Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

The Centers for Medicare & Medicaid Services (CMS) created the Star Rating Program to raise the quality of care for Medicare enrollees electing Medicare Advantage coverage from health plans versus Original Medicare. The program is aligned with CMS' quality strategy goals to optimize health outcomes, improve members' experience and access to care, and maximize efficiency and cost savings.

Star Ratings are released annually by CMS and help Medicare beneficiaries select the best Medicare Advantage plan for their healthcare needs. The ratings enable health plan performance comparison on an apples-to-apples basis and hold plans accountable for the care of their members by physicians, hospitals and other healthcare providers.

As many of the measures included in the Star Rating Program assess members' interaction with practitioners of the healthcare system, this guide outlines the Star quality and performance measures that CMS, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA) use to evaluate the care and services provided to your Medicare Advantage patients. CarePlus strives to support you in providing quality services and improving the health outcomes of your CarePlus-covered patients. This guide does not include Star measures that are not directly influenced by physicians and are strictly assessing plan information, services or member experience with the plan.

The information offered in this guide is from the Healthcare Effectiveness Data and Information Set (HEDIS®) 2020 Volume 2 Technical Specifications for Health Plans and its corresponding Value Set Directory, as well as the CMS Medicare 2020 Part C & D Star Ratings Technical Notes. This information is not meant to preclude clinical judgment. Treatment decisions should always be based on the clinical judgment of the physician or other healthcare provider at the time of care.

In the guide for each measure, we've provided the:

- Measure name and abbreviation
- Weight assigned by CMS that is used when calculating summary or overall Star Ratings
- Definition of the measure including its eligible population and expected quality activity and/or outcome
- Best practices for addressing the measure with patients
- Applicable exclusions that will remove a patient from the eligible population for a measure
- Quality result percentage ranges used to determine each of the measure's Star Rating year 2020 Star levels
- For HEDIS measures: the service(s) needed and coding guidance to ensure measure compliance
- For HOS and CAHPS measures: applicable question(s) from the respective survey administered to Medicare Advantage patients
- For Patient Safety measures: the prescription drug activity needed for compliance

You will also find information for display measures within this guide. These measures are not currently part of the Star Rating Program, but in some cases, they may be recent Star measures that underwent substantive changes and have been temporarily moved to display. Often these are new measures being performance tested before they are designated as a Star measure. They could also be former Star measures that may be retired in the future. As we do not have access to the same details that are available for Star measures, we have provided any information available from CMS' Medicare 2019 Part C & D Display Measure Technical Notes and HEDIS 2020 Volume 2 Technical Specifications.

The information in this guide is subject to change based on CMS regulatory guidance and technical specification changes from NCQA and/or PQA. Measure details can change annually (i.e., service needed for compliance, applicable codes).

Healthcare Effectiveness Data and Information Set (HEDIS)

Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans the specific areas in which a stronger focus could lead to improvements in patient health. HEDIS reporting is mandated by the NCQA for compliance and accreditation. The HEDIS measures listed here are part of the Medicare Star Rating Program governed by the Centers for Medicare & Medicaid Services (CMS) for measurement year (MY) 2020.

Adult Body Mass Index (BMI) Assessment (ABA)
Weight = N/A (retired for MY2020)

Percentage of patients 18–74 years old who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

Service needed for compliance

- For patients 20 years old and older on the date of service, determine and document patient's BMI
- For patients younger than 20 years old on the date of service, determine and document patient's BMI percentile

ABA measure best practices

- Ensure submitted claims or encounters include the appropriate ICD-10 codes.
- Place BMI charts near scales in the office as a reminder to discuss with patients.
- Place proper documentation for BMI in the medical record with all components (i.e., date, weight, height and BMI value or percentile).
  - For patients 20 years old and older on the date of service, documentation in the medical record must indicate the weight and BMI value, dated during the current or prior measurement year. The weight and BMI value must be from the same data source.
  - For patients younger than 20 years old on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile, dated during the current or prior measurement year. The height, weight and BMI percentile must be from the same data source. Ranges and thresholds do **not** meet BMI percentile criteria.
    - For BMI percentile, the following documentation meets criteria:
      - BMI percentile documented as a value (e.g., 85th percentile)
      - BMI percentile plotted on an age-growth chart

Exclusions

- Pregnant women
- Patients in hospice or using hospice services

For applicable coding: ABA (page 30)

Breast Cancer Screening (BCS)
Weight = 1

Percentage of women 52–74 years old who had a mammogram to screen for breast cancer

Service needed for compliance

- Mammogram between Oct. 1 two years prior to the measurement year and Dec. 31 of the current measurement year
- All types and methods of mammograms including digital breast tomosynthesis

Note: MRIs, ultrasounds or biopsies do not count toward this measure

BCS measure best practices

- Due to the unique 27-month measurement period, physician practices may want to consider ordering a mammogram every two years for their patients beginning at 50 years old, or sooner when risk factors such as family history exist.
- Educate patients about the importance of early detection and encourage testing.
- Schedule a mammogram for the patient.
- Engage patients to discuss their fears about mammograms and let women know that the test is more comfortable and uses less radiation than it did in the past.
- Provide female patients with a list of facilities that provide mammograms.
- Document date of service (at minimum month and year) of most recent mammogram in the medical record.
- Document mastectomy status and date of service (minimum year performed) in the medical record.

Exclusions

- Patients who have had a bilateral mastectomy or who have had both a unilateral left and unilateral right mastectomy
- A single unilateral mastectomy does not count as a full exclusion
- Patients in hospice or using hospice services
- Patients 66–74 years old who:
- Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
  AND/OR
- Have frailty and advanced illness

For applicable coding: BCS (page 31)

Care for Older Adults (COA)

Eligible population:

- Medicare Advantage patients 66 years old and older who are also enrolled in a Special Needs Plan (SNP)
  - Special Needs Plans are a type of Medicare Advantage plan designed for certain people with Medicare
  - Some Special Needs Plans are for people with certain chronic diseases and conditions, who have both Medicare and Medicaid or who live in an institution such as a nursing home

Exclusions

- Patients in hospice or using hospice services

For applicable coding: COA (page 32)

COA – Advanced Care Planning (COA–ACP)
Weight = N/A (not currently a Star or display measure)

Percentage of COA eligible patients who have had advance care planning

Service needed for compliance (any one of the following)

- An advance care plan with a dated notation in the medical record in the current measurement year
- Discussion about advance care planning in the current measurement year with a dated notation in the patient's medical record
- Documentation that the patient previously executed an advance care plan with a dated notation in the patient's medical record in the current measurement year

COA–ACP measure best practices

- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.
- Discuss the following types of advance care plans with your patients during visits and include a dated notation in their medical record document:
  - Advance directive or living will
  - Power of attorney
  - Healthcare proxy
  - Actionable medical or surrogate decision-maker

COA – Functional Status Assessment (COA–FSA)
Weight = N/A (moved to Display for MY20)

Percentage of COA eligible patients who have had a functional status assessment

Service needed for compliance

At least one complete functional status assessment performed in an outpatient setting in the current measurement year with dated notation in the patient's medical record, which may include:

- Assessment of instrumental activities of daily living (IADL) or activities of daily living (ADL)
- Results using a standardized functional assessment tool

Note: Functional status assessment limited to an acute or single condition, event or body system does not meet criteria

COA–FSA measure best practices

- Perform a comprehensive functional status assessment with older patients as a part of annual wellness or physical exam.

COA – Medication Review (COA–MDR)
Weight = 1

Percentage of COA eligible patients whose doctor or clinical pharmacist reviewed all of the patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies

Service needed for compliance (any one of the following)

- At least one medication review conducted by a prescribing practitioner or clinical pharmacist in the current measurement year with a medication list present in the patient's medical record with a dated notation
- Transitional care management services that include medication review administered during the current measurement year

COA–MDR measure best practices

- If patient is not taking any medicine, creating a dated notation in the medical record will address the measure.
- A medication review and medication list code must be billed simultaneously for a patient to be compliant. A review of side effects for a single medication at the time of prescription alone is not sufficient.
- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.

COA – Pain Screening (COA–PNS)
Weight = 1

Percentage of COA eligible patients who have had a pain screening or assessment

Service needed for compliance

At least one pain assessment or screening performed in an outpatient setting in the current measurement year with a dated notation in the patient's medical record, which may include:

- Documentation that the patient was assessed for pain
  - May include positive or negative findings for pain
- Result of assessment using a standardized pain assessment tool

Notation alone of the following activities does **not** meet criteria:

- Pain management plan
- Pain treatment plan
- Screening for or presence of chest pain

COA–PNS measure best practices

- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.

Colorectal Cancer Screening (COL)
Weight = 1

Percentage of patients 50–75 years old who had an appropriate screening for colorectal cancer

Service needed for compliance (any one of the following)

- Fecal occult blood test (FOBT) during the current measurement year (one year)
- Cologuard (FIT-DNA) test during the current measurement year or two years prior (three years)
- Flexible sigmoidoscopy or computed tomographic (CT) colonography during the current measurement year or four years prior (five years)
- Colonoscopy during the current measurement year or nine years prior (10 years)

COL measure best practices

- Clearly document administered screenings, total colectomy or colorectal cancer in patient's medical record, including date of service.
- Ask patients if they've had a colorectal cancer screening and update patient history annually.
- Encourage patients resistant to having a colonoscopy to perform and return at-home stool tests (FOBT).
- If testing of the patient's sample has unfavorable results, further diagnostic testing such as a colonoscopy is recommended.

