Professional Relations

Understanding STAR Ratings

Blue Cross and Blue Shield of Kansas
2024 Reference Guide

BlueCross BlueShield Kansas

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An introduction to the Centers for Medicare & Medicaid Services Star Ratings Program

What is Medicare star ratings program?

The Centers for Medicare & Medicaid Services (CMS) developed the Medicare star ratings program to help consumers compare Medicare Advantage (MA) health plans based on quality and performance. The program includes a set of quality performance ratings developed by the National Committee for Quality Assurance and CMS for all MA health plans. CMS rates the relative quality of service delivered by health plans and care delivered by providers based on a five-star rating scale, where five stars indicate the highest score.

How are CMS star ratings determined?

The ratings include specific clinical, member perception and operational measures. There are approximately 40 measures in the star rating framework.

To best capture a range of quality metrics, star ratings are determined using different data sets including, but not limited to the following:

- Health Effectiveness Data and Information Set collects primarily clinical outcomes and data. This HEDIS® data best reflects care delivered by the provider and staff.
- Prescription Drug Event data collected by health plans to provide insight for prescription drug-related measures.
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey sent to a random sample of members every spring to measure their experience with care delivered and the health plan. This data focuses on the member's accessibility to quality care.
- The Health Outcomes Survey (HOS) is sent every spring to a random sample of members to measure self- reported health status and the quality of their healthcare. A follow-up survey is sent to these same members two years later to measure changes in health perception.
- Operations data from health plans is used to assess the quality of customer service and other services health plans are providing to their members.

CMS star ratings: What is your role as a provider?

By providing high-quality care to patients in a timely manner, providers play a critical role in the star ratings program. There are different opportunities for providers to engage with patients to help ensure high quality and timely care while helping patients manage their health.

Areas of opportunity to align provider practices with the CMS star ratings program:

- Promote timely and appropriate screenings, tests and treatment
- Provide education to staff members for proper documentation of care delivered
- Strengthen patient and provider relationships through open communication regarding health care needs and quality of care
- Collaborative development of chronic condition care plan
- Follow-up with patients regarding medications
- Assess timeliness of care and work with office staff to optimize scheduling
- Reference the HEDIS measure tip sheets in this manual.

These practices promote patient safety, preventive medicine, early disease detection and chronic disease management, which is especially beneficial for this population.

Star ratings help members enhance relationships with providers and health plans by ensuring accessibility to care, enhanced quality of care and optimal customer service.

Healthcare Effectiveness Data Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2024 Blue Medicare Advantage STARS Incentive Program

The Blue Medicare Advantage (MA) Stars Incentive Program recognizes the impact of our participating MA primary care providers in achieving the objectives of the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) Star Ratings Program, and further acknowledges the time spent by clinics outside of face-to-face provider encounters, through outreach, referral, care coordination, administration, and much more.

This section outlines the components of the Blue MA Stars Incentive Program, qualifications, and need-to-know details to close gaps in car, and the attribution methodology utilized to assign a member to a Primary Care Provider (PCP). PCPs must have attributed members and contract with the Kansas Preferred Blue Medicare Advantage network to participate in the program.

Incentive Measures

Our Blue MA Stars Incentive Program rewards Kansas Preferred Blue Medicare Advantage (MA PPO) participating providers for their efforts in encouraging and coordinating preventive care and managing health conditions, recognizing the quality care provided daily to our fellow Kansans. For services rendered January 1, 2024 through December 31, 2024. Blue Cross and Blue Shield of Kansas (BCBSKS) will award the following fixed dollar amounts in Q2 2025, per attributed member, per gap closed, based upon member attribution as of December 2024:

Incentive Payout	Measure(s)
Quality Performance Measures	
$50	Uncontrolled Blood Pressure
$300	Annual Wellness Visit
Effectiveness of Care HEDIS Measures	
$50	Medication Adherence – Cholesterol*, Medication Adherence – Diabetes*, Medication Adherence – Hypertension*
$100	Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Glycemic Status Assessment for Patients with Diabetes, Statin Therapy for patients with Cardiovascular Disease, Statin Use in Persons with Diabetes, Transitions of Care – Medication Reconciliation, Transitions of Care – Patient Engagement
$200	Controlling Blood Pressure

*Maximum potential Blue MA Stars Incentive of $1,500 per member

Program Qualifications

The MA provider must have a valid Contracting Provider Agreement and Medicare Advantage Addendum with BCBSKS, and be in good standing with BCBSKS to qualify for and receive Blue MA Stars Incentive Program payment. BCBSKS retains the right to modify the incentive program as specified in Policy Memo No. 1. In addition, claims and supplemental

data submitted in relation to this incentive program are subject to audit.

Performance Measure Guidelines & Star Gap Closure

- Providers are credited for services provided during the measurement year, for attributed patients enrolled throughout the plan year in a BCBSKS Blue MA product.
- Gaps will be closed, and credit given to the provider for each measure when the specific, identified service is documented as rendered through:
    - Claims capturing the CPT® or CPT® II code supporting the HEDIS® measure. Claims must be for service dates spanning the measurement year and processed by February 28, 2025.
    - Supplemental medical record submission by December 16, 2024, capturing the service/test, patient demographic information and results. Records can be submitted one of the following ways:
        - **Fax:** 833-505-2348, Attn: HEDIS Ops
        - **Email:** KSOperations@advantasure.com
        - **Mail:**
          Blue Cross and Blue Shield of Kansas
          Attn: HEDIS Ops, TC1402-E
          PO Box 260
          Southfield, MI 48037-0260
- For additional information and tips for gap closure, including necessary supplemental record documentation, refer to the measurement tips in this manual. For non-HEDIS measures, refer to the appropriate heading below.

Member Attribution

BCBSKS will use up to 18 months of BCBSKS claims data to attribute BCBSKS MA Members to a Primary Care Physician (PCP). PCPs, or PCPs within a group/business entity, participating in the BCBSKS Preferred Blue Medicare Advantage network eligible for member attribution are identified by the taxonomy code of record with BCBSKS. PCPs include General Practice, Family Medicine, Internal Medicine, Obstetrics/Gynecology, Geriatric Medicine, and APRNs/Clinical Nurse Specialists and Physician Assistants practicing in a primary care field. Paid claims, with an Evaluation and Management (E/M) or Annual Wellness Visit (AWV) service (American Medical Association or AMA® Current Procedural Terminology, or CPT® procedure codes, or Healthcare Common Procedure Coding System, HCPCS, Level II codes) for dates of service within the last 18 months are utilized to determine attribution, with the member attributed to the PCP with the most claims. Pharmacy claims are utilized as a supplement when a PCP cannot be attributed based on medical claims.

Annual wellness visit (AWV) measure

The AWV incentive, recognizes the importance of these preventive visits in achieving and coordinating quality care. Providers capture this incentive by rendering and billing the appropriate Medicare wellness exam, Welcome to Medicare exam, or physical procedure code (HCPCS codes G0402, G0438, G0439, and/or CPT® codes 99381-99397.) For additional information on these codes, and details on Blue MA coverage, review the member Explanation of Coverage or MA Provider Annual Physical Exam Policy.

