QUICK REFERENCE GUIDE

HEDIS® 2025

NEBRASKA HEALTH NETWORK
METHODIST
Nebraska Medicine

SCREENINGS

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **CERVICAL CANCER SCREENING** (CCS-E)

Women 21-64 years of age who were screened for cervical cancer. "E" measures indicate that records must be sent electronically on an NHN extract or something similar with appropriate discrete data elements included. This E-Measure is required effective 2025.

✓ **Administrative Specifications** ✓ **Hybrid Specifications**

DENOMINATOR

Women aged 21-64 who need cervical cytology or aged 30-64 who need high-risk HPV testing. Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

1. Women 21-64 years who had cervical cytology within last 3 years
2. Women 30-64 years who had high-risk HPV testing within last 5 years
3. Women 30-64 years who had cervical cytology and high-risk HPV co-testing within the last 5 years

EXCLUSIONS

- Hospice/Palliative care
- Hysterectomies (absence of cervix, cervical agenesis, hysterectomy with no residual cervix) any time during the patient history through the current measurement year.
- Members with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time during the patient's history.
- Deceased during the measurement year.

TIDBITS

If in an extract, this measure is seen as "Administrative" and you only need a date of service and a code for the procedure. However, if you are submitting supplemental records as a "Hybrid" measure then the health record must contain a note indicating the date when the procedure was performed and the result of the testing/procedure.

Per payer feedback, 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. 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.

CODES Code types: CPT, HCPCS, LOINC, SNOMED (If "history" or "result only," it is only SNOMED)

Cervical Cytology Lab Test (21-64)	**CPT:** 88141 - 88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001 **LOINC:** 47527-7, 47528-5
HPV Tests (30-64)	**CPT:** 87624, 87625 **HCPCS:** G0476 **LOINC:** 38372-9, 77399-4, 77400-0
Hysterectomy with No Residual Cervix and Absence of Cervix Diagnosis	**CPT:** 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550, 58552–58554, 58570–58573, 58575, 58951, 58953, 58954, 58956, 59135 **ICD-10:** Q51.5, Z90.710, Z90.712 **SNOMED:** 1163275000

For a complete list of codes, please visit the NCQA website at **ncqa.org**, or see the HEDIS value sets. Only subsets of the NCQA-approved codes are listed in this document.

SCREENINGS

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MEASURE: **BREAST CANCER SCREENING** (BCS-E)

Women 40–74 years of age who had a mammogram to screen for breast cancer. "E" measures indicate that records must be sent electronically on an NHN extract or something similar with appropriate discrete data elements included.

Administrative Specifications **Hybrid Specifications**

DENOMINATOR

Women aged 40-74 who need screened for breast cancer.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

One or more mammograms between October 1st, two years prior to the measurement year and December 31st, of the measurement year.

- For example, the 2025 measurement year will accept mammograms from October 1, 2023 through December 31, 2025.

EXCLUSIONS

- Hospice/Palliative Care
- Those 66 years of age and older in institutional or LTC living.
- Those 66 years of age and older that have both frailty AND advanced illnesses coded.
- Dementia medications
- Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period.
- Members who had gender affirming chest surgery (CPT 19318) with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
- Deceased during the measurement year.

TIDBITS

This an "Administrative" measure with no "Hybrid" specifications within HEDIS. However, depending on the payer, this measure will accept supplemental data for a mammogram completed between October 1st, two years prior and the current year.

A laboratory claim exclusion for Absence of Left Breast Value Set and/or Absence of Right Breast Value Set (claims with POS code 81) do not meet the criteria for a BCS-E exclusion.

New Breast Biopsy value set and Breast Ultrasound value sets are only applicable to the new to 2025 Follow-Up After Abnormal Mammogram Assessment (FMA-E) numerator only.

CODES Code types: CPT, LOINCS

Mammogram	**CPT:** 77061-77063, 77065-77067 **LOINCS**: 24606-6, 26175-0, 26176-8, 26177-6, 26346-7
Bilateral Mastectomy	**ICD-10:** Z90.13
Unilateral Mastectomy	**CPT Modifier:** 50

SCREENINGS

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **COLORECTAL CANCER SCREENING** (COL-E)

Adult 45–75 years of age who had appropriate screening for colorectal cancer. "E" measures indicate that records must be sent electronically on an NHN extract or something similar with appropriate discrete data elements included.

