VNS Health

PROVIDER HEDIS® QUICK REFERENCE GUIDE

HEDIS® Measurement Year 2025

HEDIS Measure	Measure Description	Documentation Required	Applicable CPT Codes
Breast Cancer Screening **(BCS-E)**	Members ages 50 to 74 years, who have had a mammogram October 1st two years prior through the end of the MY.	Documentation must include one of the following: • Dated Mammogram report • History of Mammogram with a date of service • Mastectomy (bilateral or unilateral)	**ICD 10 Codes:** NA **CPT Codes:** 77061-77063, 77065-77067
Cervical Cancer Screening **(CCS-E)**	Members 21 to 64 years of age, who have had a cervical cytology (21 to 64) within 3 years, cervical high-risk human papillomavirus (30- 64) within 5 years or both cytology/hrHPV co- testing (30-64) within the last 5 years, to screen for cervical cancer.	Documentation must include one of the following: • Reports for cervical cytology and/or HPV including DOS and result • Evidence of hysterectomy with no residual cervix	**ICD 10 Codes:** NA **CPT Codes:** 88141-88143, 87624, 87625
Colorectal Cancer Screening **(COL- E)**	Members 45 to 75 years of age, who have had at least one of the following cancer screenings within applicable timeframe: Fecal Occult Blood Test (FOBT), Flexible Sigmoidoscopy, Colonoscopy, CT Colonography and/or Stool DNA with FIT testing.	Documentation must include date (at least the year) and type of test/history • Colonoscopy – every 10 years • Flexible sigmoidoscopy – every 5 years • CT colonography – every 5 years • FIT-DNA (Cologuard) – every 3 years • FOBT (guaiac or immunochemical/FIT) – every 1 year • History of Total Colectomy • History of Colorectal Cancer	**ICD 10 Codes:** NA **CPT Codes:** 82270, 45330, 44388,74261, 81528
Care of Older Adults **(COA)**	Members who are 66 years of age who have completed functional status assessments and medication review during the MY.	***Functional Status Assessment*** Documentation must include evidence of a complete functional status assessment and the date it was performed • Notation that the Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (iADLs) were assessed • Results of assessment using a standardized functional assessment tool ***Medication Review*** Documentation must include a separate medication list in the medical record with date when it was performed or note that the member is not taking any medications with date. Date & notation that member is not taking any medication, is also acceptable	**ICD 10 Codes:** NA **CPT Codes:** 99483, 90863, 99495, 1170F, 1159F & 1160F **HCPCS Codes:** G8427, G0438

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Controlling High Blood Pressure **(CBP)**	Members 18 to 85 years of age with a diagnosis of HTN (hypertension) whose most recent blood pressure measurement during the MY, show an adequate control of condition, as evidenced by results of <140/90mm Hg.	Compliant BP is LESS THAN 140/90 for both systolic and diastolic • TIP: If BP noncompliant, retake at the end of visit and document both blood pressures. Documentation of member reported BP is acceptable. ****3x weighted Star Measure**	**ICD 10 Codes:** I10 **CPTII Codes:** 3079F, 3078F, 3080F, 3074F, 3075F, 3077F
Glycemic Status Assessment for Patients with Diabetes **(GSD)**	Members between 18 to 75 years of age, diagnosed with diabetes (types 1 and 2), who have a completed hemoglobin A1c within the MY. *A1c levels <8.0 indicate good control and levels >9.0 indicate poor control.*	Documentation includes: • A1c lab reports • A1c result documented within a progress note must have a date • POC A1c needs a result documented • Member reported A1c must be specific enough to link to a date • Documentation must be specific enough to link it to a date: "last Wednesday", "yesterday", "last week", etc. Documentation not specific enough includes: "recent", "last", "previously", etc. ****3x weighted Star Measure**	**ICD 10 Codes:** E10.10, E10.36, E11.00 **CPT Codes:** 83036, 83067 **CPTII Codes:** 3044F, 3051F, 3052F, 3046F
Eye Exam for Patients with Diabetes **(EED)**	Members between 18 to 75 years of age, diagnosed with diabetes (types 1 and 2), who have completed a retinal eye exam.	Documentation includes: • Dated retinal exam • Results • Evidence done or reviewed by an eye care professional • Documentation of bilateral eye enucleation **Note: Blindness is not an exclusion.*	**ICD 10 Codes:** E10.10, E10.36, E11.00 **CPTII Codes:** 2022F (evidence of retinopathy), 2023F (no evidence of retinopathy)

Kidney Health Evaluation for Patients with Diabetes **(KED)**	Members between 18 to 85 years of age, diagnosed with diabetes (types 1 and 2), who completed the eGFR (estimated glomerular filtration rate) ***and*** uACR (urine albumin- creatinine ratio) lab tests during the MY.
	The uACR must have both a quantitative urine albumin test **and a urine creatinine test to be complete.*
		Documentation includes:
		• Estimated glomerular filtration rate (eGFR) AND one of the following:
		  ○ Urine albumin creatinine ratio (uACR) OR
		  ○ Quantitative urine albumin test ***and*** urine creatinine test with service dates four days or less apart
		• End stage renal disease or dialysis any time during the member's history
			ICD 10 Codes: E10.10, E10.36, E11.00
			CPT Codes: 82043, 82570, 80047
			LOINC Codes: 13705-9, 1754-1, 2161-8, 50210-4

Statin Therapy for Patients with Cardiovascular Disease **(SPC)**	Male members between 21 to 75 years of age, and female members between 40 to 75 years of age, who have had an ASCVD diagnosis (atherosclerotic cardiovascular disease) and has received statin therapy at least once during the MY, as well as maintained >80% adherence.	Documentation includes: • Current moderate or high intensity statin therapy in member's current medication list or ordered during the measurement period TIP: Members may experience side effects using high-intensity statins. Start dosage low and gradually increase the intensity, or switch to another statin.	**ICD 10 Codes:** I21.01, I21.09, I25.2