Uncontrolled blood pressure (UCB)

Uncontrolled Blood Pressure (UCB) incentive encourages usage of CPT®II codes reporting diastolic and systolic blood pressures on claim submissions. Including these procedure codes on claims is best practice and key to closing gaps for the Controlling Blood Pressure (CBP) HEDIS® measure. While we also incentivize gap closure for the CBP measure, we recognize the potential headwinds submitting these of CPT®II codes may present to your practitioners, billing staff, and IT teams and aim to recognize practices that go above and beyond to close CBP gaps in care through the use of the of CPT®II codes reporting the most recent systolic and diastolic blood pressures, as outlined in the CBP tip sheet within this manual.

Effectiveness of Care HEDIS® Measures

Advanced Illness and Frailty Exclusions Guide

The National Committee for Quality Assurance (NCQA) allows additional exclusions to Healthcare Effectiveness Data and Information Set (HEDIS®), measures for patients with advanced illness and frailty. Services measured by NCQA may not benefit older adults with limited life expectancy and advanced illness. Also, unnecessary tests or treatments could burden these patients or even be harmful. NCQA wants providers to focus on appropriate care for their patients. Therefore, patients can be excluded from certain HEDIS measures if they meet specific criteria for advanced illness and/or frailty.

Exclusionary criteria

Advanced Illness – One or more of the following during the measurement year or the year prior:

- Filled a dementia medication prescription.
- Diagnosis of an advanced illness billed on two different dates of service. Examples of advanced illness: amyotrophic lateral sclerosis (ALS), dementia, heart failure, hepatic disease, multiple sclerosis, emphysema, end-stage renal disease (ESRD), leukemia, malignant neoplasm of the pancreas or brain, certain secondary malignant neoplasms, Parkinson's disease, pulmonary fibrosis, and renal failure. See below for the full list of advanced illness diagnosis billing codes.

Frailty – Must have at least two indications of frailty billed on different dates of service during the measurement year. Examples of frailty indicators:

- Frailty devices such as a cane, commode chair, hospital bed, supplemental oxygen, walker, or wheelchair.
- Frailty diagnoses billed for bed confinement status, falls or history of falling, dependence on frailty devices listed above, dependence on care provider, muscle wasting, muscle weakness, or pressure ulcers.
- Encounters billed for home health (skilled nursing, home health aide, or personal care services), or certain physician management and care coordination services for home health or hospice care.
- Frailty symptoms like difficulty walking, failure to thrive, gait abnormalities, underweight or abnormal weight loss, weakness, or other malaise.
- See below for the full list of frailty billing codes.

Age Requirements – Patients must be at least 66 years to qualify for the advanced illness or frailty exclusions, however the requirements are different depending on the measure. The table below lists these details for applicable HEDIS measures in the Medicare Star Ratings.

HEDIS® Advanced Illness and Frailty Exclusions Guide

Star measure exclusion details

Patients 66 and older can be excluded from these measures if they meet BOTH advanced illness and frailty criteria	Patients 66-80 can be excluded from these measures if they meet BOTH illness and frailty criteria	Patients 67-80 can be excluded from these measures if they meet BOTH advanced illness and frailty criteria	Patients 81 and older can be excluded from these measures if they meet only frailty criteria
• Breast cancer screening (BCS-E) • Colorectal cancer screening (COL-E) • Eye exam for patients with diabetes (EED) • Glycemic status assessment for patients with diabetes (GSD) • Statin therapy for patients with cardiovascular disease (SPC)	• Controlling high blood pressure (CBP) • Kidney health evaluation for patients with diabetes (KED)	• Osteoporosis Management in Women who had a Fracture (OMW)	• Controlling High Blood Pressure (CBP) • Kidney health evaluation for patients with diabetes (KED) • Osteoporosis Management in Women who had a Fracture (OMW)

Billing codes

This guide includes:

- Billing codes for advanced illness exclusions and dementia medication descriptions and names
- Billing codes for frailty exclusions

Remember that use of HEDIS approved billing codes can substantially reduce medical record requests for HEDIS data collection purposes. Telehealth, telephone visits, e-visits and virtual check-ins are acceptable for advanced illness and frailty exclusions when documented in the medical record and the exclusion code is billed properly.

Advanced Illness	
ICD-10-CM code	Definition
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0-4, 7-9	Malignant neoplasm of pancreas
C71.0-9	Malignant neoplasm of brain
C77.0-5, 8-9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00-2	Secondary malignant neoplasm of lung

HEDIS® Advanced Illness and Frailty Exclusions Guide (Cont.)

Advanced Illness	
ICD-10-CM code	Definition
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30, C78.39	Secondary malignant neoplasm of unspecified or other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80, C78.89	Secondary malignant neoplasm of unspecified or other digestive organs
C79.00-2	Secondary malignant neoplasm of kidney and renal pelvis
C79.10-1, C79.19	Secondary malignant neoplasm of bladder and other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40, C79.49	Secondary malignant neoplasm of unspecified or other parts of nervous system
C79.51-2	Secondary malignant neoplasm of bone or bone marrow
C79.60-3	Secondary malignant neoplasm of ovary
C79.70-2	Secondary malignant neoplasm of adrenal gland
C79.81-2	Secondary malignant neoplasm of breast or genital organs
C79.89, C79.9	Secondary malignant neoplasm of unspecified or other sites
C91.00, C92.00, C93.00, C93.90, C93. Z0, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse
F01.50-4, F01.A0-4, F01.B0-4, F01.C0-4, F02.80-4, F02.A0-4, F02.B0-4, F02.C0-4, F03.90-4, F03. A0-4, F03.B0-4, F03.C0-4, F10.27, F10.97	Dementia
F04	Amnestic disorder due to known physiological condition
F10.96	Alcohol-induced persisting amnestic disorder
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G31.01	Pick's disease
G31.09, G31.83	Neurocognitive disorder
G35	Multiple sclerosis

HEDIS® Advanced Illness and Frailty Exclusions Guide (Cont.)

Advanced Illness	
ICD-10-CM code	Definition
I09.81, I11.0, I13.0, I13.2, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage 5
I50.1	Left ventricular failure, unspecified
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J84.10, J84.112, J84.17. J84.170, J84.178	Pulmonary fibrosis
J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.00-2, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
N18.6	End stage renal disease

Dementia Medications	
Description	Prescription
Cholinesterase inhibitors	Donepezil Galantamine Rivastigmine
Miscellaneous central nervous system agents	Memantine
Dementia Combinations	Donepezil-memantine

Frailty	
CPT code*	Definition
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care
HCPCS code	**Definition**
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147-9	Walker
E0163, E0165, E0167-8, E0170-1	Commode chair

HEDIS® Advanced Illness and Frailty Exclusions Guide (Cont.)