Exclusions

- Patients in hospice or using hospice services
- Patients 66–75 years old who:
  - Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) **AND/OR**
  - Have frailty and advanced illness
- Patients who have had total colectomy or colorectal cancer at any time during the patient's history through Dec. 31 of the current measurement year
  - Partial colectomy is not an exclusion

For applicable coding: COL (page 35)

Comprehensive Diabetes Care (CDC)

- Patients 18–75 years old with diabetes, type 1 and type 2
- Patients eligible for the CDC measures are identified based on any of the following activities during the current or prior measurement year:
  - For an insulin, hypoglycemic or antihyperglycemic medication dispensed on an ambulatory basis **OR**
  - Claim(s) submitted with a diagnosis of diabetes for:
    - One acute inpatient stay **OR**
    - Two outpatient, observation, emergency department or non-acute inpatient visits
      - Can be any combination of visit types that occurred on different dates of service

Exclusions

- Patients in hospice or using hospice services
- Patients 66–75 years old who:
  - Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) **AND/OR**
  - Have frailty and advanced illness

CDC – Blood Sugar Controlled: Hemoglobin A1c (CDC–HbA1c)
Weight = 3

Percentage of eligible diabetic patients who have evidence of HbA1c test with a level of 9% or less

Service needed for compliance

- At least one HbA1c test in current measurement year for all eligible patients with the resulting level reported
- The most recent HbA1c test in the current measurement year must have a level of 9% or less to be measure compliant

CDC–HbA1c measure best practices

- Review recommendations for diabetes care at each office visit.
- Order labs prior to patient appointments.
- When point-of-care HbA1c tests are completed in-office, bill for service with results.
- Encourage patients to monitor their blood glucose levels between office visits using at home tests or monitors
- Ensure documentation in the medical record includes the date when the HbA1c test was performed along with the result or finding.
  - Finding must be in the format of a value (e.g., 7%). Missing values or results recorded in a format other than this example will result in noncompliance for the measure.
- Adjust therapy to improve HbA1c and BP levels; follow up with patients to monitor changes.
- If result is more than 9%, order and document follow-up HbA1c testing as appropriate.
- Ensure submitted claims or encounters include the appropriate Current Procedural Terminology (CPT®) Category II codes for the most recent HbA1c level.

For applicable coding: CDC–HbA1c (page 38)

CDC – Eye Exam (CDC–EYE)
Weight = 1

Percentage of eligible diabetic patients who have evidence of HbA1c test with a level of 9% or less

Service needed for compliance (any one of the following)

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the current measurement year
- A negative retinal or dilated eye exam (negative for diabetic retinopathy) by an eye-care professional (optometrist or ophthalmologist) in the prior or current measurement year
- Bilateral eye enucleation at any time during the patient's history or the current measurement year

CDC–EYE measure best practices

- Review diabetes services needed at each office visit.
- Encourage and/or refer patients to see an eye care professional for a comprehensive dilated or retinal eye exam during the current year.
- Document the date of the most recent diabetic eye exam with results and name of eye care provider in the medical record. Negative result must be documented to be compliant for two years.
- Obtain the record of an eye exam performed in the current measurement year by an ophthalmologist or optometrist. Retain a copy of the exam in the patient's medical record.
- Obtain the record of an eye exam performed in the prior measurement year by an ophthalmologist or optometrist. The eye exam must note "no evidence of retinopathy." Retain a copy of the exam in the patient's medical record.
- Ensure submitted claims or encounters include the appropriate coding used for exam and results.
- Consider using mobile eye-exam units. Fundus photography captures an image of the retina with a camera that can be operated by healthcare provider staff after brief training.

For applicable coding: CDC–EYE (page 38)

CDC – Kidney Disease Monitoring: Nephropathy (CDC–Neph)
Weight = 1

Percentage of eligible diabetic patients who received a nephropathy screening or monitoring test, or have evidence of nephropathy in the current measurement year

Service needed for compliance (any one of the following)

- Nephropathy screening or monitoring test for albumin or protein, such as:
  - 24-hour urine/timed/spot urine for albumin, protein or total protein
  - Urine for albumin/creatinine ratio
  - Random urine for protein/creatinine ratio
- Angiotensin converting enzyme inhibitor or angiotensin receptor blocker (ACE/ARB) therapy or dispensed medication
- Evidence of or treatment for any of the following conditions:
  - Diabetic nephropathy or kidney transplant
  - End-stage renal disease (ESRD), chronic renal failure (CRF) or chronic kidney disease (CKD)
- A visit with a nephrologist

CDC–Neph measure best practices

- Review diabetes services needed at each office visit.
- Order labs prior to patient appointments.
- Ensure submitted claims or encounters include the appropriate ICD-10 and CPT Category II codes.
- Send reminders to patients with type 1 or type 2 diabetes. Include information about the required testing and a suggestion to set up an appointment.
- Encourage patients to perform and return at home tests that check for protein in their urine.
- If testing of the patient's sample has unfavorable results, further diagnostic testing is recommended.

For applicable coding: CDC–Neph (page 41)

Controlling Blood Pressure (CBP)
Weight = 1

Percentage of hypertensive patients 18–85 years old whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the current measurement year

Patients become eligible for this measure once they have had two visits with a diagnosis of hypertension (ICD-10: I10). The visits:

- Can occur during the prior year or the first six months of the current measurement year
- Must have two different dates of service
- Can be any type of outpatient visit, and any combination of visit type applies

Service needed for compliance

- BP reading during the current measurement year on or after the second diagnosis of hypertension
- Most recent reading in the current measurement year must have a representative systolic BP < 140 mm Hg and a representative diastolic BP of < 90 mm Hg to be measure compliant
- The adequately controlled result must be documented and reported administratively

Note: If there are multiple BPs on the same date of service, use the lowest systolic and diastolic BP on that date as the representative BP

CBP measure best practices

- If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. Do not round BP values. If using an automated machine, record exact values.
- Review hypertensive medication history and patient compliance and consider modifying treatment plans for uncontrolled blood pressure as needed.
- If blood pressure is out of target range, have the patient return in three months.
- Document blood pressure readings at each visit.
- Ensure submitted claims or encounters include the appropriate CPT Category II codes for BP readings.

Exclusions

- Pregnant women
- Patients in hospice or using hospice services or with end-stage renal disease (ESRD)
- Patients 66–85 years old living long-term in an institutional setting or who are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years old with frailty and advanced Illness
- Patients 81–85 years old with frailty

For applicable coding: CBP (page 44)

Medication Reconciliation Post-Discharge (MRP)
Weight = 1

The percentage of discharges from Jan. 1 to Dec. 1 of the measurement year for patients 18 years old and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days)

Service needed for compliance

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse (RN) on the day the patient is discharged from the hospital through 30 days after discharge.

- Licensed practical nurses (LPNs) and other non-licensed staff can perform the medication reconciliation, but it must be reviewed and approved by a physician, clinical pharmacist or RN.
- If a patient is directly transferred for another inpatient stay, reconciliation is not required based on initial discharge date.

Note: Inpatient stays with a discharge date of Dec. 2 to Dec. 31 are excluded from this measure.

MRP measure best practices

- Be aware of patients' inpatient stays.
- Obtain timely discharge summaries.
- Review and reconcile discharge medications against existing outpatient medications.
- See patients in the office as soon as possible after an acute discharge stay.
- Upon completion of the medication reconciliation, include CPT II code 1111F on applicable claims submitted.
- Review all discharge summaries and document all medication reconciliations in outpatient medical records (which may be done on the discharge summary filed in the outpatient medical record). Any of these medical record notations will ensure measure compliance:
  - Current medications with a notation that clinician reconciled the current and discharge medications
  - Current medications with a notation that references the discharge medications
  - Patient's current medications with a notation that the discharge medications were reviewed
  - Current medication list, a discharge medication list and a notation that both lists were reviewed on the same date of service
  - Current medication list with documentation that patient was seen for post-discharge follow-up with medications reviewed or reconciled after hospitalization/discharge
  - Documentation in the discharge summary that discharge medications were reconciled with most recent medication list in outpatient record. There must be evidence that the discharge summary was filed in outpatient record within 30 days after discharge
  - Notation that no medications were prescribed or ordered upon discharge
- Medication names are needed. While dose, route and frequency are not required, their inclusion is highly

recommended.
- The final reconciled medication list should be communicated to the patient by the physician or clinical office staff during an office or home visit. It can also be communicated telephonically or virtually.

Exclusions
- Patients in hospice or using hospice services

For applicable coding: MRP (page 45)

Osteoporosis Management in Women Who Had a Fracture (OMW)
Weight = 1

Percentage of women 67–85 years old who suffered a fracture* between July 1 of the prior year and June 30 of the current measurement year and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture

* Fractures of face, skull, fingers or toes are excluded

Patients will be removed from the eligible population if they have had a:
- BMD test within 24 months prior to the fracture
- Osteoporosis therapy within 12 months before the fracture
- Prescription to treat or prevent osteoporosis within 12 months before the fracture

Service needed for compliance (any one of the following)
Within six months of fracture date or date of discharge (if hospitalized for fracture):
- A BMD test including test administered during inpatient stay for fracture
- Osteoporosis therapy including any long-acting therapy provided during inpatient stay for fracture
- A dispensed medication to treat or prevent osteoporosis

OMW measure best practices
- For activity before the fracture, submit supplemental data (i.e., medical record) for BMD test performed within 24 months, or osteoporosis therapy medication prescribed within 12 months.
- CarePlus pays for a BMD test every two years for qualified patients—generally women older than 65 who are at risk of losing bone mass or are at risk for osteoporosis; and post-menopausal women older than 50 based on risk factors. Please encourage your at-risk patients to have a screening before a fracture occurs.
- Claims for BMD test should be submitted with an ICD-10 diagnosis code that indicates risk factors exist for osteoporosis. Claims submitted with screening diagnosis codes, such as Z13.820 may cause the claim to deny.
- Prescribe medication to treat osteoporosis. Use of calcium supplements will not meet criteria for measure.
- Promote the use of remote/mobile dual-energy X-ray absorptiometry (DEXA) scans.

Exclusions
- Patients in hospice
- Patients 67–85 years old living long-term in an institutional setting or who are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 67–80 years old with frailty and advanced illness
- Patients 81–85 years old with frailty

For applicable coding: OMW (page 46)

Plan All-Cause Readmissions (PCR)
Weight = N/A (moved to Display for MY2020)

Percentage of patients 18 years old and older who have had an acute inpatient or observation stay and experience an unplanned* readmission to a hospital within 30 days, either for the same condition or for a different reason

- Includes patients who may have been readmitted to the same hospital or a different one
- Rates of readmission are risk-adjusted and account for how sick patients were on the first admission

* Planned admissions for chemotherapy, rehabilitation, transplant, etc., are not included as readmissions. Rehabilitation exclusions are limited to fitting and adjustment of prosthesis and other medical devices, such as infusion pumps, neuropacemakers, etc.

