HIGHMARK.

Reimbursement Policy

Title: Performance Measurement

Policy Number: RP-073

Version Number: 2026.11.02

Medicare Advantage:	PA, WV, DE, NY	Version Effective:	November 2, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	July 4, 2022
Claim Type:	CMS 1500 and UB04	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

Provides reimbursement guidelines for performance measurement codes used to report and track quality-of-care measures. These codes are reporting-only and are not separately reimbursable; however, providers are required to report a nominal one-dollar charge for claim processing

Reimbursement Guidelines:

Performance measurement codes are developed from the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) to decrease the need for record abstraction and chart review. The intent was to minimize the administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care.

Performance measurement codes are to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures. These codes have evidence-based results on contributing to quality patient care.

Performance Measurement codes can relay important information related to health outcome measures such as:

- Body Mass index (BMI)
- Cardiovascular Disease (CVD) cholesterol management
- Controlling Blood Pressure
- Comprehensive diabetes care
- Tobacco cessation

The Centers for Medicare and Medicaid Services (CMS) has assigned performance measurement codes a status "M" (Measurement codes used for reporting purposes only) on the Medicare Physician Fee Schedule (MPFS) and uses these codes to assist with performance measurement for various reasons.

Also, the MPFS does not assign Relative Value Units (RVUs), nor does CMS provide reimbursement for these services. The Plan will not provide reimbursement for these codes, but providers are required to report a nominal one-dollar charge for accurate processing through the claim system.

Coding: N/A

Definitions: N/A

References:

- American Medical Association (AMA);
  Category II codes | American Medical Association (ama-assn.org)

Related Plan Policies: N/A

Policy Update History:

1 / 2024	Removed codes 1100F, 1101F, 0518F, 1090F, .and 0509F from NY MA exceptions
1 / 2025	The NY exceptions to this policy no longer apply
11 / 2026	Administrative policy review with no changes in policy and applied to new policy template

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP- 073		
Subject:	Performance Measurement		
Effective Date:	July 4, 2022	**End Date:**	
Issue Date:	January 1, 2025	**Revised Date:**	January 2025
Date Reviewed:	October 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

HISTORY

PURPOSE:

Performance measurement codes are developed from the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) to decrease the need for record abstraction and chart review. The intent was to minimize the administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care.

REIMBURSEMENT GUIDELINES:

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REFERENCES:

- American Medical Association; Category II codes
  Category II codes | American Medical Association (ama-assn.org)

POLICY UPDATE HISTORY INFORMATION:

7 / 2022	Implementation
1 / 2024	Removed codes 1100F, 1101F, 0518F, 1090F, .and 0509F from NY MA exceptions
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Exceptions only for the New York region are listed below:

Note: Codes 1111F, 3044F, 3051F, 3052F will be considered for reimbursement for Commercial and Medicare Advantage Plans.

Note: Codes 3074F, 3075F, 3078F, 3079F will be considered for reimbursement for Medicare Advantage Plans only.

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