaging of retina)

CPTR/CPT II	92229
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LOINC	105914-6 (with a result), LA34398-0, LA34399-8
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Scenario 3: Retinal imaging by a qualified reading center, billed by any provider type during the measurement year

Retinal imaging

CPT®/CPT II	92227, 92228
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SNOMED	3047001, 20067007, 314971001, 1363538008
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Scenario 4: Diabetic retinal screening negative in year prior, billed by any provider type

Diabetic retinal screening

CPT®/CPT II	3072F (do not include codes with a modifier)
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Eye Exam for Patients With Diabetes (EED) (cont.)

Scenario 5: Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider, or a combination that indicates one eye is enucleated and the other was examined

Left eye	Right eye
Retinal exam finding: Any level of retinopathy (LOINC code 71490-7) with diabetic retinopathy severity level (LOINC codes LA18644-7, LA18645-4, LA18643-9, LA18648-8, LA18646-2) during the measurement year	Retinal exam finding: Any level of retinopathy (LOINC code 71491-5) with diabetic retinopathy severity level (LOINC codes LA18644-7, LA18645-4, LA18643-9, LA18648-8, LA18646-2) during the measurement year
Retinal exam finding: No retinopathy (LOINC code 71490-7 with LOINC code LA18643-9) in the year prior to the measurement year	Retinal exam finding: No retinopathy (LOINC code 71491-5 with LOINC code LA18643-9) in the year prior to the measurement year
Enucleation: ICD-10-PCS code 08T1XZZ any time during the member's history through Dec. 31 of the measurement year	Enucleation: ICD-10-PCS code 08T0XZZ any time during the member's history through Dec. 31 of the measurement year

Scenario 6: Retinal eye exam billed by an eye care professional during the measurement year OR retinal eye exam billed by an eye care professional during the prior year with a diagnosis of diabetes without complications

Retinal eye exam	
CPT®/CPT II	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 92227, 92228
HCPCS	S0620, S0621, S3000
SNOMED	252780007, 252781006, 252782004, 252783009, 252784003, 252788000, 252789008, 252790004, 252846004, 274795007, 274798009, 308110009, 30842004, 314972008, 36844005, 391999003, 392005004, 410441007, 410450009, 410451008, 410452001, 410453006, 410455004, 416369006, 417587001, 420213007, 425816006, 427478009, 53524009, 56072006, 56204000, 6615001, 700070005, 722161008, 252785002, 252786001, 252787005, 1145354004, 1148602002
Diabetes mellitus without complications	
ICD-10 Diagnosis	E10.9, E11.9, E13.9
SNOMED	721111000124107, 721121000124104, 721201000124104, 31321000119102, 1481000119100, 111552007, 1217068008, 1217044000, 190412005, 1290118005, 313436004, 290002008, 443694000, 444073006, 444074000, 444110003, 445353002, 870528001, 164971000119101

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Eye Exam for Patients With Diabetes (EED) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members receiving palliative care • Members who died • Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: <ul style="list-style-type: none"> - Enrolled in an Institutional Special Needs Plan (I-SNP) - Living long term in an institution 	<p>Any time during the measurement year</p>
<ul style="list-style-type: none"> • Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> - Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). - Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication: Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> • Frailty diagnoses must be in the measurement year and on different dates of service • Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<ul style="list-style-type: none"> • Bilateral eye enucleation • Bilateral absence of eyes (SNOMED CT code 15665641000119103) 	<ul style="list-style-type: none"> • Any time during the member’s history through Dec. 31 of the measurement year

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Eye Exam for Patients With Diabetes (EED) (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • Members without retinopathy should have an eye exam every 2 years • Members with retinopathy should have an eye exam every year 	<ul style="list-style-type: none"> • Dilated or retinal eye exam • Fundus photography 	<ul style="list-style-type: none"> • Consultation reports • Diabetic flow sheets • Eye exam report • Progress notes

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Eye Exam for Patients With Diabetes (EED) (cont.)

Tips and best practices to help close this care opportunity

- **If documenting the history of a dilated eye exam in a member's chart and do not have the eye exam report from the eye care professional, always list the date of service, test, result and that retinopathy was assessed by an eye care professional**
 - For example: “Last diabetic eye exam with John Smith, OD, was June 2024 with no retinopathy”
- Documentation of a diabetic eye exam by an optometrist or ophthalmologist isn't specific enough to meet the criteria. The medical record must indicate that a **dilated or retinal exam** was performed. If the words “dilated” or “retinal” are missing in the medical record, a notation of “dilated drops used” and findings for macula and vessels will meet the criteria for a dilated exam.
- If history of a dilated retinal eye exam and result is in your progress notes, please ensure that a date of service, the test or result, and the care provider's credentials are documented. The care provider must be an optometrist or ophthalmologist, and including only the date of the progress note will not count.
- A slit-lamp examination will not meet the criteria for the dilated eye exam measure. There must be additional documentation of dilation or evidence that the retina was examined for a slit-lamp exam to be considered compliant
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results will be compliant.
 - Alternatively, results may be read by:
 - o A qualified reading center that operates under the direction of a medical director who is a retinal specialist
 - o A system that provides artificial intelligence (AI) interpretation
- If a copy of the fundus photography is included in your medical record it must include results, date and signature of the reading eye care professional for compliance
- To be reimbursable, billing of fundus photography code 92250 must be submitted globally by an optometrist or ophthalmologist and meet disease state criteria
- Documentation of hypertensive retinopathy should be considered the same as diabetic retinopathy
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract

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Eye Exam for Patients With Diabetes (EED) (cont.)


- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as diabetic retinal screening with an eye care professional. It can also reduce the need for some chart review.
 - Adding CPT II modifier codes to a claim may result in the gap not closing
- Dilated retinal eye exams with results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Glycemic Status Assessment for Patients With Diabetes (GSD)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

The percentage of members ages 18–75 of age with diabetes (Types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) showed their blood sugar is under control during the measurement year (adequate control is < 8.0%, poor control is > 9.0%).

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings • CMS Quality Rating System • NCQA Health Plan Ratings 	<p>Hybrid</p> <ul style="list-style-type: none"> • Automated lab data • Claim/encounter data • Medical record documentation

Codes

The following codes can be used to submit outcome results for this measure; they are not intended to be a directive of your billing practice.

HbA1c < 7.0%	
CPT®/CPT II	3044F
SNOMED	165679005
HbA1c ≥ 7.0% and < 8.0%	
CPT®/CPT II	3051F
HbA1c ≥ 8.0% and ≤ 9.0%	
CPT®/CPT II	3052F

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Glycemic Status Assessment for Patients With Diabetes (GSD) (cont.)

HbA1c > 9.0%

CPT®/CPT II	3046F
SNOMED	451061000124104

Glucose management indicator (GMI)

LOINC	97506-0
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Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members receiving palliative care Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). Advanced illness: Indicated by one of the following: <ul style="list-style-type: none"> At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). Dispensed dementia medication donepezil, donepezil-memantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be in the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<ul style="list-style-type: none"> Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution* 	Any time during the measurement year

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

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Glycemic Status Assessment for Patients With Diabetes (GSD) (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<p>HbA1c or glucose management indicator (GMI) test must be performed during the measurement year. If multiple tests were performed in the measurement year, the result from the last test is used.</p> <hr/> <p>Ranges and thresholds do not meet compliance.</p>	<ul style="list-style-type: none"> • A1c, HbA1c, HgbA1c • Glycohemoglobin • Glycohemoglobin A1c • Glycated hemoglobin • Glycosylated hemoglobin • HB1c • Hemoglobin A1c • Continuous glucose monitors (CGM) 	<ul style="list-style-type: none"> • Diabetic flow sheets • Consultation reports • Lab reports • Progress notes • Vitals sheet • Continuous glucose monitoring data

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Glycemic Status Assessment for Patients With Diabetes (GSD) (cont.)

Tips and best practices to help close this care opportunity


- **Always list the date of service, result and test together**
- Member-reported GMI results can be documented in the member's medical record and do not need to be collected by a PCP or specialist
- If test result(s) are documented in the vitals section of your progress notes, please include the date of the blood draw with the result. The date of the progress notes will not count.
- Consider point of care A1c testing in the office setting, when applicable
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as HbA1c level. It can also reduce the need for some chart review.
- HbA1c tests and results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
 - Please remember to submit LOINCs for any point of care HbA1c tests done in addition to those completed at a lab or hospital facility

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Kidney Health Evaluation for Patients With Diabetes (KED)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

Percentage of members ages 18–85 with diabetes (Types 1 and 2) who had a kidney health evaluation in the measurement year. **Both** an eGFR and a uACR test are required on same or different dates of service.

- At least 1 estimated glomerular filtration rate (eGFR); AND
- At least 1 urine albumin-creatinine ratio (uACR) test identified by one of the following:
 - A quantitative urine albumin test AND a urine creatinine test (billed for service dates 4 days or less apart);OR
 - A uACR

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Quality Rating System • CMS Star Ratings • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

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Kidney Health Evaluation for Patients With Diabetes (KED) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Estimated glomerular filtration rate lab test

CPT®/CPT II	80047, 80048, 80050, 80053, 80069, 82565
LOINC	102097-3, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6

Quantitative urine albumin lab test

CPT®/CPT II	82043
LOINC	14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7, 100158-5

Urine creatinine lab test

CPT®/CPT II	82570
LOINC	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5

Urine albumin creatinine ratio test

LOINC	13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7
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Kidney Health Evaluation for Patients With Diabetes (KED) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members receiving palliative care Members age 81 years or older who had at least 2 frailty diagnoses on different dates of service Members who died 	<p>Any time during the measurement year</p>
<p>Members with evidence of ESRD or dialysis</p>	<p>Any time during the member’s history on or prior to Dec. 31 of the measurement year</p>
<ul style="list-style-type: none"> Members 66-80 years of age as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). Advanced illness: Indicated by 1 of the following: <ul style="list-style-type: none"> At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). Dispensed dementia medication Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be in the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<p>Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:</p> <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution* 	<p>Any time during the measurement year</p>

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

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Kidney Health Evaluation for Patients With Diabetes (KED) (cont.)

Tips and best practices to help close this care opportunity

- The American Diabetes Association (ADA) and National Kidney Foundation (NKF) guidelines recommend annual kidney health evaluation for patients with diabetes
- Advise members that some complications from diabetes may be asymptomatic. For example, kidney disease is asymptomatic in its earliest stages and routine testing and diagnoses may help prevent/delay some life-threatening complications.
- Create automatic flags in EHR to alert staff to know when members are due for screenings. Use EHR to send text reminders that labs are due. Educate and remind members of the importance and rationale behind having these labs completed annually.
- Provide education to members about the disease process to help increase health literacy and improve management of the health condition
- Foster a PCP-specialist collaboration to ensure labs are completed annually and to prevent duplicate labs or non-compliance
- Order and request labs to have members complete prior to appointment to allow results to be available for discussion on the day of the office visit
- Track and reach out to members who have missed appointments

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Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

New for 2026

Update

- Bendroflumethiazide-nadolol was removed from the Beta Blocker Medications list



Yes!
Supplemental data accepted

Definition

The percentage of members ages 18 and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for 6 months after discharge.

- Persistent beta-blocker treatment: At least 135 days during 180 days post discharge

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> Medicaid 	<ul style="list-style-type: none"> Select Medicaid state reporting 	Administrative <ul style="list-style-type: none"> Claim/encounter data Pharmacy data

Medications

To comply with this measure, a member must have completed a 135-day course of 1 of the following beta-blockers:

Drug category	Medications
Noncardioselective beta-blockers	<ul style="list-style-type: none"> Carvedilol Labetalol Nadolol Pindolol Propranolol Timolol Sotalol

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Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) (cont.)

Drug category	Medications			
Cardioselective beta-blockers	<ul style="list-style-type: none"> • Acebutolol • Atenolol 	<ul style="list-style-type: none"> • Betaxolol • Bisoprolol 	<ul style="list-style-type: none"> • Metoprolol • Nebivolol 	
Antihypertensive combinations	<ul style="list-style-type: none"> • Atenolol-chlorthalidone • Bisoprolol-hydrochlorothiazide 		<ul style="list-style-type: none"> • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol 	

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Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
<p>Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:</p> <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution Members ages 81 and older as of Dec. 31 of the measurement year had at least 2 diagnoses of frailty on different dates of service 	Any time on or between July 1 of the year prior to the measurement year through the end of the measurement year
<ul style="list-style-type: none"> Members ages 66–80 as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). Dispensed dementia medication donepezil, donepezil-memantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be any time on or between July 1 of the year prior to the measurement year through the end of the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<ul style="list-style-type: none"> Members with a diagnosis that indicates a contraindication to beta-blocker therapy Medication dispensing event indicative of a history of asthma (see list below) 	Any time during the member’s history through the end of their continuous enrollment period

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Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) (cont.)

Any of the following asthma medications dispensed during the member’s history through the end of their continuous enrollment period denote a history of asthma as a required exclusion:

Drug category	Medications	
Bronchodilator combinations	<ul style="list-style-type: none"> • Budesonide-formoterol • Fluticasone-vilanterol 	<ul style="list-style-type: none"> • Fluticasone-salmeterol • Formoterol-mometasone
Inhaled corticosteroids	<ul style="list-style-type: none"> • Beclomethasone • Budesonide • Ciclesonide 	<ul style="list-style-type: none"> • Flunisolide • Fluticasone • Mometasone

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Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) (cont.)

Tips and best practices to help close this care opportunity

- As an administrative measure, it's important to submit codes that reflect a member's history of any exclusion noted in the preceding chart
- If a member is new to your practice, you can submit the exclusion diagnoses through the initial visit claim
- If a member isn't new to your practice, but their chart has documented history of 1 of the exclusion diagnoses, you can submit the diagnosis codes on any visit claim
- At each office visit, please talk with your patients about compliance and/or barriers to taking their medications and encourage adherence
- Please review your patients' prescription refill patterns and reinforce education and reminders. Consider:
 - Which patients don't fill prescriptions, are always late to fill or quit refilling over time?
 - Which patients are already motivated to fill and refill, but may skip an occasional dose and simply need reminders?

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Acute Hospital Utilization (AHU)

New for 2026

- No applicable changes to this measure

Definition

For members ages 18 and older, the risk adjusted ratio of observed to expected acute inpatient and observation stay discharges during the measurement year. For Medicaid, report members ages 18-64 only.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter

Required exclusion(s)

Exclusion	Time frame
Members in hospice or using hospice services	Any time during the measurement year

Tips and best practices to help close this care opportunity

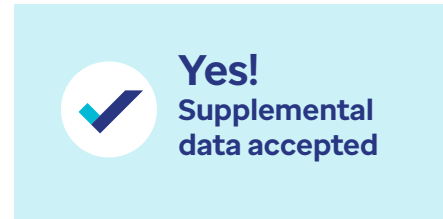
- Focus on chronic disease control with members, including regular care provider visits, to help prevent and minimize condition complications and exacerbations
- Encourage members to come in for annual wellness visits to promote early diagnosis of any conditions, and to help them complete preventive screenings and health promotion activities such as immunizations
- Educate members on personal safety such as wearing seat belts and avoiding falls, and lifestyle choices including diet, exercise, smoking and appropriate alcohol intake

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

New for 2026

- No applicable changes for this measure



Definition

Percentage of members ages 20 years and older who had an ambulatory or preventive care visit.

- For Medicaid and Medicare members: Visit must occur during the measurement year
- For commercial members: Visit must occur during the measurement year or 2 years prior to the measurement year

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • Select state reporting 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Ambulatory visits
<p>CPT®/CPT II</p> <p>92002, 92004, 92012, 92014, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99457, 99458, 98979, 99470</p>

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

Ambulatory Visits

HCPCS	G0438, G2252, G2012, G2251, T1015, G0463, G0402, G0071, G2250, G2010, S0621, S0620, G0544
ICD-10 Diagnosis	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.84, Z02.89, Z02.9, Z76.1, Z76.2
SNOMED	268565007, 699134002, 1269517007, 170254004, 170168000, 410630000, 783260003, 170132005, 401140000, 170141000, 170272005, 170250008, 170281004, 170150003, 170290006, 410625004, 410635005, 170159002, 1269518002, 170263002, 442162000, 170309003, 170300004, 170123008, 170107008, 410622001, 170114005, 243788004, 268563000, 713020001, 210098006, 712791009, 162655003, 207195004, 209099002, 19681004, 162651007, 18170008, 386472008, 314849005, 185317003, 386473003, 401267002, 410620009, 410642005, 410643000, 410629005, 410644006, 410645007, 410646008, 410631001, 410647004, 410648009, 410649001, 410632008, 410650001, 410624000, 410623006, 410633003, 410634009, 410626003, 410636006, 410637002, 410627007, 410638007, 410639004, 410640002, 410628002, 410641003, 281029006, 281031002
UBREV	0511,0983, 0521, 0517, 0523, 0510, 0520, 0522, 0514, 0519, 0529, 0982, 0515, 0513, 0516, 0526, 0525, 0524, 0528, 0527

Reason for Ambulatory Visit

ICD-10 Diagnosis	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.84, Z02.89, Z02.9, Z76.1, Z76.2
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Adults' Access to Preventive/Ambulatory Health Services (AAP) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

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Emergency Department Utilization (EDU)

New for 2026

- No applicable changes for this measure.

Definition

The risk-adjusted ratio of observed-to-expected emergency department (ED) visits for members ages 18 or older during the measurement year.

Member ED visits for the following reasons will **not** be included in the denominator:

- Electroconvulsive therapy
- Principal diagnosis of mental health or chemical dependency
- Psychiatry
- Result in an inpatient stay

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicare 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services 	Any time during the measurement year

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Emergency Department Utilization (EDU) (cont.)

Tips and best practices to help close this care opportunity

- Focus on chronic disease control with members, including regular care provider visits, to help prevent and minimize condition complications and exacerbations
- Encourage members to come in for annual wellness visits to promote early diagnosis of any conditions, and to help them complete preventive screenings and health promotion activities such as immunizations
- Educate members on personal safety such as wearing seat belts, avoiding falls and lifestyle choices including diet, exercise, smoking and appropriate alcohol intake

Talk with members about appropriate ED use and other options including:

- Asking for same-day appointments
- Calling your office's after-hours line
- Going to urgent care
- Trying telehealth
- Using their health plan's nurse line

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

New for 2026

- No applicable changes to this measure

Definition

Percentage of emergency department (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	Administrative <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 1: Outpatient and telehealth visits	
CPT®/CPT II	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 98979, 99470
HCPCS	G0439, G0438, G2252, G2012, G2251, T1015, G0463, G0402, G0071, G2250, G2010, G0544
SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 3391000175108, 185464004, 86013001, 439740005, 386472008, 314849005, 185317003, 386473003, 401267002, 185463005, 185465003

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

Scenario 1: Outpatient and telehealth visits

UBREV	0511, 0983, 0521, 0517, 0523, 0510, 0520, 0522, 0514, 0519, 0529, 0982, 0515, 0513, 0516, 0526, 0528, 0527
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Scenario 2: Transitional care management

CPT®/CPT II	99495, 99496
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Scenario 3: Case management visits

CPT®/CPT II	99366
HCPCS	T1016, T2022, T1017, T2023
SNOMED	386230005, 425604002, 416341003

Scenario 4: Complex care management

CPT®/CPT II	99439, 99487, 99489, 99490, 99491
HCPCS	G0506

Scenario 5: Outpatient or telehealth behavioral health visit

CPT®/CPT II	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231
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AND

Place of service code

Code	Location		
03	School	17	Walk-in retail health clinic
05	Indian Health Service free-standing facility	18	Place of employment - worksite
07	Tribal 638 free-standing facility	19	Off-campus outpatient hospital

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

Code	Location		
09	Prison/correctional facility	22	On-campus outpatient hospital
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	71	Public health clinic
16	emporary lodging	72	Rural health clinic
20	Urgent care facility		

Scenario 6: Outpatient or telehealth behavioral health visit

CPT®/CPT II	98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 99483, 98961, 98962, 98960, 99345, 99342, 99344, 99341, 99350, 99348, 99349, 99347, 99510, 99385, 99386, 99387, 99384, 99382, 99381, 99383, 99492, 99245, 99243, 99244, 99242, 99205, 99203, 99204, 99202, 99211, 99215, 99213, 99214, 99212, 99395, 99396, 99397, 99394, 99392, 99391, 99393, 99078, 99401, 99402, 99403, 99404, 99411, 99412, 99493
HCPCS	G0176, H0040, H0039, H0004, H0002, T1015, H0037, H0036, H2015, H2016, H2010, H2000, H2011, G0463, H0034, H0031, H2013, H2017, H2018, G0512, G0155, H2014, G0409, H2019, H2020, G0177, G0560
SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 391261003, 391257009, 391260002, 391225008, 391223001, 391224007, 3391000175108, 185464004, 86013001, 439740005, 391242002, 391237005, 391239008, 391233009, 185463005, 185465003
UBREV	0904, 0917, 0983, 0521, 0517, 0523, 0916, 0510, 0520, 0900, 0915, 0522, 0914, 0902, 0919, 0519, 0529, 0982, 0515, 0903, 0513, 0911, 0516, 0526, 0528, 0527

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

Scenario 7: Intensive outpatient encounter or partial hospitalization

CPT®/CPT II	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231
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AND

Place of service code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 8: Intensive outpatient encounter or partial hospitalization

HCPCS	H2012, S9485, S9484, G0410, S9480, G0411, H0035, S0201, H2001
SNOMED	305347001, 305345009, 305346005, 391048007, 391046006, 391047002, 391188004, 391187009, 391186000, 391185001, 391054008, 391038005, 391170007, 391153004, 391152009, 391150001, 391151002, 391195008, 391194007, 391191004, 391192006, 391211007, 391210008, 391209003, 391207001, 391208006, 391056005, 391133003, 391055009, 391256000, 391255001, 391252003, 391254002, 391042008, 391043003, 7133001, 391232004, 391228005, 391229002
UBREV	0905, 0907, 0912, 0913

Scenario 9: Community mental health center visit

CPT®/CPT II	90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231
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Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) (cont.)

AND

Place of service code

Code	Location
53	Community mental health center

Scenario 10:

Electroconvulsive therapy with any provider type and with appropriate place of service code

Electroconvulsive therapy

CPT®/CPT II	90870
ICD-10 Procedure	GZB0ZZZ, GZB2ZZZ, GZB4ZZZ
SNOMED	284468008, 23835007, 10470002, 313019002, 1010696002, 231079005, 231080008, 1010697006, 11075005, 313020008

AND

Place of service code

Code	Location
03	School
05	Indian Health Service free-standing facility
07	Tribal 638 free-standing facility
09	Prison/correctional facility
11	Office
12	Home
19	Off-campus outpatient hospital
20	Urgent care facility
22	On-campus outpatient hospital
24	Ambulatory surgical center
27	Outreach site/street
33	Custodial care facility
49	Independent clinic

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

Code	Location		
13	Assisted living facility	50	Federally qualified health center
14	Group home	52	Psychiatric facility - partial hospitalization
15	Mobile unit	53	Community mental health center
16	Temporary lodging	71	Public health clinic
17	Walk-in retail health clinic	72	Rural health clinic
18	Place of employment - worksite		

Scenario 11: Telehealth visit with any provider type and the appropriate place of service code

Visit setting unspecified

CPT®/CPT II

90847, 90853, 99238, 99239, 90875, 90876, 99223, 99222, 99221, 99255, 99253, 99254, 99252, 90849, 90791, 90792, 90845, 90840, 90839, 90832, 90833, 90834, 90836, 90837, 90838, 99233, 99232, 99231

AND

Place of service code

Code	Location
02	Telehealth
10	Telehealth

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

Scenario 12: Substance use disorder services

CPT®/CPT II	99408, 99409
HCPCS	H0001, H0022, H0050, H0007, H0005, H0015, H0016, H0047, H2036, H2035, G0396, G0397, T1006, T1012, G0443
SNOMED	827094004, 720175009, 707166002, 20093000, 720176005, 713127001, 370776007, 428211000124100, 711008001, 445662007, 774091000, 763302001, 450760003, 774090004, 445628007, 763104007, 704182008, 772813001, 865964007, 763233002, 87106005, 23915005, 182969009, 64297001, 67516001, 266707007, 792901003, 792902005, 310653000, 414054004, 414056002, 61480009, 720174008, 56876005, 720177001, 414283008, 414501008, 713107002, 713106006, 370854007, 415662004, 385989002, 386449006, 386450006, 386451005, 408934002, 408946003
UBREV	0906, 0944, 0945

Scenario 13: Substance abuse counseling and surveillance

ICD-10 Diagnosis	Z71.41, Z71.51 (do not include lab claims (claims with POS 81))
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Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in or using hospice services Members who died 	Any time during the measurement year

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

Tips and best practices to help close this care opportunity

- This measure focuses on follow up after an ED visit: See patients within 7 days
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge
- Please use Practice Assist, POCA or Reports to identify members with 2 or more eligible chronic conditions and history of ED visits; increase engagement with patients with multiple chronic conditions to avoid unnecessary ED visits
- Provide patients with alternative options to ED locations including urgent care, telehealth or in-person office visits
- Remind patients to schedule an office visit or telehealth follow-up within 7 days post ED visit as a way to ensure all patients are engaged
- Encourage the use of telehealth appointments when appropriate
- If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search liveandworkwell.com

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Initiation and Engagement of Substance Use Disorder Treatment (IET)

New for 2026

- No applicable changes to this measure

Definition

Percentage of new episodes of substance use disorder (SUD) that result in 1 or both of the following:

- Initiation of SUD treatment: Percentage of new SUD episodes that result in treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication treatment within 14 days of diagnosis
- Engagement of SUD treatment: Percentage of new SUD episodes that result in treatment within 34 days of initiation visit

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings - IET Engagement Only 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

All of the following scenarios must include a diagnosis of 1 of the below on the claim:

- Alcohol use disorder
- Opioid use disorder
- Other drug abuse and dependence

Acute or nonacute inpatient visit

For numerator compliance for engagement of treatment, at least 2 of the following scenarios must have been met on the day after the initiation encounter through 34 days after. Two engagement visits can be on the same date, but must be with different providers.

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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

Scenario 1 : Inpatient stay

UBREV	0101, 0100, 0207, 0116, 0126, 0136, 0146, 0156, 0110, 0120, 0130, 0140, 0150, 0160, 0170, 0190, 0200, 0210, 1000, 0213, 0214, 0206, 0202, 0111, 0121, 0131, 0141, 0151, 0211, 0171, 0172, 0173, 0174, 0122, 0132, 0142, 0152, 0112, 0117, 0127, 0137, 0147, 0157, 0119, 0129, 0139, 0149, 0159, 0169, 0219, 0209, 0179, 0199, 0113, 0123, 0133, 0143, 0153, 0203, 0114, 0124, 0134, 0144, 0154, 0204, 0212, 0118, 0128, 0138, 0148, 0158, 1002, 1001, 0167, 0164, 0191, 0192, 0193, 0194, 0201, 0208
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Scenario 2: Outpatient visits with outpatient place of service code(s)

CPT®/CPT II	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
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AND

Place of service code

Code	Location		
03	School	18	Place of employment - worksite
05	Indian Health Service free-standing facility	19	Off-campus outpatient hospital
07	Tribal 638 free-standing facility	20	Urgent care facility
09	Prison/correctional facility	22	On-campus outpatient hospital
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	71	Public health clinic
16	Temporary lodging	72	Rural health clinic
17	Walk-in retail health clinic		

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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

Scenario 3: Behavioral health outpatient visit

CPT®/CPT II	99483, 98961, 98962, 98960, 99345, 99342, 99344, 99341, 99350, 99348, 99349, 99347, 99510, 99385, 99386, 99387, 99384, 99382, 99381, 99383, 99492, 99245, 99243, 99244, 99242, 99205, 99203, 99204, 99202, 99211, 99215, 99213, 99214, 99212, 99395, 99396, 99397, 99394, 99392, 99391, 99393, 99078, 99401, 99402, 99403, 99404, 99411, 99412, 99493, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007
HCPCS	G0176, H0040, H0039, H0004, H0002, T1015, H0037, H0036, H2015, H2016, H2010, H2000, H2011, G0463, H0034, H0031, H2013, H2017, H2018, G0512, G0155, H2014, G0409, H2019, H2020, G0177, G0560
SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 391261003, 391257009, 391260002, 391225008, 391223001, 391224007, 3391000175108, 185464004, 86013001, 439740005, 391242002, 391237005, 391239008, 391233009, 185463005, 185465003
UBREV	0904, 0917, 0983, 0521, 0517, 0523, 0916, 0510, 0520, 0900, 0915, 0522, 0914, 0902, 0919, 0519, 0529, 0982, 0515, 0903, 0513, 0911, 0516, 0526, 0528, 0527

Scenario 4: Intensive outpatient encounter or partial hospitalization with partial hospitalization place of service code

CPT®/CPT II	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
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AND

Place of service code

Code	Location
52	Psychiatric facility - partial hospitalization

Scenario 5: Intensive outpatient encounter or partial hospitalization

HCPCS	H2012, S9485, S9484, G0410, S9480, G0411, H0035, S0201, H2001
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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

SNOMED	305347001, 305345009, 305346005, 391048007, 391046006, 391047002, 391188004, 391187009, 391186000, 391185001, 391054008, 391038005, 391170007, 391153004, 391152009, 391150001, 391151002, 391195008, 391194007, 391191004, 391192006, 391211007, 391210008, 391209003, 391207001, 391208006, 391056005, 391133003, 391055009, 391256000, 391255001, 391252003, 391254002, 391042008, 391043003, 7133001, 391232004, 391228005, 391229002
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UBREV	0905, 0907, 0912, 0913
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Scenario 6: Non-residential substance abuse treatment facility with non-residential substance abuse treatment facility place of service code

CPT®/CPT II	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
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AND

Code	Location
57	Non-residential substance abuse treatment facility
58	Non-residential opioid treatment facility

Scenario 7: Community mental health center visit with community mental health place of service code

CPT®/CPT II	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
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AND

Place of service code

Code	Location
53	Community mental health center

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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

Scenario 8: Telehealth visit with telehealth place of service code

CPT®/CPT II	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
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AND

Place of service code

Code	Location
02	Telehealth
10	Telehealth

Scenario 9: Substance use disorder services

CPT®/CPT II	99408, 99409
HCPCS	H0001, H0022, H0050, H0007, H0005, H0015, H0016, H0047, H2036, H2035, G0396, G0397, T1006, T1012, G0443
SNOMED	827094004, 720175009, 707166002, 20093000, 720176005, 713127001, 370776007, 428211000124100, 711008001, 445662007, 774091000, 763302001, 450760003, 774090004, 445628007, 763104007, 704182008, 772813001, 865964007, 763233002, 87106005, 23915005, 182969009, 64297001, 67516001, 266707007, 792901003, 792902005, 310653000, 414054004, 414056002, 61480009, 720174008, 56876005, 720177001, 414283008, 414501008, 713107002, 713106006, 370854007, 415662004, 385989002, 386449006, 386450006, 386451005, 408934002, 408946003
UBREV	0906, 0944, 0945

Scenario 10: Substance abuse counseling and surveillance

ICD-10 Diagnosis	Z71.41, Z71.51 (do not include lab claims (claims with POS 81))
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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

Scenario 11: Telephone visit

CPT®/CPT II	98967, 98968, 98966, 99442, 99443, 99441, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98979, 98980, 98981, 99457, 99458, 99470
HCPCS	G0544
SNOMED	386472008, 314849005, 185317003, 386473003, 401267002

Scenario 12: Online assessment (e-visit/virtual check-in)

CPT®/CPT II	99422, 99423, 99421, 98971, 98972, 98970, 98016
HCPCS	G2252, G2012, G2251, G0071, G2250, G2010

Scenario 13: Opioid treatment service

OUD weekly billing non-drug treatment

HCPCS	G2074, G2075, G2076, G2077, G2080
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OUD weekly billing drug treatment

HCPCS	G2067, G2068, G2073, G0533
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OUD monthly office-based treatment

HCPCS	G2086, G2087
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Scenario 14: Medication treatment for alcohol use disorder

HCPCS	J2315, G2069, G2073
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One or more medication dispensing events for alcohol use disorder:

Drug category	Medications
Aldehyde dehydrogenase inhibitor	<ul style="list-style-type: none"> Disulfiram (oral)
Antagonist	<ul style="list-style-type: none"> Naltrexone (oral and injectable)
Other	<ul style="list-style-type: none"> Acamprosate (oral; delayed-release tablet)

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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

Scenario 15: Medication treatment for opioid use disorder

HCPCS	G2067, G2068, G2069, G2070, G2072, G2073, G2078, G2079, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992, S0109
SNOMED	310653000
Drug category	Medications
Antagonist	<ul style="list-style-type: none"> Naltrexone (oral and injectable)
Partial agonist	<ul style="list-style-type: none"> Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

Test, service or procedure to close care opportunity

- Episode date is the earliest date of service for an observation, intensive outpatient, partial hospitalization, outpatient, telehealth, detoxification or ED visit not resulting in an inpatient stay with a substance use disorder diagnosis between Nov.15 of the year prior to the measurement year through Nov.14 of the measurement year. For inpatient stay or detoxification during an inpatient stay, episode date is the date of discharge.