✓ **Administrative Specifications** ✓ **Hybrid Specifications**

DENOMINATOR

Aged 45–75 years of age who need screened for colorectal cancer.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not monitor this measure

NUMERATOR/HOW MET

1. Colonoscopy during the measurement year or 9 years prior to
   - Code types: CPT, HCPCS
2. CT colonography during the measurement year or 4 years prior to
   - Code types: CPT, LOINC
3. Flexible sigmoidoscopy during the measurement year or 4 years prior to
   - Code types: CPT, HCPCS
4. FIT-DNA (Cologuard) during the measurement year or 2 years prior to
   - Code types: CPT, LOINC
5. Fecal occult blood test (FOBT) during the measurement year
   - Code types: CPT, HCPCS, LOINC

EXCLUSIONS

- Hospice/Palliative Care
- Those 66 years of age and older in institutional or LTC living.
- Those with frailty AND advanced illnesses coded during the measurement year.
- Dementia medications
- Colorectal cancer
- Total colectomy any time during patient history through measurement year.
- Deceased during the measurement year.

TIDBITS

There are different sample requirements for guaiac FOBT and immunochemical FOBT - if the record does not specify which test, HEDIS will assume that all required amounts were obtained regardless of the testing type. You cannot count FOBT performed in an office setting (testing paper that is tossed into the toilet after a bowel movement at the provider's office doesn't meet this measure) and digital rectal exams performed by a provider do not impact this measure.

In October 2020 CMS announced that for Medicare members, evidence is sufficient to cover a blood-based biomarker test as an appropriate colorectal cancer screening test once every 3 years, or at the interval designated in the Food and Drug Administration (FDA) label if the FDA indicates a specific test interval. However, these tests have not yet been approved by NCQA to close HEDIS gaps. At this time, no blood biomarker test for colorectal cancer screening will meet numerator compliance for the COL HEDIS measure.

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.

CONTINUED

MEASURE: **COLORECTAL CANCER SCREENING** (COL-E), CONTINUED

CODES

Colonoscopy	**CPT®:** 44388–44392, 44394, 44401–44408, 45378–45382, 45384-45386, 45388–45393, 45398 **HCPCS:** G0105, G0121
CT Colonoscopy	**CPT®:** 74261–74263 **LOINC:** 79101-2
Flexible Sigmoidoscopy	**CPT®:** 45330–45335, 45337–45338, 45340–45342, 45346–45347, 45349–45350 **HCPCS:** G0104
sDNA FIT Lab Test	**CPT®:** 81528 **LOINC:** 77353-1, 77354-9
FOBT (Fecal Occult Blood Test) Lab Test	**CPT®:** 82270, 82274 **HCPCS:** G0328 **LOINC:** 14563-1, 14564-9, 2335-8, 29771-3
Colorectal Cancer	**ICD-10:** C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total Colectomy	**CPT®:** 44150–44153, 44155–44158, 44210–44212

IMMUNIZATION

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MEASURE: **ADOLESCENT IMMUNIZATIONS** (IMA-E) COMBO 2 FOR OUR CONTRACTS

Adolescents 13 years of age who had one meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap), and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine. "E" measures indicate that records must be sent electronically on an NHN extract or something similar with appropriate discrete data elements included. This E-Measure is required effective 2025.

Administrative Specifications **Hybrid Specifications**

DENOMINATOR

Adolescents who turn 13 years of age during the measurement year.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

All three must be met to satisfy the IMA measure:

1. At least one meningococcal vaccine for serogroups A, C, W, Y (B does not meet the measure) on or between 10th and 13th birthday or anaphylactic reaction to the vaccine.
   - Code types: CPT, CVX
2. At least one Tdap vaccine on or between 10th and 13th birthday, anaphylactic reaction to the vaccine, or encephalitis due to vaccine.
   - Code types: CPT, CVX
3. A completed HPV vaccination series on or between 9th and 13th birthday or anaphylactic reaction to vaccine.
   - Code types: CPT, CVX

EXCLUSIONS

- Hospice
- Deceased during the measurement year.