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Osteoporosis Management in Women Who Had a Fracture **(OMW)**	Female members between 67 to 85 years of age, who have had a BMD (bone marrow density) test or prescribed a medication for osteoporosis treatment within six months, after suffering a fracture.	Documentation Includes: • Evidence of appropriate testing or treatment for osteoporosis following a fracture • Eligible testing includes a bone mineral density test, in any setting • Eligible treatment includes osteoporosis therapy, including but not limited to, Alendronate, Risedronate, Raloxifene and Teriparatide. *Note: Fractures not included in this measure include finger, toe, face and skull fractures.*	**ICD 10 Codes:** M80.00XA, M80.80XA **CPT Codes:** 76977, 77078, 77080-77081 **HCPCS Codes:** J0897, J1740, J3110, J3111, J3489
Depression Screening and Follow-Up for Adolescents and Adults **(DSF-E)**	Members 12 years of age and older who were evaluated for depression utilizing standardized screening tools, and, if a positive screen, received a follow-up care within 30 days.	Documentation Includes: • Age-appropriate standardized screening tool present in the member's medical record. • Members with a positive screen should have a follow-up within 30 days of screen; encounters may be outpatient, telephone, e-visit or virtual visits • Evidence of an additional screening tool completed the same day indicating no symptoms/depression, is compliant, so long as the secondary screen is from a full-length screening tool (ie: initial PHQ-2 screening is positive but PHQ-9 screening is negative when completed the same day).	**ICD 10 Codes:** NA **CPT Codes:** 99202-99205 **LOINC Codes:** 44261-6, 55758-7, 89208-3, 89205-9, 90853-3, 48545-8, 71956-8
Social Needs Screening and Intervention **(SNS-E)**	All members who have been screened for Food, Housing and Transportation insecurity/needs, as well as have documented interventions within 30 days of a positive screening. Screenings should be completed at least annually.	Documentation Includes: • Documentation of eligible screening tool present in the member's medical record. • Positive screenings must have documented interventions (ie: positive housing insecurity screening must have a housing inadequacy intervention documented). • Appropriate interventions may include, but not limited to, assistance, coordination, counseling, education and referrals. **Note: Providers should utilize applicable LOINC Codes to submit claims for screenings*	**ICD 10 Codes:** NA **CPT Codes:** 96156, 96160, 96161, 97802-97804 **LOINC Codes:** 88122-7, 95264-8, 71802-3, 96778-6, 93030-5

VNS Health

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Transitions of Care **(TRC)**	Members 18 years of age and older, who have been discharged after an in-patient hospitalization, and have the following noted in their outpatient medical record: *1.* ***Notification of Inpatient Admission*** within 2 days of admission. *2.* ***Receipt of Discharge information*** within 2 days of discharge. *3.* ***Patient Engagement*** within 30 days of discharge. (Cannot be completed the same day of discharge) *4.* ***Medication Reconciliation*** within 30 days of discharge. *Providers may use CPTII code 1111F.	***Notification of Inpatient Admission*:** Outpatient medical record of the ongoing care provider must include receipt of notification of admission on day of admission through 2 days after admission **Date of receipt or file date must be documented Compliant Examples: • Preadmission exam about a planned inpatient admission any time prior to the admission meets criteria • Communication from inpatient providers or ED about admission to the ongoing care provider • ADT Alerts from the hospital into members EMR ***Receipt of Discharge Information*:** Outpatient medical record of the ongoing care provider must include receipt of discharge on day of discharge through 2 days following discharge **Date of receipt or file date must be documented At minimum, discharge information must include: • Practitioner responsible for care during inpatient stay • Procedures and treatment provided • Diagnosis at discharge • Current med list • Testing results, pending tests or no tests pending • Instructions for post discharge care • Hospice care during the measurement year ***Patient Engagement*:** Outpatient medical record of the ongoing care provider must include documentation of any type of patient engagement within 30 days after discharge, including telehealth or in-person visits. **Cannot be done on the day of discharge ***Medication Reconciliation Post-Discharge*:** Outpatient medical record of the ongoing care provider must include medication reconciliation conducted by a prescribing provider, clinical pharmacist, physician assistant or registered nurse on the day of discharge through 30 days after discharge. Compliant examples: • Evidence of medication reconciliation of current medications to discharge medications • Documentation of current medication list and evidence the patient is being seen for “post hospital discharge follow-up”.	**ICD 10 Codes: NA** **CPT Codes:** 99483, 99495, 98966, 99202, 1111F

REFERENCES AND COMMENTS:

- HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Refer to www.ncqa.org/hedis/
- CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association
- LOINC (Logical Observation Identifiers Names and Codes)
- Quality Assurance Reporting Requirements (QARR) are adopted from NCQA HEDIS® with New York state-specific measures added to address health issues of particular importance in New York. This document is not inclusive of all codes and measures. The measure descriptions and codes in this document are derived from the MY2025 HEDIS® Technical Specifications/Value Set Directory, and the Quality Assurance Reporting Requirements Technical Specifications manual. For the full list of codes, please refer to the NCQA store to purchase.
- Please visit the Provider Toolkit which has more information on the HEDIS measures to help close gaps in care.

Have questions?

Please contact us at QualityManagement@vnshealth.org or Provider_Education@vnshealth.org

For additional information and resources, please visit our provider website and toolkit at https://www.vnshealthplans.org/for-health-professionals- overview/