- Initiation of SUD Treatment must take place within 14 days of the episode date
- Claims must include the visit code, original episode diagnosis and, when applicable, a place of service code
- If the episode was an inpatient discharge or an ED visit resulting in an inpatient stay, the inpatient stay is considered initiation of treatment and the member is compliant

- Initiation of SUD treatment through:
- Acute or non-acute inpatient stay
 - Group visits with an appropriate place of service code and diagnosis code
 - Medication dispensing event
 - Medication treatment
 - Online assessment with diagnosis code
 - Stand-alone visits with an appropriate place of service code and diagnosis code
 - Telephone visit with diagnosis code

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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)



Important notes (cont.)

Test, service or procedure to close care opportunity

- Engagement of SUD treatment is compliance with the initiation treatment AND 1 of the following between the day after and 34 days after the initiation visit:
 - At least 2 inpatient, outpatient or medication treatment visits (excluding methadone billed on a pharmacy claim)
 - A long-acting SUD medication administration event (MOUD/MAUD)
- Claims must include the visit code, original episode diagnosis and, when applicable, a place of service code
- For members who initiated treatment through an inpatient admission, the 34-day period for the 2 engagement visits begins the day after their discharge

Engagement of SUD treatment when a member meets the criteria for initiation of treatment and proceeds with 2 or more of the following:

- Acute or non-acute inpatient stay
- Group visits with an appropriate place of service code and diagnosis code
- Medication dispensing event
- Medication treatment
- Online assessment with diagnosis code
- Stand-alone visits with an appropriate place of service code and diagnosis code
- Telephone visit with diagnosis code
- E-visit or virtual check-in

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Initiation and Engagement of Substance Use Disorder Treatment (IET) (cont.)

Tips and best practices to help close this care opportunity

This measure focuses on follow-up treatment when diagnosing a patient with substance use disorder.

- Use screening tools to aid in diagnosing
- Screening tools (e.g., SBIRT, AUDIT-PC, Audit C Plus 2, CAGE-AID and CUDIT-R) assist in the assessment of substance use and can aid the discussion around referral for treatment. Code “Unspecified use” diagnoses sparingly. Screening tools available at providerexpress.com > Clinical Resources > Behavioral Health Toolkit for Medical Providers.
- Schedule a follow-up appointment prior to patient leaving the office with you or a substance use specialist to occur within 14 days and then 2 more visits with you or a substance use treatment provider within the next 34 days
- When a patient is in remission, please remember to remove the original diagnosis and use remission codes:
 - Alcohol abuse in remission (F10.11)
 - Alcohol dependence in remission (F10.21)
 - Cannabis abuse in remission (F12.11)
 - Other psychoactive substance dependence in remission (F19.21)
- If patient has started MOUD/MAUD then they only need 1 MOUD/MAUD follow-up visit in 34 days
- Encourage newly diagnosed individuals to include their family in their treatment
- Although community supports, such as AA and NA, are beneficial, they do not take the place of professional treatment
- Encourage newly diagnosed individuals to accept treatment by assisting them in identifying their own reasons for change
- If you need to refer your patient to a substance use specialist or need to request coordination of care, please call the number on the back of the patient’s health plan ID card or search liveandworkwell.com
- The patient must receive an initiation of substance use disorder treatment within 14 days; without this initiation visit, they are not eligible for closing the engagement care gap thereafter within 34 days.
- It is critical to ensure patients who no longer qualify for a SUD diagnoses are noted as in remission using the suitable F code to ensure members do not have a gap in care inappropriately (e.g., F11.21 = opioid dependence, in remission; F10.21 = alcohol dependence, in remission)

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Plan All-Cause Readmissions (PCR)

New for 2026

Updated

- Updated the measure definition.

Definition

The risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays) for members ages 18 and older.

A lower rate indicates a better score for this measure.

For Medicaid and commercial members, the included age range is 18–64 only.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings • CMS Quality Rating System • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services 	Any time during the measurement year
<ul style="list-style-type: none"> • Member died during the inpatient stay • Members with a principal diagnosis of pregnancy on the discharge claim • Principal diagnosis of a condition originating in the perinatal period on the discharge claim • Acute hospitalizations where the discharge claims has a diagnosis for: <ul style="list-style-type: none"> – Chemotherapy maintenance – Principle diagnosis of rehabilitation – Organ transplant – Potentially planned procedure without a principal acute diagnosis 	Jan. 1–Dec. 1 of the measurement

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Plan All-Cause Readmissions (PCR) (cont.)

Outlier exclusions – Removed from eligible population

Exclusion	Time frame
<ul style="list-style-type: none"> Medicaid and Medicare members in the initial population with 4 or more acute inpatient or observation stays 	Jan. 1–Dec. 1 of the measurement year
<ul style="list-style-type: none"> Commercial members in the initial population with 3 or more acute inpatient or observation stays 	Jan. 1–Dec. 1 of the measurement year

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Plan All-Cause Readmissions (PCR) (cont.)

Tips and best practices to help close this care opportunity

- The denominator for this measure is based on discharges and not members specifically
- An acute discharge can be from any type of facility, including behavioral health facilities
- Discharges are excluded if a direct transfer takes place after Dec. 1 of the measurement year
- Starting Jan. 1, 2022, UnitedHealthcare's Healthy at Home Program for Medicare Advantage Group Retiree members can help meet member needs post-discharge and preventing readmissions. Healthy at Home focuses on post-discharge meals, transportation, personal care and more. Contact your UnitedHealthcare representative for more information.
- Please help members avoid readmission by:
 - Following up with them within 1 week of their discharge
 - Making sure they filled their new prescriptions post-discharge
 - Implementing a robust, safe discharge plan that includes a post-discharge phone call to discuss these questions:
 - o Do you completely understand all the instructions you were given at discharge?
 - o Do you completely understand the medications and your medication instructions? Have you filled all your prescriptions?
 - o Have you made your follow-up appointments? Do you need help scheduling them?
 - o Do you have transportation to the appointment and/or do you need help arranging transportation?
 - o Do you have any questions?
- A lower **readmission** rate and comprehensive diagnosis documentation will drive better scores for this measure
- Patients with multiple comorbidities are expected to return post inpatient or observation discharge at a higher rate. Ensure all suspect conditions are appropriately identified in the patient's medical record and claims.
- Encourage members to engage in palliative care or hospice programs as appropriate to drive lower readmissions for high risk patients to reduce hospitalizations

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Transitions of Care TRCNIA - Notification of Inpatient Admission

New for 2026

- No applicable changes for this measure

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between Jan. 1–Dec. 1 of the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	<p>Hybrid</p> <ul style="list-style-type: none"> • This sub-measure is hybrid ONLY. No administrative data is available.

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who died 	<p>Any time during the measurement year</p>

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Transitions of Care TRCNIA - Notification of Inpatient Admission (cont.)



Important notes

Test, service or procedure to close care opportunity

Medical record detail including, but not limited to

- Admission is defined as the date of the inpatient admission or the date of admission when an observation stay turns into an inpatient admission
- Administrative data doesn't count toward the numerator for inpatient admission notification
- Documentation that a care provider sent a member to the ED visit(s) that resulted in an inpatient admission does not meet compliance for the numerator

(continued on next page)

- Medical record documentation must be about the admission and can include record of a discussion or information transfer between the following:
- Inpatient staff/care provider and the member's PCP or ongoing care provider
 - Emergency department (ED) facility and the member's PCP or ongoing care provider
 - Health information exchange (HIE), automated admission/discharge transfer (ADT) alert system or shared electronic medical record (EMR) system and the member's PCP or ongoing care provider
 - A shared electronic medical record system and the member's PCP or ongoing care provider
 - The member's health plan and their PCP or ongoing care provider
 - Evidence that the information was integrated in the appropriate medical record and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after discharge (3 total days) meets criteria

OR (continued on next page)

- Health history and physical
- Home health records
- Progress notes
- Skilled nursing facility minimum data set (MDS) form
- SOAP notes

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Transitions of Care TRCNIA - Notification of Inpatient Admission (cont.)



Important notes (cont.)

Test, service or procedure to close care opportunity

Medical record detail including, but not limited to

• Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days)

OR

Medical record documentation that:

- The member’s PCP or ongoing care provider admitted the member to the hospital
- A specialist admitted the member to the hospital and notified the member’s PCP or ongoing care provider
- The member’s PCP or ongoing care provider ordered tests or treatments during the member’s inpatient stay.
- The PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission

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Transitions of Care TRCMRP – Medication Reconciliation Post-Discharge

New for 2026

- No applicable changes for this measure

Definition

For members ages 18 and older, percentage with an acute or non-acute inpatient discharge on or between Jan. 1–Dec. 1 of the measurement year with medication reconciliation documented on the date of the discharge through 30 days after the discharge (31 days total).

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	Hybrid <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Medication Reconciliation	
CPT®/CPT II	1111F, 99483, 99495, 99496, 99605, 99606
SNOMED	430193006, 428701000124107

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Transitions of Care TRCMRP – Medication Reconciliation Post-Discharge (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the Medication list documented in the medical record or the process used to document the most recent Medication list in the medical record. • Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse • A medication reconciliation performed without the member present meets compliance • Medication reconciliation must be completed on the date of discharge or 30 days afterward (continued on next page) 	<ul style="list-style-type: none"> • Discharge medications and outpatient medications reconciled and documented in the outpatient medical record • Current medications and Medication list reviewed and documentation of any of the following: <ul style="list-style-type: none"> - Documentation in the discharge summary that states current and discharge medications were reconciled and filed in the outpatient medical record - Notation of current medications that also references discharge medications - Notation of current medications and that discharge medications were reconciled (continued on next page) 	<ul style="list-style-type: none"> • Health history and physical • Home health records • Medication list • Progress notes • Skilled nursing facility minimum data set (MDS) form • SOAP notes

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Transitions of Care TRCMRP – Medication Reconciliation Post-Discharge (cont.)



Important notes (cont.)

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • Medication reconciliation can be documented if there is evidence that: <ul style="list-style-type: none"> – A member was seen for a post-discharge follow-up – Medication review or reconciliation was completed at the appointment • A Medication list must be present in the outpatient record to fully comply with the measure • Documentation of post-op/ surgery follow-up without a reference to hospitalization, admission or inpatient stay does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization 	<ul style="list-style-type: none"> – Review of discharge Medication list and current Medication list on the same date of service – Notation if no medications were prescribed at discharge – Evidence the member was seen for a hospital post-discharge follow-up visit with evidence of medication reconciliation or review – Documentation and evidence the member was seen for post-discharge hospital follow-up indicating the provider was aware of the hospitalization or discharge 	

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Transitions of Care TRCMRP – Medication Reconciliation Post-Discharge (cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> Medication reconciliation does not require the member to be present If the member is unable to communicate with provider, interaction between the member’s caregiver and the provider meets numerator criteria The numerator assesses if medication reconciliation post discharge occurred. It does not attempt to assess of the quality of the Medication list in the medical record or process used to document the most recent Medication list in the medical record. The presence of a discharge summary alone in the outpatient medical record is not compliant for this measure component Medication review of the home health agency outcome and assessment information set (OASIS) form without evidence of inpatient discharge and current medications reconciled is unacceptable A provider signature is not required to meet the criteria. The printed provider name and credentials (i.e., prescribing practitioner, clinical pharmacist, or registered nurse) AND a documented reconciled/reviewed statement may be used as evidence that the appropriate provider performed the reconciliation, in place of an actual signature. 	<ul style="list-style-type: none"> Licensed practical/ vocational nurse (LPN/ LVN) services alone do not meet the criteria. However, if these services were co-signed by one of the appropriate provider types within the correct time frame, this meets the criteria. 	

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Transitions of Care TRCPE – Patient Engagement After Inpatient Discharge

New for 2026

- No applicable changes for this measure

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between Jan. 1–Dec. 1 of the measurement year with engagement documented within 30 days of the discharge. Do not include patient engagement that happens on the day of discharge.

Patient engagement can include any of the following:

- Outpatient visit (office or home)
- Telephone visit
- E-visit or virtual check-in between member and provider
- Telehealth visit
- Transitional care management

Plans(s) affected	Quality program(s) affected	Collection and reporting method
• Medicare	• CMS Star Ratings	Hybrid • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Outpatient visits	
CPT®/CPT II	99483, 99345, 99342, 99344, 99341, 99350, 99348, 99349, 99347, 99385, 99386, 99387, 99384, 99382, 99381, 99383, 99245, 99243, 99244, 99242, 99205, 99203, 99204, 99202, 99211, 99215, 99213, 99214, 99212, 99422, 99423, 99421, 99395, 99396, 99397, 99394, 99392, 99391, 99393, 99401, 99402, 99403, 99404, 99411, 99412, 98971, 98972, 98970, 99458, 99457, 98981, 98980, 98967, 98968, 98966, 99442, 99443, 99441, 99429, 99456, 99455, 98979, 99470
HCPCS	G0439, G0438, G2252, G2012, G2251, T1015, G0463, G0402, G0071, G2250, G2010, G0544

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Transitions of Care TRCPE – Patient Engagement After Inpatient Discharge (cont.)

Outpatient visits

SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 3391000175108, 185464004, 86013001, 439740005, 386472008, 314849005, 185317003, 386473003, 401267002, 185463005, 185465003
UBREV	0511, 0983, 0521, 0517, 0523, 0510, 0520, 0522, 0514, 0519, 0529, 0982, 0515, 0513, 0516, 0526, 0528, 0527

Transitional care management

CPT®/CPT II	99495, 99496
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Transitions of Care TRCPE – Patient Engagement After Inpatient Discharge (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> Member engagement must be completed within 30 days of the discharge Member engagement on the day of the discharge will <u>not</u> be compliant If the member is unable to communicate with the provider, interaction between the member’s caregiver and the provider meets criteria 	<p>Member engagement can include a:</p> <ul style="list-style-type: none"> Outpatient visit (e.g., in-home visit, office visit) Telehealth visit: Must include real-time interaction with the care provider E-visit or virtual check-in Transitional care management 	<ul style="list-style-type: none"> Health history and physical Home health records Progress notes Skilled nursing facility minimum data set (MDS) form SOAP notes

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Transitions of Care TRCRDI – Receipt of Discharge Information

New for 2026

- No applicable changes for this measure

Definition

For members ages 18 and older, percentage of acute or non-acute inpatient discharges on or between Jan. 1–Dec. 1 of the measurement year with a receipt of discharge information documented the day of or 2 days after the discharge (3 days total).

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	<p>Hybrid</p> <ul style="list-style-type: none"> • This sub-measure is hybrid ONLY. No administrative data is available.

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Transitions of Care TRCRDI – Receipt of Discharge Information (cont.)



Important notes

Test, service or procedure to close care opportunity

Medical record detail including, but not limited to

- Administrative data doesn't count toward the numerator for discharge notification
- In a shared electronic medical record system, a received date is not necessary to meet compliance for this numerator. As long as the PCP or ongoing provider has access to the discharge information on the day of discharge or 2 days after discharge meets the intent of the measure.
- Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR

- Discharge information must include all of the following in the outpatient medical record:
- The name of the care provider responsible for the member's care during the inpatient stay
 - Services or treatments provided during the inpatient stay
 - Diagnoses at discharge
 - Test results or documentation that either test results are pending or no test results are pending
 - Instructions for patient care post discharge to the PCP or ongoing care provider
 - Current Medication list

- Discharge care plan
- Discharge summary
- Health history and physical
- Home health records
- Progress notes
- Skilled nursing facility minimum data set (MDS) form
- SOAP notes

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Transitions of Care TRCRDI – Receipt of Discharge Information (cont.)

Tips and best practices to help close this care opportunity

- Transitions of care help to decrease readmissions and medication errors. It also helps with affordability and to improve communications between members and their providers.
- Transitions of care help to better coordinate care, decreasing issues before they occur and leading to better member health outcomes

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Use of Imaging Studies for Low Back Pain (LBP)

New for 2026

Removed

- Removed NCQA Health Plan Ratings from the Quality Programs Affected

Definition

Percentage of members ages 18–75 with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis .

This measure is reported as an inverted measure and a higher score indicates appropriate treatment of low back pain, where imaging studies did not occur.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Exchange/Marketplace 	<ul style="list-style-type: none"> • CMS Quality Rating System 	Administrative <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

The following codes are imaging studies that should be avoided with a diagnosis of uncomplicated **low back pain.**

Imaging studies	
CPT®/CPT II	72126, 72125, 72127, 72132, 72131, 72133, 72129, 72128, 72130, 72142, 72141, 72149, 72148, 72147, 72146, 72156, 72158, 72157, 72202, 72200, 72220, 72040, 72050, 72052, 72082, 72083, 72084, 72081, 72100, 72120, 72114, 72110, 72020, 72070, 72072, 72074, 72080

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Use of Imaging Studies for Low Back Pain (LBP) (cont.)

Imaging Studies

SNOMED

14871000087107, 713016000, 1251643002, 241592002, 16554061000119109, 702513003, 702514009, 702515005, 702516006, 711224009, 715290001, 723646000, 241580002, 702521009, 702522002, 709698004, 702523007, 572091000119106, 702487007, 702488002, 90523008, 429868005, 429860003, 431613003, 429871002, 711271003, 430021001, 430507007, 432244001, 440450002, 16328021000119109, 700320001, 700321002, 413001000119107, 702607002, 702608007, 16384831000119100, 241646009, 60443006, 571891000119109, 495741000119105, 411611000119102, 711184004, 711186002, 433141005, 433140006, 241648005, 431250008, 709652000, 726546000, 709653005, 41333006, 394451000119106, 700319007, 448641007, 241647000, 411571000119106, 91333005, 396171000119100, 772220000, 868279006, 17141000087101, 712970008, 3721000087104, 840361000, 3731000087102, 783627007, 443580006, 431496002, 711104001, 431557005, 22791004, 431892005, 431871005, 432078003, 444634007, 432770001, 715458009, 716830000, 718542005, 717912001, 718545007, 1343368005, 58211000087104

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Use of Imaging Studies for Low Back Pain (LBP) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members receiving palliative care Members who died 	<p>Any time during the measurement year</p>
<ul style="list-style-type: none"> Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> - Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). - Advanced Illness: Indicated by one of the following: <ul style="list-style-type: none"> o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be in the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year

Any member who had a diagnosis where imaging is clinically appropriate including:

<ul style="list-style-type: none"> Cancer HIV Major organ transplant Osteoporosis or osteoporosis therapy Lumbar surgery Spondylopathy 	<p>Any time in a member’s history through 28 days after the principal diagnosis of low back pain between Jan. 1–Dec. 3 of the measurement year</p>
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Use of Imaging Studies for Low Back Pain (LBP) (cont.)

Exclusion	Time frame
<ul style="list-style-type: none"> Recent trauma Fragility fractures 	Any time 90 days prior to or 28 days after the principal diagnosis of low back pain between Jan. 1–Dec. 3 of the measurement year
Prolonged use of corticosteroids – 90 consecutive days of corticosteroid treatment	Dispensed any time 12 months prior to the principal diagnosis of low back pain between Jan. 1–Dec. 3 of the measurement year
<ul style="list-style-type: none"> Intravenous drug abuse Neurologic impairment 	Any time 12 months prior to or 28 days after the principal diagnosis of low back pain between Jan.1–Dec. 3 of the measurement year
Spinal infection	Any time 12 months prior to or 28 days after the principal diagnosis of low back pain between Jan. 1–Dec. 3 of the measurement year

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Use of Imaging Studies for Low Back Pain (LBP) (cont.)



Important notes

	Test, service or procedure to avoid	Test, service or procedure to close care opportunity
The imaging studies listed in the column at right are not clinically appropriate for a diagnosis of <u>uncomplicated low back pain</u> .	<ul style="list-style-type: none"> • CT scan • MRI • Plain X-ray 	
The principal diagnosis of <u>uncomplicated low back pain</u> can come from any of the services listed in the column at right for a member to be included in this measure.		<ul style="list-style-type: none"> • E-visit or virtual check-in • Osteopathic or chiropractic manipulative treatment • Outpatient visit • Physical therapy visit • Telephone visit

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Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

New for 2026

- No applicable changes for this measure

Definition

Percentage of members ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of the treatment period.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data • Pharmacy data

Medications

To comply with this measure, a member must have remained on 1 of the following antipsychotic medications for at least 80% of the treatment period.

Oral antipsychotic medications

Drug category	Medications
Miscellaneous antipsychotic agents (oral)	<ul style="list-style-type: none"> • Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lumateperone • Lurisdone • Molindone • Olanzapine • Paliperidone • Quetiapine • Risperidone • Trospium Xanomeline • Ziprasidone

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Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) (cont.)

Drug category	Medications
Phenothiazine antipsychotics (oral)	<ul style="list-style-type: none"> • Chlorpromazine • Fluphenazine • Perphenazine • Prochlorperazine • Thioridazine • Trifluoperazine
Psychotherapeutic combinations (oral)	<ul style="list-style-type: none"> • Amitriptyline-perphenazine
Thioxanthenes (oral)	<ul style="list-style-type: none"> • Thiothixene
Long-acting injections 14-day supply	<ul style="list-style-type: none"> • Risperidone (excluding Perseris®)
Long-acting injections 28-day supply	<ul style="list-style-type: none"> • Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate • Haloperidol decanoate • Olanzapine
Long-acting injections 30-day supply	<ul style="list-style-type: none"> • Risperidone (Perseris®)
Long-acting injections 35-day supply	<ul style="list-style-type: none"> • Paliperidone palmitate (Invega Sustenna)
Long-acting injections 104-day supply	<ul style="list-style-type: none"> • Paliperidone palmitate (Invega Trinza®)
Long-acting injections 201-day supply	<ul style="list-style-type: none"> • Paliperidone palmitate (Invega Hafyera™)

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Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died Diagnosis of dementia Members ages 81 and older as of Dec. 31 of the measurement year who had at least 2 diagnoses of frailty* on different dates of service Members who did not have at least 2 antipsychotic medication dispensing events. There are 2 ways to identify dispensing events: by Claim/encounter data and by Pharmacy data. 	<p>Any time during the measurement year</p>
<p>Members ages 66-80 as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion:</p> <ul style="list-style-type: none"> Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). Dispensed dementia medication: Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be in the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<p>Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:</p> <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution* 	<p>Any time during the measurement year</p>

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

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Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) (cont.)

Tips and best practices to help close this care opportunity

This measure focuses on medication compliance.


- Encourage patients to take medications as prescribed
- Offer tips to patients such as:
 - Take medication at the same time each day
 - Use a pill box
 - Enroll in a pharmacy automatic-refill program

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Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

New for 2026

- No applicable changes to this measure



Yes!
Supplemental data accepted

Definition

Percentage of members ages 18–64 with schizophrenia or schizoaffective disorder and cardiovascular disease who had a low-density lipoprotein cholesterol (LDL-C) test during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicaid 	<ul style="list-style-type: none"> • Select Medicaid State reporting 	Administrative <ul style="list-style-type: none"> • Claim/encounter

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

LDL-C Test	
CPT®/CPT II	80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
LOINC	12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who died 	Any time during the measurement year

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Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) (cont.)



Important note

A calculated or direct LDL may be used to report compliance.

Tips and best practices to help close this care opportunity

This measure focuses on appropriate monitoring for members with schizophrenia or schizoaffective disorder and cardiovascular disease.

- Be sure to schedule an annual LDL-C screening
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as lipid profile and LDL-C test results. It can also reduce the need for some chart review.
- CPT II codes that are on a lab claim (POS 81) or include a modifier do not count toward numerator compliance
- Lipid profiles and results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
data accepted

Definition

Percentage of members ages 18–64 with schizophrenia or schizoaffective disorder and diabetes who had both an HbA1c test and a low-density lipoprotein cholesterol (LDL-C) test during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicaid 	<ul style="list-style-type: none"> • Select Medicaid State reporting 	Administrative <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

HbA1c test	
CPT®/CPT II	83036, 83037, 3044F, 3046F, 3051F, 3052F
LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4
SNOMED	165679005, 451061000124104
LDL-C test	
CPT®/CPT II	80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
LOINC	12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7

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Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

	Test, service or procedure to close care opportunity
<ul style="list-style-type: none"> Individual tests to measure cholesterol and blood glucose levels can be done on the same or different dates of service The member must have both tests to be compliant for this measure 	<ul style="list-style-type: none"> HbA1c test LDL-C test <p>HbA1c tests may include:</p> <ul style="list-style-type: none"> A1c, HbA1c, HgbA1c Glycohemoglobin Glycohemoglobin A1c Glycated hemoglobin Glycosylated hemoglobin HB1c Hemoglobin A1c

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Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) (cont.)

Tips and best practices to help close this care opportunity

This measure focuses on appropriate monitoring for members with schizophrenia or schizoaffective disorder and diabetes.

- Be sure to schedule an annual HbA1c and LDL-C test
- The use of CPT Category II codes helps UnitedHealthcare identify clinical outcomes such as HbA1c and LDL-C test results. It can also reduce the need for some chart review.
- CPT II Codes that are on a lab claim (POS 81) or include a modifier do not count toward numerator compliance
- HbA1c and lipid profile test results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
data accepted

Definition

Percentage of members ages 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicaid 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings • Select Medicaid state reporting 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Glucose test	
CPT®/CPT II	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LOINC	10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 2345-7, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7

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Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (cont.)

Glucose test

SNOMED	1179458001, 1259140002, 166890005, 166891009, 166892002, 166921001, 166922008, 442545002, 444780001
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HbA1c test

CPT®/CPT II	83036, 83037, 3044F, 3046F, 3051F, 3052F
LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4
SNOMED	165679005, 451061000124104

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> Members with diabetes. There are 2 ways to identify members with diabetes: <ul style="list-style-type: none"> - Claim/encounter data - Pharmacy data 	Measurement year or year prior to measurement year
<ul style="list-style-type: none"> Members who did not have any antipsychotic medication dispensing events. There are 2 ways to identify members with diabetes: <ul style="list-style-type: none"> - Claim/encounter data - Pharmacy data 	Any time during the measurement year

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Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (cont.)



Important notes

	Test, service or procedure to close care opportunity
HbA1c test must be performed during the measurement year.	<ul style="list-style-type: none"> • Glucose test • HbA1c test <p>HbA1c tests may include:</p> <ul style="list-style-type: none"> • A1c, HbA1c, HgbA1c • Glycohemoglobin • Glycohemoglobin A1c • Glycated hemoglobin • Glycosylated hemoglobin • HB1c • Hemoglobin A1c
<ul style="list-style-type: none"> • Members who did not have any antipsychotic medication dispensing events. There are 2 ways to identify members with diabetes: <ul style="list-style-type: none"> - Claim/encounter data - Pharmacy data 	<ul style="list-style-type: none"> • Any time during the measurement year

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Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (cont.)

Tips and best practices to help close this care opportunity

This measure focuses on appropriate monitoring for members with schizophrenia or bipolar disorder.


- Be sure to schedule an annual screening for diabetes (HbA1c or blood glucose)
- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as HbA1c test results. It can also reduce the need for some chart review.
- CPT II Codes that are on a lab claim (POS 81) or include a modifier do not count toward numerator compliance
- HbA1c test results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Follow-Up After Hospitalization for Mental Illness (FUH)

New for 2026

- No applicable changes to this measure



Yes!
Supplemental data accepted

Definition

Percentage of discharges for members ages 6 and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm and had a mental health follow-up service.

Two rates are reported:

1. Percentage of discharges where the member received follow-up within 30 days of their discharge
2. Percentage of discharges where the member received follow-up within 7 days of their discharge

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Quality Rating System (7-day and 30-day) • NCQA Health Plan Ratings (7-day only) 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Code

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 1: Behavioral health outpatient visit with a mental health provider OR with any diagnosis of mental health disorder

Behavioral health visits

CPT®/CPT II	98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015, G0560
SNOMED	185463005, 185464004, 185465003, 209099002, 281036007, 3391000175108, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 444971000124105, 456201000124103, 50357006, 77406008, 84251009, 86013001, 866149003, 90526000
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 2: Intensive outpatient or partial hospitalization

Partial hospitalization/intensive outpatient visits

HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Partial hospitalization/intensive outpatient visits

SNOMED	305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000, 7133001
UBREV	0905, 0907, 0912, 0913

Scenario 3: Outpatient visit with a mental health provider OR with any diagnosis of mental health disorder, and with the appropriate service code

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location		
03	School	18	Place of employment - worksite
05	Indian health service free-standing facility	19	Off-campus outpatient hospital
07	Tribal 638 free-standing facility	20	Urgent care facility
09	Prison/correctional facility	22	On-campus outpatient hospital
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
17	Walk-in retail health clinic		

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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Code	Location	Code	Location
14	Group home	50	Federally qualified health center
15	Mobile unit	71	Public health clinic
16	Temporary lodging	72	Rural health clinic

Scenario 4: Intensive outpatient visit or partial hospitalization with appropriate place of service code

Visit setting unspecified

CPT®/CPT II 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

AND

Place of service code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 5: Community mental health center visit with appropriate place of service code

Visit setting unspecified

CPT®/CPT II 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

Behavioral health visits

CPT®/CPT II	98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015, G0560

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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Behavioral health visits

SNOMED	185463005, 185464004, 185465003, 209099002, 281036007, 3391000175108, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 444971000124105, 456201000124103, 50357006, 77406008, 84251009, 86013001, 866149003, 90526000
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Transitional care management services

CPT®/CPT II | 99495, 99496

AND

Place of service code

Code	Location
53	Community mental health center

Scenario 6: Electroconvulsive therapy with appropriate place of service code

Electroconvulsive Therapy

CPT®/CPT II	90870
ICD-10 Procedure	GZB0ZZZ, GZB2ZZZ, GZB4ZZZ
SNOMED	10470002, 11075005, 23835007, 231079005, 231080008, 284468008, 313019002, 313020008, 1010696002, 1010697006

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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

AND
Place of service code

Code	Location		
03	School	19	Off-campus outpatient hospital
05	Indian Health Service free-standing facility	20	Urgent care facility
07	Tribal 638 free-standing facility	22	On-campus outpatient hospital
09	Prison/correctional facility	24	Ambulatory surgical center
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	52	Psychiatric facility - partial hospitalization
16	Temporary lodging	53	Community mental health center
17	Walk-in retail health clinic	71	Public health clinic
18	Place of employment - worksite	72	Rural health clinic

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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Scenario 7: Transitional care management services with a mental health provider OR with any diagnosis of mental health disorder

Transitional care management services

CPT®/CPT II	99495, 99496
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Scenario 8: Telehealth visit with a mental health provider OR with any diagnosis of mental health disorder

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
02	Telehealth provided other than in patient’s home
10	Telehealth provided in patient’s home

Scenario 9: Behavioral health care setting visit

Behavioral healthcare setting

UBREV	0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 1001
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Scenario 10: Telephone visit with a mental health provider OR with any diagnosis of mental health disorder

Telephone visits

CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98979, 98980, 98981, 99457, 99458, 99470
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HCPCS	G0544
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SNOMED	185317003, , 314849005, 386472008, 386473003, 401267002
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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Scenario 11: Psychiatric collaborative care management

Psychiatric collaborative care management

CPT®/CPT II	99492, 99493
HCPCS	G0512

Scenario 12: Peer support services with any diagnosis of mental health disorder

Peer support services

HCPCS	G0140, G0177, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017
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Scenario 13: Psychiatric residential treatment

Residential behavioral health treatment

HCPCS	H0017, H0018, H0019, T2048
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OR

Visit setting unspecified with appropriate place of service code

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
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AND

Place of service code

Code	Location
56	Psychiatric residential treatment center

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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

- Visits that occur on the date of discharge will **not** count toward compliance
- Telehealth and telephone visits with a mental health provider, or with any diagnosis of a mental health disorder are acceptable to address the care opportunity

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Follow-Up After Hospitalization for Mental Illness (FUH) (cont.)

