Integrated Healthcare Association

Frequently Asked Questions
Align. Measure. Perform. (AMP) Programs

October 2022

General	General Guideline 16: Deceased Members	Posted 10/14/2022
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** The "deceased member" exclusion is now required for MY 2023. The last bullet in the Notes section states, "This is a member-level exclusion. For episode-based measures, if one event does not meet numerator criteria, remove all member events/episodes from the measure." Does this mean that for episode-based measures that if one event meets numerator criteria the member can remain in the measure? **Response:** No. Members who die during the measurement year must be removed from all applicable measures. For episode-based measures, a member who died during the measurement year must be removed for all events (even if they meet numerator criteria for an event).	
Clinical Quality Domain	**Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Therapy for Patients With Diabetes (SPD)**	**Posted 10/14/2022**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For MY 2022 and beyond, should we exclude members with a history of allergies or intolerance to statins (including to the PCSK-9 inhibitor) from the SPC and SPD measures? **Response:** The Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Therapy for Patients With Diabetes (SPD) measures include an exclusion for members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. However, an allergy or history of an intolerance to a statin medication is not considered an exclusion for the measure.	
Clinical Quality Domain	**Multiple Measures (BCS, CCS, CCO, CHL, and OMW)**	**Posted 10/14/2022**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	**Question:** How should organizations account for transgender and non-binary members in gender-specific measures in AMP for MY 2022 and beyond? **Answer:** For gender-specific measures in AMP, currently the gender specified in enrollment data is used, as this is the gender available in administrative enrollment and claims systems. That said, if other data, such as medical record data, show that the member is biologically a different sex, then they may be removed from the measure. For example, when calculating the Cervical Cancer Screening (CCS) measure, if there is documentation that the member was assigned male at birth (e.g., transgender male to female), then this is evidence that the member does not have a cervix and the member meets the exclusion criteria and may be removed from the measure. In addition,	

documentation of cervical agenesis or clinical synonyms (e.g., evidence a patient was born without a cervix) may also be used to exclude members. If there is documentation that the member was assigned female at birth (e.g., transgender female to male), there must be documentation of absence of cervix as part of gender reassignment surgery in order to meet exclusion criteria. Male members with documentation that they were assigned female at birth and did not have the cervix removed must remain in the measure because they may still have biological risk of cervical cancer.

Codes in the Absence of Cervix Diagnosis Value Set (e.g., ICD-10-CM Diagnosis code Q51.5 [agenesis and aplasia of cervix]) may be used to exclude transgender members from the CCS measure. Please note that if the organization is unable to find the appropriate documentation, these members should remain in the measure.
Because AMP is administrative only, medical record data is considered supplemental data. Keep in mind that supplemental data must meet the supplemental data requirements outlined in General Guideline 31 in the AMP MY 2022 Technical Specifications (General Guideline 30 in the AMP MY 2023 Technical Specifications). Supplemental data requires auditor review and approval.

Testing	Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)	Posted 10/14/2022
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** How are measure elements reported by data source category in ECDS measures included in AMP in MY 2022? **Answer:** ***Electronic Method*** To qualify for ECDS reporting, data must use standard layouts, meet the measure technical specification requirements and be accessible by the care team upon request. Organizations meet this requirement if they are able to provide the requested information (e.g., by phone, secure email, direct feed, provider portal, file request) to providers who are treating their members. Organizations should have documented processes for tracking these requests to be reviewed as part of the audit. Practitioners or provider organizations 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). ***SSoR*** Measures reported using ECDS are reported by each SSoR accessed to produce the measure result. The SSoR is the authoritative data source containing the standardized elements the organization uses for reporting digital quality measure results. An SSoR may contain standard and nonstandard electronic clinical data. Refer to General Guideline 31: Supplemental Data in the final MY 2022 AMP Technical Specifications for electronic clinical data proof-of-service and verification requirements. Each electronic data source used for ECDS reporting must have: • Policies and procedures for establishing and maintaining database management systems. • Standard layout requirements. • An automated process for incremental loading of all data elements. Each SSoR is a database where semantic differences in data have been resolved through integrity testing, and the data structure is standardized so it can be electronically extracted for ECDS reporting. ***Source Priority***	