TIDBITS

HPV doses must be at least 146 days apart. Most HPV for this group is 2 doses. To close an HPV care gap the 2-dose series must be completed **PRIOR to the patient's 13th birthday**. The third dose is not usually given unless the patient age of the first vaccination is 15 or older. A generic title such as "meningococcal vaccine" can be recorded in the EMR, but if audited, must be able to prove it was the appropriate serogroups.

CODES

Meningococcal — serogroup A,C,W, and Y: (1 dose) — must be administered between 10th and 13th birthday	**CPT:** 90619, 90623, 90733, 90734 **CVX:** 32, 108, 114, 136, 147, 167, 203, 316
Tdap (1 dose) — must be administered between the 10th and 13th birthday	**CPT:** 90715 **CVX:** 115
HPV (2 or 3 dose series) — must be administered between 9th and 13th birthday with services	**CPT:** 90649–90651 **CVX:** 62, 118, 137, 165
Anaphylaxis	Use applicable SNOMED as indicated per vaccine.

For a complete list of codes, please visit the NCQA website at **ncqa.org**, or see the HEDIS value sets. Only subsets of the NCQA-approved codes are listed in this document.

IMMUNIZATION

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **CHILDHOOD IMMUNIZATIONS** (CIS-E) COMBO 10 FOR OUR CONTRACTS

Children 2 years of age who had all of the following on or by their 2nd birthday. "E" measures indicate that records must be sent electronically on an NHN extract or something similar with appropriate discrete data elements included. This E-Measure is required effective 2025.

1. Four diphtheria, tetanus and acellular pertussis (DTaP)
2. Three polio (IPV)
3. One measles, mumps and rubella (MMR)
4. Three haemophilus influenza type B (HiB)
5. Three hepatitis B (HepB)
6. One chicken pox (VZV)
7. Four pneumococcal conjugates (PCV)
8. One hepatitis A (HepA)
9. Two or three rotavirus (RV)
10. Two influenza (flu) vaccines

The measure calculates a rate for each vaccine.

Administrative Specifications **Hybrid Specifications**

DENOMINATOR

Children who turn 2 years of age during the measurement year.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

All ten must be met to satisfy the CIS measure:

1. DTaP - At least 4 vaccinations with different dates of service on or before 2nd birthday, anaphylactic reaction to vaccine, or encephalitis due to vaccine. Cannot count anything given before 42 days old. Code types: CPT, CVX

2. IPV - At least 3 vaccinations with different dates of service on or before 2nd birthday or anaphylactic reaction to vaccine. Cannot count anything given before 42 days old. Code types: CPT, CVX

3. MMR - Can give MMR or one measles and rubella vaccination with at least one mumps vaccination. Can document history of measles, mumps or rubella illness in place of vaccination or anaphylactic reaction to vaccine. Code types: CPT, CVX, ICD-10

4. HiB - At least 3 vaccinations with different dates of service on or before 2nd birthday or anaphylactic reaction to vaccine. Cannot count anything given before 42 days old. Code types: CPT, CVX

5. Hep B - At least 3 vaccinations with different dates of service on or before 2nd birthday, history of Hep B illness or anaphylactic reaction to vaccine. One of the 3 can be the newborn vaccination (given in first 7 days of life). Code types: CPT, CVX, HCPCS (newborn has ICD-10 also)

6. VZV - At least one vaccination on or before 2nd birthday or history of varicella illness or anaphylactic reaction to vaccine. CPT, CVX, ICD-10

7. Pneumococcal - At least 4 vaccinations with different dates of service on or before 2nd birthday or anaphylactic reaction to vaccine. Cannot count anything given before 42 days old. Code types: CPT, CVX, ICD-10