Tips and best practices to help close this care opportunity

This measure focuses on follow-up treatment.

- Refer patient to be seen within 7 days of discharge
 - Any medical or behavioral health provider can see the patient post discharge and need to bill using the qualified codes and mental health diagnosis and with appropriate place of service locations
- Visits can be telehealth with a mental health provider OR with any diagnosis of mental health disorder.
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge
- If you need to refer your patient to a behavioral health network practitioner for further assessment and/or additional treatment, call the Behavioral Health number on the back of their UnitedHealthcare member ID card
- Offer National Suicide Prevention Lifeline "988" for patients to call, text or chat when needed


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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

New for 2026

Added

- Added peer support services to the gap closure criteria (see scenario 15)
- Modified the gap closure criteria to allow a substance use disorder diagnosis to take any position on the claim



Yes!
Supplemental data accepted

Definition

The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members ages 13 and older that result in a follow-up visit or service for substance use disorder.

Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **7 days** after the visit or discharge
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **30 days** after the visit or discharge

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings (7-day only) 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Any of the following scenarios will meet compliance for these numerators:

Scenario 1: Acute or nonacute inpatient admission or residential behavioral health stay with a diagnosis of substance use disorder

Inpatient stay

UBREV

0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140, 0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002

Scenario 2: Outpatient visit with a diagnosis of substance use disorder

Visit setting unspecified

CPT®/CPT II

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

AND

Place of service code

Code	Location		
03	School	17	Walk-in retail health clinic
05	Indian Health Service free-standing facility	18	Place of employment - worksite
07	Tribal 638 free-standing facility	19	Off-campus outpatient hospital

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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Code	Location	Code	Location
09	Prison/correctional facility	22	On-campus outpatient hospital
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	71	Public health clinic
16	Temporary lodging	72	Rural health clinic
20	Urgent care facility		

Scenario 3: Behavioral health visit with a diagnosis of substance use disorder

Behavioral health visit

CPT®/CPT II	98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015, G0560
SNOMED	185463005, 185464004, 185465003, 209099002, 281036007, 3391000175108, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 444971000124105, 456201000124103, 50357006, 77406008, 84251009, 86013001, 866149003, 90526000
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Scenario 4: Intensive outpatient visit or partial hospitalization with appropriate place of service code with a diagnosis of substance use disorder

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 5: Intensive outpatient or partial hospitalization with a diagnosis of substance use disorder

Partial hospitalization/intensive outpatient visits

HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000, 7133001
UBREV	0905, 0907, 0912, 0913

Scenario 6: Opioid treatment service billed weekly or monthly with a diagnosis of substance use disorder

Weekly non-drug treatment

HCPCS	G2074, G2075, G2076, G2077, G2080
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Monthly office-based treatment

HCPCS	G2086, G2087, G2069
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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Scenario 7: Substance use disorder counseling and surveillance with a diagnosis of substance use disorder

Substance abuse counseling and surveillance

ICD-10-CM	Z71.41, Z71.51 Do not include lab claims from an independent lab (POS 81)
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Scenario 8: Telehealth visit with appropriate place of service code with a diagnosis of substance use disorder

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
02	Telehealth provided other than in patient's home
10	Telehealth provided in patient's home

Scenario 9: Community mental health center visit with appropriate place of service code with a diagnosis of substance use disorder

Visit setting unspecified

CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
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AND

Place of service code

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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Code	Location
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53	Community mental health center
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Scenario 10: Non-residential substance abuse treatment facility visit with appropriate place of service code with a diagnosis of substance use disorder

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
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57	Non-residential substance abuse treatment facility
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58	Non-residential opioid treatment facility
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Scenario 11: Substance use disorder service with a diagnosis of substance use disorder

Substance use disorder service

CPT®/CPT II	99408, 99409
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HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
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SNOMED	182969009, 20093000, 23915005, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 428211000124100, 445628007, 445662007, 450760003, 56876005, 61480009, 64297001, 67516001, 704182008, 707166002, 711008001, 713106006, 713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 87106005, 408934002, 408946003
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UBREV	0906, 0944, 0945
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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Scenario 12: Residential behavioral health treatment with a diagnosis of substance use disorder

Residential behavioral health treatment

HCPCS	H0017, H0018, H0019, T2048
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Scenario 13: Telephone visit with a principal diagnosis of substance use disorder

Telephone visit

CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98979, 98980, 98981, 99457, 99458, 99470
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HCPCS	G0544
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SNOMED	185317003, 314849005, 386472008, 386473003, 401267002
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Scenario 14: E-visit or virtual check-in with a diagnosis of substance use disorder

Online assessment (e-visit/virtual check-in)

CPT®/CPT II	98016, 98970, 98971, 98972, 99421, 99422, 99423
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HCPCS	G0071, G2010, G2012, G2250, G2251, G2252
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Scenario 15: Peer support services with a diagnosis of substance use disorder

Medication treatment

HCPCS	G0140, G0177, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017
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Scenario 16: Pharmacotherapy dispensing event or Medication treatment event for alcohol or opioid use disorder

Medication treatment

HCPCS	G2069, G2073, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J0577, J0578, J2315, Q9991, Q9992, S0109, G2067, G2068, G2078, G2079
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Opioid treatment service - Weekly billing

HCPCS	HCPCS G2067, G2068, G2070, G2072, G2073, G0533
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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Medications

One or more medication dispensing events for alcohol use disorder treatment:

Drug category	Medications
Aldehyde dehydrogenase inhibitor	<ul style="list-style-type: none"> Disulfiram (oral)
Antagonist	<ul style="list-style-type: none"> Naltrexone (oral and injectable)
Other	<ul style="list-style-type: none"> Acamprosate (oral; delayed-release tablet)

One or more medication dispensing events for opioid use disorder treatment:

Drug category	Medications
Antagonist	<ul style="list-style-type: none"> Naltrexone (oral and injectable)
Partial agonist	<ul style="list-style-type: none"> Buprenorphine (sublingual tablet, injection, implant)* Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

Test, service or procedure to close care opportunity

- Episode date is the date of service for any acute inpatient discharge, residential treatment or withdrawal management visit with a diagnosis of substance use disorder with any provider type on or between Jan. 1 and Dec. 1 of the measurement year.
- The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person
- Visits that occur on the date of discharge will not count toward compliance

- Follow-up for substance use disorder can be any of the following:
- Group visits with an appropriate Place of service code and diagnosis code
 - Medication dispensing event with diagnosis code
 - Medication treatment with diagnosis code
 - Online assessment with diagnosis code
 - Stand-alone visits with an appropriate Place of service code and diagnosis code
 - Telephone or telehealth visit with diagnosis code
 - Residential behavioral health treatment
 - Non-residential substance abuse treatment facility

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Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) (cont.)

Tips and best practices to help close this care opportunity

This measure focuses on follow-up treatment with any provider type.

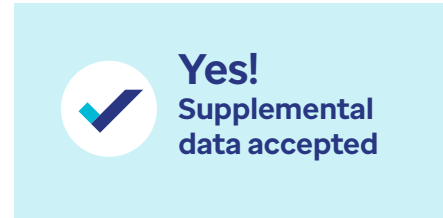
- See patients within 7 days and bill with a substance use diagnosis
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge
- Encourage the use of telehealth appointments when appropriate
- Available resources:
 - Alcohol and drug use screening tools:
 - [providerexpress.com](#) > Clinical Resources > Behavioral Health Toolkits for Medical Providers
 - Behavioral health tools and information: [providerexpress.com](#) > Clinical Resources > Behavioral Health Toolkit for Medical Providers
 - Patient education: [liveandworkwell.com](#) > Browse as a guest with company access code > Use access code “clinician” > Explore and Learn
- If you need to refer your patient to a substance use specialist or need to request coordination of care, please call the number on the back of the patient’s health plan ID card or search [liveandworkwell.com](#)

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Follow-Up After Emergency Department Visit for Mental Illness (FUM)

New for 2026

- No applicable changes to this measure



Definition

The percentage of emergency department visits for members ages 6 years and older with a principal diagnosis of mental illness or any diagnosis of intentional self-harm, who then had a follow-up visit for mental illness.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up for mental illness within the **7 days** after the visit (8 days total)
2. The percentage of ED visits for which the member received follow-up for mental illness within the **30 days** after the visit (31 days total)

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings (7-day only) 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 1: Behavioral health outpatient visit with any diagnosis of a mental health disorder

Behavioral health visits	
CPT®/CPT II	98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015, G0560
SNOMED	185463005, 185464004, 185465003, 209099002, 281036007, 3391000175108, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 444971000124105, 456201000124103, 503570006, 77406008, 84251009, 86013001, 866149003, 90526000
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 2: Intensive outpatient or partial hospitalization with any diagnosis of a mental health disorder

Partial hospitalization/intensive outpatient visits	
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485

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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

SNOMED

305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000, 7133001

UBREV

0905, 0907, 0912, 0913

Scenario 3: Outpatient visit with any diagnosis of a mental health disorder type and with appropriate place of service code

Visit setting unspecified

CPT®/CPT II

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

AND

Place of service code

Code	Location		
03	School	18	Place of employment - worksite
05	Indian Health Service free-standing facility	19	Off-campus outpatient hospital
07	Tribal 638 free-standing facility	20	Urgent care facility
09	Prison/correctional facility	22	On-campus outpatient hospital
11	Office	27	Outreach site/street
17	Walk-in retail health clinic	33	Custodial care facility
12	Home		

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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

Code		Location	
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	71	Public health clinic
16	Temporary lodging	72	Rural health clinic

Scenario 4: Intensive outpatient visit or partial hospitalization with appropriate place of service code

Place of service code

Visit setting unspecified

CPT®/CPT II | 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

AND

Place of service code

Code	Location
52	Psychiatric facility – partial hospitalization

Scenario 5: Community mental health center visit with appropriate place of service code

Visit setting unspecified

CPT®/CPT II | 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

AND

Place of service code

Code	Location
53	Community mental health center

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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

Scenario 6: Electroconvulsive therapy with appropriate place of service code

Electroconvulsive therapy

CPT®/CPT II	90870
ICD-10 Procedure	GZB0ZZZ, GZB2ZZZ, GZB4ZZZ
SNOMED	10470002, 11075005, 23835007, 231079005, 231080008, 284468008, 313019002, 313020008, 1010696002, 1010697006

AND

Place of service code

Code	Location	Code	Location
03	School	19	Off-campus outpatient hospital
05	Indian Health Service free-standing facility	20	Urgent care facility
07	Tribal 638 free-standing facility	22	On-campus outpatient hospital
09	Prison/correctional facility	24	Ambulatory surgical center
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	52	Psychiatric facility - partial hospitalization
16	Temporary lodging	53	Community mental health center
17	Walk-in retail health clinic	71	Public health clinic
18	Place of employment - worksite	72	Rural health clinic

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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

Scenario 7: Telehealth visit with any diagnosis of a mental health disorder and the appropriate place of service code

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
02	Telehealth provided other than in patient’s home
10	Telehealth provided in patient’s home

Scenario 8: Telephone visit with any diagnosis of a mental health disorder

Telephone visits

CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98979, 98980, 98981, 99457, 99458, 99470
HCPCS	G0544
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Scenario 9: E-Visit or virtual check-in with any diagnosis of a mental health disorder

Online assessment (e-visit/virtual check-in)

CPT®/CPT II	98970, 98971, 98972, 99421, 99422, 99423, 98016
HCPCS	G0071, G2010, G2012, G2250, G2251, G2252

Scenario 10: Psychiatric collaborative care management

Psychiatric collaborative care management

CPT®/CPT II	99492, 99493
HCPCS	G0512

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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

Scenario 11: Peer support services with any diagnosis of a mental health disorder

Peer support services

HCPCS	G0140, G0177, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017
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Scenario 12: Psychiatric residential treatment

Residential behavioral health treatment

HCPCS	H0017, H0018, H0019, T2048
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Scenario 13: Psychiatric residential treatment with the appropriate place of service code

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
56	Psychiatric Residential Treatment Cente

Scenario 14: Visit in a behavioral health care setting

Behavioral health care setting

UBREV	0513, 0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 1001
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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

- Visits that result in an inpatient stay are not included
- Telehealth, telephone, e-visit or virtual check-in visits with any diagnosis of a mental health disorder are acceptable to address the care opportunity
- A follow-up visit can occur on the same day as discharge to address the care opportunity

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Follow-Up After Emergency Department Visit for Mental Illness (FUM) (cont.)

Tips and best practices to help close this care opportunity

This measure focuses on follow-up treatment with a primary care provider or a behavioral health practitioner.

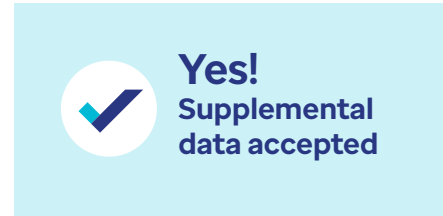
- See patients within 7 days and bill with a mental health diagnosis
 - If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge
 - Encourage the use of telehealth appointments when appropriate
 - If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search liveandworkwell.com
- Available resources:
 - Behavioral health screening tools and resources: providerexpress.com
 - Patient education: liveandworkwell.com > Browse as a guest with company access code > Use access code “clinician” > Explore and Learn
 - Mental health visits can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Follow-Up After Emergency Department Visit for Substance Use (FUA)

New for 2026

- No applicable changes to this measure



Definition

The percentage of emergency department visits for members ages 13 and older with a principal diagnosis of substance use disorder (SUD) or any drug overdose diagnosis and who had a follow-up visit.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up for SUD within the **7 days** after the visit (8 days total)
2. The percentage of visits or discharges for which the member received follow-up for SUD within the **30 days** after the visit (31 days total)

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings (7-day only) 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

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Follow-Up After Emergency Department Visit for Substance Use (FUA) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Any of the following scenarios will meet criteria for the measure when the above diagnoses are present.

Scenario 1: Outpatient visit with any diagnosis of substance use disorder or drug overdose OR with a mental health provider with the appropriate place of service code

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location		
03	School	18	Place of employment - worksite
05	Indian Health Service free-standing facility	19	Off-campus outpatient hospital
07	Tribal 638 free-standing facility	20	Urgent care facility
09	Prison/correctional facility	22	On-campus outpatient hospital
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	71	Public health clinic
16	Temporary lodging	72	Rural health clinic
17	Walk-in retail health clinic		

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Follow-Up After Emergency Department Visit for Substance Use (FUA) (cont.)

Scenario 2: Behavioral health visit with any diagnosis of substance use disorder or drug overdose OR with a mental health provider

Behavioral health visit

CPT®/CPT II	98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015, G0560
SNOMED	866149003, 444971000124105, 84251009, 77406008, 50357006, 281036007, 209099002, 90526000, 456201000124103, 391261003, 391257009, 391260002, 391225008, 391223001, 391224007, 3391000175108, 185464004, 86013001, 439740005, 391242002, 391237005, 391239008, 391233009, 185463005, 185465003
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983

Scenario 3: Intensive outpatient visit or partial hospitalization with appropriate place of service code with a mental health provider or with a diagnosis of substance use disorder or drug overdose

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
52	Psychiatric facility – partial hospitalization

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Follow-Up After Emergency Department Visit for Substance Use (FUA) (cont.)

Scenario 4: Intensive outpatient or partial hospitalization with a mental health provider or with a diagnosis of substance use disorder or drug overdose

Partial hospitalization/intensive outpatient visits

HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
SNOMED	305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000, 7133001
UBREV	0905, 0907, 0912, 0913

Scenario 5: Opioid treatment service with a diagnosis of substance use disorder or drug overdose

Weekly non-drug treatment

HCPCS	G2074, G2075, G2076, G2077, G2080
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Monthly office-based treatment

HCPCS	G2086, G2087, G2069
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Scenario 6: Peer support service with a diagnosis of substance use disorder or drug overdose

Peer support services

HCPCS	G0140, G0177, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016, T1017
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Follow-Up After Emergency Department Visit for Substance Use (FUA)(cont.)

Scenario 7: Telehealth visit with a mental health provider or with a diagnosis of substance use disorder or drug overdose, with the appropriate place of service code

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
02	Telehealth
10	Telehealth

Scenario 8: Community mental health center visit with appropriate place of service code with a mental health provider or with a diagnosis of substance use disorder or drug overdose

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
53	Community mental health center

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Follow-Up After Emergency Department Visit for Substance Use (FUA)(cont.)

Scenario 9: Non-residential substance abuse treatment facility visit with appropriate place of service code with a mental health provider or with a diagnosis of substance use disorder or drug overdose

Visit setting unspecified

CPT®/CPT II 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

AND

Place of service code

Code	Location
57	Non-residential substance abuse treatment facility
58	Non-residential opioid treatment facility

Scenario 10: Substance use disorder service, substance use services, or substance use disorder counseling and surveillance

Substance use disorder services counseling and surveillance

CPT®/CPT II	99408, 99409
HCPCS	G0396, G0397, G0443, H0001, H0005, H0006, H0007, H0015, H0016, H0022, H0028, H0047, H0050, H2035, H2036, T1006, T1012
ICD-10 Diagnosis	Z71.41, Z71.51 (Do not include lab claims from an independent lab (POS 81))
SNOMED	182969009, 20093000, 23915005, 266707007, 310653000, 370776007, 370854007, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 428211000124100, 445628007, 445662007, 450760003, 56876005, 61480009, 64297001, 67516001, 704182008, 707166002, 711008001, 713106006, 713107002, 713127001, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 87106005, 719757009, 396150002, 38670004, 390857005, 417096006, 401266006, 4266003, 417699000, 431260004, 1254709001, 423416000, 408934002, 408946003
UBREV	0906, 0944, 0945

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Follow-Up After Emergency Department Visit for Substance Use (FUA)(cont.)

Scenario 11: Behavioral health screening or assessment for substance use disorder or mental health disorders

Behavioral health assessment

CPT®/CPT II	99408, 99409
HCPCS	G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049
SNOMED	171208001, 314077000, 370854007, 391281002, 40823001, 410223002, 410229003, 414283008, 414501008, 415662004, 428211000124100, 439320000, 49474007, 584730000, 64792006, 703257008, 713106006, 713107002, 713127001, 713132000, 89732002, 56871000087106, 461381000124100

Scenario 12: Telephone visit with a mental health provider or with a diagnosis of substance use disorder or drug overdose

Telephone visits

CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98979, 98980, 98981, 99457, 99458, 99470
HCPCS	G0544
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Scenario 13: E-visit or virtual check-in with a mental health provider or with a diagnosis of substance use disorder or drug overdose

Online assessment (e-visit/virtual check-in)

CPT®/CPT II	98970, 98971, 98972, 99421, 99422, 99423, 99444, 98016
HCPCS	G0071, G2010, G2012, G2250 G2251 G2252

Scenario 14: Pharmacotherapy dispensing event or Medication treatment for alcohol or opioid use disorder

Medication treatment

HCPCS	G2069, G2070, G2072, G2073, H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J0577, J0578, J2315, Q9991, Q9992, S0109, G2067, G2068, G2078, G2079
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Follow-Up After Emergency Department Visit for Substance Use (FUA) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

- Visits that result in an inpatient stay are not included
- Telehealth, telephone, e-visit or virtual check-in visits with any diagnosis of SUD, substance use or drug overdose, or, with a mental health provider are acceptable to address the care opportunity
- Follow-up visit or medication dispensing event can occur on the same day as the ED visit to address the care opportunity

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Follow-Up After Emergency Department Visit for Substance Use (FUA)(cont.)

Tips and best practices to help close this care opportunity

- This measure focuses on follow-up treatment with a primary care provider or a substance use specialist.
- See patients within 7 days and bill with a substance use diagnosis
- If a situation arises where a patient is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge
- Encourage the use of telehealth appointments when appropriate
- The Mental Health Services Administration supports following the Screening, Brief Intervention and Referral to Treatment (SBIRT) guideline at [samhsa.gov/sbirt](https://www.samhsa.gov/sbirt)
- If you are not going to treat the patient yourself, you will need to refer your patient to a substance use specialist. To request coordination of care, please call the number on the back of the patient's health plan ID card or search [liveandworkwell.com](https://www.liveandworkwell.com).
- Available resources:
 - Alcohol and drug use screening tools: [providerexpress.com](https://www.providerexpress.com) > Clinical Resources > Behavioral Health Toolkits for Medical Providers
 - Patient education: [liveandworkwell.com](https://www.liveandworkwell.com) > Browse as a guest with company access code > Use access code "clinician" > Explore and Learn
- SUD can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Appropriate Testing for Pharyngitis (CWP)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
data accepted

Definition

Percentage of episodes for members age 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test within 3 days prior to or 3 days after the diagnosis day (7 days total). A higher rate indicates appropriate testing and treatment.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Exchange/Marketplace 	<ul style="list-style-type: none"> • CMS Quality Rating System 	Administrative <ul style="list-style-type: none"> • Claim/encounter data • Pharmacy data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Group A strep test	
CPT®/CPT II	87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880
LOINC	11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2, 101300-2, 103627-6, 105062-4, 105063-2

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Appropriate Testing for Pharyngitis (CWP) (cont.)

Medications

The following antibiotic medications, in conjunction with a strep test, will meet compliance for this measure:

Drug category	Medications
Aminopenicillins	<ul style="list-style-type: none"> • Amoxicillin • Ampicillin
Beta-lactamase inhibitors	<ul style="list-style-type: none"> • Amoxicillin-clavulanate
First generation cephalosporins	<ul style="list-style-type: none"> • Cefadroxil • Cefazolin • Cephalexin
Folate antagonist	<ul style="list-style-type: none"> • Trimethoprim
Lincomycin derivatives	<ul style="list-style-type: none"> • Clindamycin
Macrolides	<ul style="list-style-type: none"> • Azithromycin • Clarithromycin • Erythromycin
Natural penicillins	<ul style="list-style-type: none"> • Penicillin G potassium • Penicillin G sodium • Penicillin V potassium • Penicillin G benzathine
Quinolones	<ul style="list-style-type: none"> • Ciprofloxacin • Levofloxacin • Moxifloxacin • Ofloxacin
Second generation cephalosporins	<ul style="list-style-type: none"> • Cefaclor • Cefprozil • Cefuroxime
Sulfonamides	<ul style="list-style-type: none"> • Sulfamethoxazole-trimethoprim
Tetracyclines	<ul style="list-style-type: none"> • Doxycycline • Minocycline • Tetracycline
Third generation cephalosporins	<ul style="list-style-type: none"> • Cefdinir • Cefixime • Cefpodoxime • Ceftriaxone

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Appropriate Testing for Pharyngitis (CWP) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

Tips and best practices to help close this care opportunity

- Do not prescribe antibiotics until results of Group A Strep test are received
- Always bill using the LOINC codes previously listed with your strep test submission – not local codes**
- Always use a point of care rapid Group A strep test or throat culture, when appropriate, to confirm diagnosis of pharyngitis before prescribing an antibiotic
- Lab results can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

New for 2026

- No applicable changes for this measure

Definition

Percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis between July 1 of the year prior to the measurement year through June 30 of the measurement year who were **not** dispensed an antibiotic medication on or 3 days after the episode. A higher rate indicates appropriate treatment (not prescribed an antibiotic).



Yes!
Supplemental data accepted for required exclusions only

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data • Pharmacy data

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Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) (cont.)

Medications

To comply with this measure, the following antibiotics should **not** be dispensed upon diagnosis of acute bronchitis:

Drug category	Medications
Aminoglycosides	<ul style="list-style-type: none"> • Amikacin • Gentamicin • Streptomycin • Tobramycin
Aminopenicillins	<ul style="list-style-type: none"> • Amoxicillin • Ampicillin
Beta-lactamase inhibitors	<ul style="list-style-type: none"> • Amoxicillin-clavulanate • Ampicillin-sulbactam • Piperacillin-tazobactam
First-generation cephalosporins	<ul style="list-style-type: none"> • Cefadroxil • Cefazolin • Cephalexin
Fourth-generation cephalosporins	<ul style="list-style-type: none"> • Cefepime
Lincomycin derivatives	<ul style="list-style-type: none"> • Clindamycin • Lincomycin
Macrolides	<ul style="list-style-type: none"> • Azithromycin • Clarithromycin • Erythromycin
Miscellaneous antibiotics	<ul style="list-style-type: none"> • Aztreonam • Chloramphenicol • Dalfopristin-quinupristin • Daptomycin • Linezolid • Metronidazole • Vancomycin

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Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) (cont.)

Drug category	Medications	
Natural penicillins	<ul style="list-style-type: none"> • Penicillin G benzathine-procaine • Penicillin G potassium • Penicillin G procaine 	<ul style="list-style-type: none"> • Penicillin G sodium • Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	<ul style="list-style-type: none"> • Dicloxacillin • Nafcillin 	<ul style="list-style-type: none"> • Oxacillin
Quinolones	<ul style="list-style-type: none"> • Ciprofloxacin • Gemifloxacin • Levofloxacin 	<ul style="list-style-type: none"> • Moxifloxacin • Ofloxacin
Rifamycin derivatives	<ul style="list-style-type: none"> • Rifampin 	
Second-generation cephalosporin	<ul style="list-style-type: none"> • Cefaclor • Cefotetan • Cefoxitin 	<ul style="list-style-type: none"> • Cefprozil • Cefuroxime
Sulfonamides	<ul style="list-style-type: none"> • Sulfadiazine 	<ul style="list-style-type: none"> • Sulfamethoxazole-trimethoprim
Tetracyclines	<ul style="list-style-type: none"> • Doxycycline • Minocycline 	<ul style="list-style-type: none"> • Tetracycline
Third-generation cephalosporins	<ul style="list-style-type: none"> • Cefdinir • Cefixime • Cefotaxime 	<ul style="list-style-type: none"> • Cefpodoxime • Ceftazidime • Ceftriaxone
Urinary anti-infectives	<ul style="list-style-type: none"> • Fosfomycin • Nitrofurantoin 	<ul style="list-style-type: none"> • Nitrofurantoin macrocrystals-monohydrate • Trimethoprim

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Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

Tips and best practices to help close this care opportunity

- An episode for bronchitis/bronchiolitis will **not** count toward the measure denominator if the member was diagnosed with 1 of these conditions within 12 months of the event:
 - Chronic obstructive pulmonary disease (COPD)
 - Disorders of the immune system
 - Emphysema
 - HIV
 - Malignant neoplasms
 - Other malignant neoplasms of the skin
- An episode for bronchitis/bronchiolitis will **not** count toward the measure denominator if the member was diagnosed with either pharyngitis or a competing diagnosis on or 3 days after the episode date

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Appropriate Treatment for Upper Respiratory Infection (URI)

New for 2026

- No applicable changes for this measure



Yes!

Supplemental data accepted for required exclusions only

Definition

Percentage of episodes for members 3 months and older who were given a diagnosis of upper respiratory infection (URI) between July 1 of the year prior to the measurement year through June 30 of the measurement year and were **not** dispensed an antibiotic prescription on or 3 days after the diagnosis day (4 days total). A higher rate indicates appropriate treatment (not prescribed an antibiotic).

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Exchange/Marketplace 	<ul style="list-style-type: none"> • CMS Quality Rating System 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data • Pharmacy data

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Appropriate Treatment for Upper Respiratory Infection (URI) (cont.)

Medications

The following antibiotic medications should **not** be prescribed for an upper respiratory infection:

Drug category	Medications
Aminoglycosides	<ul style="list-style-type: none"> • Amikacin • Gentamicin • Streptomycin • Tobramycin
Aminopenicillins	<ul style="list-style-type: none"> • Amoxicillin • Ampicillin
Beta-lactamase inhibitors	<ul style="list-style-type: none"> • Amoxicillin-clavulanate • Ampicillin-sulbactam • Piperacillin-tazobactam
First generation cephalosporins	<ul style="list-style-type: none"> • Cefadroxil • Cefazolin • Cephalexin
Fourth generation cephalosporins	<ul style="list-style-type: none"> • Cefepime
Lincomycin derivatives	<ul style="list-style-type: none"> • Clindamycin • Lincomycin
Macrolides	<ul style="list-style-type: none"> • Azithromycin • Clarithromycin • Erythromycin
Miscellaneous antibiotics	<ul style="list-style-type: none"> • Aztreonam • Chloramphenicol • Dalfopristin-quinupristin • Daptomycin • Linezolid • Metronidazole • Vancomycin

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Appropriate Treatment for Upper Respiratory Infection (URI) (cont.)

Drug category	Medications
Natural penicillins	<ul style="list-style-type: none"> • Penicillin G benzathine-procaine • Penicillin G potassium • Penicillin G procaine • Penicillin G sodium • Penicillin V potassium • Penicillin G benzathine
Penicillinase-resistant penicillins	<ul style="list-style-type: none"> • Dicloxacillin • Nafcillin • Oxacillin
Quinolones	<ul style="list-style-type: none"> • Ciprofloxacin • Gemifloxacin • Levofloxacin • Moxifloxacin • Ofloxacin
Rifamycin derivatives	<ul style="list-style-type: none"> • Rifampin
Second generation cephalosporins	<ul style="list-style-type: none"> • Cefaclor • Cefotetan • Cefoxitin • Cefprozil • Cefuroxime
Sulfonamides	<ul style="list-style-type: none"> • Sulfadiazine • Sulfamethoxazole-trimethoprim
Tetracyclines	<ul style="list-style-type: none"> • Doxycycline • Minocycline • Tetracycline
Third generation cephalosporins	<ul style="list-style-type: none"> • Cefdinir • Cefixime • Cefotaxime • Cefpodoxime • Ceftazidime • Ceftriaxone
Urinary anti-infectives	<ul style="list-style-type: none"> • Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals-monohydrate • Trimethoprim

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Appropriate Treatment for Upper Respiratory Infection (URI) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none">Members in hospice or using hospice servicesMembers who died	Any time during the measurement year

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Use of Opioids at High Dosage (HDO)

New for 2026

- No applicable changes for this measure.