	When quality data elements to support the measure are identified in multiple data sources, a hierarchy is applied. Each SSoR used for ECDS reporting is categorized using the following priority: 1. Electronic health record (EHR)/personal health record (PHR) (the system of data origin such as laboratory, pharmacy, pathology, radiology). 2. Health information exchange (HIE)/clinical registry. 3. Case management registry. 4. Administrative. Organizations compare the list of all unique systems containing relevant member data and assign members based on the highest-ranked data category in the hierarchy. SSoRs are mapped using the data type that is loaded to the master file that identifies member eligibility for each component of a quality measure. The applied hierarchy does not imply relevance or validity of a data source; rather, it is applied in cases where a member's data are in multiple locations. Members are assigned to only on SSoR category for each measure element (e.g., denominator, numerator). For example, if administrative data are used to identify the denominator, the member is assigned to the Administrative category for the denominator. If a numerator event is identified through a query of the organization's case management system, the member is assigned to that category for the numerator even though that member may have been included in the measure's denominator using administrative data. Organizations must complete data collection for the SSoRs by the supplemental data collection deadline. Refer to the AMP Program Guide for the timeline. When appropriate, an SSoR can be refreshed according to the organizations scheduled refreshes and accounted appropriately for the measure.	
Testing	**Kidney Health Evaluation for Patients With Diabetes (KED) and Prenatal Immunization Status (PRS-E)**	**Posted 7/15/2022**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	**Question:** The Quantitative Urine Albumin Lab Test Value Set in the KED specification and the Adult Influenza Vaccine Procedure Value Set in the PRS-E specification in the MY 2022 AMP Value Set Directory (VSD) are missing SNOMED codes that are included in the MY 2022 HEDIS VSD. Why is there a discrepancy between the value sets? **Answer:** For the MY 2022 AMP VSD, SNOMED codes were inadvertently omitted from the Quantitative Urine Albumin Lab Test Value Set and the Adult Influenza Vaccine Procedure Value Set in the MY 2022 AMP VSD. **No other value sets were affected.** On July 15, 2022, the MY 2022 AMP VSD was re-released with the following changes: • Added 11 SNOMED codes to Adult Influenza Vaccine Procedure • Added 2 SNOMED codes to Quantitative Urine Albumin Lab Test Organizations should re-download the MY 2022 AMP Product Bundle from the NCQA Store to access the updated MY 2022 AMP VSD.	
Clinical Quality Domain	**Proportion of Days Covered by Medications (PDC), Statin Use in Persons with Diabetes (SUPD) and Concurrent Use of Opioids and Benzodiazepines (COB)**	**Posted 7/15/2022**
Commercial HMO/POS, Commercial ACO, Medicare Advantage,	**Question:** There are discrepancies between the hospice value sets (Hospice Encounter Value Set; Hospice Intervention Value Set) included in the PQA Value Set file included in the MY 2022 AMP Product Bundle and the hospice value sets included in the AMP Value Set Directory. Which hospice value sets should be used for the three PQA measures included in the AMP measure set?	

Medi-Cal Managed Care	**Answer:** For MY 2022, organizations should use the HEDIS Hospice Encounter Value Set and Hospice Intervention Value Set included in the MY 2022 AMP Value Set Directory to identify members in hospice for reporting the three PQA measures included in AMP.	
Clinical Quality Domain	**Blood Pressure Control for Patients With Diabetes (BPD)**	**Posted 7/15/2022**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	**Question:** In the Modifications from HEDIS section, the BPD specification states, "The exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File". However, this measure does not include the Medicare Advantage product line so this would not apply. Additionally, it states in the Exclusions section, "Medicare Advantage members 66 years of age and older as of December 31 of the measurement year". **Answer:** This is an error in the specification. The first bullet under Step 3: Exclusions should state, "Members 66 years of age and older as of December 31 of the measurement year who meet either of the following." We align the AMP specifications as closely as possible with the measure steward; however, we expect reporting to follow the product lines specified for AMP. That said, since this measure is not reported in the Medicare Advantage product line for AMP, this exclusion would not apply to any product line.	
Appropriate Resource Use Domain	**General Prescribing (GRX)**	**Posted 6/15/2022**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** Under the denominator section of Step 4 in the GRX measure, it states, "Identify and exclude claims for self-injectable drugs." Which drugs qualify as self-injectable drugs? **Answer:** For the GRX measure, self-injectable drugs are any medications with NDC codes dispensed by an outpatient pharmacy that are described as "injection." If it is prescribed and picked up at an outpatient pharmacy, the assumption is that the patient will be injecting it themselves. Additionally, the generic product name of the drug may say something like "Pen Injector" or "Prefilled syringe" or "Auto-Injector," which may indicate that the drug is set up for self-injection.	
Clinical Domain	**Cervical Cancer Screening and Cervical Cancer Overscreening**	**Posted 2/15/2022**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For the CCS and CCO measures, should we exclude transgender women (male to female, never had a cervix)? **Answer:** Administrative data, codes in the Absence of Cervix Diagnosis Value Set (e.g., ICD-10-CM Diagnosis code Q51.5 [agenesis and aplasia of cervix]) may be used to exclude transgender members from the measure. If the medical record documents that the member was born male (e.g., transgender male to female), this is evidence that the member does not have a cervix, meets required exclusion criteria and should be removed from the measure. Medical record documentation of cervical agenesis or clinical synonyms (e.g., evidence a patient was born without a cervix) can also be used to exclude these members.	
General	**Medi-Cal Managed Care Continuous Enrollment and Member Attribution**	**Posted 12/15/2021**
Medi-Cal Managed Care	**Question:** How are continuous enrollment and member attribution to provider organizations (POs) determined differently for Onpoint-generated MY 2020 results	