Frailty	
HCPCS code	**Definition**
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-7, E0301-4	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-2	BiPAP respiratory assist device
E1130, E1140, E1150, E1160, E1161, E1170-2, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-8	Wheelchair
G0162, G0299, G0300, G0493, G0494	Skilled RN services related to home health/hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124, T1000-5, T1019-22, T1030, T1031	Nursing, respite care and personal care services
ICD-10-CM code	**Definition**
L89.000 – L89.96	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified state
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.2	Difficultly in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R53.1	Weakness
R53.81	Other malaise
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA – W01.198S W06.XXXA – W10.9XXS W18.00XA – W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability

HEDIS® Advanced Illness and Frailty Exclusions Guide (Cont.)

Frailty	
ICD-10-CM Code	Definition
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator [ventilator] status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

Breast Cancer Screening (BCS-E)

Measure definition

Patients ages 50–74 who had a mammogram to screen for breast cancer, between October 1, of the two years prior to the measurement year, and December 31 of the measurement year.

Exclusions

Patients are excluded if they:

- Have a history of mastectomy on both the left and right side on the same or different dates of service.
- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are deceased during the measurement year.
- Received palliative care during the measurement year.
- Members whose assigned sex at birth was male

Information that patient medical records should include

- Date the mammogram was performed.
- Documentation of mastectomy and date performed - if exact date is unknown, the year is acceptable.

Information that patient claims should include

If the patient met exclusion criteria, include the following ICD-10-CM[1] diagnosis codes on the claim, as appropriate:

ICD-10-CM code	Description
Z90.11	Acquired absence of right breast and nipple
Z90.12	Acquired absence of left breast and nipple
Z90.13	Acquired absence of bilateral breasts and nipples

Tips for success

- Create a standing order to mail to patient for mammography.
- Provide a list of locations where mammogram screenings can be performed.
- If telehealth, telephone or e-visits are used instead of face-to-face visits, discuss the need for breast cancer screening and mail a mammogram order with location of testing facility and phone number.

Tips for talking with patients

Educate patients about the importance of routine screening:

- Many members with breast cancer do not have symptoms, which is why regular breast cancer screenings are so important.
- Mammograms are an effective method for detecting breast cancer in early stages, when it is most treatable.[2]
- The recommended frequency of routine mammograms is at least once every 24 months for all members ages 50–74. Depending on risk factors, mammograms may be done more frequently.

1 ICD-10-CM created by the National Center for Health Statistics, under authorization by the World Health Organization. WHO-copyright holder.
2 American Cancer Society.

Controlling High Blood Pressure (CBP)

Measure definition

Patients ages 18–85 in the measurement year who had a diagnosis of hypertension, and whose blood pressure was adequately controlled (<140/90 mm Hg) as of December 31 of the measurement year.

Exclusions

Patients are excluded if they:

- Had a nonacute inpatient admission during the measurement year.
- Received hospice care during the measurement year.
- Have end-stage renal disease, dialysis, nephrectomy or kidney transplant.
- Have a pregnancy diagnosis during the measurement year.
- Are age 81 or older with frailty.
- Are ages 66–80 with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

Information that patient medical records should include

Include all blood pressure readings and the dates they were obtained. The last blood pressure reading of the measurement year will be used for HEDIS compliance determination.

- Document exact readings; do not round up blood pressure readings.
  - Ranges and thresholds are not acceptable.
  - If multiple readings are taken on the same date, use billing codes that correspond to the lowest systolic and lowest diastolic results.
- Blood pressure readings can be captured during a telehealth, telephone, e-visit or virtual visit.
  - Patient reported readings taken with a digital device are acceptable and should be documented in the medical record (MR).
  - The provider does not need to see the reading on the digital device, the patient can verbally report the digital reading.

Information that patient claims should include

Blood pressure CPT II codes can be billed alone on a $0.01 claim or with an office visit. This includes telehealth, telephone, e-visit or virtual visit.

CPT® II Code	Most recent systolic blood pressure
3074F	< 130 mm Hg
3075F	130–139 mm Hg
3077F	≥ 140 mm Hg

CPT® II Code	Most recent diastolic blood pressure
3078F	< 80 mm Hg
3079F	80–89 mm Hg
3080F	≥ 90 mm Hg

Controlling High Blood Pressure (CBP) (Cont.)

Tips for taking blood pressure readings in the office

- Use the proper cuff size.
- Advise the patient not to talk during the measurement.
- Ensure that patients don't cross their legs and have their feet flat on the floor during the reading. Crossing legs can raise the systolic pressure by 2–8 mm Hg.
- Make sure the elbow is at the same level as the heart. If the patient's arm is hanging below heart level and unsupported, this position can elevate the measured blood pressure by 10–12 mm Hg.
- Take it twice. If the patient has a high blood pressure reading at the beginning of the visit, retake and record it at the end of the visit. Consider switching arms for subsequent readings.

Tips for talking with patients

- Educate patients on the importance of blood pressure control and the risks when blood pressure is not controlled.
- Encourage blood pressure monitoring at home and ask patients to bring a log of their readings to all office visits - educate patients on how to properly measure blood pressure at home.
- If the patient does not own a digital blood pressure cuff, educate them on utilizing their local pharmacy for a blood pressure reading.
- Prescribe single-pill combination medications whenever possible to assist with medication compliance.
- Discuss the importance of medication adherence at every visit.
- Encourage patients to set a reminder on their phone, app, or in a visible location to take their medications as prescribed.
- Advise patients not to discontinue blood pressure medication before contacting your office. If they experience side effects, another medication can be prescribed.
- If patients have an abnormal reading, schedule follow-up appointments for blood pressure readings until their blood pressure is controlled.
- Encourage lifestyle changes such as diet, exercise, smoking cessation and stress reduction. Consider providing handouts or education in writing on lifestyle changes as a visit takeaway to utilize as a printed plan from their provider.

Colorectal Cancer Screening (COL-E)

Measure definition

Patients ages 45–75 who had appropriate screening for colorectal cancer.[1]

- Colonoscopy within the measurement year or 9 years prior
- Flexible sigmoidoscopy within the measurement year or 4 years prior
- sDNA FIT (stool DNA with FIT test also known as Cologuard®) within the measurement year or 2 years prior
- gFOBT or FIT within the measurement year
- CT-Colonography (virtual colonoscopy) within the measurement year or 4 years prior

Exclusions

Patients are excluded if they:

- Have a history of colorectal cancer - cancer of the small intestine doesn't count.
- Had a total colectomy - partial or hemicolectomies don't count.
- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

Information that patient medical records should include

- Documentation of the date, result and type of all colorectal cancer screenings or if the patient met exclusion criteria.
- A patient-reported colorectal cancer screening; must document in their medical history the type of screening, the date performed and the screening result.

Information that patient claims should include

To ensure exclusion of patients with history of colorectal cancer and total colectomy, use the appropriate ICD-10[2] code:

ICD-10 code	Description
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus

For screenings, use the appropriate codes:

Screening	Code type	Commonly used billing codes
FIT-DNA FIT (also known as Cologuard®)	CPT	81528
Occult blood test (gFOBT, FIT, guaiac)	CPT	82270, 82274
	HCPCS	G0328

NOTE: Performing fecal occult testing on a sample collected from a digital rectal exam or on a stool sample collected in an office setting does not meet screening criteria by the American Cancer Society or HEDIS.