Yes!

Supplemental data accepted for required exclusions only

Definition

Percentage of members ages 18 and older receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage (average milligram morphine equivalent [MME] dose ≥ 90 mg).

A lower rate indicates a better score for this measure.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • Select state reporting 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter • Pharmacy data

Medications

To be included in this measure, a member must have been prescribed 1 of the following Opioid medications at an average MME ≥ 90 mg for ≥ 15 days:

Opioid medications		
<ul style="list-style-type: none"> • Benzhydrocodone • Butorphanol • Codeine • Dihydrocodeine • Fentanyl oral spray • Fentanyl buccal or sublingual tablet, transmucosal lozenge 	<ul style="list-style-type: none"> • Fentanyl transdermal film/patch • Fentanyl nasal spray • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone 	<ul style="list-style-type: none"> • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol

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Use of Opioids at High Dosage (HDO) (cont.)

These medications are not included as dispensing events for this measure:

- Cough and cold products with opioids
- Injectables
- Ionsys®
 - Fentanyl transdermal patch used in inpatient settings only
- Methadone for the treatment of opioid use disorder

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who died • Cancer • Sickle cell disease • Members receiving palliative care 	Any time during the measurement year

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Use of Opioids at High Dosage (HDO) (cont.)

Tips and best practices to help close this care opportunity

- This measure focuses on using low dosage for opioids
- For treatment of acute pain using opioids, the guidelines recommend immediate-release opioids be used at a dosage as low as possible and for as few days as needed
- For treatment of chronic pain, guidelines recommend clinicians consider non-pharmacologic and non-opioid therapies first, and only in cases where the benefits outweigh the risks, initiation of opioid therapy
- UnitedHealthcare is committed to working with care providers to help:
 - **Prevent** opioid misuse and addiction
 - **Treat** those who are addicted
 - **Support** long-term recovery

For more information about our programs to help prevent opioid overuse, please visit [UHCprovider.com](#) > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.

- Information to help you stay informed about the latest opioid research and guidelines is also available at [cdc.gov](#), [hhs.gov](#) or your state's public health department website. Here are a few suggestions to get you started:
 - **Prevention**
 - o Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at [cdc.gov](#) > CDC A - Z INDEX > D > Drug

Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain

- o U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at [hhs.gov/opioids](#) > Prevention

– Treatment

- o Substance Abuse and Mental Health Services Administration (SAMHSA) medication assisted treatment for opioid use disorder (MOUD) available at [samhsa.gov](#) > Programs & Campaigns > Medication-Assisted Treatment
- o National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at [drugabuse.gov](#) > Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
- o HHS Treatment for Opioid Use Disorder available at [hhs.gov/opioids](#) > Treatment
- o American Society of Addiction Medicine (ASAM) Educational Resources available at [asam.org](#) > Education > Educational Resources

– Recovery

- o In-network MOUD care provider search for UnitedHealthcare plan members available at [provider.liveandworkwell.com](#)
- To start a search, enter ZIP code > Select an Area of Expertise > Substance Use Disorder > Search

– Harm reduction

- o Harm Reduction Coalition Prescribe Naloxone! available at [harmreduction.org](#) > Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources

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Use of Opioids at High Dosage (HDO) (cont.)

- SAMHSA Opioid Overdose Preventive Toolkit available at [samhsa.gov](https://www.samhsa.gov) > Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)

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Use of Opioids From Multiple Providers (UOP)

New for 2026

- No applicable changes for this measure

Definition

Percentage of members ages 18 and older receiving prescription opioids for ≥ 15 days during the measurement year who received opioids from multiple providers.

Three rates are reported:

1. **Multiple prescribers:** Percentage of members receiving prescriptions for opioids from 4 or more different prescribers during the measurement year
2. **Multiple pharmacies:** Percentage of members receiving prescriptions for opioids from 4 or more different pharmacies during the measurement year
3. **Multiple prescribers and multiple pharmacies:** Percentage of members receiving prescriptions for opioids from 4 or more different prescribers and 4 or more different pharmacies during the measurement year



Yes!

Supplemental data accepted for required exclusions only

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • Select state reporting 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter • Pharmacy data

Medications

To be included in this measure, a member must have met both of the following criteria in the measurement year:

- 2 or more dispensing events on different dates of service for the following Opioid medications, and
- ≥ 15 days covered by an opioid prescription

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Use of Opioids From Multiple Providers (UOP) (cont.)

Opioid medications

- | | | | |
|---|------------------|---------------|---------------|
| • Benzhydrocodone | • Codeine | • Levorphanol | • Oxycodone |
| • Buprenorphine
(transdermal patch
and buccal film) | • Dihydrocodeine | • Meperidine | • Oxymorphone |
| • Butorphanol | • Fentanyl | • Methadone | • Pentazocine |
| | • Hydrocodone | • Morphine | • Tapentadol |
| | • Hydromorphone | • Opium | • Tramadol |

These medications are not included as dispensing events for this measure:

- Cough and cold products with opioids
- Injectables
- Ionsys®
 - Fentanyl transdermal patch used in inpatient settings only
- Methadone for the treatment of opioid use disorder
- Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder
 - Buprenorphine sublingual tablets
 - Buprenorphine subcutaneous implant
 - Buprenorphine/naloxone combination products

Required exclusion(s)

Exclusion

- Members in hospice or using hospice services
- Members who died

Time frame

Any time during the measurement year

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Use of Opioids From Multiple Providers (UOP) (cont.)

Tips and best practices to help close this care opportunity

- This measure focuses on taking caution with patients using multiple pharmacies and/or prescribers
 - Evidence suggests people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose
 - UnitedHealthcare is committed to working with care providers to help:
 - **Prevent** opioid misuse and addiction
 - **Treat** those who are addicted
 - **Support** long-term recovery
- For more information about our programs to help prevent opioid overuse, please visit [UHCprovider.com](#) > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.
- Information to help you stay informed about the latest opioid research and guidelines is also available at [cdc.gov](#), [hhs.gov](#) or your state's public health department website. Here are a few suggestions to get you started:

- Prevention

- o Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at [cdc.gov](#) > CDC A - Z INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain
- o U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at [hhs.gov/opioids](#) > Prevention

- Treatment

- o Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted medication assisted treatment for opioid use disorder (MOUD) (MAT) available at [samhsa.gov](#) > Programs & Campaigns > Medication-Assisted Treatment
- o National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at [drugabuse.gov](#) > Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
- o HHS Treatment for Opioid Use Disorder available at [hhs.gov/opioids](#) > Treatment
- o American Society of Addiction Medicine (ASAM) Educational Resources available at [asam.org](#) > Education > Educational Resources

- Recovery

- o In-network MOUD care provider search for UnitedHealthcare plan members available at [provider.liveandworkwell.com](#)
 - To start a search, enter ZIP code > Select an Area of Expertise > Substance Use Disorder > Search

- Harm reduction

- o Harm Reduction Coalition Prescribe Naloxone! available at [harmreduction.org](#) > Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources
- o SAMHSA Opioid Overdose Preventive Toolkit available at [samhsa.gov](#) > Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)

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Pharmacotherapy for Opioid Use Disorder (POD)

New for 2026

- No applicable changes for this measure



Yes!

Supplemental data accepted for required exclusions only

Definition

Percentage of new opioid use disorder pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of opioid use disorder and a new opioid use disorder pharmacotherapy event.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter • Pharmacy data

Medications

To be included in this measure, a member must have been dispensed one of the following Opioid medications:

Drug category	Medications
Antagonist	<ul style="list-style-type: none"> • Naltrexone (oral or injectable)
Partial agonist	<ul style="list-style-type: none"> • Buprenorphine (sublingual tablet, injection, implant)
Partial agonist	<ul style="list-style-type: none"> • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Methadone is not included on the Medication lists for this measure because a pharmacy claim for methadone indicates treatment for pain and not opioid use disorder.

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Pharmacotherapy for Opioid Use Disorder (POD) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

Tips and best practices to help close this care opportunity

- This measure focuses on treatment for members with opioid use disorder
- Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose
- UnitedHealthcare is committed to working with care providers to help:
 - Prevent** opioid misuse and addiction
 - Treat** those who are addicted
 - Support** long-term recovery

For more information about our programs to help prevent opioid overuse, please visit UHCprovider.com > Menu > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.

- Information to help you stay informed about the latest opioid research and guidelines is also available at cdc.gov, hhs.gov or your state’s public health department website. Here are a few suggestions to get you started:

– Prevention

- Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at cdc.gov > CDC A - Z

- INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC’s opioid prescribing guideline for chronic pain
- U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at hhs.gov/opioids > Prevention
- Treatment**
 - Substance Abuse and Mental Health Services Administration (SAMHSA) medication assisted treatment for opioid use disorder (MOUD) available at samhsa.gov > Programs & Campaigns > Medication-Assisted Treatment
 - National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at drugabuse.gov > Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
 - HHS Treatment for Opioid Use Disorder available at hhs.gov/opioids > Treatment
 - American Society of Addiction Medicine (ASAM) Educational Resources available at: asam.org > Education > Educational Resources

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Pharmacotherapy for Opioid Use Disorder (POD) (cont.)

- Recovery

- o In-network MOUD care provider search for UnitedHealthcare plan members available at provider.liveandworkwell.com

- To start a search, enter ZIP code > Select an Area of Expertise > Substance Use Disorder > Search

- Harm reduction

- o Harm Reduction Coalition Prescribe Naloxone! available at harmreduction.org > Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources

- o SAMHSA Opioid Overdose Preventive Toolkit available at samhsa.gov > Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)

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Proportion of Days Covered (PDC)

New for 2026

- No applicable changes for this measure

Definition

Percentage of members ages 18 or older who are adherent to their blood pressure, diabetes and cholesterol medication(s) at least 80% of the time in the measurement period.

Rates are reported for each of the following:

- Renin Angiotensin System Antagonists (PDC-RASA)
- Diabetes All Class (PDC-DR)
- Statins (PDC-STA)

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Exchange/ Marketplace 	<ul style="list-style-type: none"> • CMS Quality Rating System 	Administrative <ul style="list-style-type: none"> • Claim/encounter

Medications

Members who filled at least 2 prescriptions of the following medications on different dates of service during the treatment period.

Drug category	Medications
Renin Angiotensin System (RAS) Antagonists	<ul style="list-style-type: none"> • Direct Renin inhibitor • ARB medications and combinations • ACE inhibitor medications and combinations
Diabetes all class	<ul style="list-style-type: none"> • Biguanides • DPP-4 inhibitors • GIP/ GLP-1 receptor agonists • Meglitinides • SGLT2 inhibitors • Sulfonylureas • Thiazolidinediones • Sodium Glucose Co-Transporter2 inhibitors
Statin medications	<ul style="list-style-type: none"> • Atorvastatin • Fluvastatin • Lovastatin • Pitavastatin • Pravastatin • Rosuvastatin • Simvastatin

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Proportion of Days Covered (PDC) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • End Stage Renal Disease (ESRD) • Prescription claim for Sacubitril/Valsartan (PDC- RASA) • One or more prescription claim for insulin (PDC-DR) 	<p>Any time during the measurement year</p>

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Risk of Continued Opioid Use (COU)

New for 2026

- No applicable changes for this measure



Yes!

Supplemental data accepted for required exclusions only

Definition

Percentage of members ages 18 and older with a new episode of opioid use that puts them at risk for continued use.

Two rates are reported:

- The percentage of members with at least 15 days of prescription opioids in a 30-day period
- The Percentage of members with at least 31 days of prescription opioids in a 62-day period

A lower rate indicates a better score for this measure.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • Select state reporting 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter • Pharmacy data

Medications

To be included in this measure, a member must have been dispensed one of the following Opioid medications:

Opioid medications			
• Benzhydrocodone	• Codeine	• Levorphanol	• Oxycodone
• Buprenorphine (transdermal patch and buccal film)	• Dihydrocodeine	• Meperidine	• Oxymorphone
• Butorphanol	• Fentanyl	• Methadone	• Pentazocine
	• Hydrocodone	• Morphine	• Tapentadol
	• Hydromorphone	• Opium	• Tramadol

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Risk of Continued Opioid Use (COU) (cont.)

These medications are not included as dispensing events for this measure:

- Cough and cold products with opioids
- Injectables
- Ionsys®
 - Fentanyl transdermal patch used in inpatient settings only
- Methadone for the treatment of opioid use disorder
- Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder
 - Buprenorphine sublingual tablets
 - Buprenorphine subcutaneous implant
 - Buprenorphine/naloxone combination products

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> • Cancer • Sickle cell disease • Palliative care 	Any time during the 12 months prior to the index prescription start date through 61 days after

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Risk of Continued Opioid Use (COU) (cont.)

Tips and best practices to help close this care opportunity

- This measure focuses on taking caution with patients with a new prescription for opioids
- Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose
- UnitedHealthcare is committed to working with care providers to help:
 - **Prevent** opioid misuse and addiction
 - **Treat** those who are addicted
 - **Support** long-term recovery

For more information about our programs to help prevent opioid overuse, please visit [UHCprovider.com](https://www.uhcprovider.com) > Menu > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.

- Information to help you stay informed about the latest opioid research and guidelines is also available at [cdc.gov](https://www.cdc.gov), [hhs.gov](https://www.hhs.gov) or your state's public health department website. Here are a few suggestions to get you started:

– Prevention

- o Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain available at: [cdc.gov](https://www.cdc.gov) > CDC A - Z INDEX > D > Drug Overdose (OD) > Healthcare Providers > CDC's opioid prescribing guideline for chronic pain
- o U.S. Department of Health & Human Services (HHS) Prevent Opioid Abuse and Addiction available at [hhs.gov/opioids](https://www.hhs.gov/opioids) > Preventio

– Treatment

- o Substance Abuse and Mental Health Services Administration (SAMHSA) medication

- o assisted treatment for opioid use disorder (MOUD) available at [samhsa.gov](https://www.samhsa.gov) > Programs & Campaigns > Medication-Assisted Treatment
- o National Institute on Drug Abuse (NIDA) Effective Treatments for Opioid Addiction available at [drugabuse.gov](https://www.drugabuse.gov) > Drugs of Abuse > Opioids > Effective Treatments for Opioid Addiction
- o HHS Treatment for Opioid Use Disorder available at [hhs.gov/opioids](https://www.hhs.gov/opioids) > Treatment
- o American Society of Addiction Medicine (ASAM) Educational Resources available at: [asam.org](https://www.asam.org) > Education > Educational Resources

– Recovery

- o In-network MOUD care provider search for UnitedHealthcare plan members available at [provider.liveandworkwell.com](https://www.provider.liveandworkwell.com)
 - To start a search, enter ZIP code > Select an Area of Expertise > Substance Use Disorder > Search

– Harm reduction


- o Harm Reduction Coalition Prescribe Naloxone! available at [harmreduction.org](https://www.harmreduction.org) > Issues > Overdose Prevention > Prescribe Naloxone! Recent Resources
- o SAMHSA Opioid Overdose Preventive Toolkit available at [samhsa.gov](https://www.samhsa.gov) > Publications > Substances > Opioids or Opiates > Opioid Overdose Prevention Toolkit (SMA16-4742)

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Child and Adolescent Well-care visits (WCV)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental data accepted

Definition

Percentage of members ages 3-21 years who had one or more comprehensive Well-care visits with a primary care provider or OB-GYN during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings • Select Medicaid state reporting 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Well-care visits	
CPT®/CPT II	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302, S0610, S0612, S0613
ICD-10 Diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2

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Child and Adolescent Well-care visits (WCV) (cont.)

Well-care visits

SNOMED

103740001, 170099002, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260003, 1269517007, 1269518002, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106

Required exclusion(s)

Exclusion

- Members in hospice or using hospice services
- Members who died

Time frame

Any time during the measurement year



Important notes

- The well-child visit must be done by a primary care provider, but it doesn't have to be with the member's assigned primary care provider
- School-based health clinic visits count for this measure if they're for a well-care exam **and** the physician completing the exam is a primary care provider
- A sports physical does not qualify for a well-care visit because it does not include required components for a well-care exam such as the health history, preventive care, behavioral and development screenings

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Child and Adolescent Well-care visits (WCV) (cont.)

Additional measure resources

<ul style="list-style-type: none"> Bright Futures 	<p>This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. Bright Futures recommends.</p>
<ul style="list-style-type: none"> Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents AAP Books American Academy of Pediatrics 	<p>Get recommendations for child development and well-child supervision standards.</p>
<ul style="list-style-type: none"> Periodicity Schedule 	<p>Recommendations for preventive pediatric health care.</p>
<ul style="list-style-type: none"> The America’s Health Rankings® 2024 Health 	<p>Early identification of risk factors and health concerns are key in promoting better health outcomes for this population.</p>
<ul style="list-style-type: none"> Immunizations Best Practice Course 	<p>Use the quick provider web-based training to learn more about best practices for immunizations for all ages.</p>
<ul style="list-style-type: none"> CDC Vaccines & Immunizations 	<p>Find most up-to-date immunization schedules and catch-up recommendations.</p>
<ul style="list-style-type: none"> Low cost/Free Vaccination Opportunities 	<p>Discuss low-cost/free vaccination opportunities if cost is a concern.</p>
<ul style="list-style-type: none"> Immunization Action Coalition 	<p>For information about standardized tools to assist you and your practice.</p>

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Use of First-Line Psychosocial care for Children and Adolescents on Antipsychotics (APP)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
data accepted

Definition

Percentage of children and adolescents ages 1-17 who had a new prescription for an antipsychotic and had Psychosocial care or residential behavioral health treatment as first line treatment in 121 days. 121 days includes 90 days before the earliest dispensing date to 30 days after.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings • Select State Medicaid Reporting 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data • Pharmacy data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Psychosocial care	
CPT®/CPT II	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90875, 90876, 90880
HCPCS	G0176, G0177, G0409, G0410, G0411, H0004, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485

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Use of First-Line Psychosocial care for Children and Adolescents on Antipsychotics (APP) (cont.)

Psychosocial care

SNOMED

166001, 1555005, 2619005, 3518004, 5694008, 6227009, 7133001, 8411005, 9591001, 15142007, 15558000, 15711005, 17447008, 17914007, 18512000, 19997007, 21055002, 22900004, 24172008, 24621000, 26693005, 26829003, 26890005, 27482005, 27591006, 28868002, 28988002, 30808008, 31408009, 31594000, 32051004, 33661004, 35358007, 36230009, 38592005, 38678006, 39697002, 41035007, 41653002, 41838008, 45565001, 46618005, 47805006, 50160009, 51484002, 51790004, 53508008, 53769000, 57070007, 57847003, 58771002, 59364003, 59585002, 59694001, 61436009, 62474003, 63386006, 65201004, 66060003, 73139001, 75516001, 76168009, 76740001, 77170008, 78493007, 79441000, 82309004, 83474000, 84892007, 85614001, 85925008, 88848003, 89909007, 90102008, 91172002, 91425008, 91481002, 108313002, 113141001, 113143003, 113144009, 171423009, 171424003, 171425002, 171426001, 183339004, 183381005, 183382003, 183383008, 183385001, 183387009, 183388004, 183389007, 183391004, 183393001, 183395008, 183396009, 183398005, 183399002, 183401008, 183402001, 183403006, 183405004, 183406003, 183408002, 183413003, 183422002, 225160006, 225224008, 225225009, 225226005, 225227001, 225333008, 228546003, 228548002, 228549005, 228550005, 228551009, 228553007, 228554001, 228555000, 228557008, 228575009, 229216005, 229217001, 229218006, 229219003, 229220009, 229221008, 229306004, 266744007, 299695005, 302230009, 302234000, 302235004, 302236003, 302238002, 302239005, 302240007, 302242004, 302243009, 302244003, 302245002, 302247005, 302248000, 302255003, 302259009, 302260004, 302262007, 302683009, 303262000, 304637004, 304638009, 304702006, 304814008, 304815009, 304816005, 304817001, 304818006, 304819003, 304820009, 304821008, 304822001, 304824000, 304825004, 304826003, 304851002, 304888004, 304889007, 304893001, 304894007, 311460008, 311461007, 311462000, 311510000, 311511001, 311522002, 311523007, 311884008, 312043006, 312044000, 313105004, 314034001, 361229007, 361230002, 385768000, 385769008, 385770009, 385771008, 385772001, 385773006, 385774000, 385893007, 385992003, 386255004, 386256003, 386257007, 386316003, 386367000, 386429002, 386522008, 386523003, 386524009, 386525005, 390773006,

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Use of First-Line Psychosocial care for Children and Adolescents on Antipsychotics (APP) (cont.)

Psychosocial care

SNOMED (cont.)

391892008, 397074006, 401157001, 401162000, 405780009, 405792009, 405793004, 406165004, 406183007, 406184001, 406185000, 410112008, 410115005, 410118007, 410121009, 410124001, 410127008, 410130001, 425680009, 427954006, 429048003, 429159005, 429329005, , 439330009, 439436002, 439741009, 439795004, 439805004, 439820005, 439916005, 440274001, 440582002, 440646003, 443119008, 443730003, 444175001, 449030000, 700445002, 700446001, 702471009, 702780005, 711078000, 711283001, 712558003, 718023002, 718026005, 720444008, 723528003, 723619005, 734278000, 736861004, 866252000, 868185009, 1163366004, 1236920000, 1256107005, 1259023009, 1300121009, 460891000124103, 460901000124104, 461561000124103, 56911000087108, 57001000087105

Residential behavioral health treatment

HCPCS

H0017, H0018, H0019, T2048

Required exclusion(s)

Exclusion

- Members in hospice or using hospice services
- Members who died
- One or more acute inpatient encounter with a diagnosis of schizophrenia
- Members who were diagnosed on at least 2 different dates of service during the measurement year with schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorders where first-line antipsychotic medication is clinically appropriate

Time frame

Any time during the measurement year

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Use of First-Line Psychosocial care for Children and Adolescents on Antipsychotics (APP) (cont.)

Tips and best practices to help close this care opportunity:

- Make sure children and adolescents receive a psychosocial care appointment at least 90 days prior to prescribing medication or within 30 days of starting an initial prescription if there is an urgent need for medication
- Psychosocial treatments (interventions) include, but are not limited to, structured counseling, case management, care coordination, psychotherapy, crisis intervention services, individual, family and group psychotherapy, activity therapy (music, art or play therapy not for recreation) and relapse prevention
- Refer patients to a mental health professional:
 - If you need to refer your patient to a behavioral health specialist or need to request coordination of care, please call the number on the back of the patient's health plan ID card or search [liveandworkwell.com](https://www.liveandworkwell.com)
- Monitor children/adolescents prescribed antipsychotics closely as they are more at risk for serious health concerns, including weight gain, extrapyramidal side effects, hyperprolactinemia and some metabolic effects including glucose and cholesterol levels
- Educate and inform parents/guardians of the increased side effect burden of multiple concurrent antipsychotics on children's health, which has implications for future physical health concerns
- Offer National Suicide Prevention Lifeline for patient to call, text or chat 988 when needed

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

New for 2026

- No applicable changes to this measure



Yes!
Supplemental
Data Accepted

Definition

Percentage of members ages 3-17 who had an outpatient visit with a primary care provider or OB-GYN and had evidence of the following during the measurement year:

- Body mass index (BMI) percentile
- Counseling for nutrition
- Counseling for physical activity

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings (BMI Percentile Only) 	<p>Hybrid</p> <ul style="list-style-type: none"> • Claim/encounter data • Medical record documentation

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

BMI percentile

ICD-10 Diagnosis	Z68.51, Z68.52, Z68.53, Z68.54, Z68.55, Z68.56
LOINC	59574-4, 59575-1, 59576-9

Counseling for nutrition

ICD-10 Diagnosis	Z71.3
CPT®/CPT II	97802, 97803, 97804
HCPCS	G0270, G0271, G0447, S9449, S9452, S9470

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)(cont.)

Counseling for nutrition

SNOMED	11816003, 61310001, 183059007, 183060002, 183061003, 183062005, 183063000, 183065007, 183066008, 183067004, 183070000, 183071001, 226067002, 266724001, 275919002, 281085002, 284352003, 305849009, 305850009, 305851008, 306163007, 306164001, 306165000, 306626002, 306627006, 306628001, 313210009, 370847001, 386464006, 404923009, 408910007, 410171007, 410177006, 410200000, 429095004, 431482008, 443288003, 609104008, 698471002, 699827002, 699829004, 699830009, 699849008, 700154005, 700258004, 705060005, 710881000, 1230141004, 14051000175103, 428461000124101, 428691000124107, 441041000124100, 441201000124108, 441231000124100, 441241000124105, 441251000124107, 441261000124109, 441271000124102, 441281000124104, 441291000124101, 441301000124100, 441311000124102, 441321000124105, 441331000124108, 441341000124103, 441351000124101, 445291000124103, 445301000124102, 445331000124105, 445641000124105
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Counseling for physical activity

ICD-10 Diagnosis	Z02.5, Z71.82
HCPCS	G0447, S9451
SNOMED	103736005, 183073003, 281090004, 304507003, 304549008, 304558001, 310882002, 386291006, 386292004, 386463000, 390864007, 390893007, 398636004, 398752005, 408289007, 410200000, 410289001, 410335001, 429778002, 710849009, 435551000124105

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)(cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died Members with a diagnosis of pregnancy 	Any time during the measurement year



Important notes

Medical record detail including, but not limited to

- For ages 3-17, a BMI percentile or BMI percentile plotted on an age growth chart meets compliance. An absolute BMI value will not meet compliance for this age range.
 - Always record height and weight in a member's medical record
- BMI percentile ranges or thresholds will not meet compliance
 - This is true even for single ranges - for example, 17-18%
 - The only exception are values <1% or >99%
- Weight assessment and counseling for nutrition and physical activity can be completed at any appointment - not just a well-child visit. However, services specific to an acute or chronic condition will not meet compliance for counseling for nutrition or physical activity.
 - For example: Member has exercise-induced asthma or decreased appetite because of flu symptoms

- Growth charts with percentile
- History and physical
- Progress notes
- Vitals sheet
- After visit summary

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)(cont.)

Additional measure resources

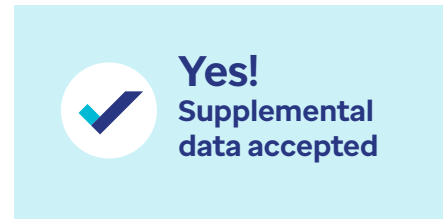
<ul style="list-style-type: none"> Bright Futures 	<p>Helpful resources about the components of care are available at brightfutures.aap.org</p>
<ul style="list-style-type: none"> Periodicity Schedule 	<p>Schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.</p>
<ul style="list-style-type: none"> Training Module: Overview of CDC Growth Charts Growth Chart Training CDC 	<p>Overview of the CDC growth charts for use among children and teens ages 2 to 20.</p>

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Well-Child Visits in the First 30 Months of Life (W30)

New for 2026

- No applicable changes for this measure



Definition

Percentage of members who turned 15–30 months old during the measurement year and had the recommended number of well-child visits with a primary care provider.

- Children 0-15 months old during the measurement year: 6 or more well-child visits in the first 15 months of life
- Children 15-30 months old during the measurement year: 2 or more well-child visits between 15–30 months of age

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System • Select Medicaid state reporting • NCQA Health Plan Ratings 	<p>Administrative</p> <ul style="list-style-type: none"> • Claim/encounter data

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Well-care visits	
CPT®/CPT II	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302, S0610, S0612, S0613
ICD-10 Diagnosis	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1, Z76.2

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Well-Child Visits in the First 30 Months of Life (W30) (cont.)

Well-care visits

SNOMED

103740001, 170099002, 170107008, 170114005, 170123008, 170132005, 170141000, 170150003, 170159002, 170168000, 170250008, 170254004, 170263002, 170272005, 170281004, 170290006, 170300004, 170309003, 171387006, 171394009, 171395005, 171409007, 171410002, 171416008, 171417004, 243788004, 268563000, 270356004, 401140000, 410620009, 410621008, 410622001, 410623006, 410624000, 410625004, 410626003, 410627007, 410628002, 410629005, 410630000, 410631001, 410632008, 410633003, 410634009, 410635005, 410636006, 410637002, 410638007, 410639004, 410640002, 410641003, 410642005, 410643000, 410644006, 410645007, 410646008, 410647004, 410648009, 410649001, 410650001, 442162000, 783260003, 1269517007, 444971000124105, 446301000124108, 446381000124104, 669251000168104, 669261000168102, 669271000168108, 669281000168106

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Well-Child Visits in the First 30 Months of Life (W30) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

Additional measure resources

<ul style="list-style-type: none"> Bright Futures 	This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. Bright Futures recommends.
<ul style="list-style-type: none"> Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents AAP Books American Academy of Pediatrics 	Get recommendations for child development and well-child supervision standards.
<ul style="list-style-type: none"> Periodicity Schedule 	Recommendations for preventive pediatric health care.
<ul style="list-style-type: none"> Immunizations Best Practice Course 	Use the quick provider web-based training to learn more about best practices for immunizations for all ages.
<ul style="list-style-type: none"> CDC Vaccines & Immunizations 	Find the most up-to-date immunization schedules and catch-up recommendations.
<ul style="list-style-type: none"> Low cost/Free Vaccination Opportunities 	Discuss low-cost/free vaccination opportunities if cost is a concern.
<ul style="list-style-type: none"> Immunization Action Coalition 	For information about standardized tools to assist you and your practice.

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Adult Immunization Status (AIS-E)

New for 2026

Added

- Added a COVID-19 indicator for adults 65 and older

Definition

Percentage of members ages 19 and older who have had the following vaccinations in the recommended time frame:

- 1 influenza vaccine
- 1 Td/Tdap vaccine
- 2 (recombinant) herpes zoster (shingles)
- 1 adult pneumococcal vaccine
- 3 childhood Hepatitis B vaccines or an adult Hepatitis B vaccine series
- 1 adult COVID-19 vaccine

Plans(s) affected	Quality program(s) affected	Collection and Reporting Method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare • Exchange/Marketplace 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings • CMS Star Ratings • CMS Quality Rating System 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close numerator gaps in care; they are not intended to be a directive of your billing practice.

Influenza vaccine

- Number of doses: 1
- Members aged 19 and older
- Vaccine administered on or between July 1 of the year prior to measurement year and June 30 of the measurement year
- Anaphylaxis due to the influenza vaccine will count toward compliance

Adult Immunization Status (AIS-E) (cont.)

CPT®/CPT II	90653, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756, 90660, 90672
CVX codes	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205, 111, 149, 320, 333
NDC	66019011251
SNOMED	471361000124100
Td/Tdap <ul style="list-style-type: none"> • Number of doses: 1 • Members age 19 and older • Vaccine administered between 9 years prior to the start of the measurement year and the end of the measurement year • Anaphylaxis or encephalitis due to the diphtheria, tetanus or pertussis vaccine will count toward compliance 	
CPT®/CPT II	90714, 90715
CVX codes	09, 113, 115, 138, 139
Encephalitis due to diphtheria, tetanus or pertussis vaccine	
SNOMED	192710009, 192711008, 192712001

Adult Immunization Status (AIS-E) (cont.)