	using health plan data in the AMP Medi-Cal Managed Care program than in the AMP Commercial HMO program? **Answer:** The AMP Medi-Cal Managed Care program does not apply continuous enrollment at the plan-PO level for Onpoint-generated quality measure results using health plan data, as the AMP HMO program does. For Onpoint-generated AMP Medi-Cal Managed Care results, a member must be enrolled in a health plan and a PO for at least 1 month before becoming eligible for a measure. The member must also be continuously enrolled in the health plan for the benefit specified for each measure (e.g., medical and/or pharmacy), accounting for any allowable gaps, to be considered continuously enrolled. Onpoint then uses a "Frequency and Last Record Hierarchy" approach to determine member attribution for AMP Medi-Cal Managed Care quality results. POs are ranked based on length of enrollment for a member for the measurement year and then attributed to the PO they are affiliated with for the longest time. If a member belongs to more than one PO for equal time, a tiebreaker is determined using the most recent PO the member was associated with. **To note, because of differences in data capture and approach, health plan results generated by Onpoint and self-reporting Medi-Cal Managed Care results may differ.** Member attribution for Onpoint-generated quality results in AMP Medi-Cal Managed Care have not changed for MY 2020 and have been applied as described above since the program's inception.	
General	**General Guideline 17: Deceased Members**	**Posted 11/15/2021**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs. This was originally released in November 2021 and updated in December 2021.* **Question:** How should we apply the "deceased members" exclusion in *General Guideline 17: Deceased Members* for episode-based measures? **Answer:** The guideline for deceased members (General Guideline 17) is a member-level exclusion. For episode-based measures, if one event does not meet numerator criteria, and the organization chooses to use this optional exclusion, remove all member events/episodes from the measure. This FAQ applies to MY 2022 and beyond.	
General	**General Guideline 32: Race and Ethnicity Stratification**	**Posted 10/15/2021**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** May supplemental data be used for race and ethnicity stratifications? **Answer:** Yes. For MY 2022 and beyond, supplemental data may be used to identify race and ethnicity when stratifying the eligible population.	
General	**PCS Questions**	**Posted 9/15/2021**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Do answers from the Policy Clarification Support system have an expiration date? **Answer:** We recommend that organizations not use PCS responses that are over 3 years old. If a question relates directly to a measure specification or a general guideline	