Colorectal Cancer Screening (COL) (Cont.)

Tips for talking with patients

- For patients who refuse a colonoscopy, discuss options of noninvasive screenings.
  - Have FIT kits readily available to give patients during the visit.
  - Ask the patient if he or she would be willing to complete an in-home sDNA (Cologuard) test.
- Educate patients about the importance of early detection:
  - Colorectal cancer usually starts as growths in the colon or rectum and doesn't typically cause noticeable symptoms.
  - You can prevent colorectal cancer by removing growths before they turn into cancer.
- Discuss the benefits and risks of different screening options and make a plan that offers the best health outcomes for your patient.

1National Committee for Quality Assurance. HEDIS® 2020 Volume 2 Technical Specifications for Health Plans (2019), 108-115
2ICD-10-CM created by the National Center for Health Statistics, under authorization by the World Health Organization. WHO-copyright holder.

Eye Exam for Patients with Diabetes (EED)

Measure definition

Patients ages 18–75 with a diagnosis of diabetes (Type 1 or Type 2) who had a retinal eye exam.

- Retinal or dilated eye exam by an eye care professional in the measurement year
- Negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year
- Bilateral eye enucleation any time during the patient's history

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

NOTE: Blindness is not an exclusion for a diabetic eye exam.

Information that patient medical records should include

A retinal or dilated eye exam must be performed by an eye care professional annually for patients with positive retinopathy, and every two years for patients without evidence of retinopathy. When you receive an eye exam report from an eye care provider for your patient with diabetes:

- Document the date of the eye exam, the retinopathy results and eye care professional's name and/or credentials in the medical record to meet HEDIS compliance.
- Review the report and note if there are any abnormalities. If so, add the abnormalities to the patient's active problem list and indicate the necessary follow-up.
- Place the report in the patient's medical record.

For patient-reported retinal or dilated eye exams, document in the patient's medical record the date of the eye exam, the retinopathy result and the eye care professional who conducted the exam with credentials. If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.

NOTES:

- Documentation of prosthetic eye(s) are acceptable for enucleation.
- Optical coherence tomography is considered imaging and is eligible for use. The fundus/retinal photography must have the date, result and eye care professional with credentials documented.
- If a primary care provider's office has equipment to complete retinal imaging with interpretation by artificial intelligence in their office, the provider can report completion of the eye exam by submitting a claim with CPT code, 92229, for the services provided AND the appropriate CPT II code to report the exam results.

Information that patient claims should include

When results are received from an eye care professional, or the patient reports an eye exam, submit the results on a $0.01

Eye Exam for Patients with Diabetes (EED) (Cont.)

Information that patient claims should include

When results are received from an eye care professional, or the patient reports an eye exam, submit the results on a $0.01 claim with the appropriate CPT® II code for HEDIS compliance:

CPT® II Code	Retinal eye exam findings
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy**
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy**
CPT® Code	**Automated eye exam with AI interpretation**
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral, interpreted by artificial intelligence

Tips for success

- Refer patients to optometrist or ophthalmologist for dilated retinal eye exam annually and explain why this is different than a screening for glasses or contacts.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- Hypertensive retinopathy is handled the same as diabetic retinopathy when reporting this measure.
- Routine eye exams for glasses, glaucoma or cataracts do not count. Must be a retinal/dilated exam.

Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

Measure definition

The percentage of emergency department (ED) visits for patients 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit.

Patients with two or more of the following chronic conditions that were diagnosed during the measurement year or the year prior to the measurement year, AND diagnosed prior to the ED visit, are included:

- Alzheimer's disease and related disorders
- Atrial fibrillation
- Chronic kidney disease
- COPD, asthma or unspecified bronchitis
- Depression
- Chronic Heart failure
- Myocardial infarction - acute
- Stroke and transient ischemic attack

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year
- Had an ED visit resulting in acute or non-acute inpatient care on day of visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission.
- Are deceased during measurement year

Information that patient medical records should include

The following visit types meet criteria:

- Outpatient
- Telephone, telehealth, e-visit, virtual check-in
- Transitional Care Management (TCM)
- Case Management
- Complex care management
- Outpatient or telehealth behavioral health
- Intensive outpatient or partial hospitalization
- Community mental health center
- Substance use disorder service or substance abuse counseling and surveillance
- Electroconvulsive therapy

Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) (Cont.)

Tips for success

- With only seven days for the follow-up visit, receiving near-time notification of the ED visit is critical. Connect with your area's automated electronic admission, discharge and transfer (ADT) systems to receive admission, discharge and transfer notifications for your patients.
- This measure is based on ED visits. If a patient has more than one ED visit, they could be in the measure more than once.
- Keep open appointments so patients with an ED visit can be seen within 7 days.
- Obtain and review patients' discharge summary.
- Obtain any test results that were not available when patients were discharged and track tests that are still pending.

Tips for talking with patients

- Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and caregivers to recite their new medication regimen back to you.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
    - Start as needed (PRN) medications.
    - Call their doctor during after-office hours.
    - Go to the emergency room.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Provide a written home management plan or after-visit summary the patient or caregiver can use to make notes during the visit and reference for their plan of care.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.

Glycemic Status Assessment for Patients with Diabetes (GSD)

Measure definition

The percentage of members 18–75 years of age 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% lower rate indicates better performance

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

Information that patient medical records should include

Document the date and result of all glycemic status assessments (HbA1c or GMI). The last glycemic status assessment of the measurement year must be less than or equal to nine to show evidence of diabetes control.

NOTES:

- GMI values must include documentation of the continuous glucose monitoring data's date range used to derive the value. The last date in the range should be used as the assessment date.
- If multiple glycemic status assessments were recorded for a single date, the lowest result will be used to determine HEDIS compliance.
- GMI results collected by the patient and documented by the provider in the patient's medical record are eligible for use in reporting. There is no requirement for the GMI to be collected by a PCP or specialist.
- Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required.

Information that patient claims should include

HbA1c results: When conducting an HbA1c in your office, submit the distinct numeric results as $0.01 on the HbA1c claim with the appropriate CPT® II code for HEDIS compliance**:**

CPT® II Code	Most recent HbA1c level
3044F	< 7%
3046F	> 9%
3051F	≥ 7% and < 8%
3052F	≥ 8% and ≤ 9%

Glycemic Status Assessment for Patients with Diabetes (GSD) (Cont.)

Tips for success

- Order labs to be completed prior to patient appointments.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- Patient-reported HbA1c results are acceptable as long as the date and result are documented in the medical record.
    - Although a lab report is not required, indication that the patients HbA1c was completed through a home kit (e.g., drugstore purchased) would not count. The test must have been processed in a lab.

Kidney Health Evaluation for Patients with Diabetes (KED)

Measure definition

Patients ages 18–85 with a diagnosis of diabetes (Type 1 or 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.