Service needed for compliance

No particular service is needed. However, practices can identify patients who have been discharged from acute facilities using daily discharge reporting. Outreaches to these patients to schedule follow-up care and medication reconciliation could reduce the risk of readmission.

tPCR measure best practices

- Promote health plan services (e.g., transition of care, care coordination, home health, etc.).
- Be aware of the daily discharge census.
- If possible, manage scheduling capacity to ensure discharged patients can be seen within seven days.
- Conduct medication reconciliation during first post-discharge visit with patient.
- Have a discussion with patients to determine if they have issues accessing the resources necessary to prevent a readmission.
- Connect patient to community resources and/or health plan care management services to help remove barriers to care and/or access to resources.

Exclusions

- Pregnant women
- Patients in hospice
- Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1
- For stays that included a direct transfer, exclude original admission's discharge date. Only the last discharge should be considered.

Disease-Modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis (ART)
Weight = 1

Percentage of patients age 18 years old and older who were diagnosed with rheumatoid arthritis (RA) and who were dispensed at least one ambulatory prescription for a DMARD

Patients become eligible for this measure once they have had two visits with a diagnosis of RA. The visits:

- Can occur during the current measurement year from Jan. 1 to Nov. 30
- Must have two different dates of service
- Can be any type of outpatient visit and any combination of visit type applies

Service needed for compliance

- A dispensed DMARD medication during the current measurement year

ART measure best practices

- For medications given to the patient in a clinical setting, document in the medical record the DMARD medication name, the date that it was dispensed, and its dosage/strength and administration route. This documentation can then be submitted as supplemental data.
- Confirm RA diagnosis versus osteoarthritis (OA) or joint pain.
- Assess for DMARD therapy, if necessary.
- Refer patients diagnosed with RA to a network rheumatologist, as warranted.
- Coordinate care and DMARD therapy with rheumatologists, as appropriate.
- Complete and return a rheumatoid arthritis verification form for any patient who has been diagnosed with RA who has not yet received a prescription for a DMARD.

Exclusions

- Pregnant women
- Patients diagnosed with human immunodeficiency virus (HIV)
- Patients in hospice
- Patients 66 years old and older living long term in an institutional setting or who are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66–80 years old with frailty and advanced illness
- Patients 81 years old and older with frailty

For applicable coding: ART (page 48)

Statin Therapy for Patients With Cardiovascular Disease (SPC)
Weight = 1

Percentage of men 21–75 years old and women 40–75 years old during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year.

Note: The HEDIS SPC measure component for statin adherence of 80% is not included in the Star Rating Program.

Patients become eligible for this measure by event or by diagnosis.

- Event: any of the following during the prior measurement year:
  - Inpatient discharges with a myocardial infarction (MI)
  - Visits in any setting for coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or any other revascularization procedure
- Diagnosis: Claim(s) submitted during the current or prior measurement year:
  - With a diagnosis of ischemic vascular disease (IVD)
    In an inpatient or outpatient setting

Service needed for compliance

At least one dispensing event for a high- or moderate-intensity statin medication in the measurement year

SPC measure best practices

- Use lists of SPC eligible patients to review medications and evaluate addition of statin therapy to regimen.
- Assess patients with cardiovascular disease for statin therapy in alignment with the 2018 American College of Cardiology/American Heart Association (ACC/AHA) guidelines.
- Be sure to share with patients that statin therapy can reduce their risk of heart attack and stroke.
- For patients beginning statin therapy: Discuss common side effects such as muscle weakness and advise them to contact your practice to discuss options before discontinuing.
- To minimize potential side effects, select the appropriate dose based on patient's health factors and any drug-to-drug interactions with current medications.
- For medications given to the patient in a clinical setting, document in the medical record the statin name, the date that it was dispensed, and its dosage/strength and administration route. This documentation can then be submitted as supplemental data.

Exclusions

- Patients in hospice
- Patients 66–75 years old who:
  - Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) **AND/OR**
  - Have frailty and advanced illness
- Patients with the following diagnoses or services in the current or prior measurement year for:
  - Pregnancy
  - In-vitro fertilization (IVF)
  - Dispensed clomiphene medication
  - End-stage renal disease (ESRD)
  - Cirrhosis
- Patients with myalgia, myositis, myopathy or rhabdomyolysis during the current measurement year

For applicable coding: SPC (page 50)

Health Outcomes Survey (HOS)

HOS is an annual patient-reported outcome survey conducted for Medicare Advantage plans by a vendor contracted by the Centers for Medicare & Medicaid Services (CMS). The goal of the survey is to gather valid and reliable health status data for use in quality improvement activities, public reporting, Medicare Advantage organization accountability and improving health outcomes. The survey contains questions regarding physical and mental health, chronic medical conditions, functional status (e.g., activities of daily living), clinical measures and other health status indicators. Five of the survey areas are included in the CMS Star quality measures.

Improving Bladder Control
Management of Urinary Incontinence in Older Adults (MUI)
Weight = 1

Percentage of surveyed patients 65 years old and older who reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider.

Patient survey questions

- Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
- During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
- Have you ever talked with a doctor, nurse or other healthcare provider about 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 healthcare provider about any of these approaches?

MUI measure best practices

- Discuss bladder control issues and symptoms with your older patients.
- Ask patients to keep a daily diary tracking when they urinate and when they experience urine leakage.
- Assist patients in determining the right bladder control product for their size, lifestyle and severity of condition.
- Determine if exercise or other treatment options, such as medications or surgery, may help.
- If surgery is needed, refer patient to a specialist to follow through on the care plan.

Exclusions

- Patients in hospice

Improving or Maintaining Mental Health (IMMH)
Weight = 3

Percentage of surveyed patients 65 years old and older whose mental health status was the same or better than expected after two years

Patient survey questions

- 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

  Answer choices: *No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; or Yes, all of the time*

These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

- 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?

Answer choices: *All of the time; Most of the time; A good bit of the time; Some of the time; A little of the time; or None of the time*

- 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.)?

Answer choices: *All of the time; Most of the time; Some of the time; A little of the time; or None of the time*

IMMH measure best practices

- Discuss mental/emotional health and explain to patients that this is a part of their well-being and is as important as their physical health.
- Listen to patients' stories and suggest activities or recommend medication, if necessary.
- Administer PHQ-2 and PHQ-9 Mental Health Assessments.

Improving or Maintaining Physical Health (IMPH)
Weight = 3

Percentage of surveyed patients 65 years old and older whose physical health status was the same or better than expected after two years

Patient survey questions

- In general, would you say your health is:
  Answer choices: *Excellent; Very good; Good; Fair; or 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

  Answer choices: *Yes, limited a lot; Yes, limited a little; No, not limited at all*
- 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 as a result of your physical health?

  Answer choices: *No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; or Yes, all of the time*
- During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
  Answer choices: *Not at all; A little bit; Moderately; Quite a bit; or Extremely*

IMPH measure best practices

- Assess the overall physical health of your patients annually.
- Ensure patients understand the personalized health advice you provide based on their risk factors.
- Develop a plan for preventive screenings and services that will help patients manage their chronic conditions.
- Determine an exercise or physical therapy program that is appropriate for patients' needs and abilities.
- Perform a pain assessment to determine if a pain management or treatment plan is needed.

Monitoring Physical Activity
Physical Activity In Older Adults (PAO)
Weight = 1

Percentage of surveyed patients 65 years old and older who have had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity

Patient survey questions

- In the past 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.
- In the past 12 months, did 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.

PAO measure best practices

- Explain to patients that an exercise regimen could increase quality of life and longevity.
- Determine if it is appropriate for your patients to start, maintain or increase the level of physical activity, based on their overall health.
- Include any recommended activity with frequency and duration in the patient after-visit summary. Use physical activity prescription pads to "prescribe" the exercise regimen.

Exclusions

- Patients in hospice
- Patients responding "I had no visits in the past 12 months"

Reducing the Risk of Falling
Fall Risk Management (FRM)
Weight = 1

Percentage of patients 65 years old and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.

Patient survey questions

- A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you 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 other health provider done anything to help 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

FRM measure best practices

- Take advantage of the CDC's Stopping Elderly Accidents, Deaths & Injuries (STEADI) online training and materials.
- Discuss with patients if they have fallen, are afraid of falling or feel unsteady.
- Talk with your patients about the factors that can lead to a higher risk of falls.
- Determine interventions for your patients for factors present that can be impacted.
- Share information with your patients on how to make their homes safer.
- Recommend that they wear shoes that provide extra security.

Exclusions

- Patients in hospice

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an annual patient survey conducted for Medicare Advantage plans by a contracted CMS vendor. The goal of the survey is to assess the experiences of beneficiaries in Medicare Advantage plans. The results of the survey are published in the "Medicare & You" handbook and on the Medicare website: www.medicare.gov. Nine areas of the patient survey are included in the Star measures reporting. The six areas below directly correlate to patients experiences with their physicians and other healthcare providers.

Annual Flu Vaccine (FLU)
Weight = 1

Percentage of surveyed patients who report they received an influenza vaccination between July of the prior year and the date on which they are responding to the Medicare CAHPS survey (March–June each year)

Patient survey question

- Have you had a flu shot since July 1 (prior year)?

FLU measure best practices

- Stress the importance of flu vaccination for all patients in your practice, as it can increase the herd immunity effect. This occurs when the vaccination of a significant portion of a population (or herd) provides a measure of protection for individuals who have not developed immunity.
- Talk to patients about getting the flu shot when they are in for their regularly scheduled appointment during flu season.
- Reach out to your patients who are at a higher risk of experiencing flu complications with a reminder to be vaccinated. High-risk patients include:
  - Individuals who are 65 years old and older
  - Patients with cardiovascular and/or respiratory disease
  - Cancer patients and survivors
  - Diabetic patients
- Ensure any practice staff who are scheduling appointments are aware of community resources for flu vaccines.
- Encourage patients to take advantage of vaccination opportunities at convenient locations, such as their local pharmacies.
- During their next office visit, confirm patients were vaccinated.