	that was revised from a previous measurement year, we recommend resubmitting the question.	
Appropriate Resource Use	**Acute Hospital Utilization and Emergency Department Utilization**	**Posted 9/15/2021**
Commercial HMO/POS, Commercial ACO	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** May covariance values be rounded before using them in the variance calculation? **Answer:** No. Do not round covariance values for use in variance calculations. Member-level PPD and PUCD should be unrounded in covariance and variance calculations, although truncation to 10 decimal points is applied, per the previous step. NCQA intends to evaluate truncation and rounding logic throughout intermediate calculations to ensure consistency and reduce potential bias in a future measurement year.	
Appropriate Resource Use	**Acute Hospital Utilization and Emergency Department Utilization**	**Posted 9/15/2021**
Commercial HMO/POS Commercial ACO	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** When should rounding occur for variance calculations? **Answer:** The variance should not be rounded until the final step in the calculation. The final variance calculation for reporting should be rounded to four decimal places using the .5 rule. For example, the PPD and PUCD values are truncated to 10 decimal places, multiplied together at the member level and summed across members for the total. Round the total sum to four decimal places.	
General	**General Guideline 13: Members with Dual Enrollment**	**Posted 1/15/2021**
Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: What type of Medicare enrollment counts when assessing members with dual Medi-Cal Managed Care and Medicare Advantage enrollment? **Answer**: General Guideline 13 includes language about Medicare contracts required to report. These are meant to indicate Medicare Advantage. Having only Medicare Part D does not qualify as coverage for dual enrollment.	
General	**General Guideline 13: Members with Dual Enrollment**	**Posted 1/15/2021**
Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: When a member has dual Medi-Cal Managed Care/Medicare Advantage enrollment, how long must the member be enrolled in Medicare Advantage to be removed from the Medi-Cal Managed Care product line? **Answer**: There is no minimum enrollment requirement. Per General Guideline 13, members must meet the measure's continuous enrollment requirements and be considered dually enrolled based on continuous enrollment criteria or the service date. Organizations must follow General Guideline 13 with regard to assessing coverage and should review enough data to meet the measure specification requirement.	
Appropriate Resource Use	**Frequency of Selected Procedures**	**Posted 1/15/2021**
Commercial HMO/POS,	*Note: This FAQ was released for HEDIS and applies to the AMP programs.*	

Medi-Cal Managed Care	**Question**: Are members with unknown or third gender excluded from member months tables that only designate binary gender? **Answer**: Yes. Members with unknown or non-binary gender are excluded from only the utilization measures that require a specific gender (male or female) because the measure requires a gender to be assigned in the reporting tables (applies to the FSP measure only for AMP). NCQA continues to track industry standards for non-binary gender.	
Clinical Quality	**Controlling High Blood Pressure**	**Posted 12/15/2020**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Is the use of average blood pressure readings allowed? **Answer**: Yes, but only average readings that include separate values for systolic and diastolic blood pressure may be used for reporting.	
Appropriate Resource Use	**Emergency Department Utilization**	**Posted 12/15/2020**
Commercial HMO/POS, Commercial ACO	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: In the EDU measure, step 1 for the Calculation of Observed Events says to exclude ED visits that result in an inpatient stay or an observation stay. Should denied claims be used when looking for both an inpatient stay and an observation stay in this case? **Answer**: Yes. When confirming that an ED visit does not result in an inpatient stay or an observation stay, all inpatient and observation stays must be considered, regardless of payment status (paid, suspended, pending, denied). Measure Certification will test this scenario to ensure all inpatient and observation stays are considered, regardless of payment status. For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the Emergency Department Utilization measure when identifying observed ED visits. Refer to Guideline 1 under "Guidelines for HEDIS Risk Adjusted Utilization Measures" in the AMP Technical Specifications.	
Clinical Quality	**Child and Adolescent Well-Care Visits**	**Posted 9/15/2020**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: When reporting the WCV measure using supplemental data, may organizations combine documentation from multiple visits to meet criteria? **Answer**: No, combining documentation from multiple visits is not allowed. Medical record data must come from a single date of service and must indicate that a well-care visit occurred that was equivalent to the definition of one of the codes in the Well-Care Value Set.	
Clinical Quality	**Child and Adolescent Well-Care Visits**	**Posted 9/15/2020**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: For the WCV measure, what are the required data elements for supplemental data? **Answer**: Services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification. The organization determines this, and it is reviewed by the auditor. Supplemental data must adhere to requirements in *General Guideline 31* of the AMP Technical Specifications.	
Clinical Quality	**Controlling High Blood Pressure**	**Posted**

Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Do BP readings taken by the member need to meet the member-reported requirements included in *General Guideline 40*? **Answer**: No. BPs taken by the member do not need to meet requirements for member-reported data described in *General Guideline 40* (collected by a PCP or other specialist while taking the patient's history). If the BP result is documented in the member's medical record, it may be used to assess numerator criteria if the BP does not meet any exclusion criteria listed in the measure specification.	
Clinical Quality	**Childhood Immunization Status**	**Posted 9/15/2020**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Does the live attenuated influenza vaccine (LAIV) vaccination have to be given on the child's second birthday? **Answer**: Yes. The LAIV vaccination only counts if it is administered on the child's second birthday. The minimum age for LAIV is 2 years, so vaccines given before that age do not meet criteria. You can view the recommendation guidelines on the CDC website (https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf).	
Clinical Quality	**Palliative Care Exclusion (Cross-cutting)**	**Posted 9/15/2020**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: May supplemental data be used to identify members for the Palliative Care exclusion? **Answer**: Yes. Although the required palliative care exclusion is intended to be identified using administrative data, supplemental data may also be used. If organizations use supplemental data to remove members in palliative care, they must follow the supplemental data guidelines (*General Guideline 31*). Use of supplemental data are subject to auditor approval.	
Clinical Quality	**Childhood Immunization Status/Immunizations for Adolescents**	**Posted 1/15/2020**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	**Question:** Beginning in December 2019, the California Immunization Registry (CAIR) updated their data sharing process, giving patients the choice not to disclose their immunization records (http://cairweb.org/docs/Revised_HEDIS_12112019.pdf). How will IHA handle the CIS and IMA performance rates, if providers are unable to use data from CAIR records for reporting? **Answer:** IHA is aware of the policy change and will monitor the MY2019 data to determine any effects of the CAIR policy change on reporting, and identify measures for addressing it, if necessary.	
Clinical Quality	**Cervical Cancer Overscreening**	**Posted 1/15/2020**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	**Question:** There is a note in the measure specification which says "If two or more claims/encounters with qualifying numerator codes for cervical cytology occur within 14 days of each other, count only the first one. Refer to General Guideline 35." Does this general guideline also apply to hrHPV tests? **Answer:** The guidance applies to both cervical cytology and high-risk HPV tests. If two or more claims for hrHPV testing occur within 14 days of each other, count only the first one.	
General	**General Guideline 50: Mapping Proprietary or Other Codes**	**Posted 12/16/2019**

Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Organizations may map NDC or RxNorm codes based on generic name (or brand name), strength/dose and route. What information is used to map "dose" or "route"? **Answer**: For mapping purposes, the organization must demonstrate that the medication being mapped is the same as a medication listed in the Medication List Directory (MLD). For example, the route for "benralizumab" is listed as "injection" in the Asthma Controller Medications table. The MLD lists generic products for benralizumab, including "1 ML benralizumab 30 MG/ML Prefilled Syringe" and "benralizumab 30 MG/ML Prefilled Syringe," where the Route is listed as "injection." Therefore, it would be appropriate to map a code with the generic name "benralizumab" and strength "30 MG/ML and dose form or route of either "syringe" or "prefilled syringe" or "injection." Another example is fluticasone, which is listed as "inhalation" in the Asthma Controller Medications table. The MLD (Generic Product Name) identifies appropriate dose/forms as "metered dose inhaler" or "dry powder inhaler," and lists the route as "inhalation." Therefore, it would be appropriate to map codes for fluticasone if the strength/dose matches one in the MLD and if the dose form or route is "inhaler" or "metered dose inhaler" or "powder inhaler" or "inhalation." It would not be appropriate to map codes for fluticasone with dose form or route of "nasal spray."	
Clinical Quality	**The "Route" column in the Asthma Medication Ratio measure**	**Posted 12/16/2019**
Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: In the Asthma Controller Medications table and the Asthma Reliever Medications table (in the AMR measure specifications), what is the "Route" column used for? **Answer**: Use the "Route" information from the tables to apply the "Definitions" for calculating an "inhaler dispensing event" and an "injection or intravenous dispensing event." For routes listed as "subcutaneous" or "intravenous," use the "injection or intravenous dispensing event" definition. *Note: In the Medication List Directory (MLD), the "Route" column lists "subcutaneous" and "intravenous" as "injection."*	
General	**Codes Found in Medical Records**	**Posted 10/23/2019**
Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: For General Guideline 31: Supplemental Data, may codes found in the medical record be used as proof of service even if there is no additional documentation of the service provided? **Answer**: No. Codes alone (without additional documentation of the service provided) do not meet criteria for proof of service. If a provider performs a service, it is expected that additional documentation exists in the medical record or in the primary source document. Auditors must validate, through primary source verification, all elements required by the administrative measure specification.	