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Have evidence of ESRD or dialysis any time during the patient's history on or prior to December 31 of the measurement year.
- Are age 66 and older with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are age 81 and older with frailty during the measurement year.
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

Information that patient medical records should include

Documentation that patients received both an eGFR and a uACR test during the measurement year on the same or different dates of service. Documentation should include test date, type and result for both of the following reported annually:

- At least one estimated glomerular filtration rate (eGFR)
- At least one urine albumin creatinine ratio (uACR) identified by the following:
  - **Both** a quantitative urine albumin test and a urine creatinine test with service dates four days or fewer apart
  - **Or** a uACR

Information that patient claims should include

When conducting an eGFR or a uACR in your office, submit a claim using the appropriate codes below. A quantitative urine albumin test and a urine creatinine test must have service dates four days or fewer apart.

CPT® Code	Treatment
80047, 80048, 80050, 80053, 80069, 82565	Estimated Glomerular Filtration Rate Lab Test (eGFR)
82043	Quantitative Urine Albumin Test
82570	Urine Creatinine Lab Test

Tips for success

- Order labs to be completed prior to patient appointments.
- Make sure uACR labs (e.g., Quantitative Urine Albumin and Urine Creatinine) are completed within four days of each other.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.

Medication Adherence

Measure definition

Patients ages 18 and older with a prescription for diabetes, hypertension or cholesterol medications who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.

The three measures are:

- Medication Adherence for Diabetes Medications (Non-Insulins)
- Medication Adherence for Hypertension (RAS Antagonists)
- Medication Adherence for Cholesterol (Statins)

Medications included in each measure		
Diabetes	**Hypertension**	**Cholesterol**
• Biguanides • Sulfonylureas • Thiazolidinediones • Dipeptidyl peptidase (DPP)-IV inhibitors • GLP-1 receptor agonists* • Meglitinides • Sodium glucose cotransporter 2 (SGLT2) inhibitors	Renin-angiotensin system (RAS) antagonists: • Angiotensin converting enzyme (ACE) inhibitors • Angiotensin II receptor blockers (ARBs) • Direct renin inhibitors	Statins

**Diabetes treatment only; obesity and weight loss medications are excluded from Medicare coverage.*

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Have an end stage renal disease diagnosis or dialysis coverage dates.
- Diabetes measure only: Have a prescription for insulin.
- Hypertension measure only: Have a prescription for sacubitril/valsartan.

Tips for talking with patients

- Provide short and clear instructions for all prescriptions.
- Emphasize the benefits of taking the medication and the risks of not taking the medication. The benefits should outweigh the risks.
- At each visit, ask your patients about their medication habits, including the average number of doses they may miss each week. Continue with open-ended questions to identify barriers to taking medications:
  - What side effects have you had from the medication, if any?
  - How many doses have you forgotten to take?
  - Are there any financial barriers preventing you from obtaining your prescriptions?
  - What issues prevent you from refilling your prescription?

Medication Adherence (Cont.)

Tips for talking with patients (cont.)

- Offer recommendations for improvement:
  - Recommend weekly or monthly pillboxes, smart phone apps with medication reminder alerts and placing medications in a visible area (but in properly closed containers and safely out of reach of children or pets) for patients who forget to take their medications.
  - Encourage patients to call your office if they experience side effects to discuss alternative medications.
  - Refer patients to their health plan to learn about mail-order options for their prescriptions.

Tips for success

- Instruct patients to fill prescriptions using their pharmacy benefit. Claims filled through pharmacy discount programs, cash claims and medication samples would not count. Gap closure is dependent on pharmacy claims.
- Encourage patients to enroll in auto-refill programs through their pharmacy for chronic maintenance medications.
- Write 90-day supplies of maintenance medications and have your patients use a mail-order pharmacy.
- Write prescriptions with refills for patients who are stable on their medications to reduce the risk of any time lapse between fills.
- Schedule a follow-up visit within 30 days when prescribing a new medication to assess how the medication is working. Schedule this visit while your patient is still in the office.

Osteoporosis Management in Women with a Fracture (OMW)

Measure definition

Female patients ages 67–85 who suffered a fracture and had **either** a bone mineral density (BMD) test or received a prescription to treat osteoporosis within six months after the fracture

- **Note:** Fractures of finger, toe, face or skull are *not* included in this measure.

Exclusions

Patients are excluded if they:

- Had a bone mineral density test 24 months prior to the fracture.
- Received osteoporosis medication therapy or a prescription to treat osteoporosis within 12 months prior to the fracture.
- Received hospice care during the measurement year.
- Are age 81 or older with frailty within the measurement year.
- Are ages 67–80 with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are deceased during the measurement year.
- Received palliative care between July 1 of the year prior to the measurement year through the end of the measurement year.

Patient medical records should include either

- A BMD test on the fracture date or within 180 days (six months) after the fracture, BMD tests during an inpatient stay are acceptable.
- Osteoporosis medication therapy or a prescription to treat osteoporosis that's filled on the fracture date or within six months/180 days (six months) of the fracture.

Category	Prescription
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate • Risedronate • Zoledronic acid
Others	• Abaloparatide • Denosumab • Raloxifene • Romosozumab • Teriparatide

Osteoporosis Management in Women with a Fracture (OMW) (Cont.)

Tips for success

- The U.S. Preventive Services Task Force[1] recommends BMD screening for:
  - Female patients starting at age 65 to reduce the risk of fractures.
  - Postmenopausal women younger than age 65 if they are at high risk.
- Provide patients with a BMD prescription and where to call for an appointment.
- Encourage them to obtain the screening and follow up with the patient to ensure the test was completed.
- If telehealth, telephone or e-visits are used instead of face-to-face visits:
  - Discuss the need for a bone mineral density testing and mail an order to the patient that contains the location and phone number of a testing site
  - Mail a prescription for, or e-scribe, an osteoporosis medication, if applicable.
- Prescribe pharmacological treatment when appropriate.
  - Patients should fill prescriptions using their pharmacy benefit. Gap closure is dependent on pharmacy claims
- Document and bill exclusions annually (see the Advanced Illness and Frailty guide for details).
- Bill fracture-related encounters according to the current CMS official coding guidelines.[2]
  - Use appropriate ICD-10 codes to identify how the fracture happened (e.g., fall).
  - Only initial fracture encounters should have a 7th character of A, B, or C in the diagnosis code, indicating active treatment of a new fracture.
  - Subsequent encounters for routine care in the healing or recovery phase (after the patient has completed active treatment for the fracture) should be billed with the appropriate 7th character in the diagnosis code (such as D or S).
  - Patients who have a history of osteoporosis fractures should be coded as Z87.310 “Personal history of (healed) osteoporosis fracture”.

Tips for talking with patients

- Discuss osteoporosis prevention, including calcium and vitamin D supplements, weight-bearing exercises and modifiable risk factors.
- Ask patients if they have had any recent falls or fractures, since treatment may have been received elsewhere.
- Discuss fall prevention such as:
  - The need for assistive devices, e.g., cane, walker.
  - Removing trip hazards, using night lights and installing grab bars.