Care Coordination (CC)
Weight = 2

Assesses how well patient care is coordinated including whether doctors had the records and information they needed about patients' care and how quickly patients got their test results.

Patient survey questions

- 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?
- In the last six months, 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?
- In the last six months, 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?
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

CC measure best practices

- Within patients' medical records, document services rendered with date of service and results.
- During visits, use family history, medical record information and any reporting available to you to provide personalized health advice based on each patient's risk factors.
- Contact patients with the results of any screenings as soon as they are available and schedule any necessary follow-up care.
- Talk to patients about the specialists providing care to them and document the names of patient's interdisciplinary care team members, as well as the results of any services rendered by other healthcare providers.
- Schedule specialist follow-ups on behalf of your patients before they leave your office.
- If specialist follow-up care cannot be scheduled when your patients are in your office, give them the names and phone numbers to call specialists.
- Ask patients to follow up within one month of specialist visits to discuss the results.
- Advise your patients to bring in all prescription medicines they are taking to their next appointment so you can evaluate whether changes are needed.
- Review all of your patient's medications, including prescription medicines, over-the-counter medications and herbal or supplemental therapies.
- Complete and provide a medication action plan and/or personal medication list to educate and help patients organize medication-related information.

Getting Appointments and Care Quickly (GACQ)
Weight = 2

Assesses how quickly the patients were able to get appointments and care

Patient survey questions

- In the last six months, when you needed care right away, how often did you get care as soon as you needed?
- In the last six months, how often did you get an appointment for a check-up or routine care as soon as you needed?
- In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?

GACQ measure best practices

- Schedule patients' follow-up visits before they leave their current appointment.
- Reach out periodically to patients who have not been in for their annual visits to make sure they do not wait until the end of the year to schedule them.
- Advise patients to schedule appointments outside of your practice's busiest hours.
- Try to take patients back to the exam room within 15 minutes of their scheduled appointment time even if they aren't seeing the physician right away.
- If possible, avoid overscheduling patients to prevent appointments from backing up.

Getting Needed Care (GNC)
Weight = 2

Assesses how easy it was for patients to get needed care and see specialists

Patient survey questions

- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last six months, how often was it easy to get the care, tests or treatment you needed?

GNC measure best practices

- Schedule specialist follow-ups on behalf of your patients before they leave your office.
- If specialist follow-up care cannot be scheduled when your patients are in your office, give them the names and phone numbers to call specialists.
- Use specialist appointment reminder tear-off pads so patients remember that your office assisted in scheduling the follow-up appointment.
- If a service requires preauthorization, obtain approval from CarePlus before performing or ordering it.

Getting Needed Prescription Drugs (GNRx)
Weight = 2

Assesses how easy it is for patients to get the medicines their doctor prescribed

Patient survey questions

- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

GNRx measure best practices

- Consult the CarePlus formulary prior to prescribing a new medication to a patient.
- Prior to prescribing higher-cost brand medication, consider a generic or lower cost brand alternative drug or therapeutic equivalent, if available and clinically appropriate.
- Recommend switching to 90-day supplies from their community pharmacy or via mail-order pharmacy.

Rating of Healthcare Quality (RHCQ)
Weight = 2

Assesses patients' view of the quality of the healthcare they received

Patient survey question

- Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last six months?

RHCQ measure best practices

- Ask questions to gauge the patient's current experience and perception of the care he or she is receiving from your practice, specialists and other healthcare providers.
- Based on feedback, discuss options to improve his or her healthcare.
- Provide insights on patients' perception of the healthcare they are receiving.
- Make efforts to confirm patients understand:
  - Their care plan
  - Services performed or ordered
  - How to manage their chronic conditions
  - When and how to best take their medications

Patient Safety

CMS includes measures to assess prescription drug plan (Part D) quality and performance in the Star Rating Program. The five Patient Safety measures below monitor Part D services to ensure the safety of Medicare Advantage enrollees. These measures are developed and endorsed by the Pharmacy Quality Alliance (PQA). They apply to both Medicare Advantage plans with prescription drug coverage (MAPD) and prescription drug-only plans (PDP). When a prescription is filled under a Medicare Part D plan, a prescription drug event (PDE) is submitted to CMS by Medicare Advantage organizations, such as CarePlus. Only PDE information is used by CMS to evaluate these measures; therefore, no reporting is required by physicians.

Medication Adherence

CMS uses a metric called proportion of days covered, or PDC, to determine medication adherence. PDC is determined by dividing the days of medication coverage—which is determined based on the claims billed to the insurance plan—by the number of days in the period being measured. The specific number of days included in the measurement period, or calendar year, is determined based on the start date of the medication.

If a patient's PDC is greater than or equal to 80%, the patient is deemed adherent. A rate lower than 80% is considered nonadherent. The PDC threshold of 80% is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit based on clinical evidence.

Best practices for medication adherence measures

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers.
- Reinforce patients' understanding of the role of diabetes, cholesterol and hypertension medications in their therapy and the expected duration of the therapy.
- Ask if transportation to pharmacy is an issue. Retail 90-day fills may offer less-frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery.
- Encourage adherence by providing a 90-day prescription for maintenance drugs.
- Provide an updated prescription to the pharmacy if the patient's medication dose has changed since the original prescription.

Medication Adherence for Cholesterol (Statins)
Proportion of Days Covered: Statins (PDC–STA)
Weight = 3

Percentage of patients with Part D benefits with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

Exclusions

- Patients in hospice
- Patients with end-stage renal disease (ESRD)

Medication Adherence for Diabetes Medications
Proportion of Days Covered: Diabetes All-Class Rate (PDC–DR)
Weight = 3

Percentage of patients with Part D benefits with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

Drug therapy across these classes of diabetes medications are included in this measure: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Exclusions

- Patients in hospice
- Patients with end-stage renal disease (ESRD)
- Prescriptions filled for insulin

Medication Adherence for Hypertension (RAS Antagonists)
Proportion of Days Covered: Renin Angiotensin System Antagonists (PDC–RASA)
Weight = 3

Percentage of patients with Part D benefits with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

Blood pressure medication therapy programs for these renin angiotensin system (RAS) antagonists are included in this measure: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.

Exclusions

- Patients in hospice
- Patients with end-stage renal disease (ESRD)
- Prescriptions filled for Entresto® (sacubitril/valsartan)

Medication Therapy Management (MTM)
Program Completion Rate for Comprehensive Medication Review (CMR)
Weight = 1

Percentage of Part D patients eligible for and enrolled in the MTM program for at least 60 days who received a comprehensive medication review (CMR) during the measurement year.

To be eligible for MTM, patients must:

- Have three of five chronic diseases—congestive heart failure, diabetes, dyslipidemia, rheumatoid arthritis or asthma
- Be taking a minimum of eight Part D medications
- Have anticipated drug costs totaling more than $4,255 per year

Activity needed for compliance

- An interactive, person-to-person or telehealth medication review and consultation of all medications completed by a pharmacist or qualified healthcare professional during the measurement year
  - The review should include all of your patients' medication such as prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies.
- Following the CMR, the patient should receive a written summary of the discussion, including an action plan that recommends what the patient can do to better understand and use his or her medications.

CMR measure best practices

- Reference health plan reports for MTM-eligible patients.
- Conduct discussions with MTM-eligible patients, explaining the importance and benefits of completing a CMR.
- Complete and provide a written summary of the CMR discussion to patients. The summary should:
- Remind patient of what occurred during the CMR
  - How to contact the MTM program
  - Include a plan to assist in resolving current drug therapy issues
  - Help achieve treatment goals with specific action items
  - Have a reconciled list of all medications in use at the time of the CMR
- Refer patients with CarePlus coverage to the CarePlus member services department at 1-800-794-5907, seven days a week, 8 a.m. to 8 p.m. Please note that from Feb. 15 to Sept. 30, the department is open Monday through Friday, 8 a.m. to 8 p.m. TTY users should call 711.

Exclusions

- Patients in hospice

Statin Use in Persons With Diabetes (SUPD) **Weight = 3**
Percentage of patients with Part D benefits who are 40–75 years old, who received at least two diabetic medication fills during the measurement year and were dispensed a statin medication fill during the measurement year
Activity needed for compliance • At least one fill for a statin medication of any intensity in the measurement year
SUPD measure best practices • Use lists of SUPD-eligible patients to review medications and evaluate addition of statin therapy to regimen. • Assess patients with cardiovascular disease for statin therapy in alignment with the 2018 American College of Cardiology/American Heart Association (ACC/AHA) guidelines. • Be sure to share with patients that statin therapy can reduce their risk of heart attack and stroke. • For patients beginning statin therapy, discuss common side effects such as muscle weakness and advise them to contact your practice to discuss options before discontinuing. • To minimize potential side effects, select the appropriate dose based on patient's health factors and any drug-to-drug interactions with current medications. **Exclusions** • Patients in hospice • Patients with end-stage renal disease (ESRD)

Display measures

Measures on display are those that are not included in the Star Ratings calculation for the current measure year, but they may become Star measures in future years or may have previously been Star measures. The performance of these measures is released by CMS at the end of each year, but as they are not rated they are also not weighted. The measures listed here are directly impactable by physicians and other healthcare providers.

HEDIS display measures

Access to Primary Care Doctor Visits (AAP)

Percentage of patients 20 years old and older who had an ambulatory or preventive care visit during the measurement year.

Exclusions

- Patients in hospice

Antidepressant Medication Management (AMM)

Percentage of patients 18 years old and older with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days.

Exclusion

- Patients in hospice

Continuous Beta-Blocker Treatment (PBH)

Percentage of patients 18 years old and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Exclusions

- Patients with any of the following identified at any time during their medical history:
  - Asthma
  - Chronic obstructive pulmonary disease (COPD)
  - Obstructive chronic bronchitis
  - Chronic respiratory conditions due to fumes and vapors
  - Hypotension, heart block > 1 degree or sinus bradycardia
  - A medication dispensing event indicative of a history of asthma
  - Intolerance or allergy to beta-blocker therapy
- Patients in hospice or using hospice services
- Patients 66 years old and older living long term in an institutional setting or enrolled in an institutional special needs plan (I-SNP)
- Patients 66–80 years old with frailty and advanced Illness
- Patients 81 years old and older with frailty

Follow-Up After Emergency Department Visit for Patients With Multiple Chronic Conditions (FMC)

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

Exclusion

- ED visits that were followed by an admission to an inpatient setting on the date of or within seven days after the ED visit

Follow-Up Visit After Hospital Stay for Mental Illness (FUH)

Percentage of discharges for patients 6 years old and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge.