CONTINUED

IMMUNIZATION

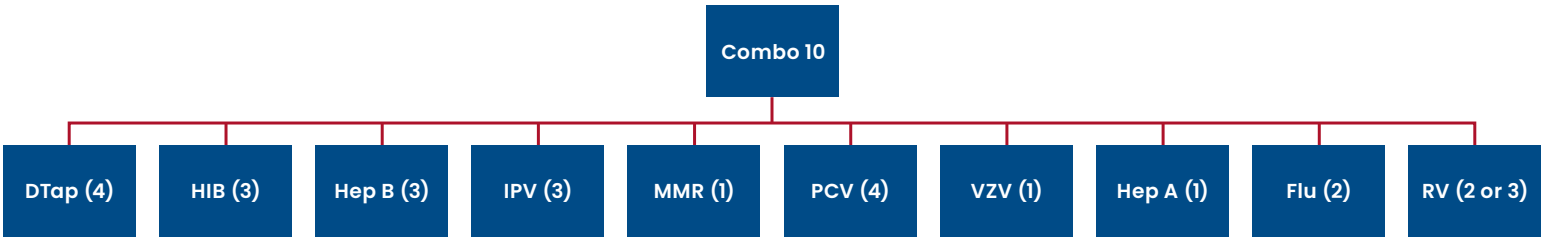
NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **CHILDHOOD IMMUNIZATIONS** (CIS-E) COMBO 10 FOR OUR CONTRACTS, CONTINUED

8. Hep A - At least one vaccination on or before 2nd birthday or history of Hep A illness or anaphylactic reaction to vaccine. Code types: CPT, CVX

9. Rotavirus - At least 1-2 (depends if given 1 of the 2 dose or 2 of the 3 dose) vaccinations with different dates of service on or before 2nd birthday or anaphylactic reaction to vaccine. Cannot count anything given before 42 days old. Code types: CPT, CVX, ICD-10

10. Influenza - At least 2 influenza vaccinations on or before 2nd birthday. Cannot count anything given prior to 6 months old. Code types: CPT, CVX, ICD-10



EXCLUSIONS

- Hospice
- Members who had a contraindication to a childhood vaccine on or before their second birthday.
- Organ and Bone Marrow Transplants
- Deceased during the measurement year.

TIDBITS

Can use combination vaccinations that cover more than one vaccination. Vaccinations marked as "at delivery" or "in the hospital" can be counted if there is not a minimum age restriction on that vaccination.

CODES Code types: CPT, CVX

DTaP (4 dose)	**CPT:** 90697, 90698, 90700, 90723 **CVX:** 20, 50, 106, 107, 110, 120, 146
HIB (3 dose)	**CPT:** 90644, 90647, 90648, 90697, 90698, 90748 **CVX:** 17, 46, 47, 48, 49, 50, 51, 120, 146, 148
Newborn Hep B (3 dose)	**CPT:** 90697, 90723, 90740, 90744, 90747, 90748 **CVX:** 08, 44, 45, 51, 110, 146 **HCPCS:** G0010 **ICD-10:** B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
IPV (3 dose)	**CPT:** 90697, 90698, 90713, 90723 **CVX:** 10, 89, 110, 120, 146

CONTINUED

IMMUNIZATION

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **CHILDHOOD IMMUNIZATIONS** (CIS-E) COMBO 10 FOR OUR CONTRACTS, CONTINUED

CODES CONTINUED CPT, CVX, ICD-10, HCPCS

MMR (1 dose)	**CPT:** 90707, 90710 **CVX:** 03, 94 **ICD-10:** B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9, B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9, B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Pneumococcal Conjugate PCV (4 dose)	**CPT:** 90670, 90671 **CVX:** 109, 133, 152, 216 **ICD-10:** G0009
Varicella VZV (1 dose)	**CPT:** 90710, 90716 **CVX:** 21, 94 **ICD-10:** 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
Hep A (1 dose)	**CPT:** 90633 **CVX:** 31, 83, 85 **ICD-10:** B15.0, B15.9
Influenza Flu (2 dose) LAIV vaccination must be administered on the child's 2nd birthday	**CPT:** 90655, 90657, 90660, 90661, 90672, 90674, 90685–90689, 90756 **CVX:** 88, 140, 141, 150, 153, 155, 158, 161, 111, 149, 171, 186 **ICD-10:** G0008
Rotavirus (2 Dose)	**CPT:** 90681 **CVX:** 119
Rotavirus (3 Dose)	**CPT:** 90680 **CVX:** 116, 122
Anaphylaxist	Use applicable SNOMED as indicated per vaccine