1 U.S. Preventive Services Task Force.
https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/osteoporosis-screening
2 CMS ICD-10-CM Official Guidelines for Coding and Reporting, pages 59 – 60, and 77-78.

Plan All-cause Readmissions (PCR)

Measure definition

The number of acute inpatient and observation stays for patients ages 18 and older that were followed by an unplanned acute readmission for any diagnosis within 30 days of discharge date.

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Died during the hospital stay.
- Are members who are diagnosed with pregnancy or of a condition originating in the perinatal period.

Tips for success

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of their discharge.
- When scheduling the post-discharge visit, ask patients to bring in all their prescription medications and over-the-counter medications and supplements so that the medication reconciliation can be performed.
- Obtain and review patients' discharge summary.
- Obtain any test results that were not available when patients were discharged and track tests that are still pending.
- Connect with your area's automated electronic admission, discharge and transfer, or ADT systems to receive admission, discharge and transfer notifications for your patients.
- If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
- Consider implementing:
    - A post-discharge process to track, monitor and follow up with patients.
    - A transitional care management for recently discharged patients.
- This measure is based on discharges. If a patient has more than one discharge, they may appear in the measure more than once.

Tips for talking with patients

- Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and/or caregivers to describe their new medication regimen back to you.
    - Document and date the medication reconciliation in the patients' outpatient medical record.
    - Submit a claim with CPT® II code 1111F as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.
    - Provide the patient with a current list of medications.

Plan All-cause Readmissions (PCR) (Cont.)

Tips for talking with patients (cont.)

- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
  - Start as needed (PRN) medications.
  - Call their doctor during after office hours.
  - Go to the emergency room.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.
- Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Measure definition

Male patients ages 21–75, and female patients ages 40–75, who are identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high-intensity, or moderate-intensity, statin medication and who were at least 80 percent adherent for the remainder of the measurement year.

Exclusions

Patients are excluded if they:

- Cannot tolerate statin medications, as evidenced by a claim for myalgia, myositis, myopathy, or rhabdomyolysis, during the measurement year.
- Received hospice care during the measurement year.
- Received palliative care during the measurement year.
- Have end-stage renal disease or dialysis in the measurement year or the year prior to the measurement year.
- Have cirrhosis in the measurement year or the year prior to the measurement year.
- Are age 66 and older with advanced illness and frailty - for additional definition information, see the Advanced Illness and Frailty Guide.
- Are deceased during the measurement year.
- Having a diagnosis of pregnancy, IVF or at least one prescription for clomiphene (estrogen agonists) during the measurement year or the year prior to the measurement year.

Information that patient medical records should include

In order to exclude patients from the measure who cannot tolerate statin medications, a claim **MUST** be submitted **annually** using the appropriate ICD-10-CM code:

Category	Medication
Myalgia	M79.10–M79.12, M79.18
Myositis	M60.80–M60.819; M60.821–M60.829; M60.831–M60.839; M60.841–M60.849; M60.851–M60.859; M60.861–M60.869; M60.871–M60.879; M60.88–M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82

Tips for success

- Prescribe high-intensity or moderate-intensity statin medication to patients diagnosed with ASCVD when clinically appropriate.
- Once patients demonstrate they can tolerate statin therapy, utilize 90-day prescription fills to encourage medication adherence.
- Instruct patients to fill prescriptions using their pharmacy benefit. Claims filled through pharmacy discount programs, cash claims and medication samples would not count. Gap closure is dependent on pharmacy claims.

Statin Therapy for Patients with Cardiovascular Disease (SPC) (Cont.)

Category	Medication	
High-intensity	• Atorvastatin 40–80 mg• • Amlodipine-atorvastatin 40–80 mg • Rosuvastatin 20–40 mg	• Ezetimibe-simvastatin 80 mg • Simvastatin 80 mg
Moderate-intensity	• Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg	• Pravastatin 40–80 mg • Lovastatin 40 mg • Fluvastatin 40–80 mg • Pitavastatin 1-4mg

Tips for talking with patients

- Educate your patients on the importance of statin medication adherence.
- Remind patients to contact you if they think they are experiencing adverse effects. If the patient experiences any of the excluded symptoms/conditions, submit an office visit claim with the appropriate ICD-10 code listed on previous page.

Statin use in Persons with Diabetes (SUPD)

Measure definition

Diabetic patients ages 40–75 who were dispensed at least two diabetes medication fills and also received a statin medication fill at any time during the measurement year.

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Have an end stage renal disease diagnosis or dialysis coverage dates.
- Have liver disease, pre-diabetes, or polycystic ovary syndrome (PCOS).
- Are pregnant, lactating, or undergoing fertility treatment.
- Have rhabdomyolysis or myopathy or adverse effects of statin therapy

Information that patient medical records should include

In order to exclude patients from the measure who cannot tolerate statin medications, a claim **MUST** be submitted **annually** using the appropriate ICD-10-CM code:

Condition	ICD-10-CM code
Cirrhosis:	
Alcoholic cirrhosis of liver without ascites	K70.30
Alcoholic cirrhosis of liver with ascites	K70.31
Toxic liver disease with fibrosis and cirrhosis of liver	K71.7
Primary biliary cirrhosis	K74.3
Secondary biliary cirrhosis	K74.4
Biliary cirrhosis, unspecified	K74.5
Unspecified cirrhosis of liver	K74.60
Other cirrhosis of liver	K74.69
End Stage Renal Disease / Dialysis:	
Chronic kidney disease, stage 5	N18.5
End stage renal disease	N18.6
Dependence on renal dialysis	Z99.2
Pregnancy and/or Lactation	Numerous > 1k
Polycystic Ovarian Syndrome	E28.2
Pre-diabetes	R73.03
Other abnormal blood glucose	R73.09
Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter*	T46.6X5A

Statin use in Persons with Diabetes (SUPD) (Cont.)

Condition	ICD-10-CM code
Rhabdomyolysis/myopathy/myositis*:	
Drug-induced myopathy	G72.0
Other specified myopathies	G72.89
Myopathy, unspecified	G72.9
Other myositis, unspecified site	M60.80
Other myositis, unspecified shoulder	M60.819
Other myositis, unspecified upper arm	M60.829
Other myositis, unspecified forearm	M60.839
Other myositis, unspecified hand	M60.849
Other myositis, unspecified thigh	M60.859
Other myositis, unspecified lower leg	M60.869
Other myositis, unspecified ankle and foot	M60.879
Myositis, unspecified	M60.9
Rhabdomyolysis	M62.82

*The condition the code refers to does not necessarily need to occur in the same year the code was billed. The member's medical chart should reflect 'history of'. These codes are intended to close Star measure gaps and do not apply to payment or reimbursement. Only the codes listed above will exclude the member from the SUPD measure.

