

HEDIS® Adult Pocket Guide: 2026 Measurement Year

For a complete list of codes, please visit the NCQA website at [ncqa.org](https://www.ncqa.org), or see the HEDIS value sets. The following is a subset only of the NCQA approved codes.

Prevention and Screening

Measure	Codes	Best Practice
(AAP) Adults' Access to Preventive/ Ambulatory Health Services (Age 20+) ^{1,2}	99381–99387, 99391–99397, G0402, G0438, G0439, S0620, S0621	Once a year. Commercial member who had an ambulatory or preventive care visit during the MY or the two years prior to the MY.
(BCS-E) Breast Cancer Screening (Persons Age 40–74) ^{1,2}	77061–77063, 77065–77067, G9054, Z90.13	Mammogram – every 2 years
(CCS-E) Cervical Cancer Screening (Persons Age 21–64) ²	88141–88143, 88147, 88148, 88150, 88152, 88153, 88164–88167, 88174, 88175, G0123, G0124, G0141, G0143–G0145, G0147, G1048, P3000, P3001	Cervical Cytology Lab Test (age 21–64)
	87624–87626, G0476	High-risk human papillomavirus (hrHPV) Test (age 30–64)
(CHL) Chlamydia Screening (Age 16–24) ²	87110, 87270, 87320, 87490–87492, 87810	Chlamydia Test
(COL-E) Colorectal Cancer Screening (Age 45–75) ^{1,2}	44388–44392, 44394, 44401–44408, 45378–45382, 45384–45386, 45388–45393, 45398, G0105, G0121	Colonoscopy – within past 10 years
	45330–45335, 45337–45338, 45340–45342, 45346, 45347, 45349, 45350, G0104	Flexible Sigmoidoscopy – within past 5 years
	74261–74263	Computed tomography (CT) Colonography – within past 5 years
	81528, O464U	Stool DNA fecal immunochemical test (sDNA FIT) Lab Test – within past 3 years
	82270, 82274, G0328	Fecal Occult Blood Test (FOBT) Lab Test – within measurement year
	C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048	Colorectal Cancer

Cardiovascular Conditions

Measure	Codes	Best Practice
(CBP) Controlling High Blood Pressure (Age 18–85) ^{1,2}	3077F	Systolic Greater Than/Equal to 140
	3074F, 3075F	Systolic Less Than 140
	3080F	Diastolic Greater Than/Equal to 90
	3079F	Diastolic 80–89
	3078F	Diastolic Less Than 80

(COA) Care for Older Adults

Measure	Codes	Best Practice
Medication Review ¹	90863, 99483, 99605, 99606, 1159F and 1160F, G8427	Medication List & Medication Review (Must be completed, signed and dated by a prescribing practitioner or clinical pharmacist. Both list and review must be present to close the care gap or a signed and dated notation that the person is not taking any medications.)
Functional Status Assessment ¹	99483, 1170F, G0438, G0439	Evidence of 5 ADLs or 4 iADLs assessed

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Diabetes		
Measure	Codes	Best Practice
(EED) Eye Exam for Patients with DM (Age 18–75) ^{1,2}	Autonomous Eye Exam: 92229	Dilated Retinal Eye Exam (DRE) – Yearly. Negative retinal or dilated eye exam (negative for retinopathy) in the year prior to MY. NOTE: All eye exams must have result.
	Eye Exam Without Retinopathy: 2023F, 2025F, 2033F	
	Eye Exam With Retinopathy: 2022F, 2024F, 2026F	
	Retinal Eye Exam: 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92230, 92235, 92250, S0620, S0621, S3000	
(GSD) Glycemic Status Assessment for Patients with Diabetes (Age 18–75) ^{1,2}	< 7.0: 3044F 7–7.9: 3051F 8–9: 3052F > 9: 3046F Note: Do not include a modifier when using CPT-CAT-II codes.	Last hemoglobin A1c in MY (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels: <ul style="list-style-type: none"> • Glycemic Status Controlled <8.0 • Glycemic Status Poor Control >9.0
(KED) Kidney Health Evaluation for Patients with DM (Age 18–85) ^{1,2}	eGFR: 80047, 80048, 80050, 80053, 80069, 82565	Option 1 – Urine albumin creatinine ratio (uACR): 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7 Option 2 – (Must be within 4 days of each other) Quantitative Urine Albumin: 82043 Urine Creatinine: 82570

Care Coordination

Measure	Codes	Best Practice
(ACP) Advance Care Planning (Age 66+) ¹	99483, 99497, 1123F, 1124F, 1157F, 1158F, S0257, Z66	Evidence of discussion of advance care planning
(TRC) Transitions of Care (Age 18+) ¹	Medication Reconciliation Intervention: 1111F	<ul style="list-style-type: none"> • Inpatient Admission Notification • Discharge Information Received • Post-Discharge Patient Engagement • Medication Reconciliation After Discharge <ul style="list-style-type: none"> – May be completed by a prescriber, pharmacist, PA, or RN – Must document medication reconciliation with reference to the hospitalization – Can be completed without the member present
	Medication Reconciliation: 99483, 99495–99496	
	Outpatient and Telehealth: 98966–98968, 98970–98972, 98980–98981, 99202–99205, 99211–99215, 99242–99245, 99341, 99342, 99344, 99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99421–99423, 99429, 99441–99443, 99455–99458, 99483, G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250–G2252, T1015	
	Transitional Care Management Services: 99495, 99496	

Medication Management

Measure	Codes	Best Practice
(OMW) Osteoporosis Management (Female Age 67–85) ¹	76977, 77080, 77081, 77085, 77086	Bone Mineral Density Tests
	J0897, J1740, J3110, J3111, J3489	Osteoporosis Medications
	J0897, J1740, J3489	Long-Acting Osteoporosis Medications during Inpatient Stay

(SDOH) Social Determinants of Health: Improving Patient Outcomes by Identifying and Addressing Social Needs

Description	Codes	Best Practice
Occupational Exposure to Risk Factors	ICD-10: Z57.0–Z57.9	Include supplemental codes in the patient’s diagnosis section on a claim form
Problems Related to Education and Literacy	ICD-10: Z55.0–Z55.9	
Problems Related to Employment and Unemployment	ICD-10: Z56.0–Z56.9	
Problems Related to Physical Environment	ICD-10: Z58.0–Z58.9	
Problems Related to Housing And Economic Circumstances	ICD-10: Z59.0–Z59.9	
Problems Related to Social Environment	ICD-10: Z60.0–Z60.9	
Problems Related to Upbringing	ICD-10: Z62.0–Z62.9	
Problems Related to Primary Support Group, Including Family Circumstances	ICD-10: Z63.0–Z63.9	
Problems Related to Certain Psychosocial Circumstances	ICD-10: Z65.0–Z65.9	