DISEASE MANAGEMENT

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)

NCQA revised and renamed Hemoglobin A1c Control for Patients with Diabetes (HBD) to be replaced with Glycemic Status Assessment for Patients with Diabetes (GSD) to include a glucose management indicator with hemoglobin A1c.

Adult 18–75 with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

Administrative Specifications **Hybrid Specifications**

DENOMINATOR

Aged 18-75 diabetics (Type 1 or Type 2).
Determined by claims data (Diabetes coded) and pharmacy data (certain prescriptions filled) during current measurement year and the year prior.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

The result of the most recent glycemic status assessment (HbA1c or GMI) is <8.0% and the result of the most recent glycemic status assessment is >9.0%. Code types: CPT, HCPCS, LOINC

EXCLUSIONS

- Hospice/Palliative Care
- Those 66 years and older in institutional or LTC living.
- Those 66 years of age and older that have both frailty AND advanced illnesses coded.
- Dementia medications
- Deceased during the measurement year.

TIDBITS

A1c poor control is a hybrid measure and the record must contain the date of test and the result of the test. It must be the most recent lab in the measurement year. Pharmacy data used for the denominator-Glucophage or metformin prescription alone are not included because they are used to treat conditions other than diabetes. Lower score is better.

CODES

HbA1c Lab Test	**CPT:** 83036, 83037 **LOINC:** 4548-4, 17855-8, 17856-6, 4548-4
HbA1c Level Less than 7 Codes	**CPT-CAT-II:** 3044F
HbA1c Level Greater Than/ Equal to 7 and Less than 8	**CPT-CAT-II:** 3051F

CONTINUED

MEASURE: **GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES** (GSD), CONT.

CODES CONTINUED

HbA1c Level Greater Than/ Equal to 8 and Less Than/ Equal to 9	**CPT-CAT-II:** 3052F
HbA1c Greater Than 9.0	**CPT-CAT-II:** 3046F

No modifier codes are included

****A1C completion remains a core NHN measure but it was retired by HEDIS in 2022.*

DISEASE MANAGEMENT

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **DIABETIC EYE EXAM** (EED)

Adult 18–75 years of age with diabetes (Type 1 and Type 2) who had a diabetic retinal screening.

Administrative Specifications **Hybrid Specifications**

DENOMINATOR

Aged 18-75 diabetics (Type 1 or Type 2).

Determined by claims data (Diabetes coded) and pharmacy data (certain prescriptions filled) during current measurement year and the year prior.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

1. A retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year.
   - Code types: CPT, CPT II, HCPCS

2. A negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year.
   - Code types: CPT II

3. Autonomous eye exam billed by any provider type during the measurement year.
   - Code types: CPT, LOINC

EXCLUSIONS

- Hospice/Palliative Care
- Those 66 years of age and older in institutional or LTC living.
- Those 66 years of age and older that have both frailty AND advanced illnesses coded.
- Dementia medications
- Bilateral absence of eyes (SNOMED CT code 15665641000119103) any time during the member's history through December 31 of the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year:
  - Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (CPT Modifier code 50)
  - Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
  - Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service.
  - A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart.
  - A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart.
- Deceased during the measurement year.

CONTINUED

DISEASE MANAGEMENT

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **DIABETIC EYE EXAM** (EED), CONTINUED

TIDBITS

Diabetic eye exam is a hybrid measure. Acceptable documentation would be one of the following:

1. A note or letter can be used if it is prepared by the PCP, an ophthalmologist, an optometrist or other health-care professional stating there was an ophthalmoscopic exam and what the results were but the actual exam must be performed by an ophthalmologist or optometrist.
2. Chart note or photography with the date when the fundus exam was performed that either includes that an ophthalmologist or optometrist reviewed the results, a qualified reader read the results or the results were read by artificial intelligence.
3. Evidence of bilateral eye enucleation or absence of both eyes at any point in the patient history through the measurement year.
4. Documentation of a negative retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year or year prior. Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy but it must be clear that the patient had a dilated or retinal eye exam, and that retinopathy was not present. A note that indicates "diabetes without complications" does not meet criteria.