Anaphylaxis due to diphtheria, tetanus or pertussis vaccine

SNOMED	428281000124107, 428291000124105
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Adult pneumococcal vaccine

- Number of doses: 1
- Members age 65 and older
- Vaccine administered on or after member's 19th birthday and before or during the measurement year
- Anaphylaxis to the pneumococcal vaccine any time before or during the measurement year will count toward compliance

CPT®/CPT II	90670, 90671, 90677, 90732, 90684
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CVX codes	33, 109, 133, 152, 215, 216, 327
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HCPCS	G0009
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Anaphylaxis due to pneumococcal vaccine

SNOMED	471141000124102
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Herpes Zoster (shingles)

- Number of doses: 2 doses of herpes zoster recombinant vaccine
- Members ages 50 and older
- Vaccine administered on Oct. 20, 2017, through the end of the measurement year
- The recombinant vaccine must be at least 28 days apart
- Anaphylaxis to the herpes zoster will count toward compliance

CPT®/CPT II	90750
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CVX codes	187
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Anaphylaxis due to herpes zoster vaccine

SNOMED	471371000124107, 471381000124105
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Adult Immunization Status (AIS-E) (cont.)

Hepatitis B vaccine

- 3 doses of childhood hepatitis B vaccine administered on or before the 19th birthday; or
- An adult hepatitis B vaccine series administered on or after the 19th birthday
 - 2 doses of the recommended 2-dose adult hepatitis B vaccine at least 28 days apart; or
 - 3 doses of any other recommended adult hepatitis B vaccine on different dates of service
- History of hepatitis B vaccine any time before or during the measurement year
- Anaphylaxis to the hepatitis B vaccine any time before or during the measurement year will count toward compliance

Childhood hepatitis B vaccine

CPT/CPT II	90740, 90747, 90744, 90723, 90697, 90748
CVX codes	08, 44, 45, 51, 110, 146, 198
HCPCS	G0010

Newborn hep B Number of doses: 1 of 3 eligible

ICD-10 Procedure	3E0234Z
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Adult hepatitis B vaccine series

CPT/CPT II	90739, 90740, 90743, 90744, 90746, 90747, 90759
CVX codes	43, 44, 45, 104, 189, 220

Positive hepatitis B surface antigen, surface antibody, or core antigen test result

LOINC	104785-1, 10900-9, 13919-6, 13952-7, 16933-4, 16935-9, 16935-9, 22316-4, 22318-0, 22319-8, 22322-2, 24113-3, 31204-1, 32019-2, 32685-0, 39535-0, 40725-4, 48070-7, 49177-9, 49495-5, 5185-4, 5186-2, 5187-0, 5188-8, 51914-0, 5193-8, 5193-8, 5194-6, 5195-3, 5196-1, 5197-9, 58405-2, 58452-4, 63557-3, 65633-0, 70154-0, 75378-0, 75409-3, 75410-1, 7905-3, 83100-8, 95234-1, 99385-7
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Adult Immunization Status (AIS-E) (cont.)

Positive hepatitis B surface antigen, surface antibody, or core antigen test result

SNOMED	10828004, 165806002, 260373001, 271511000, 313234004, 406117000, 736687002, 105811000119100
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History of hepatitis

ICD-10 Diagnosis	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
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SNOMED	116000, 13265006, 26206000, 38662009, 50167007, 53425008, 60498001, 61977001, 66071002, 76795007, 111891008, 165806002, 186624004, 186626002, 186639003, 235864009, 235865005, 235869004, 235871004, 271511000, 313234004, 406117000, 424099008, 424340000, 442134007, 442374005, 446698005, 838380002, 1230342001, 59851000119103, 153091000119109, 551621000124109, 16859701000119100
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Anaphylaxis due to hepatitis B vaccine

SNOMED	428321000124101
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COVID-19 Vaccine

- At least 1 dose of an adult COVID-19 vaccine administered both on or between July 1 of the measurement year and on or after their 65th birthday
- Anaphylaxis to the COVID-19 vaccine any time before or during the measurement year will count toward compliance

Adult COVID-19 Vaccine

CPT/CPT II	91304, 91320, 91322, 91323
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CVX Codes	309, 312, 313, 334
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Anaphylaxis Due to COVID-19 Vaccine

SNOMED	914587451000119107
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Adult Immunization Status (AIS-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year

Tips and best practices to help close this care opportunity:

- Standing orders can help your office staff be part of the vaccination process
 - Offer vaccine information sheets (VIS) to read while patients wait
 - Medical assistants can verify interest and obtain the vaccine to be administered
 - Train staff to answer questions, administer and document in the patient's chart
 - Consider having front office staff offer VISs in the patient's preferred language
 - Immunize.org offers numerous translations that can be selected and printed, as needed
- Have office staff wear pins that show they've been vaccinated to help prompt patients to ask questions
 - Example: A 'Got my flu shot' button may prompt someone to ask if flu shots are available
- Provide patients information about vaccines based on timing and eligibility
 - As members are turning 50, share information about the shingles vaccine
 - Ask or check when patients received their last Tdap, has it been 10 years?
 - If they have a qualifying health condition or turning 65, share information about pneumonia vaccines
- September through November provide information on influenza vaccines
- Offer flu shots to eligible members at all visits during flu season
- Ask whether the patient has been screened for adult Hepatitis B and if they have had a vaccination. If not, offer the screening and vaccination.
- Stock vaccines in your office to make the visit a single stop for the patient and leverage trained staff to administer as part of their visit
- Consider which vaccines are most commonly needed based on your community
- Have a quick reference where patients can get vaccines not stocked at your office
- Place images and information about vaccinations throughout your office, including that they may be covered by the patient's health plan or low cost, on:
 - Posters
 - Placards
 - Stickers on charts

Breast Cancer Screening (BCS-E)

New for 2026

Removed

- Removed required exclusion for the combination of unilateral mastectomy with a bilateral modifier



Yes!
Supplemental
Data Accepted

Definition

Percentage of members ages 40-74 who were recommended for routine breast cancer screening and had a mammogram screening completed on or by Oct. 1, 2 years prior to the measurement year through Dec. 31 of the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings • CMS Quality Rating System • NCQA Health Plan Ratings 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Mammography	
CPT®/CPT II	77061, 77062, 77063, 77065, 77066, 77067
LOINC	103885-0, 103886-8, 103892-6, 103893-4, 103894-2, 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3

Breast Cancer Screening (BCS-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died Members receiving palliative care 	Any time during the measurement year
<p>Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion:</p> <ul style="list-style-type: none"> Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine 	<p>Frailty diagnoses must be in the measurement year and on different dates of service</p> <p>Advanced illness diagnosis must be in the measurement year or year prior to the measurement year</p>
<p>Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:</p> <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution 	Any time during the measurement year

Breast Cancer Screening (BCS-E) (cont.)

Exclusion	Time frame
<p>Bilateral mastectomy</p> <ul style="list-style-type: none"> • History of bilateral mastectomy • Any combination of the following that indicate a mastectomy on both the left and right side: <ul style="list-style-type: none"> - Absence of the left and right breast - Left unilateral mastectomy - Right unilateral mastectomy • Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria 	<p>Any time in a member's history through Dec. 31 of the measurement year</p>



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
<ul style="list-style-type: none"> • This measure does not include biopsies, breast ultrasounds or MRIs • If documenting a mammogram in a member's history, please include the month and year. The result is not required. 	<p>Mammogram - all types and methods including screening, diagnostic, film, digital or digital breast tomosynthesis</p>	<ul style="list-style-type: none"> • Consultation reports • Diagnostic reports • Health history and physical

Breast Cancer Screening (BCS-E) (cont.)

Tips and best practices to help close this care opportunity

- **Always include a date of service – year and month is acceptable – when documenting a mammogram reported by a member**
- Thermography for any indication (including breast lesions which were excluded from Medicare coverage on July 20, 1984) is excluded from Medicare coverage
- As an ECDS measure, it's important to submit the appropriate ICD-10 Diagnosis code that reflects a member's history of bilateral mastectomy, Z90.13
 - If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim
 - If a member isn't new to the care provider, but the member's chart has a documented history of the diagnosis, the ICD-10 Diagnosis code should be submitted on any visit claim
- Breast cancer screening or mastectomy codes can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Member refusal will not make them ineligible for this measure

Breast Cancer Screening (BCS-E) (cont.)

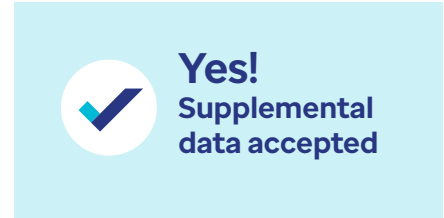
Additional measure resources

<ul style="list-style-type: none"> • ACS NBCRT Risk Assessment Toolkit – NBCRT 	<p>The American Cancer Society National Breast Cancer Roundtable (ACS NBCRT) assembled this digital toolkit to support practices and providers in conducting breast cancer risk assessments. Breast cancer risk assessment helps identify individuals at higher risk for breast cancer to enable personalized screening, prevention and early detection strategies. This toolkit presents evidence-based breast cancer risk assessment tools and provides guidance for providers on their effective use.</p>
<ul style="list-style-type: none"> • Recommendation: Breast Cancer: Screening United States Preventive Services Taskforce 	<p>U.S. Preventive Services Task Force recommendations for biennial screening for women aged 40-74 years.</p>
<ul style="list-style-type: none"> • Safety Considerations for COVID-19 Vaccines COVID-19 CDC 	<p>Per the CDC, lymphadenopathy may occur 4-6 weeks after the COVID-19 vaccination. Please encourage your patients to wait the appropriate amount of time before scheduling their mammogram or complete the mammogram before receiving the COVID-19 vaccine, to account for lymphadenopathy. This will help prevent the vaccine impacting screening results.</p>

Cervical Cancer Screening (CCS-E)

New for 2026

- No applicable changes for this measure



Definition

Percentage of members ages 21-64 who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members recommended for routine cervical cancer screening ages 21-64 who had Cervical cytology performed in the measurement year or 2 years prior
- Members recommended for routine cervical cancer screening ages 30-64 who had Cervical cytology/ high-risk human papillomavirus (hrHPV) co-testing performed in the measurement year or four years prior. The member must have been at least age 30 on the date of the test.
- Members recommended for routine cervical cancer screening ages 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or four years prior

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Cervical Cancer Screening (CCS-E) (cont.)

Codes

Cervical cytology	
CPT®/CPT II	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001
LOINC	10524-7, 18500-9, 19762-4, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5, 104866-9
SNOMED	1155766001, 168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 62051000119105, 62061000119107, 700399008, 700400001, 98791000119102
High-risk HPV test	
CPT®/CPT II	87624, 87625, 87626, 0502U
HCPCS	G0476
LOINC	104132-6, 77379-6, 82354-2, 77399-4, 59263-4, 82456-5, 82675-0, 59420-0, 30167-1, 21440-3, 77400-0, 59264-2, 75694-0, 95539-3, 71431-1, 104170-6, 38372-9, 69002-4, 104752-1, 104766-1, 104783-6
SNOMED	35904009, 448651000124104, 718591004

Cervical Cancer Screening (CCS-E)(cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members receiving palliative care Members who died 	Any time during the measurement year
Members with sex assigned at birth (LOINC code 76689-9) of male (LOINC code LA2-8)	Any time in a member's history through Dec. 31 of the measurement year
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix. Exclusion codes listed below.	Any time in a member's history through Dec. 31 of the measurement year
ICD-10-CM/ ICD10PCS	Q51.5, Z90.710, Z90.712, OUTC0ZZ, OUTC4ZZ, OUTC7ZZ, OUTC8ZZ
CPT®/CPT II	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135
SNOMED	10738891000119107, 116140006, 116142003, 116143008, 116144002, 1163275000, 1287897002, 176697007, 236888001, 236891001, 24293001, 248911005, 27950001, 287924009, 307771009, 31545000, 35955002, 361222003, 361223008, 37687000, 387626007, 414575003, 41566006, 428078001, 429290001, 429763009, 440383008, 446446002, 446679008, 46226009, 473171009, 59750000, 608805000, 608806004, 608807008, 708877008, 708878003, 723171001, 739671004, 739672006, 739673001, 739674007, 740514001, 740515000, 767610009, 767611008, 767612001, 82418001, 86477000, 88144003

Cervical Cancer Screening (CCS-E)(cont.)



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
Measurement year or 2 years prior	<ul style="list-style-type: none"> Cervical cytology for members ages 21-64 	<ul style="list-style-type: none"> Medical record must include date and result or findings
Measurement year or 4 years prior – test must be performed when the member is age 30 or older	<ul style="list-style-type: none"> High-risk HPV test (hrHPV) for members ages 30-64 	<ul style="list-style-type: none"> Consultation reports Diagnostic reports Health history and physical Lab reports

Tips and best practices to help close this care opportunity

- Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting
 - Documentation of “HPV Test” can be counted as evidence of hrHPV Test, as long as the result is documented
- As an administrative measure, it's important to submit the appropriate ICD-10 diagnosis code that reflects a member's history of “Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix”
 - If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim
 - If a member isn't new to the care provider but the member's chart has a documented history of the diagnosis, the ICD-10 diagnosis code should be submitted on any visit claim
- Documentation of a “hysterectomy” alone will **not** meet the intent of the exclusion
 - The documentation must include the words “total,” “complete” or “radical” abdominal or vaginal hysterectomy
 - Documentation of a “vaginal Pap smear” with documentation of “hysterectomy”
 - Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screening
- Member reported information documented in the patient's medical record is acceptable as long as there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix. The member reported information must be logged in the patient's chart by a care provider.
- Biopsies are diagnostic and therapeutic, and not valid for primary cervical cancer screening
- Test results from self-collected samples processed by a laboratory or provider's office may be used for reporting

Cervical Cancer Screening (CCS-E)(cont.)

- Lab results for cervical cancer screening or procedure codes for hysterectomy can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Assess and address member barriers to regular cervical cancer screening (e.g., access to care, transportation, cost, fear/anxiety)
- Educate members on the importance of early detection and encourage routine screening
- Create care gap alerts in your electronic medical record and proactively outreach to members who are not scheduled (scheduling calls, emails, time for screening postcards, etc.)

Childhood Immunization Status (CIS-E)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
Data Accepted

Definition

Percentage of children age 2 who had 4 doses of diphtheria, tetanus and a cellular pertussis (DTaP) vaccine; 1 hepatitis A (Hep A) vaccine; 3 doses of hepatitis B (Hep B) vaccine; 3 doses of haemophilus influenza type B (HiB) vaccine; 2 doses of influenza (flu) vaccine; 3 doses of polio (IPV) vaccine; 1 measles, mumps and rubella (MMR) vaccine; 4 doses of pneumococcal conjugate (PCV) vaccine; 2 or 3 doses of rotavirus (RV) vaccine; and 1 chicken pox (VZV) vaccine on or before their second birthday.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System (Combination 10) • NCQA Health Plan Ratings (Combination 10) 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

DTaP vaccine

Number of doses: 4

Special circumstances

- Do not count dose administered from birth through 42 days
- If applicable, anaphylaxis or encephalitis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications

CPT®/CPT II	90697, 90698, 90700, 90723
CVX codes	20, 50, 106, 107, 110, 120, 146, 198

Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine

SNOMED	428281000124107, 428291000124105
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Childhood Immunization Status (CIS-E) (cont.)

Encephalitis due to the diphtheria, tetanus or pertussis vaccine

SNOMED	192710009, 192711008, 192712001
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Hep A vaccine or history of hepatitis A illness

Number of doses: 1

Special circumstances

- Must be administered on or between a child's first and second birthdays
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications

CPT®/CPT II	90633
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CVX codes	31, 83, 85
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History of Hepatitis A

ICD-10 Diagnosis	B15.0, B15.9
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SNOMED	16060001, 18917003, 25102003, 40468003, 43634002, 79031007, 111879004, 424758008, 428030001
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Anaphylaxis due to the hepatitis A vaccine

SNOMED	471311000124103
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Hep B vaccine, history of hepatitis B illness

Number of doses: 3

Special circumstances

- One of the 3 can be the newborn hepatitis B vaccine given at hospital on date of birth or 7 days after (see code below)
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications

CPT®/CPT II	90697, 90723, 90740, 90744, 90747, 90748
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CVX codes	08, 44, 45, 51, 110, 146, 198
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HCPCS	G0010
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Childhood Immunization Status (CIS-E) (cont.)

Newborn Hep B

Number of doses: 1 of 3 eligible

ICD-10 Procedure | 3E0234Z

History of hepatitis B

ICD-10 Diagnosis | B16.0, B16.1, B16.2, B16.9, B18.0, B18.1, B19.10, B19.11

SNOMED | 1116000, 13265006, 26206000, 38662009, 50167007, 53425008, 61977001, 66071002, 76795007, 111891008, 186624004, 186626002, 186639003, 235864009, 235865005, 235869004, 235871004, 424099008, 424340000, 429721005, 442134007, 442374005, 446698005, 838380002, 1230342001, 59851000119103, 153091000119109, 551621000124109, 16859701000119109, 713966008, 103611000119102

Anaphylaxis due to the hepatitis B vaccine

SNOMED | 1428321000124101

HiB vaccine

Number of doses: 3

Special circumstances

- Do not count dose administered from birth through 42 days
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using hybrid specifications

CPT®/CPT II | 90644, 90647, 90648, 90697, 90698, 90748

CVX codes | 17, 46, 47, 48, 49, 50, 51, 120, 146, 148, 198

Anaphylaxis due to the haemophilus B vaccine

SNOMED | 433621000124101

Influenza vaccine

Number of doses: 2

Special circumstances

- Do not count dose administered prior to 180 days after birth
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications

CPT®/CPT II | 90655, 90657, 90661, 90674, 90685, 90686, 90687, 90688, 90689, 90756, 90656, 90658

CVX codes | 88, 140, 141, 150, 153, 158, 161, 171, 186, 320

NDC | 66019011251

Childhood Immunization Status (CIS-E) (cont.)

Anaphylaxis due to the influenza vaccine on or before the child's second birthday

SNOMED	471361000124100
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Live attenuated influenza virus

Number of doses: 1

Special circumstances

- Must be administered on the second birthday
- Only 1 of the 2 required vaccinations can be LAIV

CPT®/CPT II	90660, 90672
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CVX codes	111, 149, 333
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IPV vaccine

Number of doses: 3

Special circumstances

- Do not count dose administered from birth through 42 days
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications

CPT®/CPT II	90697, 90698, 90713, 90723
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CVX codes	10, 89, 110, 120, 146
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Anaphylaxis due to the inactivated polio vaccine

SNOMED	471321000124106
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MMR vaccine or history of measles, mumps or rubella

Number of doses: 1

Special circumstances

- Must be administered on or between a child's first and second birthdays
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications

CPT®/CPT II	90707, 90710
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CVX codes	03, 94
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Childhood Immunization Status (CIS-E) (cont.)

Anaphylaxis due to the measles, mumps and rubella vaccine on or before the child's second birthday

SNOMED | 471331000124109

History of measles

ICD-10 Diagnosis | B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9

SNOMED | 14189004, 28463004, 60013002, 74918002, 161419000, 186561002, 186562009, 195900001, 240483006, 240484000, 359686005, 371111005, 406592004, 417145006, 424306000, 105841000119101, 293721000119101

History of mumps

ICD-10 Diagnosis | B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9

SNOMED | 10665004, 17121006, 31524007, 31646008, 36989005, 40099009, 44201003, 63462008, 72071001, 75548002, 78580004, 89231008, 89764009, 161420006, 235123001, 236771002, 237443002, 240526004, 240527008, 240529006, 371112003, 1163539003, 105821000119107, 293721000119101

History of rubella

ICD-10 Diagnosis | B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9

SNOMED | 10082001, 13225007, 19431000, 36653000, 51490003, 64190005, 79303006, 128191000, 161421005, 186567003, 186570004, 192689006, 231985001, 232312000, 240485004, 253227001, 1092361000119109, 1857005, 47082005, 111868009, 278968001, 302811004, 1285608004, 105791000119104, 293721000119101, 1092351000119107

PCV Vaccine

Number of doses: 4

Special Circumstances

- Do not count dose administered from birth through 42 days.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II | 90670, 90671, 90677

CVX codes | 109, 133, 152, 215, 216

HCPCS | G0009

Anaphylaxis due to the pneumococcal conjugate vaccine

SNOMED | 471141000124102

Childhood Immunization Status (CIS-E) (cont.)

Rotavirus vaccine

Number of doses: 2 or 3 (depending on vaccine manufacturer)

Special circumstances

- Do not count dose administered from birth through 42 days
- Can combine at least 1 dose of the 2-dose vaccine and at least 2 doses of the 3-dose vaccine
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications

CPT®/CPT II	Rotavirus 2 dose: 90681, Rotavirus 3 dose: 90680
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CVX codes	Rotavirus 2 dose: 119, Rotavirus 3 dose: 116, 122
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Anaphylaxis due to the rotavirus vaccine

SNOMED	428331000124103
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VZV vaccine or history of varicella zoster

Number of doses: 1

Special circumstances

- Must be administered on or between a child's first and second birthdays

CPT®/CPT II	90710, 90716
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CVX codes	21, 94
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Anaphylaxis due to the varicella vaccine on or before the child's second birthday

SNOMED	471341000124104
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History of Varicella Zoster

ICD-10 Diagnosis	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9
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Childhood Immunization Status (CIS-E) (cont.)

History of varicella zoster

SNOMED

4740000, 10698009, 21954000, 24059009, 31920006, 36292003, 38907003, 42448002, 55560002, 87513003, 161423008, 195911009, 230176008, 230198004, 230262004, 230536009, 232400003, 235059009, 240468001, 240470005, 240471009, 240472002, 240473007, 240474001, 309465005, 397573005, 400020001, 402897003, 402898008, 402899000, 410500004, 410509003, 421029004, 422127002, 422446008, 422471006, 422666006, 423333008, 423628002, 424353002, 424435009, 424801004, 424941009, 425356002, 426570007, 428633000, 713250002, 713733003, 713964006, 715223009, 838357005, 1163465001, 1163483009, 1179456002, 12551000132107, 12561000132105, 12571000132104, 98541000119101, 331071000119101, 681221000119108, 1087131000119100, 15678761000119100, 15678801000119100, 15678841000119100, 15680201000119100, 15680241000119100, 15681321000119100, 15681401000119100, 15685081000119100, 15685121000119100, 15685161000119100, 15936581000119100, 15936621000119100, 15989271000119100, 15989311000119100, 15989351000119100, 15991711000119100, 15991751000119100, 15991791000119100, 15992351000119100, 16000751000119100, 16000791000119100, 16000831000119100, 10491005, 186509002, 193190005, 240469009, 277644009, 416718008, 449783002, 733167008, 870310004, 870321008, 1142085005, 1144351000, 1144352007, 1254866003, 1263534009, 28721000119108, 2490001000004101, 15680281000119103, 15681361000119105, 15685201000119100, 15685241000119103, 15685281000119108, 15992271000119100, 15992311000119100, 16540531000119103

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> Members who have had a contraindication to a childhood vaccine Members who have had organ and bone marrow transplants 	Any time on or before a member's second birthday

Childhood Immunization Status (CIS-E) (cont.)



Important notes

Medical record detail including, but not limited to

A member's medical record must include:

- A note with the name of the specific antigen and the date the vaccine was administered
- An immunization record from an authorized health care provider or agency - for example, a registry - including the name of the specific antigen and the date the vaccine was administered

Documentation that a member is up-to-date with all immunizations, but doesn't include a list of the immunizations and dates they were administered, will **not** meet compliance.

Documentation of physician orders, CPT codes or billing charges will **not** meet compliance.

For Hep A, Hep B, MMR or VZV, documented history of the illness counts as numerator compliance events - but they must occur on or before a child's second birthday.

For all 10 antigens documented history of anaphylaxis due to the vaccine counts as numerator compliance.

Documentation that a vaccine was given at birth or in the hospital will count as numerator compliance for any vaccines that don't have minimum age specifications.

- History and physical
- Immunization record
- Lab results
- Problem list with illnesses dated
- Progress notes

Childhood Immunization Status (CIS-E) (cont.)

Additional measure resources

<ul style="list-style-type: none"> Immunizations Best Practice Course 	Use the quick provider web-based training to learn more about best practices for immunizations for all ages.
<ul style="list-style-type: none"> CDC Vaccines & Immunizations 	Find the most up-to-date immunization schedules and catch-up recommendations.
<ul style="list-style-type: none"> Low cost/Free Vaccination Opportunities 	Discuss low-cost/free vaccination opportunities if cost is a concern.
<ul style="list-style-type: none"> Immunization Action Coalition 	A resource dedicated to empowering health care professionals through accessible educational resources and championing the removal of systemic barriers to ensure equitable access to vaccination for all populations.
<ul style="list-style-type: none"> Child Health and Well Visits 	UnitedHealthcare's Children's Health page offers insights into developmental milestones, preventive care checklists, vaccination schedules and tips for preparing for well-child visits.
<ul style="list-style-type: none"> Facilitate Return for Vaccination 	The CDC's IQIP strategy for facilitating return visits for vaccination emphasizes scheduling the next immunization appointment before the patient leaves the clinic, ideally during the exam or at checkout.
<ul style="list-style-type: none"> Coding for Pediatric Preventive Care 2025 	This initiative provides clinicians with tools and guidance to accurately document and bill for well-child visits and other preventive services.
<ul style="list-style-type: none"> Bright Futures 	This essential resource from the American Academy of Pediatrics provides comprehensive, evidence-informed recommendations for pediatric health supervision from birth through age 21.

Colorectal Cancer Screening (COL-E)

New for 2026

- No applicable changes to this measure

Definition

Percentage of members ages 45–75 who had an appropriate screening for colorectal cancer. Rates stratified for race and ethnicity.



Yes!
Supplemental
Data Accepted

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid (admin only) • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings • CMS Quality Rating System • Medicaid select state reporting • NCQA Health Plan Ratings 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Colonoscopy

CPT®/CPT II	44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398
HCPCS	G0105, G0121
SNOMED	8180007, 12350003, 25732003, 73761001, 174158000, 174185007, 235150006, 302052009, 367535003, 443998000, 444783004, 446521004, 446745002, 447021001, 709421007, 710293001, 711307001, 789778002, 1209098000, 48021000087103, 48031000087101, 174173004, 174179000, 609197007, 771568007, 1217313001, 1304042004, 1304043009, 1304044003, 1304045002, 1304049008, 1304050008, 174171002, 311774002, 426699005, 773128008, 773129000, 1351202006, 10371000132109

History of colonoscopy

SNOMED	851000119109
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When using SNOMED codes to identify history of procedures, the date of the procedure must be available (do not use the date when the provider documented the procedure as the date of the procedure).

Colorectal Cancer Screening (COL-E) (cont.)

Computed tomography (CT) colonography

CPT®/CPT II	74261, 74262, 74263 This service isn't covered for UnitedHealthcare Medicare Advantage members.
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LOINC	60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3
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Stool DNA (sDNA) with FIT test

CPT®/CPT II	81528, 0464U
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LOINC	77353-1, 77354-9
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SNOMED	708699002
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Flexible sigmoidoscopy

CPT®/CPT II	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
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Flexible sigmoidoscopy

HCPCS	G0104
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History of flexible sigmoidoscopy

SNOMED	44441009, 396226005, 425634007, 841000119107
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When using SNOMED codes to identify “history of” procedures, the date of the procedure must be available (do not use the date when the provider documented the procedure as the date of the procedure).

FOBT

CPT®/CPT II	82270, 82274
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HCPCS	G0328
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LOINC	12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6, 104738-0, 107189-3, 107190-1, 107191-9
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SNOMED	59614000, 167667006, 389076003, 71711000112103
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Colorectal Cancer Screening (COL-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members receiving palliative care Members who died 	Any time during the measurement year
Members who had colorectal cancer or a total colectomy	Any time during the member's history through Dec. 31 of the measurement year
<ul style="list-style-type: none"> Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: <ul style="list-style-type: none"> - Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). - Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be in the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year
<p>Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:</p> <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution 	Any time during the measurement year

Colorectal Cancer Screening (COL-E) (cont.)



Important notes

Test, service or procedure to close care opportunity

Measurement year or 9 years prior	Colonoscopy
Measurement year or 4 years prior	<ul style="list-style-type: none"> • Flexible sigmoidoscopy • CT colonography
Measurement year or 2 years prior	Stool DNA (sDNA) with FIT Test
Measurement year	iFOBT, gFOBT, FIT

Colorectal Cancer Screening (COL-E) (cont.)

Tips and best practices to help close this care opportunity

- Patient-reported screenings are acceptable **only if**:
 - Taken as part of the patient's history by a **PCP or specialist who provides primary care**
 - Included in the patient's **medical or health history**.
 - Clearly state:
 - o **Type of test performed**
(e.g., colonoscopy, flexible sigmoidoscopy, stool DNA [sDNA] with FIT, CT colonography, FOBT)
 - Example: "Colonoscopy completed in 2024"
 - o **Date of service** (year when the screening was performed)
- It's important to submit any codes that reflect a member's history of malignancy for colorectal cancer
 - If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim
 - If a member isn't new to the care provider, but the member's chart has documented history of the diagnosis, the ICD-10 Diagnosis code should be submitted on any visit claim
- Member refusal will **not** make them ineligible for this measure
 - Please recommend a Flexible sigmoidoscopy, stool DNA (sDNA) with FIT test or FOBT if a member refuses or can't tolerate a colonoscopy
- There are 2 types of acceptable FOBT tests - guaiac (gFOBT) and immunochemical (iFOBT)
- Blood-based biomarker tests are not currently approved by NCQA and not the part of MY2026 Value set to close HEDIS gaps. Therefore blood-based biomarker test does not meet numerator compliance.
- Contact your laboratory services provider to procure iFOBT supplies for use in your office
 - Physicians, nurse practitioners and physician assistants can provide the kit to the members during their routine office visits. Members can then collect the sample at home and send the specimen and requisition form directly to the laboratory services vendor in a post-paid envelope.
- Digital Rectal Exams (DRE) performed in the office setting will not meet compliance. If the member collected the stool sample in accordance with the manufacturer's instructions provided with the kit, it will address any existing gaps.
- Lab results and procedure codes for colorectal cancer screening can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

Colorectal Cancer Screening (COL-E) (cont.)

Additional measure resources

<p>American Cancer Society and National Colorectal Cancer Roundtable</p> <ul style="list-style-type: none"> • Lead Time Messaging Guidebook: A tool to encourage on-time colorectal cancer screening 	<p>Evidence-based tailored messaging for patients can help patients prioritize screening. Population-specific strategies are provided.</p>
<ul style="list-style-type: none"> • STEPS for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices 	<p>Evidence-based strategies, tools and templates for primary care settings. A summary of case studies of practices demonstrates effectiveness of interventions.</p>
<ul style="list-style-type: none"> • Increasing Colorectal Cancer Screening in Rural Communities: A Practical Guide 	<p>A guidebook that outlines recommended actions to increase screening rates in rural areas. Case studies highlight best practices.</p>
<p>United States Preventative Services Task Force Colorectal Cancer: Screening United States Preventive Services Taskforce</p> <ul style="list-style-type: none"> • Colorectal Cancer: Screening United States Preventive Services Taskforce • Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement Colorectal Cancer JAMA JAMA Network 	<p>Recommendations for screening and practice considerations for colorectal cancer.</p>

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UnitedHealthcare will make the final determination regarding reimbursement upon receipt of a claim. Submitting a claim with a code included in this document is not a guarantee of payment. Payment of covered services is contingent upon coverage within an individual member's benefit plan, your eligibility for payment, any claim processing requirements, and your participation agreement with UnitedHealthcare.