Tips for success

- Prescribe at least one statin medication during the measurement year to patients diagnosed with diabetes, when clinically appropriate. Medication samples, when given, are not captured as a billed pharmacy claim and do not close SUPD gaps.
- Compliance can only be achieved through prescription drug event (PDE) data. Prescriptions that are filled through pharmacy discount programs or non-network pharmacies will not result in compliance and patients may pay more for that statin than if they used their prescription drug coverage.
- This measure overlaps with the Statin Therapy for Patients with Cardiovascular Disease measure. Patients with ASCVD should be prescribed a moderate-intensity or high-intensity statin, when clinically appropriate.
- Educate patients on the importance of taking their medications regularly and as prescribed. Once patients demonstrate they tolerate statin therapy, utilize 90-day prescription fills to encourage medication adherence.
- For patients turning 76 this year (born in 1945), a statin must be filled no later than the month before they turn 76 for the claim to close the SUPD gap.

Tips for talking with patients

- Educate patients on the importance of statin medications for diabetic patients over the age of 40, regardless of LDL levels.
- Remind patients to contact you if they think they are experiencing adverse effects, such as myalgia, to statins. Consider trying a different statin that is more hydrophilic or reducing the dose or frequency.

Transitions of Care (TRC)

Measure definition

The percentage of discharges for patients 18 years of age or older, who had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year, and met each of the following components:

1. Notification of inpatient admission within two days
2. Receipt of discharge information within two days
3. Patient engagement after inpatient discharge within 30 days
4. Medication reconciliation post-discharge within 30 days

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year
- Are deceased during measurement year

Information that patient medical records should include

Documentation of all 4 components must be in any outpatient record, as well as accessible by the PCP or ongoing care provider.

Component	Criteria	Outpatient medical record requirements
1. Notification of inpatient admission	Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total).	Must document the **date of receipt** and include at least one of the following criteria: • Communication from inpatient provider, hospital staff or emergency department regarding admission (phone call, email, or fax). Referral to an emergency department does not meet criteria. • Documentation that the patient's PCP or ongoing care provider admitted the patient, or a specialist admitted the patient and notified the patient's PC. • Communication through a health information exchange; an admission, discharge, and transfer alert system (ADT); or a shared electronic medical record. • Documentation indicating the patient's PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay. • Documentation of a preadmission exam or a planned admission prior to the admit date. The exam must pertain to the specific admission event.
2. Receipt of discharge information	Receipt of discharge information on the day of the discharge through 2 days after the discharge (3 days total).	Must include the date of receipt and ALL of the following criteria: • The practitioner responsible for the patient's care during the inpatient stay • Procedures or treatment provided • Diagnoses at discharge • Current medication list • Testing results, documentation of pending tests, or documentation of no tests pending • Instructions for patient care post discharge

Transitions of Care (TRC) (Cont.)

Component	Criteria	Outpatient medical record requirements
3. Patient engagement after inpatient discharge	Patient engagement provided within 30 days after discharge. - May not occur on the date of discharge.	Must include the date of service and clinical notes for any of the following: • An outpatient visit including office visits and home visits. • A telephone visit. • A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication. • An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the member and provider). NOTE: If the patient is unable to communicate with the practitioner, interaction between the patient's caregiver and the provider meets criteria.
4. Medication reconciliation post-discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days). NOTES: - Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse. Other staff members (MA or LPN) may document the medication reconciliation, but it must be signed off by the prescribing practitioner. - Medication reconciliation must be documented in the outpatient medical record, but an outpatient face-to-face visit isn't required	Must include all three items described below: 1. Date the medication reconciliation was performed. 2. Current medication list (at date of reconciliation) 3. Chart documentation of any one of the following: ○ Notation that the provider reconciled the current and discharge medications. ○ Notation that references the discharge medications (e.g., no changes in meds post discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed). ○ Notation that the discharge medications were reviewed. ○ A discharge medication list with notation that both it and the current medications were reviewed on the same date of service. ○ Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. (Evidence includes notation of follow-up for "hospitalization," "admission", "discharge", or "inpatient stay".) • *NOTE: Documentation of "post-op/surgery follow-up" alone is not considered sufficient chart evidence of a hospitalization.* ○ Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. Discharge summary must be dated and filed in the outpatient record within 30 days after discharge. ○ Notation that no medications were prescribed or ordered upon discharge.

Transitions of Care (TRC) (Cont.)

Tips for success

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of their discharge.
- When scheduling the post-discharge visit, ask patients to bring in all their prescription medications and over-the-counter medications and supplements so that the medication reconciliation can be performed.
- Obtain and review patients' discharge summary.
- Obtain any test results that were not available when patients were discharged and track tests that are still pending.
- Connect with your area's automated electronic admission, discharge and transfer (ADT) system to receive admission, discharge and transfer notifications for your patients.
- If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
- Consider implementing:
  - A post-discharge process to track, monitor and follow up with patients.
  - A transitional care management program for recently discharged patients.
- You can reduce errors at time of discharge by using the computer order entry system to generate a list of medications used before and during the hospital admission.
- Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with patient comprehension of his or her discharge instructions.
- Documentation of notification must include a date when the document was received.
- This measure is based on discharges. If a patient has more than one discharge, they may appear in the measure more than once.
- Examples of documentation that are not acceptable:
  - Documentation that the member or the member's family notified the member's primary or ongoing care provider of the admission of discharge.
  - Documentation of notification that doesn't include a date when the documentation was received.

Tips for talking with patients

- Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and/or caregivers to describe their new medication regimen back to you.
  - Document and date the medication reconciliation in the patients' outpatient medical record.
  - Submit a claim with CPT® II code 1111F as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.
  - Provide the patient with a current list of medications.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
  - Start as needed (PRN) medications.
  - Call their doctor during after office hours.
  - Go to the emergency room.

Transitions of Care (TRC) (Cont.)

Tips for talking with patients (cont.)

- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.
- Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment.

Tips for coding

- Visits with a practitioner can be with or without a telehealth modifier.

CPT® II code	Description	Component
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.	4. Medication reconciliation
CPT® Code	**Description**	**Component**
98966 – 8, 98970 – 2, 98980 – 1, 99202 – 5, 99211 – 5, 99241 – 5, 99341 – 5, 99347 – 9, 99350, 99381 – 7, 99391 – 7, 99401 – 4, 99411 – 2, 99421 – 3, 99429, 99441 – 3, 99455 – 8, 99483	Outpatient and telehealth evaluation & management services	3. Patient engagement
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.	4. Medication reconciliation
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face visit within **14 days** or discharge.	3. Patient engagement 4. Medication reconciliation
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face visit within **7 days** of discharge.	3. Patient engagement 4. Medication reconciliation

Member Experience STAR Measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

Why is the CAHPS survey important?

Research shows that a positive health care experience for patients is associated with positive clinical outcomes and better business outcomes, including lower medical malpractice risk and less employee turnover.[1]

CAHPS survey questions and provider impact

Providers can affect patient responses to CAHPS survey questions. The table below lists some key CAHPS survey questions with tips to ensure patients have a positive experience.