Pharmacy data used for the denominator - Glucophage or metformin prescription alone are not included because they are used to treat conditions other than diabetes.

Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

CODES

Autonomous Eye Exam	**CPT:** 92229 **LOINC:** 105914-6	
Diabetic Retinal Screening Negative in Prior Year	**CPT-CAT-II:** 3072F*	**3072F corresponds to the result performed in prior year to the measurement period and not present year. For tests performed this year, please report 2022F–2033F.*
Eye Exam With Retinopathy	**CPT-CAT-II:** 2022F, 2024F, 2026F **HCPCS:** S0620, S0621, S3000	
Eye Exam Without Retinopathy	**CPT-CAT-II:** 2023F, 2025F, 2033F	
Unilateral Eye Enucleation	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114	
Unilateral Eye Enucleation With a Bilateral Modifier	**CPT Modifier:** 50	

DISEASE MANAGEMENT

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **CONTROLLED BLOOD PRESSURE** (CBP)

Adult 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was taken during the measurement year.

Administrative Specifications **Hybrid Specifications**

DENOMINATOR

Aged 18–85 who had a diagnosis of hypertension (HTN).
Members who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1st, of the year prior to the measurement year and June 30th, of the measurement year.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

BP was obtained and controlled (<140/90 mm Hg) during the measurement year – both systolic and diastolic numbers must be controlled to count.
Code types: CPT

EXCLUSIONS

- Hospice/Palliative Care
- Those 66 years of age and older in institutional or LTC living.
- Those 66 years of age and older with frailty AND advanced illness coded during the measures year (or those aged 81 and old with frailty).
- Dementia medications
- End stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year.
- Dialysis any time during the measurement year.
- Kidney transplant any time during the measurement year.
- Pregnancy
- Deceased during the measurement year.

TIDBITS

- The BP measurement must occur after the date of the second code for HTN.
- It must be the most recent BP reading of the year (No inpatient or ED, no same day as diagnostic and no same day as a procedure that requires change in diet like colonoscopy).
- BP submitted as controlled must be taken with a manual cuff and a stethoscope. If multiple BP measurements are taken on the same date, the lowest value is counted. However, the systolic and diastolic do NOT need to be from the same reading to count as controlled.
- HEDIS says if the member has a PCP you should use that BP unless they see another practitioner for their HTN like a cardiologist.
- The NHN uses the CMS guidance for this measure due to its simplicity. If you wish to learn about the CMS guidance for controlling blood pressure you will find it at: **https://ecqi.healthit.gov/ecqm/ec/2024/cms0165v12?compare=2024to2025**

CMS Guidance

CONTINUED

MEASURE: **CONTROLLED BLOOD PRESSURE** (CBP), CONTINUED

CODES

Systolic Greater Than/Equal to 140	**CPT-CAT-II:** 3077F
Systolic Less Than 140	**CPT-CAT-II:** 3074F, 3075F
Diastolic Greater Than/Equal to 90	**CPT-CAT-II:** 3080F
Diastolic 80-89	**CPT-CAT-II:** 3079F
Diastolic Less Than 80	**CPT-CAT-II:** 3078F
Remote BP Monitoring — Supports Telehealth	**CPT:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474
Systolic Blood Pressure	**LOINC:** 8480-6
Diastolic Blood Pressure	**LOINC:** 8462-4

**Codes subject to change.*

For a complete list of codes, please visit the NCQA website at **ncqa.org**, or see the HEDIS value sets. Only subsets of the NCQA-approved codes are listed in this document.

DISEASE MANAGEMENT

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

Adults 18–85 years of age with diabetes (Type 1 and Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **AND** a urine albumin-creatinine ratio (uACR), during the measurement year.