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

New for 2026

Added

- Added PROMIS Emotional Distress instrument for adults 18 and over to the list of depression screening

Description

Members ages 12 and older as of Jan. 1 of the measurement year who had:

- Depression screening: Documented result of depression in the measurement year using a age-appropriate standardized instrument
- Follow-up on positive screening result: Upon documentation of a positive depression screening, members receive follow-up (medication or treatment) within 30 days of the positive screening
 - **Note:** If a positive screen is followed up with a negative finding on the same day, that will count toward the numerator

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • Select state reporting • CMS Quality Rating System 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close numerator gaps in care; they are not intended to be a directive of your billing practice.

Eligible screening instruments with thresholds for positive findings include:

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

Instruments for adolescents (≤17 years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9) [®]	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M) [®]	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2) [®]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS) [®]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale–Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60
Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9) [®]	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2) [®]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS) [®]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale–Revised (CESD-R)	89205-9	Total score ≥17

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

Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
Duke Anxiety–Depression Scale (DUKE-AD) [®]	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3) [®]	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score (T Score) ≥60
PROMIS Depression Emotional Distress–Depression–Short Form	77861-3	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

Scenario 1: Follow-up on positive screening result – Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Behavioral health encounter	
CPT[®]/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
SNOMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002

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

Behavioral health encounter

UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919
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Depression case management encounter

CPT®/CPT II	99366, 99492, 99493
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HCPCS	G0512, T1016, T1017, T2022, T2025
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SNOMED	182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002, 1344983001, 1344984007, 1344994002, 1345003009, 1345013001, 1345014007, 621561000124106, 661051000124109, 662081000124106, 662541000124107, 842901000000108
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Follow-up visit

CPT®/CPT II	98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98979, 99470
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HCPCS	G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015, G0544
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SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
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UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
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Encounter for exercise counseling diagnosis

ICD-10-CM	Z71.82 (do not include lab claims (claims with POS 81))
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Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> History of bipolar diagnosis Diagnosis of depression 	Any time during the member's history, through the end of the measurement year

Tips and best practices to help close this care opportunity

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search [liveandworkwell.com](https://www.liveandworkwell.com)
- Encourage the use of telehealth when appropriate
- Offer National Suicide Prevention Lifeline "988" for patients to call, text or chat when needed

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

New for 2026

- No applicable changes for this measure

Definition

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication between March 1 of the year prior to the measurement year through the last day of February in the measurement year and who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. A new prescription is defined as having no new or refill ADHD medications 120 days prior to an ADHD medication dispense date.

Two rates are reported:

- 1. Initiation phase:** Percentage of members ages 6-12 with an ambulatory prescription dispensed for ADHD medication who had 1 follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. A member must be between ages 6-12 when the first prescription for an ADHD medicine was dispensed.
- 2. Continuation and maintenance phase:** Percentage of members ages 6-12 with an ambulatory 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 2 follow-up visits with a practitioner on different dates of service within 270 days – 9 months – after the Initiation Phase ended. A member must be between ages 6-12 when the first prescription for an ADHD medicine was dispensed.



Yes!
Supplemental
Data Accepted

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

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> Commercial Medicaid 	<ul style="list-style-type: none"> NCQA Health Plan Ratings 	<ul style="list-style-type: none"> Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Initiation phase

Scenario 1: Outpatient visit with a practitioner with prescribing authority and with appropriate place of service code (place of service code must be billed with visit code)

Visit setting unspecified

CPT®/CPT II	Codes
	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

AND

Place of service code

Code	Location	Code	Location
03	School	17	Walk-in retail health clinic
05	Indian Health Service free-standing facility	18	Place of employment - worksite
07	Tribal 638 free-standing facility	19	Off-campus outpatient hospital
09	Prison/correctional facility	20	Urgent care facility

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

Code	Location		
11	Office	27	Outreach site/street
12	Home	33	Custodial care facility
13	Assisted living facility	49	Independent clinic
14	Group home	50	Federally qualified health center
15	Mobile unit	71	Public health clinic
16	Temporary lodging	72	Rural health clinic
22	On-campus outpatient hospital		

Initiation phase

Scenario 2: Behavioral health outpatient visit with a practitioner with prescribing authority

Behavioral health visits

CPT®/CPT II	98960, 98961, 98962, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99510, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007
HCPCS	G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H0211, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015, G0560
SNOMED	50357006, 77406008, 84251009, 86013001, 90526000, 185463005, 185464004, 185465003, 209099002, 281036007, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 866149003, 3391000175108, 444971000124105, 456201000124103

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

UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
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Scenario 3: Intensive outpatient encounter or partial hospitalization with a practitioner with prescribing authority and with appropriate place of service code (place of service code must be billed with visit code)

Visit setting unspecified

CPT®/CPT II	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
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AND

Place of service code

Code	Location
52	Psychiatric facility – partial hospitalization

Initiation Phase

Scenario 4: A health and behavior assessment/intervention with a practitioner with prescribing authority

A health and behavior assessment/intervention

CPT®/CPT II	96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
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Scenario 5: Intensive outpatient encounter or partial hospitalization with a practitioner with prescribing authority

Partial hospitalization/intensive outpatient visits

HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
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Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) (cont.)

Partial hospitalization/intensive outpatient visits

SNOMED

7133001, 305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000

UBREV

0905, 0907, 0912, 0913

Scenario 6: Community mental health center visit with a practitioner with prescribing authority and with appropriate place of service code

Visit setting unspecified

CPT®/CPT II

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

AND

Place of service code

Code

Location

53

Community mental health center

Scenario 7: Telehealth With a Practitioner With Prescribing Authority and With Appropriate Place of service code

Visit setting unspecified

CPT®/ CPT II

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

AND

Place of service code

Code

Location

02

Telehealth provided other than in patient's home

10

Telehealth provided in patient's home

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

Scenario 8: Telephone with a practitioner with prescribing authority

Telephone visits	
CPT®/CPT II	98966, 98967, 98968, 99441, 99442, 99443, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98979, 98980, 98981, 99457, 99458, 99470
HCPCS	G0544
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002

Continuation phase: Initiation phase scenarios 1-9 in addition to the following (only 1 of 2 follow-up visits during days 31-300 may be e-visit or virtual check-in)

Scenario 9: E-visit or virtual check-in with a practitioner with prescribing authority

Online assessment (e-visit/virtual check-in) *Only 1 of the 2 visits for continuation may be an e-visit or virtual check-in	
CPT®/CPT II	98970, 98971, 98972, 99421, 99422, 99423, 98016
HCPCS	G0071, G2010, G2012, G2250, G2251, G2252

Medications

The following ADHD medications dispensed during the 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year identify members for this measure.

Drug category	Medications
CNS stimulants	<ul style="list-style-type: none"> • Dexmethylphenidate • Methylphenidate • Dextroamphetamine • Methamphetamine • Lisdexamfetamine
Alpha-2 receptor agonists	<ul style="list-style-type: none"> • Clonidine • Guanfacine
Miscellaneous ADHD medications	<ul style="list-style-type: none"> • Atomoxetine • Viloxazine

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

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
Narcolepsy	Any time during a member's history through Dec. 31 of the measurement year
Members who had an acute inpatient encounter with principal diagnosis of mental, behavioral or neurodevelopmental disorder or those diagnoses on the discharge claim	During the 30 days after the earliest prescription dispensing date

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



Important notes

Medical record detail including, but not limited to

- Initiation phase – When prescribing ADHD medication for the first time:
 - Schedule a member’s follow-up appointment within 21–28 days after they receive their initial prescription to assess effectiveness and address any side effects
 - Write the initial prescription for the number of days until the follow-up appointment to increase the likelihood that a patient will come to the visit
 - Use screening tools such as the Vanderbilt Assessment Scale to assist with diagnosing ADHD
- Continuation and maintenance phase – When providing ongoing care:
 - Schedule at least 2 more follow-up appointments within the next 9 months to help ensure the member is stabilized on an appropriate dose
 - An e-visit or virtual check-in visit is eligible for 1 visit toward the continuation and maintenance phase

- Medication list
- Progress notes

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

Tips and best practices to help close this care opportunity:

- Continue to monitor patient with 2 or more visits in the next 9 months
- Encourage the use of telehealth appointments when appropriate
- Screening tools such as the National Institute for Children's Health Quality (NICHQ) Vanderbilt Assessment Scale can help with diagnosing ADHD
- When prescribing ADHD medication for the first time, make sure all members are scheduled for a follow-up visit within 30 days
- Write the initial prescription for the number of days until a member's follow-up visit to increase the likelihood they'll come to the appointment
- Schedule at least 3 follow-up visits at the time a member's diagnosed and gets their prescription
 - The first appointment should be 21 to 28 days after they receive their initial prescription so you can assess the medication's effectiveness and address any side effects
 - Schedule at least 2 or more follow-up appointments within the next 9 months to confirm the member's stable and taking the appropriate dose
- Review members' history of prescription refill patterns and reinforce education and reminders to take their medication as prescribed
- At each office visit, talk with members about following your treatment plan and/or barriers to taking their medications, and encourage adherence
- ADHD follow-up visits can be accepted as supplemental data. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.

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

New for 2026

- No applicable changes for this measure

Definition

Members ages 12 and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

Three assessment periods include:

- Assessment period 1: Jan.1–April 30
- Assessment period 2: May 1–Aug. 31
- Assessment period 3: Sept. 1–Dec. 31

This measure is episode based and not member based. Members may have an eligible encounter in all 3 assessment periods.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • Select state reporting 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close numerator gaps in care; they are not intended to be a directive of your billing practice.

Utilization of PHQ-9 period 1, 2 or 3

LOINC	44261-6, 89204-2, 44261-6
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Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> History of bipolar disorder, personality disorder, psychotic disorder or pervasive developmental disorder 	Any time during the member's history through the end of the measurement year



Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
Use age appropriate PHQ-9 assessments: <ul style="list-style-type: none"> PHQ-9: ages 12 years and older PHQ-9 Modified for Teens: ages 12-17 	The PHQ-9 can be conducted using telehealth, telephone or a web-based portal/application	<ul style="list-style-type: none"> This measure is episode based and not member based

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

Tips and best practices to help close this care opportunity

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search [liveandworkwell.com](https://www.liveandworkwell.com)
- Encourage the use of telehealth when appropriate
- Offer National Suicide Prevention Lifeline "988" for patients to call, text or chat when needed
- PHQ-2 and PHQ-9 survey tools must be scored and assessed by the provider

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

New for 2026

- No applicable changes for this measure

Definition

Members ages 12 and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4-8 months of the elevated score.

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

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • Select state reporting 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close numerator gaps in care; they are not intended to be a directive of your billing practice.

Scenario 1:

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

Scenario 2:

Depression remission: Members who demonstrate remission of depression symptoms with the most recent PHQ-9 total score of <5 during the depression period

Scenario 3:

Depression response: Members with a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score of at least 50% lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period

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

PHQ-9 total score

LOINC | 44261-6, 89204-2, 44261-6

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year
<ul style="list-style-type: none"> History of bipolar disorder, personality disorder, psychotic disorder or pervasive developmental disorder 	Any time during the member's history through the end of the measurement year



Important notes

Test, service or procedure to close care opportunity

Use age appropriate PHQ-9 assessments:

- PHQ-9: ages 12 years and older
- PHQ-9 Modified for Teens: ages 12-17

The PHQ-9 can be conducted using telehealth, telephone or a web-based portal/application

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

Tips and best practices to help close this care opportunity

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search [liveandworkwell.com](https://www.liveandworkwell.com)
- Encourage the use of telehealth when appropriate
- Offer National Suicide Prevention Lifeline "988" for patients to call, text or chat when needed
- PHQ-2 and PHQ-9 survey tools must be scored and assessed by the provider

Immunizations for Adolescents (IMA-E)

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
Data Accepted

Definition

Percentage of adolescents age 13 who had 1 dose of meningococcal vaccine, 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and at least 2 doses of human papillomavirus (HPV) vaccine by their 13th birthday.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Exchange/Marketplace • Medicaid 	<ul style="list-style-type: none"> • CMS Quality Rating System • NCQA Health Plan Ratings (Combination 2) 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

HPV Vaccine

Number of doses: 2

Special Circumstances

- Dose must be administered on or between the ninth and 13th birthdays.
- There must be at least 146 days between the first and second dose of HPV vaccine.
- If 3 HPV vaccines were given, they must be on different dates of service.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II	90649, 90650, 90651
CVX codes	62, 118, 137, 165

Immunizations for Adolescents (IMA-E) (cont.)

Anaphylaxis due to the human papillomavirus vaccine on or before the child's 13th birthday

SNOMED	428241000124101
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Meningococcal conjugate vaccine

Number of doses: 1

Special circumstances

- Dose must be administered on or between the 10th and 13th birthdays.
- If applicable, anaphylaxis due to vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications.

CPT®/CPT II	90619, 90623, 90624, 90733, 90734
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CVX codes	32, 108, 114, 136, 147, 167, 203, 316, 328
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Anaphylaxis due to the meningococcal vaccine on or before the child's 13th birthday

SNOMED	428301000124106
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Tdap vaccine

Number of doses: 1

Special circumstances

- Dose must be administered on or between the 10th and 13th birthdays
- If applicable, encephalitis or anaphylaxis due to the vaccine and the date it occurred must be documented in the medical record to count toward the numerator using the hybrid specifications

CPT®/CPT II	90715
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CVX codes	115
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Anaphylaxis due to tetanus, diphtheria or pertussis vaccine on or before the child's 13th birthday

SNOMED	428281000124107, 428291000124105
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Encephalitis due to the tetanus, diphtheria or pertussis vaccine on or before the child's 13th birthday

SNOMED	192710009, 192711008, 192712001
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Immunizations for Adolescents (IMA-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

Medical record detail including, but not limited to

A member's medical record must include:

- A note with the name of the specific antigen and the date the vaccine was administered
- An immunization record from an authorized health care provider or agency - for example, a registry - including the name of the specific antigen and the date the vaccine was administered

For meningococcal conjugate, meningococcal recombinant - serogroup B (MenB) - will **not** meet compliance.

Documentation that a member is up to date with all immunizations, but doesn't include a list of the immunizations and dates they were administered, will **not** meet compliance.

Documentation of physician orders, CPT codes or billing charges will **not** meet compliance.

For documented history of anaphylaxis or encephalitis, there must be a note indicating the date of the event, which must have occurred by the member's 13th birthday.

- History and physical
- Immunization record
- Lab results
- Problem list
- Progress notes

Immunizations for Adolescents (IMA-E) (cont.)

Additional measure resources

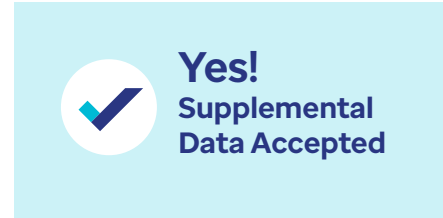
<ul style="list-style-type: none"> • Immunization Best Practices • Older children and teens need vaccines too! Vaccines & Immunizations CDC 	<p>Use the quick provider web-based training to learn more about best practices for immunizations for all ages.</p>
<ul style="list-style-type: none"> • Vaccine & Immunization Information for Health Care Providers CDC Vaccinate with Confidence 	<p>Most up-to-date immunization schedules and catch-up recommendations for adolescents.</p>
<ul style="list-style-type: none"> • Parent’s hesitance about HPV Vaccine: Using the CASE approach to address their concerns - PMC 	<p>Educational information to address parent’s hesitance around HPV vaccine via CASE approach.</p>
<ul style="list-style-type: none"> • HPV Educational Tools and Resources HPV CDC • Immunize.org 	<p>Materials for providers, office staff and parents.</p>
<ul style="list-style-type: none"> • HPV (Human Papillomavirus) American Cancer Society 	<p>Educational information about HPV, its connection to cervical and other cancers, along with options for testing and vaccination.</p>
<p>ACIP</p> <ul style="list-style-type: none"> • Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the US • Human papillomavirus vaccination • Meningococcal vaccination 	<p>Recommendations of the Advisory Committee on Immunization Practices for Tdap, HPV and meningococcal vaccination.</p>

Lead Screening in Children (LSC-E)

New for 2026

Updated

- LSC will now be referred to as LSC-E and will be an electronic measure only



Definition

Percentage of children who turn age 2 during the measurement year who had one or more capillary or venous lead blood test for lead poisoning on or by their second birthday.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicaid 	<ul style="list-style-type: none"> • Select Medicaid State reporting 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Lead test	
CPT®/CPT II	83655
LOINC	10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5674-7, 77307-7

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Lead Screening for Children (LSC) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

Medical record detail including, but not limited to

Date of service and result must be documented with the notation of the lead screening test.

- History and physical
- Lab results
- Progress notes

Tips and best practices to help close this care opportunity:

- Lab tests can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Risk assessment does not meet criteria in the Medicaid population. Universal blood lead test screening is required to close the care gap.
- Only one screening is required by the child's second birthday to close the HEDIS LSC care gap and includes look back. Ideal screening is between 9-12 months of age. It does not require screening in the current measurement year.
- Take advantage of every office visit, including sick visits, to test children
- Consider implementing a standing order protocol for lead testing to avoid missed opportunities
- Visit [cdc.gov](https://www.cdc.gov) for additional information for providers and caregivers

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

New for 2026

- No applicable changes for this measure



Yes!
Supplemental
Data Accepted

Definition

Percentage of children and adolescents ages 1–17 who had 2 or more antipsychotic prescriptions and had metabolic testing.

Three rates are reported:

- The percentage of children and adolescents on antipsychotics who received blood glucose testing
- The percentage of children and adolescents on antipsychotics who received cholesterol testing
- The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings (blood glucose and cholesterol testing-total) • Select State Medicaid reporting 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Glucose test	
CPT®/CPT II	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
Glucose test	
LOINC	10450-5, 1492-8, 1494-4, 1496-9, 1499-3, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 20440-4, 2345-7, 26554-6, 41024-1, 49134-0, 6749-6, 9375-7
SNOMED	66890005, 166891009, 166892002, 166921001, 166922008, 442545002, 444780001, 1179458001, 1259140002

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

HbA1c test

CPT®/CPT II	83036, 83037, 3044F, 3046F, 3051F, 3052F
LOINC	17855-8, 17856-6, 4548-4, 4549-2, 96595-4
SNOMED	165679005, 451061000124104

Cholesterol test other than LDL

CPT®/CPT II	82465, 83718, 83722, 84478
LOINC	2085-9, 2093-3, 2571-8, 3043-7, 9830-1
SNOMED	166830008, 166848004, 259557002, 365793008, 365794002, 365795001, 365796000, 439953004, 707122004, 707123009, 1162800007, 1172655006, 1172656007, 67991000119104

LDL-C test

CPT®/CPT II	80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F
LOINC	12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2, 96259-7

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

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

Medical record detail including, but not limited to

- | | |
|---|--|
| <ul style="list-style-type: none"> A member must have metabolic screening tests that measure <u>both</u> blood glucose and cholesterol Individual tests to measure cholesterol and blood glucose levels can be done on the same or different dates of service | <ul style="list-style-type: none"> Glucose test or HbA1c test and Cholesterol lab test LDL or LDL-C lab test |
|---|--|

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

Additional measure resources

<ul style="list-style-type: none">Immunizations Best Practice Course	Use the quick provider web-based training to learn more about best practices for immunizations for all ages.
<ul style="list-style-type: none">CDC Vaccines & Immunizations	Get the most up-to-date immunization schedules and catch-up recommendations.
<ul style="list-style-type: none">Immunization Action Coalition	For information about standardized tools to assist you and your practice.

Prenatal Immunization Status (PRS-E)

New for 2026

- No applicable changes for this measure

Definition

Members who had a live birth in the measurement period (Jan. 1-Dec. 31 of the measurement year) and who have had the following vaccinations in the recommended time frame:

- 1 influenza vaccine
- 1 Td/Tdap vaccine

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid 	<ul style="list-style-type: none"> • NCQA Health Plan Ratings • Select state reporting 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

Influenza vaccine

- Number of doses: 1
- Vaccine administered on or between July 1 of the year prior to measurement year and the delivery date
- Anaphylaxis due to the influenza vaccine will count toward compliance

CPT®/CPT II	90653, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756
CVX	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205, 320
SNOMED	471361000124100

Prenatal Immunization Status (PRS-E) (cont.)

Tdap

- Vaccine administered during the pregnancy (including delivery date)
- Anaphylaxis or encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date will count toward compliance

CPT®/CPT II	90715
CVX	115
SNOMED	192710009, 192711008, 192712001, 428281000124107, 428291000124105

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who died • Deliveries that occurred at less than 37 weeks gestation 	Any time during the measurement year

Prenatal Immunization Status (PRS-E) (cont.)

Additional measure resources

<ul style="list-style-type: none">Immunizations Best Practice Course	Use the quick provider web-based training to learn more about best practices for immunizations for all ages
<ul style="list-style-type: none">CDC Vaccines & Immunizations	Most up-to-date immunization schedules and catch-up recommendations
<ul style="list-style-type: none">Immunization Action Coalition	For information about standardized tools to assist you and your practice

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

New for 2026

Added

- Added PROMIS Emotional Distress instrument for adults ages 18 and older to the list of depression screening

Definition

Members who had a live birth from Sept. 8 of the year prior to the measurement period through Sept. 7 of the measurement period and who received the following during their postpartum period (7–84 days after the delivery):

- **Depression screening:** Clinical depression screening using a standardized instrument
- **Follow-up on positive screening result:** Upon documentation of a positive depression screening, members receive follow-up within 30 days of the positive screening
 - **Note:** If a positive screen is followed up with a negative finding on the same day, that will count toward the numerator. Screening must have been done using a full-length instrument (e.g., PHQ-9, PROMIS Depression)

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid 	<ul style="list-style-type: none"> • Select state reporting 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

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

Codes

The following codes can be used to close numerator gaps in care; they are not intended to be a directive of your billing practice.

Depression Screening: Clinical depression screening using a standardized instrument

Eligible screening instruments with thresholds for positive findings include:

Instruments for adolescents (≤17 years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9) [®]	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M) [®]	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2) [®]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS) [®]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60
Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9) [®]	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2) [®]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS) [®]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD) [®]	90853-3	Total score ≥30

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

Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥ 10
My Mood Monitor (M-3) [®]	71777-7	Total score ≥ 5
PROMIS Depression	71965-8	Total score (T Score) ≥ 60
PROMIS Depression Emotional Distress–Depression–Short Form	77861-3	Total score (T Score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥ 31

Scenario 1: Follow-Up on Positive Screening Result – Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Behavioral health encounter

CPT[®]/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
SNOMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919

Depression case management encounter

CPT[®]/CPT II	99366, 99492, 99493
HCPCS	G0512, T1016, T1017, T2022, T2023

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

Depression case management encounter

SNOMED	1344983001, 1344984007, 1344994002, 1345003009, 1345013001, 1345014007, 182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002, 621561000124106, 661051000124109, 662081000124106, 662541000124107, 842901000000108
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Follow-up visit

CPT®/CPT II	98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98979, 99470
HCPCS	G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015, G0544
SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Encounter for exercise counseling diagnosis

ICD-10-CM	Z71.82 (do not include lab claims (claims with POS 81))
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Scenario 2. Dispensed an antidepressant medication

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

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died 	Any time during the measurement year



Important notes

Test, service or procedure to close care opportunity

Use age appropriate PHQ-9 assessments:

- PHQ-9: Ages 12 years and older
- PHQ-9 modified for teens ages 12-17

The PHQ-9 can be conducted using telehealth, telephone or a web-based portal/application

Tips and best practices to help close this care opportunity

- To refer your patient to a behavioral health specialist or to request coordination of care, please call the number on the back of the patient's health plan ID card or search [liveandworkwell.com](https://www.liveandworkwell.com)
- Encourage the use of telehealth when appropriate
- PHQ-2 and PHQ-9 survey tools must be scored and assessed by the provider

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

New for 2026

Added

- Added PROMIS Emotional Distress instrument for adults ages 18 and older to the list of depression screening

Definition

Members who had a live birth in the measurement year and who received the following during their pregnancy in the measurement period (Jan. 1 to Dec. 31 of the measurement year)

- **Depression Screening:** Clinical depression screening using a standardized instrument
- **Follow-Up on Positive Screening Result:** Upon documentation of a positive depression screening, members receive follow-up within 30 days of the positive screening
 - **Note:** If a positive screen is followed up with a negative finding on the same day, that will count toward the numerator. Screening must have been done using a full-length instrument (e.g., PHQ-9, PROMIS Depression)

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid 	<ul style="list-style-type: none"> • Select state reporting 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close numerator gaps in care; they are not intended to be a directive of your billing practice.

Depression Screening: Clinical depression screening using a standardized instrument

Eligible screening instruments with thresholds for positive findings include:

Instruments for adolescents (≤17 years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9) [®]	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ- 9M) [®]	89204-2	Total score ≥10

Prenatal Depression Screening and Follow-Up (PND-E) (cont.)

Instruments for adolescents (≤17 years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire-2 (PHQ-2) [®]	55758-7	Total score ≥3
Beck Depression Inventory–Fast Screen (BDI-FS) [®]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale–Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60

Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9) [®]	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2) [®]	55758-7	Total score ≥3
Beck Depression Inventory–Fast Screen (BDI-FS) [®]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale–Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD) [®]	90853-3	Total score ≥30
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3) [®]	71777-7	Total score ≥5

Prenatal Depression Screening and Follow-Up (PND-E) (cont.)

Instruments for adults (18+ years)	Total score LOINC codes	Positive finding
PROMIS Depression	71965-8	Total score (T Score) ≥ 60
PROMIS Depression Emotional Distress–Depression–Short Form	77861-3	Total score (T Score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥ 31

Scenario 1: Follow up on positive screening result – Outpatient visit with a diagnosis of depression or other behavioral health diagnosis

Behavioral health encounter

CPT®/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493
HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, S0201, S9480, S9484, S9485
SNOMED	5694008, 10197000, 10997001, 38756009, 45392008, 79094001, 88848003, 90407005, 91310009, 165171009, 165190001, 225337009, 370803007, 372067001, 385721005, 385724002, 385725001, 385726000, 385727009, 385887004, 385889001, 385890005, 401277000, 410223002, 410224008, 410225009, 410226005, 410227001, 410228006, 410229003, 410230008, 410231007, 410232000, 410233005, 410234004, 439141002
UBREV	0900, 0901, 0902, 0903, 0904, 0905, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919

Depression case management encounter

CPT®/CPT II	99366, 99492, 99493
HCPCS	G0512, T1016, T1017, T2022, T2023

Prenatal Depression Screening and Follow-Up (PND-E) (cont.)

Depression Case Management Encounter

SNOMED	1344983001, 1344984007, 1344994002, 1345003009, 1345013001, 1345014007, 182832007, 225333008, 385828006, 386230005, 409022004, 410216003, 410219005, 410328009, 410335001, 410346003, 410347007, 410351009, 410352002, 410353007, 410354001, 410356004, 410360001, 410363004, 410364005, 410366007, 416341003, 416584001, 424490002, 425604002, 737850002, 621561000124106, 661051000124109, 662081000124106, 662541000124107, 842901000000108
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Follow-up visit

CPT®/CPT II	98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99078, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98979, 99470
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HCPCS	G0071, G0463, G2010, G2012, G2250, G2251, G2252, T1015, G0544
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SNOMED	42137004, 50357006, 86013001, 90526000, 108220007, 108221006, 185317003, 185389009, 281036007, 314849005, 386472008, 386473003, 390906007, 401267002, 406547006, 870191006
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UBREV	0510, 0513, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
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Encounter for exercise counseling diagnosis

ICD-10-CM	Z71.82 (do not include lab claims (claims with POS 81))
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Scenario 2: Dispensed an antidepressant medication

Prenatal Depression Screening and Follow-Up (PND-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none">• Members in hospice or using hospice services• Members who died• Deliveries that occurred at less than 37 weeks gestation	Any time during the measurement year

Tips and best practices to help close this care opportunity

- PHQ-2 and PHQ-9 survey tools must be scored and assessed by the provider

Social Need Screening and Intervention (SNS-E)

New for 2026

Added

- Added provider assessments to the screening gap closure criteria for food, housing and transportation

Removed

- The age requirement for exclusion of Medicare enrollees in an institutional SNP (I-SNP) or living long-term in an institution (LTI)

Definition

Percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if screened positive.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicaid 	<ul style="list-style-type: none"> • Medicaid P4P program 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

Codes

The following codes can be used to close numerator gaps in care for the screening and intervention components of the measure; they're not intended to be a directive of your billing practice.

Food Screening & Intervention

Eligible food insecurity screening instruments with thresholds for positive findings include:

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	88122-7 88123-5	LA28397-0 LA6729-3

Social Need Screening and Intervention (SNS-E) (cont.)

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC codes
Health Leads Screening Panel	95251-5	LA33-6
Hunger Vital Sign (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)	95400-8 95399-2	LA33-6
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey—Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

Food Intervention

CPT/CPT II

97802, 97803, 97804

HCPCS

S5170, S9470, G0019, G0022, G0023, G0024, G0140

Social Need Screening and Intervention (SNS-E) (cont.)

Food Intervention (cont.)

SNOMED

61310001, 103699006, 308440001, 385767005, 710824005, 711069006, 713109004, 1004110005, 1148446004, 1162436000, 1230338004, 1268662008, 1268726004, 1268727008, 1269404007, 441041000124100, 441201000124108, 441231000124100, 441241000124105, 441251000124107, 441261000124109, 441271000124102, 441281000124104, 441291000124101, 441301000124100, 441311000124102, 441321000124105, 441331000124108, 441341000124103, 441351000124101, 445291000124103, 445301000124102, 445641000124105, 461481000124109, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464031000124101, 464041000124106, 464051000124108, 464061000124105, 464071000124103, 464081000124100, 464091000124102, 464101000124108, 464111000124106, 464121000124103, 464131000124100, 46414100012410, 464151000124107, 464161000124109, 464171000124102, 464181000124104, 464191000124101, 464201000124103, 464211000124100, 464221000124108, 464231000124106, 464241000124101, 464251000124104, 464261000124102, 464271000124109, 464281000124107, 464291000124105, 464301000124106, 464311000124109, 464321000124101, 464331000124103, 464341000124108, 464351000124105, 464361000124107, 464371000124100, 464381000124102, 464401000124102, 464411000124104, 464421000124107, 464431000124105, 464611000124102, 464621000124105, 464631000124108, 464641000124103, 464651000124101, 464661000124104, 464671000124106, 464681000124109, 464691000124107, 464701000124107, 464721000124102, 467591000124102, 467601000124105, 467611000124108, 467621000124100, 467631000124102, 467641000124107, 467651000124109, 467661000124106, 467671000124104, 467681000124101, 467691000124103, 467711000124100,

Social Need Screening and Intervention (SNS-E) (cont.)

Food Intervention (cont.)