Exclusion

- Patients in hospice

Hospitalization for Potentially Preventable Complications (HPC)

For patients 67 years old and older, the rate of acute inpatient and observation discharges with a diagnosis considered a chronic or acute ambulatory care sensitive condition (ACSC) per 1,000 members and the risk-adjusted ratio of observed-to-expected discharges for ACSC.

The rate is risk-adjusted based on comorbidity, age and gender.

Patients may be identified as a chronic or acute ACSC outlier once they have three or more hospital stays (acute inpatient and observation) for related ACSCs.

Chronic ACSCs considered for this measure are:

- Diabetes – short/long-term complications
- Uncontrolled diabetes
- Lower extremity amputation among patients with diabetes
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Hypertension
- Heart failure

Acute ACSCs considered for this measure are:

- Bacterial pneumonia
- Urinary tract infection
- Cellulitis
- Pressure ulcer

Service needed for compliance

No particular service is needed. However, by working with patients to manage chronic and acute ambulatory care-sensitive conditions, preventable and/or unnecessary hospital stays may be reduced.

HPC measure best practices

- Ensure early identification of patients and appropriate outpatient management for ACSCs, with an emphasis on:
  - Increasing patient engagement through disease management and lifestyle change programs
  - Developing condition-specific action plans for exacerbations
- Promote health coaching and case management services, and coordinate efforts with specialists and other healthcare providers to prevent complications and subsequent admissions.
- Provide prompt follow-up care post-discharge to prevent complications and subsequent readmissions.
- Inform patients of access to after-hours care by providing a list of options (primary care physician [PCP] after-hours clinic, access to urgent care, telemedicine, etc.).
- Use in-home programs as necessary for evaluation and treatment to prevent unnecessary emergency room and inpatient care.

Exclusions

- Patients with three or more inpatient or observation stay chronic ACSCs during the measurement year
- Patients with three or more inpatient or observation stay acute ACSCs during the measurement year
- Patients enrolled in an Institutional Special Needs Plan (I-SNP) or residing in long-term institutional settings

Initiation and Engagement of Alcohol or Other Drug (AOD) Treatment (IET)

Percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis—and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator
Percentage of chronic obstructive pulmonary disease (COPD) exacerbations for patients 40 years old and older who had an acute inpatient discharge or emergency department (ED) encounter on or between Jan. 1 and Nov. 30 of the measurement year and who were dispensed a bronchodilator within 30 days of the event.
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid
Percentage of chronic obstructive pulmonary disease (COPD) exacerbations for patients 40 years old and older who had an acute inpatient discharge or emergency department (ED) encounter on or between Jan. 1 and Nov. 30 of the measurement year and who were dispensed a systemic corticosteroid within 14 days of the event.
Testing to Confirm Chronic Obstructive Pulmonary Disease (SPR)
Percentage of patients 40 years old and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) during the measurement year who received appropriate spirometry testing to confirm the diagnosis. **Exclusions** • Patients in hospice
Transitions of Care (TRC) – Medication Reconciliation Post-Discharge
Percentage of discharges for patients 18 years old and older who had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). **Exclusions** • Patients in hospice
Transitions of Care (TRC) – Notification of Inpatient Admission
Percentage of discharges for patients 18 years old and older who had documentation of receipt of notification of inpatient admission on the day of admission or within the two following days. **Exclusions** • Patients in hospice
Transitions of Care (TRC) – Patient Engagement After Inpatient Discharge
Percentage of discharges for patients 18 years old and older who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. **Exclusions** • Patients in hospice
Transitions of Care (TRC) – Receipt of Discharge Information
Percentage of discharges for patients 18 years old and older who had documentation of receipt of discharge information on the day of discharge or within the two following days. **Exclusions** • Patients in hospice
Transitions of Care (TRC) – Average
Assesses the average TRC rate using the rates for the other TRC measures: • Medication Reconciliation Post-Discharge • Notification of Inpatient Admission • Patient Engagement After Inpatient Discharge • Receipt of Discharge Information **Exclusions** • Patients in hospice

HOS display measures
Osteoporosis Testing
Percentage of patients 65 years old and older who report ever having received a bone density test to check for osteoporosis
Patient survey questions Have you ever had a bone density test to check for osteoporosis, sometimes thought of as “brittle bones?” This test may have been done to your back, hip, wrist, heel or finger.
CAHPS display measures
Doctors Who Communicate Well
Assesses how well doctors communicate
Patient survey questions • In the last six months, how often did your personal doctor explain things in a way that was easy to understand? • In the last six months, how often did your personal doctor listen carefully to you? • In the last six months, how often did your personal doctor show respect for what you had to say? • In the last six months, how often did your personal doctor spend enough time with you?
Pneumonia Vaccine
Percentage of surveyed Medicare patients who report if they have ever received a pneumococcal vaccine
Patient survey question • Have you ever had one or more pneumonia shots? Two shots are usually given in a person’s lifetime and these are different from a flu shot. It is also called the pneumococcal vaccine.
Reminders to Fill Prescriptions
Percentage of surveyed Medicare patients who reported that they were reminded about filling or refilling a prescription
Patient survey question • In the last six months, did anyone from a doctor’s office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription?
Reminders to Take Medications
Percentage of surveyed Medicare patients who reported that they were reminded about taking medications as directed
Patient survey question • In the last six months, did anyone from a doctor’s office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription?

Patient Safety display measures
Antipsychotic Use in Persons With Dementia
Percentage of patients with Part D benefits who are 65 years old and older with a diagnosis of or prescriptions for dementia, who received at least one prescription and greater than 30 days' supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's syndrome
Antipsychotic Use in Persons With Dementia – For Community-Only Residents
Percentage of patients with Part D benefits 65 years old and older with a diagnosis of or prescriptions for dementia, who received at least one prescription and greater than a 30 days supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's syndrome AND who spent zero days in a nursing home during the measurement period
Antipsychotic Use in Persons With Dementia – For Long-Term Nursing Home Residents
Percentage of patients with Part D benefits who are 65 years old and older with a diagnosis of or prescriptions for dementia, who received at least one prescription and greater than 30 days' supply for any antipsychotic medication, AND who did not have a diagnosis for schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome AND were long-term nursing home (LTNH) residents
Diabetes Medication Dosing
Percentage of patients with Part D benefits who were dispensed a dose higher than the daily recommended dose for the following diabetes treatment therapeutic categories of oral hypoglycemics: biguanides, sulfonlyureas, thiazolidinediones and DiPeptidyl Peptidase (DPP)-IV inhibitors
Drug-to-Drug Interaction
Percentage of patients with Part D benefits who received a prescription for a target medication during the measurement period and who were dispensed a prescription for a contraindicated medication with or subsequent to the initial prescription
High-Risk Medication
Percentage of patients with Part D benefits who are 65 years old and older and received two or more prescription fills for the same high-risk medication (HRM) drug with a high risk of serious side effects in the elderly **Exclusions** • Patients in hospice
Use of Opioids at High Dosage and From Multiple Providers (OHDMP)
Proportion (XX out of 1,000) of patients with Part D benefits who are 18 years old and older without cancer or enrolled in hospice receiving prescriptions for opioids with a daily morphine milligram equivalent (MME) greater than 120 mg for 90 consecutive days or longer, AND who received opioid prescriptions from four or more prescribers AND four or more pharmacies

HEDIS measure coding

Adult BMI Assessment (ABA)

This HEDIS measure records the patient's body mass index (BMI) or BMI percentile, a statistical measure of a person's weight scaled according to height. The ICD-10-CM diagnosis codes below are used to identify BMI. Please make sure when capturing height and weight to also calculate and document BMI in the medical record. Also, please include the appropriate diagnosis code when submitting a claim for an outpatient visit during which the patient's BMI or BMI percentile was assessed.

ICD-10 codes

Code	Code type	Definition
Z68.1	Diagnosis	Body mass index (BMI) 19.9 or less, adult
Z68.20	Diagnosis	Body mass index (BMI) 20.0 to 20.9, adult
Z68.21	Diagnosis	Body mass index (BMI) 21.0 to 21.9, adult
Z68.22	Diagnosis	Body mass index (BMI) 22.0 to 22.9, adult
Z68.23	Diagnosis	Body mass index (BMI) 23.0 to 23.9, adult
Z68.24	Diagnosis	Body mass index (BMI) 24.0 to 24.9, adult
Z68.25	Diagnosis	Body mass index (BMI) 25.0 to 25.9, adult
Z68.26	Diagnosis	Body mass index (BMI) 26.0 to 26.9, adult
Z68.27	Diagnosis	Body mass index (BMI) 27.0 to 27.9, adult
Z68.28	Diagnosis	Body mass index (BMI) 28.0 to 28.9, adult
Z68.29	Diagnosis	Body mass index (BMI) 29.0 to 29.9, adult
Z68.30	Diagnosis	Body mass index (BMI) 30.0 to 30.9, adult
Z68.31	Diagnosis	Body mass index (BMI) 31.0 to 31.9, adult
Z68.32	Diagnosis	Body mass index (BMI) 32.0 to 32.9, adult
Z68.33	Diagnosis	Body mass index (BMI) 33.0 to 33.9, adult
Z68.34	Diagnosis	Body mass index (BMI) 34.0 to 34.9, adult
Z68.35	Diagnosis	Body mass index (BMI) 35.0 to 35.9, adult
Z68.36	Diagnosis	Body mass index (BMI) 36.0 to 36.9, adult
Z68.37	Diagnosis	Body mass index (BMI) 37.0 to 37.9, adult
Z68.38	Diagnosis	Body mass index (BMI) 38.0 to 38.9, adult
Z68.39	Diagnosis	Body mass index (BMI) 39.0 to 39.9, adult
Z68.41	Diagnosis	Body mass index (BMI) 40.0 to 44.9, adult
Z68.42	Diagnosis	Body mass index (BMI) 45.0 to 49.9, adult
Z68.43	Diagnosis	Body mass index (BMI) 50 to 59.9, adult
Z68.44	Diagnosis	Body mass index (BMI) 60.0 to 69.9, adult
Z68.45	Diagnosis	Body mass index (BMI) 70 or greater, adult
Z68.51	Diagnosis	Body mass index (BMI) pediatric, less than 5th percentile for age
Z68.52	Diagnosis	Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
Z68.53	Diagnosis	Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age
Z68.54	Diagnosis	Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age

Breast Cancer Screening (BCS)

This measure evaluates the percentage of women 52–74 years old who had a mammogram to screen for breast cancer. The table below outlines Current Procedural Terminology (CPT) codes that indicate these services have been performed.