Administrative Specifications **Hybrid Specifications**

DENOMINATOR

Aged 18–85 with diabetes (Type 1 and Type 2) who need a kidney health evaluation during the measurement year.
Determined by claims data (Diabetes coded) and pharmacy data (certain prescriptions filled) during current measurement year and the year prior.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

Aged 18-85 with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) during the measurement year and a urine albumin-creatinine ratio (uACR) during the measurement year or a quantitative urine albumin test with a urine creatinine test no more than four days apart (two different codes) during the measurement year.
Code types:
eGFR: CPT, LOINC
uACR: LOINC
Quantitative urine albumin: CPT, LOINC
Urine creatinine: CPT, LOINC

EXCLUSIONS

- Hospice/Palliative Care
- Those 66 years of age and older in institutional or LTC living.
- Those 66 years of age and older that have both frailty AND advanced illnesses coded (or aged 81 and older with frailty).
- Dementia medications
- End stage renal disease (ESRD)
- Dialysis
- Deceased during the measurement year.

TIDBITS

Pharmacy data used for the denominator- Glucophage or metformin prescription alone are not included because they are used to treat conditions other than diabetes.

Please note: the uACR can be fulfilled with separate quantitative urine albumin test and a urine creatinine test. If using quantitative urine albumin and creatinine tests those 2 components must be performed no more than 4 days apart (two different codes) in order to be measure compliant.

CONTINUED

MEASURE: KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED), CONTINUED

CODES

Estimated Glomerular Filtration Rate (eGFR)	**CPT-CAT-II:** 80047, 80048, 80050, 80053, 80069, 82565 **LOINC:** 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-CAT-II:** 82043 **LOINC:** 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
Urine Creatinine Lab Test	**CPT-CAT-II:** 82570 **LOINC:** 20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Urine Albumin Creatinine Ratio Test (uACR*)	**LOINC:** 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7

Codes subject to change.
**Urine albumin and urine creatinine ratio must be within 4 days of each other.*

MEDICATIONS

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEASURE: **STATIN THERAPY FOR PATIENTS WITH DIABETES** (SPD)

Aged 40-75 years with diabetes (type 1 and 2).

✓ **Administrative Specifications** ✗ **Hybrid Specifications**

DENOMINATOR

Aged 40–75 years during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD).
Determined by claims data (diabetes coded) and pharmacy data (certain prescription filled) during current measurement year and the year prior.
Coverage gaps allowed:

- Up to 45-day coverage gap allowed
- Medicaid does not allow more than one month (28-31 days depending on month)

NUMERATOR/HOW MET

Members who were dispensed at least one statin medication of any intensity during the measurement year.
Gap closure: Pharmacy claims only

EXCLUSIONS

- Hospice/Palliative Care
- Those 66 and older in institutional or LTC living.
- Those 66 years of age and older that have both frailty AND advanced illnesses coded (or aged 81 and older with frailty).
- Dementia medications
- Members who are pregnant, taking estrogen agonists, had IVF, have ESRD, are on dialysis, have cirrhosis, have a history of MI, CABG, PCI in the measurement year or year prior.
- Members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. Note there is a new HEDIS new value set of codes effective 2025, Muscular Reactions to Statins Value Set.
- Deceased during the measurement year.

TIDBITS

Pharmacy data drops patients into the denominator - Glucophage or metformin prescription alone are not included because they are used to treat conditions other than diabetes.

STATIN

High-Intensity Statin Therapy	Amlodipine-atorvastatin 40–80 mg Atorvastatin 40–80 mg Ezetimibe-simvastatin 80 mg	Rosuvastatin 20–40 mg Simvastatin 80 mg
Moderate-Intensity Statin Therapy	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	Ezetimibe-simvastatin 10mg Fluvastatin 20 mg Lovastatin 10–20 mg	Pravastatin 10–20 mg Simvastatin 5–10 mg

For a complete list of codes, please visit the NCQA website at **ncqa.org**, or see the HEDIS value sets. Only subsets of the NCQA-approved codes are listed in this document.

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