Measure	Sample survey questions to patient
Annual flu vaccine	Have you had a flu shot since July 1
Tips for success • Administer flu shot as soon as it is available each fall. • Eliminate barriers to accessing flu shots and offer multiple options for patients to get their shot (walk-in appointments, flu shot clinics, flu shots at every appointment type if the patient's eligible). • **Promote flu shots through website, patient portal and phone greeting.**	
Getting appointments and care quickly	In the last six months: • How often did you see the person you came to see within 15 minutes of your appointment time? • When you needed care right away, how often did you get care as soon as you needed? • How often did you get an appointment for a check-up or routine care as soon as you needed?
Tips for success • Patients are more tolerant of appointment delays if they know the reasons for the delay. When the provider is behind schedule: ○ Front office staff should update patients often and explain the cause for the schedule delay. Offer reasonable expectations of when the patient will be seen and give the patient options, showing respect for their time. ○ Staff members interacting with the patient should acknowledge the delay with the patient. • Consider implementing advanced access scheduling (same-day scheduling) or consider: ○ Leaving a few appointment slots open each day for urgent visits, including post-inpatient discharge visits. ○ Offering appointments with a nurse practitioner or physician's assistant to patients who want to be seen on short notice. ○ Offering online appointments and telehealth visits, making it convenient for patients to connect with the practice ○ Asking patients to make routine checkups and follow-up appointments in advance.	
Overall rating of health care quality	Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?
Tips for success • Survey your patients, asking how you can improve their health care experience. • Create a patient council for regular feedback	

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

Measure	Sample survey questions to patient
Care coordination	In the last six months: • When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them? • How often did you and your personal doctor talk about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about the care you got from specialists?
Tips for success • Before walking in the exam room, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits and any specialist visits or other referral orders. • Implement a system in your office to ensure timely notifications of test results, ask patients how they would prefer to receive test results and communicate clearly with patients on when they'll receive test results. • Utilize or implement a patient portal to share test results and consider automatically releasing the results once they are reviewed by the provider. • Ask your patients if they saw another provider since their last visit. If you know patients receive specialty care, discuss their visit and treatment plan, including new prescriptions. • Complete a medication review or reconciliation at every visit and discuss with the patient during the appointment.	
Getting needed care	In the last six months: • How often did you get an appointment to see a specialist as soon as you needed? • How often was it easy to get the care, tests or treatment you needed?
Tips for success • Set realistic expectations around how long it could take to schedule an appointment with the specialist if the appointment is not urgent. • If applicable, advise your patient on how you can help secure an appointment sooner if your clinic has an established relationship with a specialist. • Help the patient understand why you are recommending certain types of care, tests or treatments, especially if the patient requested or asked about other types. • Review with patients what role they play in securing care, tests or treatment (e.g., scheduling with specialists, timely appointments).	

1 https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/cahps-ambulatory-care-guide-full.pdf

Health Outcomes Survey (HOS)

Why is the HOS important?

The goal of the HOS is to gather clinically meaningful health status data from Medicare Advantage patients to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

HOS questions and provider impact

Providers can significantly impact how patients assess their health care experience in response to HOS questions. Some key HOS questions are listed in the table below along with tips to ensure patients feel well supported.

Measure	Sample survey questions to patient
Improving or maintaining physical health	In general, would you say your health is: Excellent; very good; good; fair; poor? The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? • Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf • Climbing several flights of stairs During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? • Accomplished less than you would like as a result of your physical health? • Were limited in the kind of work or other activities you were able to perform as a result of your physical health? During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
Tips for success • Develop a plan with your patients to take steps to improve physical health. ○ Consider annual assessments of health risks and functional status, provide health education on topics such as strength training, cardiovascular exercise, reducing alcohol or caffeine intake, smoking cessation, nutrition, and fall prevention. ○ Schedule a check-in to discuss progress on this plan. • Ask patients if they have pain, and if so, is it affecting their ability to complete daily activities? Ask what goals the patient has, then identify ways to improve the patient's pain. • Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist or other specialist. • Consider physical therapy and cardiac or pulmonary rehab when appropriate.	
Improving or maintaining mental health	During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? • Accomplished less than you would like as a result of any emotional problems. • Didn't do work or other activities as carefully as usual as a result of any emotional problems. How much of the time during the past four weeks? • Have you felt calm and peaceful? • Did you have a lot of energy? • Have you felt downhearted and blue? During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Health Outcomes Survey (HOS) (Cont.)

Measure	Sample survey questions to patient
Tips for success • Incorporate annual depression screening into visits, such as PHQ-2 or PHQ-9. • Discuss options for therapy with a mental health provider, when appropriate. • Develop a plan with your patients to take steps to improve mental health. ○ Consider exercise, sleep habits, hobbies, volunteering, attending religious services, identifying stress triggers, reducing alcohol or caffeine intake, meditation, connecting with supportive family and friends. ○ Schedule a check-in to discuss progress on this plan. • Consider a hearing test when appropriate, as loss of hearing can feel isolating.	
Monitoring Physical activity	In the last 12 months, did: • You talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise. • A doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.
Tips for success • Talk to patients about their physical activity and the health benefits of staying active. Studies show that having patients fill out a questionnaire is not enough to gauge their activity level. Show interest in ensuring patients remain active. • Develop a plan with your patient to take steps to start or increase physical activity. ○ Offer suggestions based on the patient's physical ability, interests, and access. ○ Schedule a check-in to discuss progress on this plan. • Refer patients with limited mobility to physical therapy to learn safe and effective exercises.	
Improving bladder control	Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?
Tips for success • Ask patients if they have any trouble holding their urine. If yes, ask the following questions: ○ When do you notice leaking (exercise, coughing, after urinating)? ○ Is there urgency associated with the leaking? ○ Do you have any issues emptying your bladder (incomplete, takes too long, pain)? ○ How often do you empty your bladder at night? During the day? ○ Do you have pain when you urinate? ○ Have you noticed a change in color, smell, appearance or volume of your urine? ○ How impactful are your urinary issues to your daily life? • For men, ask all the same questions, plus: ○ Is there any change in stream? ○ Any sexual dysfunction (new, historical or changing)? • Communicate that urinary leakage problems can be common as we grow older, but there are treatments that can help. Discuss potential treatment options such as behavioral therapy, exercises, medications, medical devices and surgery. • Use informational brochures and materials as discussion starters for this sensitive topic.	

Health Outcomes Survey (HOS) (Cont.)

Measure	Sample survey questions to patient
Reducing the risk of falling	• A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • In the past 12 months, have you had a problem with balance or walking? • Has your doctor or health provider done anything to help you prevent falls or treat problems with balance or walking? Some things they might do include: ○ Suggest that you use a cane or walker. ○ Suggest that you do an exercise or physical therapy program ○ Suggest a vision or hearing test.

Tips for success

- Promote exercise, physical therapy and strengthening and balance activities (tai chi, yoga).
- Review medications for any that increase fall risk.
- Discuss home safety tips such as removing trip hazards, installing handrails and using nightlights.
- Suggest the use of a cane or walker, if needed.
- Suggest physical therapy and cardiac or pulmonary rehab when appropriate.
- Recommend a vision or hearing test.

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