Supplemental data is accepted for the BCS measure. The health plan will need the procedure report from the healthcare provider who performed the procedure, along with the results/findings. Patient-reported BCS data can be accepted to satisfy this measure, as long as it is reported by the patient to the primary care physician while taking the patient's history and is recorded in the medical record. A documented date of the procedure and result are required. Proof-of-service documents need to be submitted by the healthcare professional to the health plan to be compliant.

Code	Code type	Definition
77061	CPT	Breast, mammography
77062	CPT	Breast, mammography
77063	CPT	Breast, mammography
77065	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	CPT	Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed
Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing. CPT: 77055, 77056 and 77057; HCPCS: G0202, G0204 and G0206; and ICD-9 Procedure: 87.36 and 87.37		

Care for Older Adults (COA)

This measure evaluates the percentage of Medicare Advantage patients 66 years old and older who are also enrolled in a Medicare Special Needs Plan (SNP) and who have had each of the following during the measurement year:

- Advance care planning
- Functional status assessment
- Medication review
- Pain screening

Below are the Current Procedural Terminology (CPT), Current Procedural Terminology Category II (CPT II) and Healthcare Common Procedure Coding System (HCPCS) codes that indicate these services have been performed. Please include the appropriate code(s) when submitting a claim for an outpatient visit during which one or more of these services were administered.

COA – Advance Care Planning (ACP)		
Code	**Code type**	**Definition**
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99497	CPT	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
1123F	CPT II	Advance care planning discussed; advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)
1124F	CPT II	Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)
1157F	CPT II	Advance care plan or similar legal document present in the medical record
1158F	CPT II	Advance care planning discussion documented in the medical record
S0257	HCPCS	Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
Z66	ICD-10	Do not resuscitate

COA – Functional Status Assessment (FSA)		
Code	**Code type**	**Definition**
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
1170F	CPT II	Functional status assessed
G0438	HCPCS	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439	HCPCS	Annual wellness visit; includes a personalized prevention plan of service (pps), subsequent visit
COA – Medication Review (MDR)		
Code	**Code type**	**Definition**
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an Advance Care Plan and creation of a written care plan
99495	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit within 14 calendar days of discharge
99496	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge
99605	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, new patient
99606	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, established patient
1159F	CPT II	Medication list documented in medical record
1160F	CPT II	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
G8427	HCPCS	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

COA – Pain Screening (PNS)		
Code	**Code type**	**Definition**
1125F	CPT II	Pain severity quantified; pain present
1126F	CPT II	Pain severity quantified; no pain present

Colorectal Cancer Screening (COL)

This measure evaluates the percentage of patients 50–75 years old who had appropriate screening for colorectal cancer through the performance of a fecal occult blood test (FOBT), Cologuard (FIT-DNA) test, flexible sigmoidoscopy, CT colonography or colonoscopy. Below are the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that indicate these services have been performed.

Supplemental data are accepted for the COL measure. The health plan will need the procedure report from the healthcare provider who performed the procedure, along with the results/findings. Patient-reported COL data can be accepted to satisfy this measure, as long as they are reported by the patient to the primary care physician while taking the patient's history and are recorded in the medical record. A documented date of the procedure and result is required. Proof-of-service documents need to be submitted by the healthcare professional to the health plan to be measure compliant.

Fecal occult blood test (FOBT)

Code	Code type	Definition
82270	CPT	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, one determination
82274	CPT	Blood, occult, by fecal hemoglobin, qualitative, one to three simultaneous determinations
G0328	HCPCS	Colorectal cancer screening, fecal occult blood test, immunoassay, one to three simultaneous determinations

Flexible sigmoidoscopy

Code	Code type	Definition
45330	CPT	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	CPT	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	CPT	Sigmoidoscopy, flexible; with removal of foreign body
45333	CPT	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	CPT	Sigmoidoscopy, flexible; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	CPT	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	CPT	Sigmoidoscopy, flexible; with decompression (for pathological distention) (e.g. volvulus, megacolon) including placement of decompression tube, when performed
45338	CPT	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45340	CPT	Sigmoidoscopy, flexible; with transendoscopic balloon dilation
45341	CPT	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	CPT	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45346	CPT	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guidewire passage, when performed)
45347	CPT	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45349	CPT	Sigmoidoscopy, flexible; with endoscopic mucosal resection
45350	CPT	Sigmoidoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0104	HCPCS	Colorectal cancer screening; flexible sigmoidoscopy

Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing.
CPT: 45339 and 45345 and ICD-9 Procedure Code: 45.24

Colonoscopy

Code	Code type	Definition
44388	CPT	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	CPT	Colonoscopy through stoma; with biopsy, single or multiple
44390	CPT	Colonoscopy through stoma; with removal of foreign body
44391	CPT	Colonoscopy through stoma; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	CPT	Colonoscopy through stoma; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps
44394	CPT	Colonoscopy through stoma; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
44401	CPT	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
44402	CPT	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
44403	CPT	Colonoscopy through stoma; with endoscopic mucosal resection
44404	CPT	Colonoscopy through stoma; with directed submucosal injection(s), any substance
44405	CPT	Colonoscopy through stoma; with transendoscopic balloon dilation
44406	CPT	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407	CPT	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44408	CPT	Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45378	CPT	Colonoscopy, flexible diagnostic; including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of foreign body
45380	CPT	Colonoscopy, flexible, proximal to splenic flexure, with biopsy, single or multiple
45381	CPT	Colonoscopy, flexible, proximal to splenic flexure, with directed submucosal injection(s), any substance
45382	CPT	Colonoscopy, flexible, proximal to splenic flexure, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45384	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45386	CPT	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	CPT	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

45389	CPT	Colonoscopy, flexible, with endoscopic stent placement (includes pre- and post-dilation and guidewire passage, when performed
45390	CPT	Colonoscopy, flexible, with endoscopic mucosal resection
45391	CPT	Colonoscopy, flexible, proximal to splenic flexure, with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45392	CPT	Colonoscopy, flexible, proximal to splenic flexure, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45393	CPT	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45398	CPT	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0105	HCPCS	Colorectal cancer screening, colonoscopy on individual at high risk
G0121	HCPCS	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk
Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing**.** CPT: 44393, 44397, 45355, 45383 and 45387 and ICD-9 Procedure: 45.22, 45.23, 45.25, 45.42 and 45.43		

CT colonography

Code	Code type	Definition
74261	CPT	Computed tomographic (CT) colonography, diagnostic, including image post-processing; without contrast material
74262	CPT	Computed tomographic (CT) colonography, diagnostic, including image post processing; with contrast material(s) including non-contrast images, if performed
74263	CPT	Computed tomographic (CT) colonography, screening, including image post-processing

Cologuard test

Code	Code type	Definition
81528	CPT	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
G0464	HCPCS	Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

Comprehensive Diabetes Care – Blood Sugar Controlled (CDC-HbA1c)

Comprehensive Diabetes Care – Hemoglobin A1c Testing (CDC–HbA1c) measures the percentage of patients 18–75 years old with a diagnosis of diabetes (type 1 or type 2) who had hemoglobin A1c testing and either have their blood sugar controlled or under poor control. Below are the Current Procedural Terminology (CPT) codes for A1c testing and Category II (CPT II) codes that indicate the control level.

Code	Code type	Definition
83036	CPT	Hemoglobin; glycosylated (A1c)
83037	CPT	Hemoglobin; glycosylated (A1c) by device cleared by FDA for home use
3044F	CPT II	Most recent hemoglobin A1c level less than 7%
3046F	CPT II	Most recent hemoglobin A1c level greater than 9%
3051F	CPT II	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
3052F	CPT II	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing**.** CPT: 3045F		

Comprehensive Diabetes Care – Eye Exam (CDC–EYE)

The Comprehensive Diabetes Care – Eye Exam (CDC–EYE) measure is the percentage of patients 18–75 years old with a diagnosis of diabetes (type 1 or type 2) who had a retinal eye exam performed. Below are the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and ICD-10 Procedure Coding System (PCS) codes that indicate an eye exam has been performed.

Supplemental data are accepted for the CDC–EYE measure. The health plan will need the procedure report from the healthcare provider who performed the procedure, along with the results/findings. Patient-reported retinal eye exam information, performed by an eye care specialist, and documented in the medical record by the primary care physician while taking the patient's history is accepted as supplemental data. A documented date of the procedure is required.