SNOMED

467721000124108 , 467741000124101, 467751000124104, 467761000124102, 467771000124109, 467781000124107, 467791000124105, 467801000124106, 467811000124109, 467821000124101, 468401000124109, 470231000124107, 470241000124102, 470261000124103, 470281000124108, 470291000124106, 470301000124107, 470311000124105, 470321000124102, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472331000124100, 551101000124107, 661101000124109, 661181000124100, 662151000124104, 662651000124105, 663081000124100, 663211000124100, 225348002, 306238000, 370840004, 710873001, 718524000, 11541000175105, 32021000175107, 428481000124106, 470271000124105, 581041000124102, 651121000124109, 662871000124101, 761131000124106, 761291000124101, 761301000124100, 841421000124108, 841431000124106, 851301000124109

Housing Screening & Intervention

Eligible housing instability, homelessness and housing inadequacy screening instruments with thresholds for positive findings include:

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	71802-3	LA31994-9 LA31995-6
Health Leads Screening Panel	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]	93033-9 71802-3	LA33-6 LA31995-6

Social Need Screening and Intervention (SNS-E) (cont.)

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-4 LA32694-2 LA32695-1 LA32696-9 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2

Social Need Screening and Intervention (SNS-E) (cont.)

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Norwalk Community Health Center Screening Tool [NCHC]	99134-9	LA33-6
	99135-6	LA31996-4 LA28580-1 LA31997-2 LA31999-8 LA32000-4 LA32001-2

Housing Intervention

Housing Instability Procedures

HCPCS	
	G0019, G0022, G0023, G0024, G0140
SNOMED	308440001, 711069006, 1148446004, 1148818006, 1156869006, 1162436000, 1162437009, 1230338004, 1268662008, 1268726004, 1268727008, 1269404007, 461481000124109, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470471000124109, 470481000124107, 470491000124105, 470501000124102, 470591000124109, 470601000124101, 470611000124103, 471041000124101, 471051000124104, 471061000124102, 471071000124109, 471111000124101, 471121000124109, 471131000124107, 472021000124101, 472041000124108, 472081000124102, 472091000124104, 472131000124102, 472151000124109, 472161000124106, 472191000124103, 472221000124105, 472241000124103, 472261000124104, 472271000124106, 472281000124109, 472291000124107, 472331000124100, 472381000124104, 480841000124109, 480851000124106, 480861000124108, 480901000124101, 551091000124101, 551101000124107, 581041000124102, 661181000124100, 663211000124100, 225348002, 306238000, 370840004, 710873001, 718524000, 1338044007, 1338051003, 1343612009, 1343661006, 1344653007, 11541000175105, 32021000175107, 428481000124106, 651121000124109, 662871000124101, 761131000124106, 761291000124101, 761301000124100, 831201000124100, 841151000124108, 841161000124105, 841171000124103, 841181000124100, 841191000124102, 841201000124104, 41211000124101, 841221000124109, 841231000124107, 841261000124103, 841271000124105, 841421000124108, 841431000124106, 851301000124109, 851311000124107, 901381000124103, 901391000124100, 901401000124103, 901411000124100

Social Need Screening and Intervention (SNS-E) (cont.)

Homelessness Procedures

HCPCS

G0019, G0022, G0023, G0024, G0140

SNOMED

308440001, 711069006, 1148446004, 1148818006, 1162436000, 1162437009, 1230338004, 1268662008, 1268726004, 1268727008, 1269404007, 461481000124109, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470471000124109, 470481000124107, 470491000124105, 470501000124102, 470581000124106, 470591000124109, 470601000124101, 470611000124103, 470781000124104, 470791000124101, 470801000124100, 470811000124102, 470821000124105, 470831000124108, 470841000124103, 471021000124108, 471031000124106, 471041000124101, 471071000124109, 471081000124107, 471091000124105, 471101000124104, 471111000124101, 471121000124109, 471131000124107, 472031000124103, 472041000124108, 472051000124105, 472081000124102, 472091000124104, 472101000124105, 472111000124108, 472121000124100, 472131000124102, 472141000124107, 472151000124109, 472161000124106, 472191000124103, 472221000124105, 472241000124103, 472261000124104, 472301000124108, 472311000124106, 472321000124103, 472331000124100, 472341000124105, 472351000124107, 472361000124109, 480791000124106, 480801000124107, 480811000124105, 480821000124102, 480831000124104, 480871000124101, 480901000124101, 480921000124106, 480931000124109, 480941000124104, 480961000124100, 480971000124107, 480981000124105, 551101000124107, 661181000124100, 663211000124100, 225348002, 306238000, 370840004, 710873001, 718524000, 1303097003, 1343661006, 11541000175105, 32021000175107, 428481000124106, 471051000124104, 480841000124109, 480851000124106, 480861000124108, 581041000124102, 651121000124109, 662871000124101, 761131000124106, 761291000124101, 761301000124100, 761371000124106, 831201000124100, 841211000124101, 841221000124109, 841241000124102, 841421000124108, 841431000124106, 851281000124105, 851291000124108, 851301000124109, 851311000124107, 901381000124103, 901391000124100, 901401000124103, 901411000124100

Social Need Screening and Intervention (SNS-E) (cont.)

Housing Inadequacy Procedures

HCPCS	G0019, G0022, G0023, G0024, G0140
SNOMED	49919000, 308440001, 711069006, 1148446004, 1162436000, 1230338004, 1268662008, 1268686005, 1268726004, 1268727008, 1269404007, 461481000124109, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470431000124106, 470441000124101, 470451000124104, 470461000124102, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472201000124100, 472211000124102, 472231000124108, 472251000124101, 472331000124100, 472371000124102, 480881000124103, 480891000124100, 480911000124103, 480951000124102, 551041000124105, 551051000124107, 551061000124109, 551071000124102, 551081000124104, 551101000124107, 661181000124100, 663211000124100, 225348002, 306238000, 370840004, 710873001, 718524000, 1338044007, 1338045008, 1338046009, 1338051003, 1340000005, 11541000175105, 32021000175107, 428481000124106, 581041000124102, 651121000124109, 662871000124101, 761131000124106, 761231000124100, 761291000124101, 761301000124100, 761321000124105, 761381000124109, 761531000124102, 831201000124100, 841201000124104, 841231000124107, 841271000124105, 841421000124108, 841431000124106, 851301000124109, 851331000124101

Transportation Screening & Intervention

Eligible transportation insecurity screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	99594-4	LA33093-8 LA30134-3

Social Need Screening and Intervention (SNS-E) (cont.)

Transportation Screening & Intervention (cont.)

Eligible transportation insecurity screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel	99553-0	LA33-6
Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF-PAI)–version 4.0 [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form–version E–Discharge from Agency [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form–version E–Start of Care [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]	93030-5	LA30133-5 LA30134-3
PROMIS	92358-1	LA30024-6 LA30026-9 LA30027-8
WellRx Questionnaire	93671-6	LA33-6

Transportation intervention

HCPCS	G0019, G0022, G0023, G0024, G0140
SNOMED	228615008, 308440001, 711069006, 716730006, 716732003, 716733008, 1148446004, 1162436000, 1230338004, 1268662008, 1268726004, 1268727008, 1269404007, 461481000124109, 462481000124102, 462491000124104, 464001000124109, 464011000124107, 464021000124104, 464131000124100, 464161000124109, 464291000124105, 464301000124106, 464311000124109, 464611000124102, 470231000124107, 470591000124109, 470601000124101, 470611000124103, 471111000124101, 471121000124109, 471131000124107, 472151000124109, 472331000124100, 551101000124107

Social Need Screening and Intervention (SNS-E) (cont.)

Transportation intervention (cont.)

SNOMED

551111000124105, 551121000124102, 551141000124109, 551161000124108, 551191000124100, 551231000124105, 551251000124103, 551261000124101, 551271000124108, 551281000124106, 551291000124109, 551301000124105, 551311000124108, 551321000124100, 551331000124102, 551341000124107, 551351000124109, 551361000124106, 551371000124104, 551381000124101, 551391000124103, 551401000124101, 551411000124103, 551421000124106, 551431000124109, 610961000124100, 610971000124107, 610981000124105, 610991000124108, 611001000124109, 611011000124107, 611021000124104, 611031000124101, 611041000124106, 611051000124108, 611061000124105, 611071000124103, 611081000124100, 611091000124102, 611101000124108, 611111000124106, 611121000124103, 611281000124107, 611291000124105, 611301000124106, 611311000124109, 611361000124107, 611371000124100, 611381000124102, 611391000124104, 611401000124102, 611411000124104, 611421000124107, 611431000124105, 611441000124100, 611451000124103, 651011000124100, 651031000124106, 661181000124100, 662351000124101, 663211000124100, 225348002, 306238000, 370840004, 710873001, 718524000, 11541000175105, 32021000175107, 428481000124106, 581041000124102, 651121000124109, 662871000124101, 761081000124106, 761091000124109, 761101000124103, 761111000124100, 761121000124108, 761131000124106, 761201000124108, 761211000124106, 761221000124103, 761291000124101, 761301000124100, 841421000124108, 841431000124106, 851301000124109

Social Need Screening and Intervention (SNS-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who die 	<ul style="list-style-type: none"> Any time during the measurement period Any time during the measurement period
<p>Medicare enrollees who meet either of the following:</p> <ul style="list-style-type: none"> Enrolled in an Institutional Special Needs Plan (I-SNP) Living long term in an institution 	<ul style="list-style-type: none"> Any time during the measurement period

Tips and best practices to help close this care opportunity

- Each member should have 1 screening code annually for food, housing and transportation
- Each member who screens positive should also have a corresponding intervention code within 30 days

Statin Therapy for Patients With Cardiovascular Disease (SPC-E)

New for 2026

Added

- Added to the SPC inclusion section criteria to identify persons with ASCVD diagnosis, and expanded ASCVD diagnosis criteria to allow diagnosis in the measurement period or the year prior to the measurement period

Updated

- SPC will now only be referred to as SPC-E and will be an electronic measure only

Removed

- Removed required exclusion for persons enrolled in an I-SNP or LTI
- Removed sex specific age bands

Definition

- Percentage of members ages 21–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:
 - Received statin therapy: Members who were dispensed at least 1 high- or moderate-intensity statin medication during the measurement year
 - Statin adherence 80%: Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period

SPC-E inclusion (event, diagnosis or both)

Event	Time frame of event or diagnosis
<ul style="list-style-type: none"> • Myocardial infraction (MI) • Coronary artery bypass graft (CABG) • Percutaneous coronary intervention (PCI) • Other revascularization 	Year prior to the measurement year
Diagnosis	Time frame of event or diagnosis
<ul style="list-style-type: none"> • Ischemic vascular disease (IVD) • At least 2 diagnoses of ASCVD on different dates of service 	Both measurement year and year prior to the measurement year

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Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Important note: The **treatment period** is defined as the earliest prescription dispensing date in the measurement year for any statin medication of at least moderate intensity through the last day of the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> Commercial 	<ul style="list-style-type: none"> NCQA Health Plan Ratings 	<ul style="list-style-type: none"> Electronic Clinical Data Systems (ECDS) reporting

Medications

To comply with this measure, 1 of the following medications must have been dispensed:

Drug category	Medications
High-intensity statin therapy	<ul style="list-style-type: none"> Atorvastatin 40–80 mg Amlodipine-atorvastatin 40–80 mg Rosuvastatin 20–40 mg Simvastatin 80 mg Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	<ul style="list-style-type: none"> Atorvastatin 10–20 mg Amlodipine-atorvastatin 10–20 mg Rosuvastatin 5–10 mg Simvastatin 20–40 mg Ezetimibe-simvastatin 20–40 mg Pravastatin 40–80 mg Lovastatin 40–60 mg Fluvastatin 40–80 mg Pitavastatin 1–4 mg

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Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died Members receiving palliative care: Z51.5 Myalgia, myositis, myopathy or rhabdomyolysis diagnosis : G72.0, G72.2, G72.9, M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, M60.9, M62.82, M79.10, M79.11, M79.12, M79.18 	<p>Any time during the measurement year</p>
<ul style="list-style-type: none"> Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81 Dispensed at least 1 prescription for clomiphene End-stage renal disease (ESRD): N18.5, N18.6, Z99.2 Dialysis: 90935, 90937, 90945, 90947, 90997, 90999, 99512 Members with a diagnosis of pregnancy: O00.101, O99.019, O99.210, O99.340, O99.810, O99.820, Z33.1, Z34.00, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93 In vitro fertilization 	<p>Any time during the measurement year or the year prior to the measurement year</p>
<ul style="list-style-type: none"> Myalgia or rhabdomyolysis caused by a statin: 16524291000119105, 16524331000119104, 16462851000119106, 787206005 	<p>Any time during the member's history through Dec. 31 of the measurement year</p>

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Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Required exclusion(s) (cont.)

Exclusion	Time frame
<p>Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion:</p> <ul style="list-style-type: none"> • Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81) • Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> - At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). - Dispensed dementia medication donepezil, donepezil-memantine, galantamine, rivastigmine or memantine 	<ul style="list-style-type: none"> • Frailty diagnoses must be in the measurement year and on different dates of service • Advanced illness diagnosis must be in the measurement year or year prior to the measurement year

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Statin Therapy for Patients With Cardiovascular Disease (SPC-E) (cont.)

Tips and best practices to help close this care opportunity:

- Importance of taking a statin: American Heart Association (AHA) and American College of Cardiology (ACC) suggest people with clinical atherosclerotic cardiovascular disease (ASCVD) take a high-intensity statin therapy or maximally tolerated statin therapy. Statins can reduce the risk of heart attack and stroke, even in patients who do not have high cholesterol.

Meta-analysis with 5 randomized controlled trials have shown that high-intensity statins reduced major vascular events by 15% compared with moderate-intensity statin therapy in patients with clinical ascvd.² According to AHA/ACC, the larger the LDL-C reduction, the larger proportional reduction in major vascular events.
- If member has intolerance or side effects such as myalgias, if clinically
 - A different statin that is hydrophilic (e.g., rosuvastatin or pravastatin)
 - A lower dose such as a moderate-intensity dose statin than previously tried
 - Reducing the frequency
- For members who meet exclusion criteria, a claim using appropriate ICD-10 code must be submitted ANNUALLY if applicable
- Only statins satisfy the measure; other cholesterol medications such as ezetimibe or PCSK9 inhibitors do not satisfy the measure
- Consider extended day fills (e.g., 90- or 100-day supply) or send to home delivery
- Consider prescribing a high- or moderate-intensity statin, as appropriate. If you determine medication is appropriate, please send a prescription to the member's preferred pharmacy.

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Statin Therapy for Patients With Diabetes (SPD-E)

New for 2026

Updated

- SPD will now only be referred to as SPD-E and will be an electronic measure only
- Updated the required exclusions section to exclude persons with an ASCVD diagnosis

Removed

- Removed required exclusion for persons enrolled in an I-SNP or LTI

Definition

Percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria:

- Received statin therapy: Members who were dispensed at least 1 statin medication of any intensity during the measurement year
- Statin adherence 80%: Members who remained on a statin medication of any intensity for at least 80% of the treatment period

Important note:

The **treatment period** is defined as the earliest prescription dispensing date in the measurement year for any statin medication at any intensity through the last day of the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Commercial • Medicaid • Medicare 	<ul style="list-style-type: none"> • NCQA Accreditation • NCQA Health Plan Ratings 	<ul style="list-style-type: none"> • Electronic Clinical Data Systems (ECDS) reporting

*Please refer to **SUPD** for the Part D measure.

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Statin Therapy for Patients With Diabetes (SPD-E) (cont.)

Medications

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

Drug category	Medications
High-intensity statin therapy	<ul style="list-style-type: none"> • Amlodipine-atorvastatin 40–80 mg* • Atorvastatin 40–80 mg • Ezetimibe-simvastatin 80 mg** • Rosuvastatin 20–40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	<ul style="list-style-type: none"> • Amlodipine-atorvastatin 10–20 mg* • Atorvastatin 10–20 mg • Ezetimibe-simvastatin 20–40 mg** • Fluvastatin 40–80 mg • Lovastatin 40–60 mg • Pitavastatin 1–4 mg • Pravastatin 40–80 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg
Low-intensity statin therapy	<ul style="list-style-type: none"> • Ezetimibe-simvastatin 10 mg** • Fluvastatin 20 mg • Lovastatin 10–20 mg • Pravastatin 10–20 mg • Simvastatin 5–10 mg

*The 10–80 mg is referring to atorvastatin strength.

**The 10–80 mg is referring to simvastatin strength.

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Statin Therapy for Patients With Diabetes (SPD-E) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members in hospice or using hospice services Members who died Members receiving palliative care Myalgia, myositis, myopathy or rhabdomyolysis diagnosis 	<p>Any time during the measurement year</p>
<p>Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion:</p> <ul style="list-style-type: none"> Frailty: At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). Advanced Illness: Indicated by 1 of the following: <ul style="list-style-type: none"> At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). Dispensed dementia medication Donepezil, Donepezil-Memantine, Galantamine, Rivastigmine or Memantine 	<ul style="list-style-type: none"> Frailty diagnoses must be in the measurement year and on different dates of service Advanced illness diagnosis must be in the measurement year or year prior to the measurement year

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Statin Therapy for Patients With Diabetes (SPD-E) (cont.)

Exclusion	Time frame
<ul style="list-style-type: none"> • Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81 • Dispensed at least 1 prescription for clomiphene • End Stage Renal Disease (ESRD): N18.5, N18.6, Z99.2 • Dialysis • Members with a diagnosis of pregnancy • In vitro fertilization 	<p>Any time during the measurement year or the year prior to the measurement year</p>
<ul style="list-style-type: none"> • Coronary artery bypass grafting (CABG) • Myocardial infarction • Other revascularization procedure • Percutaneous coronary intervention (PCI) 	<p>Any time during the year prior to the measurement year</p>
<p>Members who had at least 2 diagnoses of ASCVD (Atherosclerotic Cardiovascular Disease) on different dates of service</p>	<p>Any time during the measurement year or the year prior to the measurement year</p>
<p>Myalgia or rhabdomyolysis caused by a statin</p>	<p>Any time during the member's history through Dec. 31 of the measurement year</p>

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Statin Therapy for Patients With Diabetes (SPD-E) (cont.)

Tips and best practices to help close this care opportunity:

- Consider prescribing a high- or moderate-intensity statin, as appropriate. If you determine medication is appropriate, please send a prescription to the member's preferred pharmacy.*
- To address the SPD care opportunity, a member must use their insurance card to fill 1 of the statins or statin combinations in the strengths/doses listed in the "Medications" table on the previous page by the end of the measurement year

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

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Concurrent Use of Opioids and Benzodiazepines (COB)

New for 2026

- No applicable changes for this measure

Definition

Percentage of Medicare Part D beneficiaries ages 18 and older (as of Jan. 1, 2026) with concurrent use of prescription opioids and benzodiazepines.

Note: Lower rates represent better performance.

Eligible population criteria

Members with 2 or more prescription claims for opioids on different dates of service with ≥ 15 cumulative days' supply during the measurement year. The Index Prescription Start Date (IPSD) or date of first fill must be ≥ 30 days from the last day of the measurement year (i.e., between Jan. 1 through Dec. 2).

- Claims can be for the same or different opioids
- For multiple opioid claims with the same date of service, use the longest days' supply
- For multiple opioid claims with different dates of service, sum the days' supply for all the prescription claims

Members are not included in the denominator if continuous enrollment criteria is not met (no more than 1 gap in enrollment of up to 31 days during the measurement year).

Numerator criteria

The number of members from the eligible population with:

- ≥ 2 prescription claims for any benzodiazepine with different dates of service

AND

- Concurrent use of opioids and benzodiazepines for ≥ 30 cumulative days during the measurement period

Compliance

To be compliant with this measure, concurrent use of opioids and benzodiazepines must be avoided or limited to less than 30 cumulative overlapping days during the measurement period.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	Part D prescription claims <ul style="list-style-type: none"> • Pharmacy data

Concurrent Use of Opioids and Benzodiazepines (COB) (cont.)

Drug classes

Drug class	Medication		
Opioids	Benzhydrocodone	Hydrocodone	Opium
	Buprenorphine	Hydromorphone	Oxycodone
	Butorphanol	Levorphanol	Oxymorphone
	Codeine	Meperidine	Pentazocine
	Dihydrocodeine	Methadone	Tapentadol
	Fentanyl	Morphine	Tramadol
	Benzodiazepines	Alprazolam	Diazepam
Chlordiazepoxide		Estazolam	Quazepam
Clobazam		Flurazepam	Temazepam
Clonazepam		Lorazepam	Triazolam
Clorazepate		Midazolam	

Note: Includes combination products. Excludes injectable formulations, sublingual sufentanil (used in supervised setting) and single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine Implant kit subcutaneous implant and all buprenorphine/naloxone combination products).

Exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> Members with at least 1 day of hospice coverage Members diagnosed with cancer Members diagnosed with Sickle Cell Disease <ul style="list-style-type: none"> Sickle Cell ICD_10 code list: D57.00, D57.01, D57.02, D57.03, D57.04, D57.09, D57.1, D57.20, D57.211, D57.212, D57.213, D57.214, D57.218, D57.219, D57.40, D57.411, D57.412, D57.413, D57.414, D57.418, D57.419, D57.42, D57.431, D57.432, D57.433, D57.434, D57.438, D57.439, D57.44, D57.451, D57.452, D57.453, D57.454, D57.458, D57.459, D57.80, D57.811, D57.812, D57.813, D57.814, D57.818, D57.819 Members diagnosed with palliative care <ul style="list-style-type: none"> Palliative care ICD_10 code: Z51.5 Members diagnosed with cancer-related pain treatment <ul style="list-style-type: none"> Cancer-related pain ICD_10 code: G89.3 	Any time during the measurement year

Concurrent Use of Opioids and Benzodiazepines (COB)

Tips and best practices to help close this care opportunity

- Avoid prescribing a benzodiazepine to a patient already taking an opioid
- Evaluate concurrent use of benzodiazepine and opioids and consider discontinuing one of the medications or using alternative therapy as appropriate; keep in mind a gradual tapering of the medication may be needed
- Educate patients about the risks of taking opioids and benzodiazepines concurrently
- Help patients explore alternative methods for managing pain
- Coordinate care with all of the patient's treating providers to avoid co-prescriptions
- Identify at-risk members using UnitedHealthcare reporting tools
- Consider leveraging provider practice EMR system to assist with identifying at-risk members, avoiding co-prescribing that could lead to concurrent use, limiting/reducing default quantities and refills
- CMS offers 5 central principles for co-prescribing benzos and opioids:
 - Avoid initial combination by offering alternative approaches
 - If new prescriptions are needed, limit the dose and duration
 - Taper long-standing medications gradually, and discontinue whenever possible
 - Continue long-term co-prescribing only when necessary and monitor closely
 - Provide rescue medication (e.g., naloxone) to high-risk patients and their caregivers

Additional resources

For additional tips and best practices to close this care opportunity, please refer to these 3rd-party resources:

- [CDC.gov: CDC Clinical Practice Guideline for Prescribing Opioids for Pain](#)
- [Journal of General Internal Medicine: Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations When Risks Outweigh Benefits](#)
- [CMS.gov: Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines](#)

Concurrent Use of Opioids and Benzodiazepines (COB) (cont.)

COB measure medications and potentially safer alternatives

The Centers for Medicaid and Medicare Services (CMS) has a Part D measure that focuses on concurrent use of medications that are deemed a serious safety concern. The measure is Concurrent Use of Opioids and Benzodiazepines (COB).

Refer to the following chart for potentially safer alternatives to consider when evaluating drug therapy for your patients who are on concurrent therapy of opioids and benzodiazepines.

Measure name	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
COB opioids and benzodiazepines	Opioids	Benzhydrocodone, buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol	Pain	Acetaminophen, ibuprofen, naproxen, topical analgesics Nonpharmacologic alternatives: Ice, heat, elevation, rest, immobilization, exercise, physical therapy, acupuncture, chiropractic, meditation, cognitive therapy
			Insomnia	Trazodone, melatonin (OTC) Nonpharmacological treatment: Sleep hygiene, cognitive behavioral therapy
COB opioids and benzodiazepines	Benzodiazepines	Alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam	Anxiety	Buspirone Nonpharmacological treatment: Cognitive behavioral therapy

* This list includes medications that are part of broad formulary coverage available across UnitedHealthcare Medicare formularies, as well as OTC and nonpharmacological alternatives that may not be covered by insurance. Please refer to specific formulary for coverage details. The medication alternatives may not be appropriate in all clinical situations, nor are they intended to replace a prescriber's clinical judgment.

Medication Adherence for Cholesterol (MAC)

New for 2026

Updated

- MAC will be single-weighted for MY 2026 per CMS Technical Notes (triple-weighting will resume in MY 2027)
- This measure will be risk adjusted for age, sex, LIS/DSNP, disabled
- This measure is no longer adjusted for Inpatient (IP) and Skilled Nursing Facility (SNF) stays

Definition

Percentage of members ages 18 and older who adhere to their cholesterol (statin) medication at least 80% of the time in the measurement period.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	<p>Part D prescription claims</p> <ul style="list-style-type: none"> • Pharmacy data

Compliance

To comply with this measure, a member must have a proportion of days covered (PDC) of 80% or higher for their statin medication in the measurement period.

Exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • End Stage Renal Disease (ESRD): I20.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis 	<p>Any time during the measurement year</p>

Medication Adherence for Cholesterol (MAC) (cont.)

Tips and best practices to help close this care opportunity

- Please check your Patient Care Opportunity Report (PCOR) or Practice Assist often to see members with open care opportunities. If you have questions, your UnitedHealthcare representative can help.
 - **Focus on members marked yellow in your PCOR because they may be at risk for non-adherence**
- Log on to Practice Assist to review members with open care opportunities
 - Select **Medication Adherence** to view your patient list
 - The list is updated every day and prioritizes members at highest risk for not taking their medications. You can also use the tool to document a member's progress.
- Improve health literacy. Talk with members about why they're on a statin medication, and how it's important to take their medication as prescribed and get timely refills.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
- Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill
 - For members who qualified for the measure denominator:
 - o Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have a zero or greater allowable days remaining (ADR) at the end of the measurement period.
 - Members can't achieve 80% Proportion of Days covered (PDC) when the allowable days is less than zero. ADR must be zero or higher for a member to be adherent.

Broad formulary coverage available under UnitedHealthcare Medicare Advantage Prescription Drug Plan formularies.

Please refer to specific plan formulary for coverage details.

U.S. Department of Health and Human Services Health/Resource Services Administration (HRSA) requirements say network pharmacy providers owned by a 340(b) participating entity may discount or waive the cost-sharing amounts owed by members if there's genuine financial need.

In these cases, Medicare rules and your agreement with OptumRx requires your pharmacy to:

1. Submit claims for Part D drugs for Medicare Part D members to OptumRx using the POS System.
2. If applicable, adjust the member's cost-sharing portion after submitting claims when collecting payment, using guidance on genuine financial need as described by HRSA.

Medication Adherence for Cholesterol (MAC) (cont.)

- Consider extended days' supply prescriptions. When clinically appropriate, consider writing 3-month supplies for prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue. UnitedHealthcare Medicare Advantage benefit plans include coverage for a 3-month supply of prescriptions that can be delivered to a patient's home or picked up at a retail pharmacy.
 - o For some health plans, members have \$0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have \$0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have \$0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have \$0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Confirm instructions. Check that the directions on members' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy.
- Use prescription benefit at the pharmacy. Remind your patients who are UnitedHealthcare members to use their health plan ID card at the pharmacy to get the best value. **Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.**
- Try home delivery. If getting to a pharmacy is difficult, ask members about the possibility of filling their prescriptions through a UnitedHealthcare network mail order pharmacy so they can get their medication delivered to their home. For more information, please call Optum Home Delivery® at 800-791-7658 or contact your UnitedHealthcare representative.
- Stay organized. Encourage members to use a pillbox to keep organized and to set an alarm on their phone or clock as a reminder to take their medication.
- Join a reminder program. Ask members to sign up for a refill reminder program at their pharmacy, if available.

Broad formulary coverage available under UnitedHealthcare Medicare Advantage Prescription Drug Plan formularies.

Please refer to specific plan formulary for coverage details.

U.S. Department of Health and Human Services Health/Resource Services Administration (HRSA) requirements say network pharmacy providers owned by a 340(b) participating entity may discount or waive the cost-sharing amounts owed by members if there's genuine financial need.

In these cases, Medicare rules and your agreement with OptumRx requires your pharmacy to:

1. Submit claims for Part D drugs for Medicare Part D members to OptumRx using the POS System.
2. If applicable, adjust the member's cost-sharing portion after submitting claims when collecting payment, using guidance on genuine financial need as described by HRSA.

Medication Adherence for Diabetes Medications (MAD)

New for 2026

Updated

- MAD will be single-weighted for MY 2026 per CMS Technical Notes (triple-weighting will resume in MY 2027)
- This measure will be risk adjusted for age, sex, LIS/DSNP, disabled
- This measure is no longer adjusted for Inpatient (IP) and Skilled Nursing Facility (SNF) stays

Definition

Percentage of members ages 18 or older who are adherent to their diabetes medications at least 80% of the time in the measurement period.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	Part D prescription claims <ul style="list-style-type: none"> • Pharmacy data

Compliance

To comply with this measure, a member* must have a proportion of days covered (PDC) of 80% or higher for their diabetes medication(s) in the measurement period. These classes of diabetes medications are included in this measure:

- Biguanides
- DPP-4 inhibitors
- GLP-1 receptor agonists
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

*Members who take insulin during the treatment period using their Part D benefit are not included in this measure.

Exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • End Stage Renal Disease (ESRD): I20.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis 	Any time during the measurement year
<ul style="list-style-type: none"> • One or more prescription claim for insulin with their Part D benefit 	Any time during the treatment period

Medication Adherence for Diabetes Medications (MAD) (cont.)

Tips and best practices to help close this care opportunity

- Please check your Patient Care Opportunity Report (PCOR) or Practice Assist often to see members with open care opportunities. If you have questions, your UnitedHealthcare representative can help.
 - **Focus on members marked yellow in your PCOR because they may be at risk for non-adherence**
- Log on to Practice Assist to review members with open care opportunities
 - Select **Medication Adherence** to view your patient list
 - The list is updated every day and prioritizes members at highest risk for not taking their medications. You can also use the tool to document a member's progress.
- Improve health literacy. Talk with members about why they're on a diabetic medication, and how it's important to take their medication as prescribed and get timely refills.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
 - **Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill**
 - For members who qualified for the measure denominator:
 - o Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have zero or greater allowable days remaining (ADR) at the end of the measurement period.

Broad formulary coverage available under UnitedHealthcare Medicare Advantage Prescription Drug Plan formularies. Please refer to specific plan formulary for coverage details.

U.S. Department of Health and Human Services Health/Resource Services Administration (HRSA) requirements say network pharmacy providers owned by a 340(b) participating entity may discount or waive the cost-sharing amounts owed by members if there's genuine financial need.

In these cases, Medicare rules and your agreement with OptumRx requires your pharmacy to:

1. Submit claims for Part D drugs for Medicare Part D members to OptumRx using the POS System.
2. If applicable, adjust the member's cost-sharing portion after submitting claims when collecting payment, using guidance on genuine financial need as described by HRSA.

Medication Adherence for Diabetes Medications (MAD) (cont.)

- Members can't achieve 80% Proportion of Days covered (PDC) when the allowable days is less than zero. ADR must be zero or higher for a member to be adherent.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue. UnitedHealthcare Medicare Advantage benefit plans include coverage for a 3-month supply of prescriptions that can be delivered to a patient's home or picked up at a retail pharmacy.
 - o For some health plans, members have \$0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have \$0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have \$0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have \$0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Confirm instructions. Check that the directions on members' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy.
- Use prescription benefit at the pharmacy. Remind your patients who are UnitedHealthcare members to use their health plan ID card at the pharmacy to get the best value. Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.
- Try home delivery. If getting to a pharmacy is difficult, ask members about the possibility of filling their prescriptions through a UnitedHealthcare network mail order pharmacy so they can get their medication delivered to their home. For more information, please call Optum Home Delivery at 800-791-7658 or contact your UnitedHealthcare representative.
- Stay organized. Encourage members to use a pillbox to keep organized and to set an alarm on their phone or clock as a reminder to take their medication.
- Join a reminder program. Ask members to sign up for a refill reminder program at their pharmacy, if available.

Broad formulary coverage available under UnitedHealthcare Medicare Advantage Prescription Drug Plan formularies. Please refer to specific plan formulary for coverage details.

U.S. Department of Health and Human Services Health/Resource Services Administration (HRSA) requirements say network pharmacy providers owned by a 340(b) participating entity may discount or waive the cost-sharing amounts owed by members if there's genuine financial need.

In these cases, Medicare rules and your agreement with OptumRx requires your pharmacy to:

1. Submit claims for Part D drugs for Medicare Part D members to OptumRx using the POS System.
2. If applicable, adjust the member's cost-sharing portion after submitting claims when collecting payment, using guidance on genuine financial need as described by HRSA.

Medication Adherence for Hypertension (RAS Antagonists) (MAH)

New for 2026

Updated

- MAH will be single-weighted for MY 2026 per CMS Technical Notes (triple-weighting will resume in MY 2027)
- This measure will be risk adjusted for age, sex, LIS/DSNP, disabled
- This measure is no longer adjusted for Inpatient (IP) and Skilled Nursing Facility (SNF) stays

Definition

Percentage of members ages 18 or older who adhere to their hypertension (RAS antagonist) medication at least 80% of the time in the measurement period.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare 	<ul style="list-style-type: none"> • CMS Star Ratings 	<p>Part D prescription claims</p> <ul style="list-style-type: none"> • Pharmacy data

Compliance

To comply with this measure, a member* must have a proportion of days covered (PDC) of 80% or higher for their hypertension (RAS antagonist) medication in the measurement period. RAS antagonist medications include:

- Angiotensin II receptor blockers (ARBs)
- Angiotensin-converting enzyme (ACE) inhibitors
- Direct renin inhibitors

*Members who take sacubitril/valsartan (Entresto) during the treatment period using their Part D benefit are not included in this measure.

Exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • End Stage Renal Disease (ESRD): I20.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis 	Any time during the measurement year
<ul style="list-style-type: none"> • One or more prescription claim for sacubitril/valsartan (Entresto) with their Part D benefit 	Any time during the treatment period

Medication Adherence for Hypertension (RAS antagonists) (MAH) (cont.)

Tips and best practices to help close this care opportunity

- Please check your Patient Care Opportunity Report (PCOR) or Practice Assist often to see members with open care opportunities. If you have questions, your UnitedHealthcare representative can help.
 - **Focus on members marked yellow in your PCOR because they may be at risk for non-adherence**
- Log on to Practice Assist to review members with open care opportunities
 - Select **Medication Adherence** to view your patient list
 - The list is updated every day and prioritizes members at highest risk for not taking their medications. You can also use the tool to document a member's progress.
- Improve health literacy. Talk with members about why they're on a medication for high blood pressure, and how it's important to take their medication as prescribed and get timely refills.
- Assess adherence barriers. Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- Discuss continued therapy. If ongoing therapy is appropriate, talk with members about getting timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits for future fills.
 - **Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill**
 - For members who qualified for the measure denominator:
 - o Pay attention to allowable days remaining and days of therapy missed year-to-date (YTD) in your PCOR or in Practice Assist. Members should have zero or greater allowable days remaining (ADR) at the end of the measurement period.

Broad formulary coverage available under UnitedHealthcare Medicare Advantage Prescription Drug Plan formularies. Please refer to specific plan formulary for coverage details.

U.S. Department of Health and Human Services Health/Resource Services Administration (HRSA) requirements say network pharmacy providers owned by a 340(b) participating entity may discount or waive the cost-sharing amounts owed by members if there's genuine financial need.

In these cases, Medicare rules and your agreement with OptumRx requires your pharmacy to:

1. Submit claims for Part D drugs for Medicare Part D members to OptumRx using the POS System.
2. If applicable, adjust the member's cost-sharing portion after submitting claims when collecting payment, using guidance on genuine financial need as described by HRSA.

Medication Adherence for Hypertension (RAS antagonists) (MAH) (cont.)

- Members can't achieve 80% Proportion of Days covered (PDC) when the allowable days is less than zero. ADR must be zero or higher for a member to be adherent.
- Consider extended days' supply prescriptions. When clinically appropriate, consider writing a 3-month supply of prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy – especially if getting to the pharmacy is an issue. UnitedHealthcare Medicare Advantage benefit plans include coverage for a 3-month supply of prescriptions that can be delivered to a patient's home or picked up at a retail pharmacy.
 - o For some health plans, members have \$0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have \$0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Prescribe low-cost generics. When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs. For some health plans, members have \$0 copays on Tier 1 drugs (1-month and 3-month supplies). A few health plans even have \$0 copays for Tier 1 and Tier 2 drugs (1-month and 3-month supplies).
- Confirm instructions. Check that the directions on members' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the member's pharmacy.
- Use prescription benefit at the pharmacy. Remind your patients who are UnitedHealthcare members to use their health plan ID card at the pharmacy to get the best value. Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.
- Try home delivery. If getting to a pharmacy is difficult, ask members about the possibility of filling their prescriptions through a UnitedHealthcare network mail order pharmacy so they can get their medication delivered to their home. For more information, please call Optum Home Delivery at 800-791-7658 or contact your UnitedHealthcare representative.
- Stay organized. Encourage members to use a pillbox to keep organized and to set an alarm on their phone or clock as a reminder to take their medication.
- Join a reminder program. Ask members to sign up for a refill reminder program at their pharmacy, if available.

Broad formulary coverage available under UnitedHealthcare Medicare Advantage Prescription Drug Plan formularies. Please refer to specific plan formulary for coverage details.

U.S. Department of Health and Human Services Health/Resource Services Administration (HRSA) requirements say network pharmacy providers owned by a 340(b) participating entity may discount or waive the cost-sharing amounts owed by members if there's genuine financial need.

In these cases, Medicare rules and your agreement with OptumRx requires your pharmacy to:

1. Submit claims for Part D drugs for Medicare Part D members to OptumRx using the POS System.
2. If applicable, adjust the member's cost-sharing portion after submitting claims when collecting payment, using guidance on genuine financial need as described by HRSA.

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMR)

New for 2026

- No applicable changes to this measure

Definition

Percentage of members ages 18 or older enrolled in a medication therapy management (MTM) program who received a comprehensive Medication review (CMR) during the reporting period.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> • Medicare Part D 	<ul style="list-style-type: none"> • CMS Star Ratings (returning in measurement year 2027) 	<p>Part D prescription claims</p> <ul style="list-style-type: none"> • Pharmacy data • Medical claim data • Part D reporting

Exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice • Members who were enrolled in a MTM program for less than 60 days during the reporting period and didn't receive a CMR 	<p>Any time during the measurement year</p>

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMR) (cont.)



Important notes

Time frame

CMR must be completed by a pharmacist or other health care professional during a member's enrollment in a MTM program.

Within the reporting period

- To be enrolled in UnitedHealthcare's MTM program, a member must meet certain eligibility requirements that include:
 - Diagnosis of 3 of these 10 chronic conditions: Alzheimer's disease, bone disease-arthritis (osteoporosis, osteoarthritis and rheumatoid arthritis), chronic congestive heart failure (CHF), diabetes, dyslipidemia end-stage renal disease (ESRD), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hypertension, mental health (depression, schizophrenia, bipolar disorder and other chronic/disabling mental health conditions) and respiratory disease (asthma, chronic obstructive pulmonary disease (COPD) and other chronic lung disorders), AND
 - Prescription fills of at least 8 Medicare Part D-covered medications for chronic conditions, AND
 - Total prescription costs of at least \$1,276 for Medicare Part D-covered drugs this year, OR
 - At-risk beneficiaries in a drug management program to help better manage and safely use medications, such as those used for pain
- UnitedHealthcare identifies eligible members quarterly, and automatically enrolls them in our MTM program
 - Participants are contacted by mail or phone and asked to schedule a personal medication review with a pharmacist or other qualified care provider. A written summary including a personal medication list, action plan and information on safe disposal of medications is provided following the CMR.

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMR) (cont.)

Tips and best practices to help close this care opportunity:

- UnitedHealthcare’s MTM program is offered at no cost to eligible plan members with Medicare Part D coverage. Once enrolled, members can complete a CMR with one of our pharmacists.
- To identify members who may be eligible for an annual Medication review, check the CMR flag within the Practice Assist tool. Your UnitedHealthcare representative can show you how.
- At office visits, ask eligible members to call our MTM pharmacist team at 866-216-0198, TTY 711. Or, call “live” during a visit so they can do their CMR right from your office or schedule for a later date.
 - Pharmacists are available Monday – Friday, 9 a.m. – 9 p.m. ET, and can often do a review right away
- Let eligible members know the program can help them:
 - Take their medications as you prescribed
 - Recognize the benefits of their medications
 - Better understand side effects to help lower the risk for adverse reactions
- At every appointment, remind members about the importance of taking their medications as prescribed

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH)

New for 2026

- No applicable changes for this measure

Definition

The percentage of Medicare Part D beneficiaries ages 65 and older (as of Jan. 1, 2026) with concurrent use of 2 or more unique (different active ingredient) anticholinergic (ACH) medications. Includes members with at least 2 fills of each medication on different dates of service in the targeted drug class during the measurement period. Concurrent use is defined as overlapping days' supply for at least 30 cumulative days during the measurement period.

Note: Lower rates represent better performance.

Eligible population criteria

Members with ≥ 2 prescription claims for the same anticholinergic medication (same active ingredient) on different dates of service in 2026.

- The earliest date of service for any target medication should be at least 30 days from the last day of the measurement year (i.e., between Jan. 1- Dec. 2).
- Members are not included in the measure if continuous enrollment criteria is not met (no more than 1 gap in enrollment of up to 31 days during the measurement year).

Numerator criteria

The number of patients from the eligible population with:

- ≥ 2 unique ACH medications (different active ingredients) with each ACH medication having ≥ 2 prescription claims on different dates of service during 2026

AND

- Concurrent use (overlapping days' supply for ≥ 2 unique ACH medications) for ≥ 30 cumulative days during the measurement year

Compliance

To be compliant with this measure, concurrent use of 2 or more anticholinergics must be avoided or if necessary limited to less than 30 days during the measurement year.

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> Medicare 	<ul style="list-style-type: none"> CMS Star Ratings 	Part D prescription claims <ul style="list-style-type: none"> Pharmacy data

Drug classes

Drug class	Medication
Antihistamines	<ul style="list-style-type: none"> Brompheniramine Chlorpheniramine Cyproheptadine Dimenhydrinate Diphenhydramine (oral) Doxylamine Hydroxyzine Meclizine Triprolidine
Antiparkinsonian Agents	<ul style="list-style-type: none"> Benzotropine Trihexyphenidyl
Skeletal Muscle Relaxants	<ul style="list-style-type: none"> Cyclobenzaprine Orphenadrine
Antidepressants	<ul style="list-style-type: none"> Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (> 6 mg/day) Imipramine Nortriptyline Paroxetine
Antimuscarinic (urinary incontinence)	<ul style="list-style-type: none"> Darifenacin Fesoterodine Flavoxate Oxybutynin Solifenacin Tolterodine Trospium
Antipsychotics	<ul style="list-style-type: none"> Chlorpromazine Clozapine Olanzapine Perphenazine

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Drug class	Medication
Antispasmodics	<ul style="list-style-type: none"> • Atropine (excludes ophthalmic) • Dicyclomine • Clidinium-chlordiazepoxide • Homatropine (excludes ophthalmic) • Hyoscyamine • Scopolamine (excludes ophthalmic)
Antiemetics	<ul style="list-style-type: none"> • Prochlorperazine • Promethazine

Note:

- Includes combination products that contain a target medication listed and the following routes of administration: buccal, nasal, oral, transdermal, rectal, and sublingual. Injectable and inhalation routes of administration are not included (not able to accurately estimate days’ supply needed for measure logic). For combination products that contain more than one target medication, each target medication (active ingredient) should be considered independently.
- Chlordiazepoxide is not a target medication as a single drug.

Exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members with at least 1 day of hospice coverage during the measurement period 	Any time during the measurement year

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Tips and best practices to help close this care opportunity:

- Identify patients taking 2 or more anticholinergic medications
- Review indication, duration of therapy and evaluate if potential risk of continued therapy outweighs the benefit
- Evaluate concurrent use of anticholinergic medications and consider discontinuing one of the medications or using alternative therapy as appropriate
- Identify at-risk members using UnitedHealthcare reporting tools
- Consider leveraging provider practice EMR system to assist with identifying at-risk members, avoiding co-prescribing that could lead to concurrent use, limiting/reducing default quantities and refills
- Educate patients and caregivers about the risks and side effects of using multiple anticholinergic medications including cognitive decline and what to do if they experience side effects
- Take a holistic patient approach when evaluating appropriateness including patient goals, current guidelines and co-morbid conditions
- Coordinate care with all of the patient's treating providers to avoid co-prescriptions.

Additional resources

For additional tips and best practices to close this care opportunity, please refer to these 3rd-party resources:

- [American Geriatrics Society \(AGS\): American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults](#)
- [PharmD Live: Anticholinergic Medications in the Beers Criteria](#)
- [HealthinAging.org: Learn More: Alternatives for Medications Listed in the AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults](#)
- [Patient Safety Network: STOPP/START criteria for potentially inappropriate prescribing in older people: version 3](#)

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Poly-ACH measure medications and potentially safer alternatives

The Centers for Medicaid and Medicare Services (CMS) have a Part D measure that focuses on concurrent use of medications that are deemed a serious safety concern. The measure is Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH).

Refer to the following chart below for potentially safer alternatives to consider when evaluating drug therapy for your patients who are on concurrent therapy of 2 or more anticholinergics.

Measure name	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
Poly-ACH anticholinergics	Antihistamines	Brompheniramine, chlorpheniramine, cyproheptadine, dimenhydrinate, diphenhydramine, doxylamine, hydroxyzine, meclizine, triprolidine	Seasonal allergies symptoms	Second-generation antihistamine (e.g., levocetirizine, desloratidine, loratidine) Intranasal steroid (e.g., fluticasone, mometasone) Intranasal antihistamine (e.g., azelastine) Intranasal normal saline (OTC)
			Anxiety	Buspirone
			Pruritus	Second-generation antihistamine (e.g., cetirizine, loratidine) Topical steroid (e.g., alclometasone)
			Nausea	Ondansetron

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Poly-ACH measure medications and potentially safer alternatives

Measure name	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
Poly-ACH anticholinergics	Antiemetics	Prochlorperazine, promethazine	Nausea/ Vomiting	Ondansetron
			Cough/Cold	OTCs: Guaifenesin, dextromethorphan, cough/throat lozenges
	Gastrointestinal (Antispasmodics)	Atropine, clidinium-chlordiazepoxide, dicyclomine, homatropine, hyoscyamine, scopolamine	GI motility disorders- constipation, diarrhea	Lactulose oral solution, Linzess, lubiprostone OTCs: Miralax, Benefiber, Senna, Metamucil, docusate, loperamide
	Skeletal muscle relaxants	Cyclobenzaprine, orphenadrine	Muscle spasms	Tizanidine, acetaminophen, ibuprofen, naproxen, topical analgesics Nonpharmacologic treatment: Stretching, heat/ice, physical therapy, TENS unit
Antimuscarinics (Urinary Incontinence)	Darifenacin, fesoterodine, flavoxate, oxybutynin, solifenacin, tolterodine, trospium	Incontinence/ overactive bladder	Gemtesa (vibegron), Myrbetriq (mirabegron) Nonpharmacological treatment: Bladder training, scheduled voids, limit caffeine, etc.	

Polypharmacy – Use of Multiple Anticholinergics Medications in Older Adults (Poly-ACH) (cont.)

Poly-ACH measure medications and potentially safer alternatives

Measure name	Therapeutic class	Measure medications	Common indications	Potential alternatives* (if clinically appropriate)
Poly-ACH anticholinergics	Antidepressants	Amitriptyline, amoxapine, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, paroxetine	Depression	Bupropion, vilazodone, mirtazapine
			Insomnia	Mirtazepine, trazodone, melatonin (OTC) Nonpharmacological treatment: Sleep hygiene, cognitive behavioral therapy
			Neuropathic pain	Lidocaine patch Nonpharmacologic treatment: Exercise, physical therapy
			Migraine prophylaxis	Propranolol
	Antiparkinsonian Agents	Benztropine, trihexyphenidyl	Parkinson disease	Carbidopa/levodopa combinations, amantadine, rasagiline, ropinirole, pramipexole, selegiline
			Drug-induced extrapyramidal symptoms	
	Antipsychotics	Chlorpromazine, clozapine, olanzapine, perphenazine	Schizophrenia	Lurasidone, paliperidone, ziprasidone

* This list includes medications that are part of broad formulary coverage available across UnitedHealthcare Medicare formularies, as well as OTC and nonpharmacological alternatives that may not be covered by insurance. Please refer to specific formulary for coverage details. The medication alternatives may not be appropriate in all clinical situations, nor are they intended to replace a prescriber’s clinical judgment.

Statin Use in Persons With Diabetes (SUPD)

New for 2026

Updated

- Members who do not meet numerator compliance or have additional exception criteria and have at least 1 prescription claim during the measurement period using their Part D benefits for either a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (Repatha or Praluent) or bempedoic acid (Nexletol), will be removed from the denominator

Definition

Percentage of Medicare members with diabetes ages 40-75 who receive at least 1 fill of a statin medication during the measurement period using their Part D benefit. Members with diabetes are defined as those who have at least 2 fills of diabetes medications during the measurement year.

Plans(s) affected	Quality program(s) affected	Collection and reporting method
<ul style="list-style-type: none"> Medicare 	<ul style="list-style-type: none"> CMS Star Ratings 	<p>Part D prescription claims</p> <ul style="list-style-type: none"> Pharmacy data

Compliance

To comply with this measure, a member with diabetes must have a fill for at least 1 statin or statin combination medication in any strength or dose using their Part D benefit during the measurement year. The statins shown here are on a member’s UnitedHealthcare Medicare Advantage formulary.^{i,ii}

Formulary tier	Medications
Tier 1*	<ul style="list-style-type: none"> Atorvastatin Lovastatin Pravastatin Ezetimibe-simvastatin Simvastatin Rosuvastatin Amlodipine-atorvastatin Fluvastatin
Tier 3**	<ul style="list-style-type: none"> Livalo®

ⁱ All product names are registered ® trademarks of their respective holders. Use of them does not imply any affiliation with or endorsement by them.

ⁱⁱ The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

*** not complete ICD 10 list

Statin Use in Persons With Diabetes (SUPD) (cont.)

Required exclusion(s)

Exclusion	Time frame
<ul style="list-style-type: none"> • Members in hospice or using hospice services • Members who have filled a PCSK9 inhibitor or bempedoic acid using Part D benefits during the measurement year and do not have a statin fill or other exclusion • End Stage Renal Disease: I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 • Dialysis: Z91.15, Z99.2 • Beneficiaries with rhabdomyolysis or myopathy: G72.0, G72.89, G72.9, M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9, M62.82 • Lactation: O91.03, O91.13, O91.23, O92.03, O92.5, O92.13, O92.70, O92.79, Z39.1 • Pregnancy (1000+ codes) ***: O00.101, O09.00, O10.011, O20.0, O30.331, O99.019, O99.210, O99.340, O99.810, O99.820, Z33.1, Z34.00, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93 • Fertility: Captured via a pharmacy claim for Clomiphene adjudicated with Part D coverage • Cirrhosis: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69 • Polycystic ovary syndrome (PCOS): E28.2 • Pre-diabetes: R73.03, R73.09 	<p>Any time during the measurement year</p>

i All product names are registered® trademarks of their respective holders. Use of them does not imply any affiliation with or endorsement by them.

ii The formulary and pharmacy network may change at any time.

*Lowest copay of all tier levels

**Tiers for these medications may be different for group retiree plans

*** not complete ICD 10 list

Statin Use in Persons With Diabetes (SUPD) (cont.)

Tips and best practices to help close this care opportunity:

- Please check your Patient Care Opportunity Report (PCOR) or Practice Assist often. Look in the Pharmacy Detail tab for members with open care opportunities
- Log on to Practice Assist to review members with open care opportunities
 - Select **Medication Adherence** to view our patient list
 - Members without a statin fill this year will be marked with a “Gap” under the SUPD measure
- Consider prescribing a statin, as appropriate. If you determine a statin medication is appropriate, please send a prescription to the member’s preferred pharmacy.*
- Importance of taking a statin: American Diabetes Association (ADA), American Heart Association (AHA) and American College of Cardiology (ACC) suggest people with diabetes take a moderate statin therapy without calculating a 10-year ASCVD risk. In patients with diabetes and higher cardiovascular risk, a high-intensity statin is reasonable. Statins can reduce the risk of heart attack and stroke, even in patients who do not have high cholesterol. Patients with type 1 and type 2 diabetes have increased prevalence of lipid abnormalities that leads to increased risk of developing atherosclerotic cardiovascular disease (ASCVD).¹⁻² Statin use in patients with diabetes has shown to decrease incidence of cardiovascular events by 21% per 39 mg/dL decrease in LDL and decrease mortality by 9% per 39 mg/dL.³
- Prescription must be filled through Part D insurance card to close this care opportunity. Prescriptions filled through cash claims, discount programs (such as GoodRx) and medication samples will not close the measure.
- If member has intolerance or side effects such as myalgias, if clinically appropriate, consider:
 - A different statin that is hydrophilic (e.g., rosuvastatin or pravastatin)
 - A lower dose statin than previously tried
 - Reducing the frequency
- For members who meet exclusion criteria, a claim using appropriate ICD-10 code must be submitted ANNUALLY if applicable
- Only statin medications will close the care opportunity; other cholesterol medications such as ezetimibe or fenofibrate do not close the care gap. PCSK9 inhibitors and bempedoic acid, filled during the measurement year through Part D benefits, will remove non-compliant members from the denominator.
- Consider extended day fills (e.g., 90- or 100-day supply) or send to home delivery
- Unstructured or supplemental data cannot be submitted for gap closure or exclusion capture for SUPD

References:

1. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol. *Circulation*. 2018;139(25):e1046-e1081. doi:10.1161/cir.0000000000000625. Accessed February 24, 2024
2. Nuha A, ElSayed, Grazia Aleppo, Vanita R. Aroda, et al. on behalf of the American Diabetes Association, 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes --2024. *Diabetes Care* 1 January 2024; 46 (Supplement_1): S158 -S190. <https://doi.org/10.2337/dc23-S010>. Accessed February 24, 2024
3. Naeem F, McKay G, Fisher M. Cardiovascular outcomes trials with statins in diabetes. *British Journal of Diabetes*. 2018; 18(1):7-13.

*Member may use any pharmacy in the network, but may not receive preferred retail pharmacy pricing. Pharmacies in the Preferred Retail Pharmacy Network may not be available in all areas. Co-pays apply after deductible.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)



This health plan member survey is a multi-year survey that evaluates consumer/member experiences. We use CAHPS results to compare data on members' experience of care between UnitedHealthcare and prescription drug plans.

The example survey questions here use the Medicare and Medicaid look-back period of 6 months. The questions for commercial members use a 12-month look-back.

Frequency: Annually between February and June

Target Population: Medicare Advantage, commercial and Medicaid members

Measurement Year Look-Back: 6 months for Medicare and Medicaid, 12 months for commercial

Getting Appointments and Care Quickly

Survey questions

- When you needed care right away, how often did you get care as soon as you needed it?
- How often did you get an appointment for a check-up or routine care as soon as you needed?

Compliance needed to meet the intent of the measure

This case-mix adjusted composite measure is used to assess how quickly members were able to get appointments and care. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Getting Needed Prescription Drugs – Medicare Only

Survey questions

- How often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- How often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?

- How often was it easy to use your prescription drug plan to fill a prescription by mail?

Compliance needed to meet the intent of the measure

This case-mix adjusted composite measure is used to assess how easy it is for members to get prescribed medicines both from their local pharmacy and by mail. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Getting Needed Care

Survey questions

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

Compliance needed to meet the intent of the measure

This case-mix adjusted composite measure is used to assess how easy it was for members to get needed care and see specialists. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) (cont.)

Rating of Health Care

Survey question

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care?

Compliance needed to meet the intent of the measure

This case-mix adjusted measure is used to assess members' view of the quality of care received from the health plan. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Rating of Health Plan

Survey question

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Compliance needed to meet the intent of the measure

This case-mix adjusted measure is used to assess the overall view members have of their health plan. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Rating of Personal Doctor – Commercial and Medicaid Only

Survey Question

- Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

Compliance needed to meet the intent of the measure

This measure is used to assess the overall view members have of their personal doctor.

Rating of Specialist Seen Most Often – Medicaid Only

We want to know your rating of the specialist you saw most often. Using any number from 0 to 10, where is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

Compliance needed to meet the intent of the measure

This measure is used to assess the overall view members have of the specialist they see most often.

Rating of Drug Plan – Medicare Only

Survey question

Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?

Compliance needed to meet the intent of the measure

This case-mix adjusted measure is used to assess the overall view members have of their prescription drug plan. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) (cont.)

Care Coordination

Survey questions address:

- Whether the personal doctor is informed and up to date about care you received from other health care providers
- Whether the doctor had medical records and other information about the member's care (Medicare only)
- Whether there was follow-up with the member to provide test results (Medicare only)
- How quickly the member got the test results (Medicare only)
- Whether the doctor spoke with the member about prescription medicines (Medicare only)
- Whether the member received help managing care (Medicare only)

Compliance needed to meet the intent of the measure for medicare advantage plan members

This case-mix adjusted composite measure is used to assess care coordination. The CAHPS score uses the mean of the distribution of responses converted to a scale of 0 to 100.

Customer Service

Survey questions

- How often did your health plan's customer service give you the information or help you needed?
- How often did your health plan's customer service treat you with courtesy and respect?
- How often were the forms for your health plan easy to fill out? (Medicare only)

Compliance needed to meet the intent of the measure

This case-mix adjusted composite measure is used to assess how easy it was for members to get information and help when needed. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100.

Medical Assistance With Smoking and Tobacco Use Cessation-Commercial, Medicaid and Exchange

Survey questions

- Do you now smoke cigarettes or use tobacco every day, some days, or not at all?
- In the last 6 months (12 months for commercial), how often were you advised to quit smoking or using tobacco by a doctor or other health provider?
- In the last 6 months (12 months for commercial), how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
- In the last 6 months (12 months for commercial), how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?

Consumer Assessment of Healthcare Providers and Systems (CAHPS) (cont.)

Compliance needed to meet the intent of the measure

This measure is used to assess the number of members who indicated that they were advised to quit, or were provided cessation methods and strategies by their doctor or other health care provider.

Annual Flu Vaccine – Medicare Only

Survey question

- Have you had a flu shot since July 1, [year prior to survey]?

Compliance needed to meet the intent of the measure

This measure is to assess a member's recall of receiving the annual flu vaccine. The CAHPS score uses the percentage of "Yes" responses.

Health Outcomes Survey (HOS)



This health plan member survey is used to gather valid, reliable and clinically meaningful health status data in the Medicare Advantage program for use in quality improvement activities, pay for performance, program oversight, public reporting and improving health. All managed care organizations with Medicare Advantage contracts must participate. The survey looks at physical and mental health outcomes measures, urinary incontinence in older adults, physical activity in older adults, fall risk management and osteoporosis testing in older women.

Frequency: Annually between July and November

Target population: Medicare Advantage

Improving bladder control

HOS data only

Cohort follow-up data collection and cohort baseline data collection:

- HOS Question 33: Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?
- HOS Question 34: During the past 6 months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
- HOS Question 36: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?

Compliance needed to meet the intent of the measure

Percentage of Medicare members ages 65 and older who reported having urine leakage in the past 6 months (Question 33) and who discussed treatment options for their urinary incontinence with a health care provider (Question 36).

Improving or maintaining mental health

HOS data only Cohort follow-up data collection and cohort baseline data collection:

- HOS Question 4a: During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Accomplished less than you would like: None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 4b: During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Didn't do work or other activities as carefully as usual: None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 6a: How much of the time during the past 4 weeks have you felt calm and peaceful? None of the time, a little of the time, some of the time, most of the time, all of the time

Health Outcomes Survey (HOS) (cont.)

- HOS Question 6b: How much of the time during the past four weeks did you have a lot of energy? None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 6c: How much of the time during the past four weeks have you felt downhearted and blue? None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 7: During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 7: During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 2a: The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf: Limited a lot, limited a little, not limited at all
- HOS Question 2b: The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? Climbing several flights of stairs: Limited a lot, limited a little, not limited at all
- HOS Question 3a: During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? Accomplished less than you would like: None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 3b: During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? Were limited in the kind of work or other activities: None of the time, a little of the time, some of the time, most of the time, all of the time
- HOS Question 5: During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? Not at all, a little bit, moderately, quite a bit, extremely

Compliance needed to meet the intent of the measure

Percentage of sampled Medicare members ages 65 and older whose mental health status was the same or better than expected (Questions 4a-b, 6a-c and 7).

Improving or maintaining physical health

HOS data only

Cohort follow-up data collection and cohort baseline data collection:

- HOS Question 1: In general, would you say your health is excellent, very good, good, fair or poor?

Health Outcomes Survey (HOS) (cont.)

Compliance needed to meet the intent of the measure

Percentage of sampled Medicare members ages 65 and older whose physical health status was the same, or better than expected (Questions 1, 2a-b, 3a-b and 5).

Monitoring physical activity

HOS data only

Cohort follow-up data collection and cohort baseline data collection:

- **HOS Question 37:** In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- **HOS Question 38:** In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or maintain your current exercise program. Compliance Needed to Meet the Intent of the Measure Percentage of sampled Medicare members ages 65 and older who had a doctor's visit in the past 12 months and who received advice to start, increase, or maintain their level of exercise or physical activity (Question 43).

Reducing the risk of falling

HOS data only

Cohort follow-up data collection and cohort baseline data collection:

- **HOS Question 39:** A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?
- **HOS Question 40:** Did you fall in the past 12 months?
- **HOS Question 41:** In the past 12 months, have you had a problem with balance or walking?
- **HOS Question 42:** Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
 - Suggest you use a cane or walker
 - Suggest you do an exercise or physical therapy program
 - Suggest vision or hearing testing

Compliance needed to meet the intent of the measure

Percentage of sampled Medicare members ages 65 and older who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity (Question 43).



Contact us to learn more.

For more information about how our programs can help support your patients who are UnitedHealthcare plan members, please contact your UnitedHealthcare representative.