Code	Code type	Definition
65091	CPT	Evisceration of ocular contents; without implant
65093	CPT	Evisceration of ocular contents; with implant
65101	CPT	Enucleation of eye; without implant
65103	CPT	Enucleation of eye; with implant, muscles not attached to implant
65105	CPT	Enucleation of eye; with implant, muscles attached to implant
65110	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; only
65112	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone
65114	CPT	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap
67028	CPT	Intravitreal injection of a pharmacologic agent (separate procedure)
67030	CPT	Discussion of vitreous strands (without removal), pars plana approach
67031	CPT	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036	CPT	Vitrectomy, mechanical, pars plana approach

67039	CPT	Vitrectomy, mechanical, pars plana approach, with focal endolaser photocoagulation
67040	CPT	Vitrectomy, mechanical, pars plana approach, with endolaser panretinal photocoagulation
67041	CPT	Vitrectomy, mechanical, pars plana approach, with removal of preretinal cellular membrane (e.g., macular pucker)
67042	CPT	Vitrectomy, mechanical, pars plana approach, with removal of internal limiting membrane of retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil)
67043	CPT	Vitrectomy, mechanical, pars plana approach, with removal of subretinal membrane (e.g., choroidal neovascularization), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil) and laser photocoagulation
67101	CPT	Repair of retinal detachment, one or more sessions, cryotherapy or diathermy, with or without drainage of subretinal fluid
67105	CPT	Repair of retinal detachment, one or more sessions, photocoagulation, with or without drainage of subretinal fluid
67107	CPT	Repair of retinal detachment, scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation and drainage of subretinal fluid
67108	CPT	Repair of retinal detachment, with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling and/or removal of lens by same technique
67110	CPT	Repair of retinal detachment, by injection of air or other gas (e.g., pneumatic retinopexy)
67113	CPT	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling and/or removal of lens
67121	CPT	Removal of implanted material, posterior segment, intraocular
67141	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, cryotherapy, diathermy
67145	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, photocoagulation (laser or xenon arc)
67208	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, cryotherapy, diathermy
67210	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, photocoagulation
67218	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, radiation by implantation of source (includes removal of source)
67220	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photocoagulation (e.g., laser), one or more sessions
67221	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photodynamic therapy (includes intravenous infusion)
67227	CPT	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions, cryotherapy, diathermy
67228	CPT	Treatment of extensive or progressive retinopathy, one or more sessions, (e.g., diabetic retinopathy), photocoagulation

92002	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, intermediate, new patient
92004	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, comprehensive, new patient, one or more visits
92012	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, intermediate, established patient
92014	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, comprehensive, established patient, one or more visits
92018	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, complete
92019	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, limited
92134	CPT	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina
92225	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, initial
92226	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, subsequent
92227	CPT	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228	CPT	Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
92230	CPT	Fluorescein angioscopy with interpretation and report
92235	CPT	Fluorescein angiography (includes multiframe imaging) with interpretation and report
92240	CPT	Indocyanine green angiography with interpretation and report
92250	CPT	Fundus photography with interpretation and report
92260	CPT	Ophthalmodynamometry
99203	CPT	Office or other outpatient visit for evaluation and management of a new patient, 30 minutes
99204	CPT	Office or other outpatient visit for evaluation and management of a new patient, 45 minutes
99205	CPT	Office or other outpatient visit for evaluation and management of a new patient, 60 minutes
99213	CPT	Office or other outpatient visit for evaluation and management of an established patient, 15 minutes
99214	CPT	Office or other outpatient visit for evaluation and management of an established patient, 25 minutes
99215	CPT	Office or other outpatient visit for evaluation and management of an established patient, 40 minutes
99242	CPT	Office consultation for a new or established patient, 30 minutes
99243	CPT	Office consultation for a new or established patient, 40 minutes
99244	CPT	Office consultation for a new or established patient, 60 minutes
99245	CPT	Office consultation for a new or established patient, 80 minutes
2022F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)

2023F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	CPT II	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
2025F	CPT II	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	CPT II	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy
2033F	CPT II	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3072F	CPT II	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)
S0620	HCPCS	Routine ophthalmological examination including refraction, new patient
S0621	HCPCS	Routine ophthalmological examination including refraction, established patient
S3000	HCPCS	Diabetic indicator, retinal eye exam, dilated, bilateral
08B00ZX	ICD-10-PCS	Excision of right eye, open approach, diagnostic
08B00ZZ	ICD-10-PCS	Excision of right eye, open approach
08B03ZX	ICD-10-PCS	Excision of right eye, percutaneous approach, diagnostic
08B03ZZ	ICD-10-PCS	Excision of right eye, percutaneous approach
08B0XZX	ICD-10-PCS	Excision of right eye, external approach, diagnostic
08B0XZZ	ICD-10-PCS	Excision of right eye, external approach
08B10ZX	ICD-10-PCS	Excision of left eye, open approach, diagnostic
08B10ZZ	ICD-10-PCS	Excision of left eye, open approach
08B13ZX	ICD-10-PCS	Excision of left eye, percutaneous approach, diagnostic
08B13ZZ	ICD-10-PCS	Excision of left eye, percutaneous approach
08B1XZX	ICD-10-PCS	Excision of left eye, external approach, diagnostic
08B1XZZ	ICD-10-PCS	Excision of left eye, external approach

Comprehensive Diabetes Care – Kidney Disease Monitoring: Nephropathy (CDC–NEPH)

Comprehensive Diabetes Care – Medical Attention for Nephropathy (CDC-Neph) measures the percentage of patients 18–75 years old with a diagnosis of diabetes (type 1 or type 2) who have received medical attention for nephropathy through a screening test. Below are the Current Procedural Terminology (CPT) and Current Procedural Terminology Category II (CPT II) codes that indicate a nephropathy screening test has been performed.

Urine protein test

Code	Code type	Definition
81000	CPT	Non-automated, with microscopy
81001	CPT	Automated, with microscopy
81002	CPT	Non-automated, without microscopy
81003	CPT	Automated, without microscopy
81005	CPT	Urinalysis; qualitative or semi quantitative, except immunoassays
82042	CPT	Albumin; urine or other source, quantitative, each specimen
82043	CPT	Albumin; urine, microalbumin, quantitative
82044	CPT	Albumin; urine, microalbumin, semiquantitative (e.g., reagent strip assay)
84156	CPT	Protein, total, except by refractometry; urine
3060F	CPT II	Positive microalbuminuria test result documented and reviewed (diabetes mellitus)

3061F	CPT II	Negative microalbuminuria test result documented and reviewed (diabetes mellitus)
3062F	CPT II	Positive macroalbuminuria test result documented and reviewed (DM)

Nephropathy treatment

Code	Code type	Definition
3066F	CPT II	Documentation of treatment for nephropathy
4010F	CPT II	Evidence of ACE/ARB therapy

Stage 4 chronic kidney disease, end-stage renal disease or dialysis procedure

Code	Code type	Definition
90935	CPT	Hemodialysis procedure with single evaluation by a physician or other qualified healthcare professional
90937	CPT	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
90945	CPT	Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified healthcare professional
90947	CPT	Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified healthcare professional, with or without substantial revision of dialysis prescription
90997	CPT	Hemoperfusion (e.g., with activated charcoal or resin)
90999	CPT	Unlisted dialysis procedure, inpatient or outpatient
99512	CPT	Home visit for hemodialysis
G0257	HCPCS	Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility
S9339	HCPCS	Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
N18.4	ICD-10	Chronic kidney disease, stage 4 (severe)
N18.5	ICD-10	Chronic kidney disease, stage 5
N18.6	ICD-10	End-stage renal disease
Z99.2	ICD-10	Dependence on renal dialysis
3E1M39Z	ICD-10-PCS	Irrigation of Peritoneal Cavity using Dialysate, Percutaneous Approach
5A1D00Z	ICD-10-PCS	Performance of Urinary Filtration, Single
5A1D60Z	ICD-10-PCS	Performance of Urinary Filtration, Multiple
5A1D70Z	ICD-10-PCS	Performance of Urinary Filtration, Intermittent, Less than 6 Hours Per Day
5A1D80Z	ICD-10-PCS	Performance of Urinary Filtration, Prolonged Intermittent, 6–18 Hours Per Day
5A1D90Z	ICD-10-PCS	Performance of Urinary Filtration, Continuous, Greater than 18 Hours Per Day

Nephrectomy or kidney transplant

Code	Code type	Definition
50340	CPT	Recipient nephrectomy (separate procedure)
50360	CPT	Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365	CPT	Renal allotransplantation, implantation of graft; with recipient nephrectomy
50370	CPT	Removal of transplanted renal allograft
50380	CPT	Renal autotransplantation, reimplantation of kidney

S2065	HCPCS	Simultaneous pancreas kidney transplantation (S2065)
0TB00ZX	ICD-10-PCS	Excision of Right Kidney, Open Approach, Diagnostic
0TB00ZZ	ICD-10-PCS	Excision of Right Kidney, Open Approach
0TB03ZX	ICD-10-PCS	Excision of Right Kidney, Percutaneous Approach, Diagnostic
0TB03ZZ	ICD-10-PCS	Excision of Right Kidney, Percutaneous Approach
0TB04ZX	ICD-10-PCS	Excision of Right Kidney, Percutaneous Endoscopic Approach, Diagnostic
0TB04ZZ	ICD-10-PCS	Excision of Right Kidney, Percutaneous Endoscopic Approach
0TB07ZX	ICD-10-PCS	Excision of Right Kidney, Via Natural or Artificial Opening, Diagnostic
0TB07ZZ	ICD-10-PCS	Excision of Right Kidney, Via Natural or Artificial Opening
0TB08ZX	ICD-10-PCS	Excision of Right Kidney, Via Natural or Artificial Opening Endoscopic, Diagnostic
0TB08ZZ	ICD-10-PCS	Excision of Right Kidney, Via Natural or Artificial Opening Endoscopic
0TB10ZX	ICD-10-PCS	Excision of Left Kidney, Open Approach, Diagnostic
0TB10ZZ	ICD-10-PCS	Excision of Left Kidney, Open Approach
0TB13ZX	ICD-10-PCS	Excision of Left Kidney, Percutaneous Approach, Diagnostic
0TB13ZZ	ICD-10-PCS	Excision of Left Kidney, Percutaneous Approach
0TB14ZX	ICD-10-PCS	Excision of Left Kidney, Percutaneous Endoscopic Approach, Diagnostic
0TB14ZZ	ICD-10-PCS	Excision of Left Kidney, Percutaneous Endoscopic Approach
0TB17ZX	ICD-10-PCS	Excision of Left Kidney, Via Natural or Artificial Opening, Diagnostic
0TB17ZZ	ICD-10-PCS	Excision of Left Kidney, Via Natural or Artificial Opening
0TB18ZX	ICD-10-PCS	Excision of Left Kidney, Via Natural or Artificial Opening Endoscopic, Diagnostic
0TB18ZZ	ICD-10-PCS	Excision of Left Kidney, Via Natural or Artificial Opening Endoscopic
0TY00Z0	ICD-10-PCS	Transplantation of Right Kidney, Allogeneic, Open Approach
0TY00Z1	ICD-10-PCS	Transplantation of Right Kidney, Syngeneic, Open Approach
0TY00Z2	ICD-10-PCS	Transplantation of Right Kidney, Zooplastic, Open Approach
0TY10Z0	ICD-10-PCS	Transplantation of Left Kidney, Allogeneic, Open Approach
0TY10Z1	ICD-10-PCS	Transplantation of Left Kidney, Syngeneic, Open Approach
0TY10Z2	ICD-10-PCS	Transplantation of Left Kidney, Zooplastic, Open Approach
Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing**.** ICD-9 Diagnosis: 585.4, 585.5, 585.6 and V45.11; ICD-9 Procedure: 39.95, 54.98, 55.61 and 55.69		

Controlling Blood Pressure (CBP)

The Controlling Blood Pressure (CBP) measure evaluates the percentage of patients 18–85 years old who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (less than 140/90). The HEDIS technical specifications advise adequate control for HTN is indicated in the medical records by both a representative systolic blood pressure of less than 140 mm Hg and a representative diastolic blood pressure of less than 90 mm Hg (blood pressure in the normal or high-normal range).

Code	Code type	Definition
I10	ICD-10	Essential (primary) hypertension
3074F	CPT II	Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD)
3075F	CPT II	Most recent systolic blood pressure 130–139 mm Hg (DM)
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
3078F	CPT II	Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
3079F	CPT II	Most recent diastolic blood pressure 80–89 mm Hg (HTN, CKD, CAD) (DM)
3080F	CPT II	Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)
93784	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report
93788	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report
93790	CPT	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; review with interpretation and report
99091	CPT	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, and training
99453	CPT	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	CPT	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	CPT	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Medication Reconciliation Post-Discharge (MRP)

This measure evaluates the percentage of discharges from Jan. 1–Dec. 1 of the measurement year for patients 18 years old and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days).

Code	Code type	Definition
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99495	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge
99496	CPT	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge medical decision making of high complexity during the service period face-to-face visit, within seven calendar days of discharge
1111F	CPT II	Discharge medications reconciled with the current medication list in outpatient medical record

Osteoporosis Management in Women Who Had a Fracture (OMW)

Osteoporosis Management in Women Who Had a Fracture (OMW) measures the percentage of women 67–85 years old who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat or prevent osteoporosis in the six months after the fracture. Fractures of fingers, toes, face and skull are not included in this measure. Below are the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and ICD-10-CM procedure codes that indicate either a BMD test has been performed or a prescription has been given.

Supplemental data are accepted for the OMW measure. The health plan will need the documentation of a:

- Bone mineral density (BMD) test completed in any setting in the 180-day (six-month) period after the fracture date or within 24 months prior to the fracture
- Dispensed prescription to treat osteoporosis in the 180-day (six-month) period after the fracture date or within 12 months before the fracture.

Code	Code type	Definition
76977	CPT	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77078	CPT	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77080	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	CPT	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
J0897	HCPCS	Injection, denosumab, 1 mg
J1740	HCPCS	Injection, ibandronate sodium, 1 mg
J3110	HCPCS	Injection, teriparatide, 10 mcg
J3489	HCPCS	Injection, zoledronic acid, 1 mg
BP48ZZ1	ICD-10-PCS	Ultrasonography of right shoulder, densitometry
BP49ZZ1	ICD-10-PCS	Ultrasonography of left shoulder, densitometry
BP4GZZ1	ICD-10-PCS	Ultrasonography of right elbow, densitometry
BP4HZZ1	ICD-10-PCS	Ultrasonography of left elbow, densitometry
BP4LZZ1	ICD-10-PCS	Ultrasonography of right wrist, densitometry
BP4MZZ1	ICD-10-PCS	Ultrasonography of left wrist, densitometry
BP4NZZ1	ICD-10-PCS	Ultrasonography of right hand, densitometry
BP4PZZ1	ICD-10-PCS	Ultrasonography of left hand, densitometry
BQ00ZZ1	ICD-10-PCS	Plain radiography of right hip, densitometry
BQ01ZZ1	ICD-10-PCS	Plain radiography of left hip, densitometry
BQ03ZZ1	ICD-10-PCS	Plain radiography of right femur, densitometry
BQ04ZZ1	ICD-10-PCS	Plain radiography of left femur, densitometry
BR00ZZ1	ICD-10-PCS	Plain radiography of cervical spine, densitometry
BR07ZZ1	ICD-10-PCS	Plain radiography of thoracic spine, densitometry
BR09ZZ1	ICD-10-PCS	Plain radiography of lumbar spine, densitometry
BR0GZZ1	ICD-10-PCS	Plain radiography of whole spine, densitometry

Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing.
CPT: 77082 and ICD-9 Procedure: 88.98

Osteoporosis medications

Drug type	Drug name	HCPCS codes
Bisphosphonates	Alendronate	N/A
	Ibandronate	J1740
	Zoledronic acid	J3489
	Risedronate	N/A
Other agents	Denosumab	J0897
	Raloxifene	N/A
	Teriparatide	J3110
	Abaloparatide	N/A

Note: The National Committee for Quality Assurance (NCQA) has a comprehensive list of medications and National Drug Code (NDC) codes posted at www.ncqa.org.

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

This measure evaluates patients 18 years old and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD). The tables below outline acceptable HCPCS codes and the DMARD medications that are used to address rheumatoid arthritis (RA) opportunities. The following DMARDs are included in the Star Rating Program and HEDIS measure that states "when prescribing DMARDs for your RA patients, please consider if these drugs would be an effective treatment for their personal medical situation."

Supplemental data are accepted for the ART measure. The health plan will need documentation of at least one ambulatory prescription dispensed for a DMARD during the measurement year.

Code	Code type	Definition
J0129	HCPCS	Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J0135	HCPCS	Injection, adalimumab, 20 mg
J0717	HCPCS	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1438	HCPCS	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1602	HCPCS	Injection, golimumab, 1 mg, for intravenous use
J1745	HCPCS	Injection, infliximab, 10 mg
J3262	HCPCS	Injection, tocilizumab, 1 mg
J7502	HCPCS	Cyclosporine, oral, 100 mg
J7515	HCPCS	Cyclosporine, oral, 25 mg
J7516	HCPCS	Cyclosporin, parenteral, 250 mg
J7517	HCPCS	Mycophenolate mofetil, oral, 250 mg
J7518	HCPCS	Mycophenolic acid, oral, 180 mg
J9250	HCPCS	Methotrexate sodium, 5 mg
J9260	HCPCS	Methotrexate sodium, 50 mg
J9310	HCPCS	Injection, rituximab, 100 mg
J9311	HCPCS	Injection, rituximab, 10 mg and hyaluronidase
J9312	HCPCS	Injection, rituximab, 10 mg
Q5103	HCPCS	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
Q5104	HCPCS	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
Q5109	HCPCS	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg
Please note: Listed here are obsolete codes that are in the HEDIS value set but are no longer recognized by organizations such as the American Medical Association (AMA) and, if received on claims/encounters submission, will be denied for payment processing. HCPCS: Q5102		

DMARD Medications

Description	Drug	HCPCS codes
5-aminosalicyclates	Sulfasalazine	N/A
Alkylating agents	Cyclophosphamide	N/A
Aminoquinolines	Hydroxychloroquine	N/A
Anti-rheumatics	Auranofin Leflunomide	N/A N/A

	Methotrexate Penicillamine	J9250, J9260 N/A
Biologic response modifiers (immunomodulators)	Abatacept Adalimumab Anakinra Certolizumab pegol Etanercept Golimumab Infliximab Rituximab Tocilizumab Sarilumab	J0129 J0135 N/A J0717 J1438 J1602 J1745, Q5102, Q5103, Q5104, Q5109 J9310, J9311, J9312 J3262 N/A
Immunosuppressive agents	Azathioprine Cyclosporine Mycophenolate	N/A J7502, J7515, J7516 J7517, J7518
Janus kinase (JAK) inhibitor	Tofacitinib Baricitinib	N/A N/A
Tetracyclines	Minocycline	N/A

Note: The National Committee for Quality Assurance (NCQA) has a comprehensive list of medications and National Drug Code (NDC) codes at www.ncqa.org.

Statin Therapy for Patients With Cardiovascular Disease (SPC)

This measure evaluates the percentage of males 21–75 years old and females 40–75 years old during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year.

Below are the medications that when prescribed and dispensed will ensure eligible patients are compliant with the SPC measure requirements.

High-intensity statin therapy	**Moderate-intensity statin therapy**
Daily dose lowers LDL-C on average by at least 50%	Daily dose lowers LDL-C on average between 30% and 50%
Atorvastatin *(40)* 80 mg (*Lipitor*) †	Atorvastatin 10 *(20)* mg (*Lipitor*)
Rosuvastatin 20 *(40)* mg (*Crestor*)	Rosuvastatin *(5)* 10 mg (*Crestor*)
Simvastatin 80 mg ‡ (*Zocor*)	Simvastatin 20–40 mg (*Zocor*)
	Pravastatin 40 *(80)* mg (*Pravachol*)
	Lovastatin 40 mg (*Mevacor*)
	Fluvastatin XL 80 mg *(Lescol XL)*
	Fluvastatin 40 mg bid (*Lescol*)
	Pitavastatin 2–4 mg *(Livalo)*
† Evidence from one randomized controlled trial (RCT) only: down-titration if unable to tolerate atorvastatin 80 mg in incremental decrease in events through aggressive lipid lowering (IDEAL). ‡ Although simvastatin 80 mg was evaluated in RCTs, initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the Food and Drug Administration due to the increased risk of myopathy, including rhabdomyolysis.	

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). It is a set of standardized performance measures designed to help compare the performance of health plans on an "apples-to-apples" basis. The details of its measures can change annually.

HOS is the Health Outcomes Survey, an annual-reported outcome survey conducted on behalf of CMS. CAHPS® is the Consumer Assessment of Healthcare Providers and Systems conducted on behalf of CMS. CPT® codes are developed by the American Medical Association.

HCPCS is the Healthcare Common Procedure Coding System used by CMS and maintained by the American Medical Association (AMA).

ICD-10-CM is the International Classification of Diseases, 10th Revision, Clinical Modification developed by the World Health Organization and provided by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS).