2022 Clinical Quality Corner Tip Sheets

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2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Breast Cancer Screening (BCS)

Effectiveness of Care HEDIS® Measure

Measurement definition

Female patients ages 52–74 who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusions

Patients are excluded if they:

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

Information that patient medical records must include

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

continued

Information that patient claims should include

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

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

Tips for success

- Review completed screening dates with patients at all visits.
  - Document all patient reported mammogram dates in the history and/or preventive service section of the medical record
- If the exact date of the last mammogram is unknown, avoid using words such as "approximate" or "about" when documenting. Instead, document the month/year or year alone.
- Create a standing order to mail to patient for mammography.
- Provide a list of locations where mammogram screenings can be performed.
- If telehealth, telephone or e-visits are used instead of face-to-face visits, discuss the need for breast cancer screening and mail a mammogram order with location of testing facility and phone number.

Tips for talking with patients

Educate patients about the importance of routine screening:

- Many women with breast cancer do not have symptoms, which is why regular breast cancer screenings are so important.
- Mammograms are an effective method for detecting breast cancer in early stages, when it is most treatable.[2]
- The recommended frequency of routine mammograms is at least once every 24 months for all women ages 50–74. Depending on risk factors, mammograms may be done more frequently.
- The accuracy of mammography improves as women age and has an overall detection rate of about 85 percent.[3]

[1]ICD-10-CM created by the National Center for Health Statistics, under authorization by the World Health Organization. WHO-copyright holder.

[2]American Cancer Society. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html

[3]American Cancer Society. https://www.cancer.org/cancer/breast-cancer/frequently-asked-questions-about-the-american-cancer-society-new-breast-cancer-screening-guideline.html

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Colorectal Cancer Screening (COL)

Effectiveness of Care HEDIS® Measure

Measurement definition

Patients ages 50–75 who had appropriate screenings for colorectal cancer.[1]

- Colonoscopy every 10 years
- Flexible sigmoidoscopy every five years
- FIT-DNA (Cologuard®) every three years
- FIT (Fecal Immunochemical Test), or FOBT (Fecal Occult Blood Test) every year
- CT-Colonography (virtual colonoscopy) every five years

Exclusions

Patients are excluded if they:

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

Information that patient medical records must include

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

continued

Information that patient claims should include

For exclusions, use the appropriate ICD-10[2] code:

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

For screenings, use the appropriate codes:

Screening	Code type	Commonly used billing codes
FIT-DNA (known as Cologuard®)	CPT	81528
	HCPCS	G0464
Occult blood test (FOBT, FIT, guaiac)	CPT	82270, 82274
	HCPCS	G0328

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

Tips for talking with patients

- For patients who refuse a colonoscopy, discuss options of noninvasive screenings and have FIT kits readily available to give patients during the visit.
- FIT tests and FIT-DNA (Cologuard®) tests are **NOT** the same screening.
  - **FIT** uses antibodies to detect blood in the stool (completed annually).
  - **FIT-DNA** combines the FIT with a test that detects altered DNA in the stool (completed every 3 years).
- If telehealth, telephone or e-visits are used instead of face-to-face visits, ask the patient if he or she would be willing to complete an in-home FIT-DNA (Cologuard®) test.
- Educate patients about the importance of early detection:
  - Colorectal cancer usually starts as growths in the colon or rectum and doesn't typically cause noticeable symptoms.
  - You can prevent colorectal cancer by removing growths before they turn into cancer.
- Discuss the benefits and risks of different screening options and make a plan that offers the best health outcomes for your patient.

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

2022 Star Measure Tips

One in a series of tip sheets about HEDIS® and other measures that contribute to star ratings of Medicare Advantage plans.

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

Member perception star measure

Why is the CAHPS survey important?

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

CAHPS survey questions and provider impact

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

Measure	Sample survey questions to patient
Annual flu vaccine	Have you had a flu shot since July 1?

Tips for success

- Administer flu shot as soon as it's available each fall.
- Eliminate barriers to accessing flu shots and offer multiple options for patients to get their shot (walk-in appointments, flu shot clinics, flu shots at every appointment type if the patient's eligible).
- Promote flu shots through website, patient portal, and phone greeting.

continued

Getting appointments and care quickly	In the last six months: • How often did you see the person you came to see within 15 minutes of your appointment time? • When you needed care right away, how often did you get care as soon as you needed? • How often did you get an appointment for routine care as soon as you needed?

Tips for success

- Patients are more tolerant of appointment delays if they know the reasons for the delay. When the provider is behind schedule:
  - Front office staff should update patients often and explain the cause for the schedule delay. Offer reasonable expectations of when the patient will be seen and give the patient options, showing respect for their time.
  - Staff members interacting with the patient should acknowledge the delay with the patient.
- Consider implementing advanced access scheduling (same-day scheduling) or consider:
  - Leaving a few appointment slots open each day for urgent visits, including post-inpatient discharge visits.
  - Offering appointments with a nurse practitioner or physician's assistant to patients who want to be seen on short notice.
  - Offering online appointments, making it convenient for patients to connect with the practice
  - Asking patients to make routine checkups and follow-up appointments in advance.

Overall rating of health care quality	Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?

Tips for success

- Survey your patients, asking how you can improve their health care experience.
- Create a patient council for regular feedback

continued

Care coordination	In the last six months: • When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • When your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them? • How often did you and your personal doctor talk about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about the care you got from specialists?

Tips for success

- Before walking in the exam room, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits.
- Implement a system in your office to ensure timely notifications of test results, ask patients how they would prefer to receive test results and communicate clearly with patients on when they'll receive test results.
- Utilize or implement a patient portal to share test results and consider automatically releasing the results once they are reviewed by the provider.
- Ask your patients if they saw another provider since their last visit. If you know patients receive specialty care, discuss their visit and treatment plan, including new prescriptions. Contact specialty provider and request the medical records.
- Complete a medication reconciliation at every visit.

continued

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

Tips for success

- Set realistic expectations around how long it could take to schedule an appointment with the specialist if the appointment is not urgent.
- If applicable, advise your patient on how you can help secure an appointment sooner if your clinic has an established relationship with a specialist.
- Help the patient understand why you are recommending certain types of care, tests or treatments, especially if the patient requested or asked about other types.
- Review with patients what role they play in securing care, tests or treatment (e.g., scheduling with specialists, timely appointments).

Resources

1. Agency for Healthcare Research and Quality (AHRQ). 2020. "The CAHPS Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience." **ahrq.gov/cahps/quality-improvement/improvement-guide/improvement-guide.html**

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Controlling high blood pressure (CBP)

Effectiveness of Care HEDIS® Measure

Measurement definition

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

Exclusions

Patients are excluded if they:

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

Information that patient medical records should include

- Document all blood pressure readings and the dates they were obtained. The last blood pressure reading of the year will be used for HEDIS compliance determination.
- Document exact readings; do not round up blood pressure readings
  - Ranges and thresholds are not acceptable
  - Document all BPs taken on the same date and report the lowest systolic and lowest diastolic readings.

continued

- Blood pressure readings can be captured during a telehealth, telephone, e-visit or virtual visit.
  - Patient reported readings taken with a digital device are acceptable and should be documented in the medical record (MR).
  - The provider does not need to see the reading on the digital device, the patient can verbally report the digital reading.
- BP readings can be captured from a specialty or urgent care visit if the consult note is part of the patient's medical record.

Information that patient claims should include

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

CPT® II code	Most recent systolic blood pressure
3074F	< 130 mm Hg
3075F	130–139 mm Hg
3077F	≥ 140 mm Hg
CPT® II code	**Most recent diastolic blood pressure**
3078F	< 80 mm Hg
3079F	80–89 mm Hg
3080F	≥ 90 mm Hg

Tips for taking blood pressure readings in the office

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

continued

Tips for talking with patients

According to the American Heart Association and American College of Cardiology, one of the biggest challenges is convincing patients of the importance of maintaining a healthy blood pressure.

- Educate patients on the importance of blood pressure control and the risks when blood pressure is not controlled.
- Encourage blood pressure monitoring at home and ask patients to bring a log of their readings to all office visits (educate patients on how to properly measure blood pressure at home).
- If the patient does not own a digital blood pressure cuff, educate them on utilizing their local pharmacy for a blood pressure reading.
- Prescribe single-pill combination medications whenever possible to assist with medication compliance.
- Discuss the importance of medication adherence at every visit. According to the Centers for Disease Control and Prevention:
  - Only about one in four adults (24%) with hypertension have their condition under control.[1]
  - One in four patients with Medicare Part D prescription insurance are not taking their blood pressure medication as prescribed.[2]
- Advise patients not to discontinue blood pressure medication before contacting your office. If they experience side effects, another medication can be prescribed.
- If patients have an abnormal reading, schedule follow-up appointments for blood pressure readings until their blood pressure is controlled.
- Encourage lifestyle changes such as diet, exercise, smoking cessation and stress reduction.

[1]Centers for Disease Control and Prevention. https://www.cdc.gov/bloodpressure/facts.htm

[2]Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/65/wr/mm6536e1.htm

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Eye Exam for Patients with Diabetes (EED)

Effectiveness of Care HEDIS® Measure

Measurement definition

Patients ages 18–75 with a diagnosis of diabetes (Type 1 or Type 2) who received screening or monitoring for diabetic retinal disease.

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

Exclusions

Patients are excluded if they:

- Have no diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year, and a diagnosis of:
  - Gestational or steroid-induced diabetes, or polycystic ovarian syndrome in the measurement year or the year prior to the measurement year.
- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

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

continued

Information that patient medical records must include

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

- Review the report and note if there are any abnormalities. If so, add the abnormalities to the patient's active problem list and indicate the necessary follow-up.
- Place the report in the patient's medical record.
- Make sure the date of service, eye exam results, and eye care professional's name with credentials are included for HEDIS compliance.
- If a copy of the report isn't available, document in the patient's medical history the date of the eye exam, the result and the eye care professional who conducted the exam with credentials. If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.
- Documentation of prosthetic eye(s) are acceptable for enucleation.

Information that patient claims should include

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

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

continued

Tips for success

- Refer patients to optometrist or ophthalmologist for dilated retinal eye exam annually and explain why this is different than a screening for glasses or contacts.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- If a primary care provider's office has equipment to complete retinal imaging with interpretation by artificial intelligence in their office, the provider can report completion of the eye exam by submitting a claim with CPT code, 92229, for the services provided AND the appropriate CPT II code to report the exam results.
- Diabetic eye exams are covered under the patient's medical insurance and may be subject to copays and deductibles.
- Optical coherence tomography is considered imaging and is eligible for use. The fundus/retinal photography must have the date, result and eye care professional with credentials documented.
- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure.
- Routine eye exams for glasses, glaucoma or cataracts do not count. Must be a retinal/dilated exam.

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

Effectiveness of Care HEDIS® Measure

Measurement definition

The percentage of emergency department (ED) visits for patients 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit (8 days total. This includes visits that occur on the date of the ED visit).

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

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

Exclusions

Patients are excluded if they:

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

continued

Information that patient medical records should include

The following visit types meet criteria:

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

Tips for success

- This measure is based on ED visits. If a patient has more than one ED visit, they could be in the measure more than once.
- Keep open appointments so patients with an ED visit can be seen within 7 days of their discharge.
- In addition to an office visit, follow-up can be provided via a telehealth, telephone, e-visit or virtual visit.

Tips for talking with patients

- Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and caregivers to recite their new medication regimen back to you.

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Health Outcomes Survey (HOS)

Member perception star measures

Why is the HOS important?

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

HOS questions and provider impact

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

Measure	Sample survey questions to patient
Improving or maintaining physical health	In general, how would you rate your health? Does your health now limit you in these activities? • Moderate activities like vacuuming or bowling • Climbing several flights of stairs During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? • Accomplished less than you would like • Were limited in the kind of work or other activities you were able to perform During the past four weeks, how much did pain interfere with your normal work?

Tips for success

Ask patients if they have pain, and if so, is it affecting their ability to complete daily activities? Ask what goals the patient has, then identify ways to improve the patient's pain.

Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist or other specialist.

Consider physical therapy and cardiac or pulmonary rehab when appropriate.

continued

Improving or maintaining mental health	During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems? • Accomplished less than you would like • Didn't do work or other activities as carefully as usual 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 or blue? During the past four weeks, how much of the time have your physical or emotional problems interfered with your social activities?

Tips for success

Empathize with the patient.

Incorporate annual depression screening into visits, such as PHQ-2 or PHQ-9.

Discuss options for therapy with a mental health provider, when appropriate.

Develop a plan with your patient to take steps to improve mental health. Consider exercise, sleep habits, hobbies, volunteering, attending religious services, identifying stress triggers, reducing alcohol or caffeine intake, meditation, connecting with supportive family and friends.

- Schedule a check-in to discuss progress on this plan.

Consider a hearing test when appropriate, as loss of hearing can feel isolating.

Monitoring physical activity	In the past 12 months, did: You talk with a doctor or other health care provider about your level of exercise or physical activity? A doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?

Tips for success

Talk to patients about their physical activity and the health benefits of staying active. Studies show that having patients fill out a questionnaire is not enough to gauge their activity level. Show interest in ensuring patients remain active.

Develop a plan with your patient to take steps to start or increase physical activity. Offer suggestions based on the patient's physical ability, interests, and access.

- Schedule a check-in to discuss progress on this plan.

Refer patients with limited mobility to physical therapy to learn safe and effective exercises.

continued

Improving bladder control	In the past six months, have you experienced leaking of urine? There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?

Tips for success

Ask patients if they have any trouble holding their urine. If yes, ask the following questions:

- When do you notice leaking (exercise, coughing, after urinating)?
- Is there urgency associated with the leaking?
- Do you have any issues emptying your bladder (incomplete, takes too long, pain)?
- How often do you empty your bladder at night? During the day?
- Do you have pain when you urinate?
- Have you noticed a change in color, smell, appearance or volume of your urine?
- How impactful are your urinary issues to your daily life?

For men, ask all the same questions, plus:

- Is there any change in stream?
- Any sexual dysfunction (new, historical or changing)?

Communicate that urinary leakage problems can be common as we grow older, but there are treatments that can help. Discuss potential treatment options such as behavioral therapy, exercises, medications, medical devices and surgery.

Use informational brochures and materials as discussion starters for this sensitive topic.

Reducing the risk of falling	In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? Did you fall in the past 12 months? In the past 12 months, have you had a problem with balance or walking? Has your doctor or health provider done anything to help you prevent falls or treat problems with balance or walking?

Tips for success

Promote exercise, physical therapy and strengthening and balance activities (tai chi, yoga).

Review medications for any that increase fall risk.

Discuss home safety tips such as removing trip hazards, installing handrails and using nightlights.

Suggest the use of a cane or walker, if needed.

Recommend a vision or hearing test.

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Hemoglobin A1c Control for Patients with Diabetes (HBD)

Effectiveness of Care HEDIS® Measure

Measurement definition

Patients ages 18–75 with a diagnosis of diabetes (Type 1 or Type 2) whose HbA1c was adequately controlled (<9%) as of December 31 of the measurement year.

Exclusions

Patients are excluded if they:

- Have no diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year, and a diagnosis of:
  - Gestational or steroid-induced diabetes, or polycystic ovarian syndrome in the measurement year or the year prior to the measurement year.
- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

Information that patient medical records must include

HbA1c results: HbA1c should be completed two to four times each year with result date and distinct numeric result. The last HbA1c result of the year must be less than or equal to nine to show evidence of diabetes control.

continued

Information that patient claims should include

HbA1c results: When conducting a HbA1c in your office, submit a $0.01 claim with the following CPT® II codes to report the result.

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

Tips for success

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

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Kidney Health Evaluation for Patients with Diabetes (KED)

Effectiveness of Care HEDIS® Measure

Measurement definition

Patients ages 18–85 with a diagnosis of diabetes (Type 1 or Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Exclusions

Patients are excluded if they:

- Members who did not have a diagnosis of diabetes in any setting during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes in any setting during the measurement year or the year prior to the measurement year.
- Received hospice care during the measurement year.
- Have evidence of ESRD or dialysis any time during the patient's history on or prior to December 31 of the measurement year.
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).
- Are age 81 and older with frailty during the measurement year.
- Are deceased during the measurement year.
- Received palliative care during the measurement year.

continued

Information that patient medical records must include

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

1. At least one estimated glomerular filtration rate (eGFR)
2. At least one urine albumin creatinine ratio (uACR) identified by either of the following:
   - **Both** a Quantitative Urine Albumin test **and** a Urine Creatinine test **with** service dates four days or less apart
   - Or a Urine Albumin Creatinine Ratio test (uACR)

Submit a claim for an estimated glomerular filtration rate lab test (eGFR), as well as for both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart. Patient claims should include:

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

Tips for success

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

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Medication Reconciliation Post-Discharge (TRC-M)

A component of Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measurement definition

Patients ages 18 and older in the measurement year with Medicare coverage whose medications were reconciled on the date of discharge through 30 days after discharge (a total of 31 days).

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Deceased during the measurement year.

Information that patient medical records must include

- Documentation must indicate that the provider is aware of the member's hospitalization or discharge
- Must include date medication reconciliation was performed.
- Medication reconciliation must be conducted or cosigned by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse.
- Documentation of the current medications with evidence of medication reconciliation must include:
  - Notation that the provider reconciled the current and discharge medications.
  - Notation that references the discharge medications (e.g., no change in medications since discharge, same medications at discharge, discontinue all discharge medications).
  - Evidence that the patient was seen for post-discharge hospital follow up with medication reconciliation review.
  - Notation that no medications were prescribed or ordered upon discharge.

continued

Information that patient claims should include

When the following CPT® codes are billed within 30 days of discharge, it will close the treatment opportunity, reducing medical record requests.

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.

CPT® codes	Description
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **moderate** complexity and a face-to-face visit within **14** days of discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **high** complexity and a face-to-face visit within **seven** days of discharge.

- Visits with a practitioner can be with or without a telehealth modifier.
- Bill 1111F as soon as medication reconciliation is completed. It is not necessary to wait for all components of TCM or care planning service codes to be met.
- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

Tips for success

- Medication Reconciliation does not require a visit with the member, but documentation must be in the outpatient medical record.
- A post-discharge visit (office visit, home visit, telehealth, e-visit or virtual check-in) is encouraged to support patient engagement after an inpatient discharge. Schedule appointments with recently discharged patients within seven days of their discharge.
- Request patients' discharge summary with medication list and any discharge instructions from the inpatient facility.
- Conduct medication reconciliation by comparing the medication list from the hospital discharge summary against the patients' outpatient provider list of current medications and document that the reconciliation was done.
- Ensure the medication reconciliation is completed and signed by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse.
  - May be performed by other medical professionals (e.g., MA, LPN) if signed off by an acceptable provider.

continued

Tips for talking with patients

- Discuss the condition that resulted in the hospitalization and review the patients' medications.
- Ensure patients understanding of new medications and which medications to discontinue.
- Ask patients to bring all their prescription and over-the-counter medications, including herbal supplements and topical agents to the hospital follow-up appointment.

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Medication Adherence

Pharmacy Quality Alliance-endorsed performance measures

Measurement definition

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

The three measures are:

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

Medications included in each measure

Diabetes	Hypertension	Cholesterol
• Biguanides • Sulfonylureas • Thiazolidinediones • Dipeptidyl peptidase (DPP)-IV inhibitors • Incretin mimetics • Meglitinides • Sodium glucose cotransporter 2 (SGLT2) inhibitors	Renin-angiotensin system (RAS) antagonists: • Angiotensin converting enzyme (ACE) inhibitors • Angiotensin II receptor blockers (ARBs) • Direct renin inhibitors	Statins

continued

Exclusions

Patients are excluded if they:

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

Tips for talking with patients

- Provide short and clear instructions for all prescriptions.
- Emphasize the benefits of taking the medication and the risks of not taking the medication. The benefits should outweigh the risks.
- At each visit, ask your patients about their medication habits, including the average number of doses they may miss each week. Continue with open-ended questions to identify barriers to taking medications:
  - What side effects have you had from the medication, if any?
  - How many doses have you forgotten to take?
  - What financial barriers prevent you from obtaining your prescriptions?
  - What issues prevent you from refilling your prescription?
- Offer recommendations for improvement:
  - Recommend weekly or monthly pillboxes, smart phone apps with medication reminder alerts and placing medications in a visible area (but in properly closed containers and safely out of reach of children or pets) for patients who forget to take their medications.
  - Encourage patients to call your office if they experience side effects to discuss alternative medications.
  - Refer patients to their health plan to learn about mail-order options for their prescriptions.

Tips for success

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

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Effectiveness of Care HEDIS® Measure

Measurement definition

Female patients ages 67–85 who suffered a fracture and had **either** a bone mineral density test or were dispensed a prescription to treat osteoporosis within six months of the fracture.

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

Exclusions

Patients are excluded if they:

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

continued

Patient medical records should include either

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

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

Tips for success

- The U.S. Preventive Services Task Force[1] recommends BMD screening for:
  - Female patients starting at age 65 to reduce the risk of fractures.
  - Postmenopausal women younger than age 65 if they are at high risk.
- Provide patients with a prescription to treat osteoporosis when appropriate.
  - Patients should fill prescriptions using their pharmacy benefit. Gap closure is dependent on pharmacy claims
- Instruct patients where to call for a Bone Mineral Density test.
- Encourage patients to obtain the screening and follow up with the patient to ensure the test was completed.
- If telehealth, telephone or e-visits are used instead of face-to-face visits:
  - Discuss the need for a bone mineral density test and mail an order to the patient that contains the location and phone number of a testing site
  - Mail a prescription for, or e-scribe, an osteoporosis medication, if applicable.
- Document and bill exclusions annually (see the *Advanced Illness and Frailty guide* for details).
  - Bill the ICD-10 code to identify how the fracture happened (e.g., fall).

Tips for talking with patients

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

[1]U.S. Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/osteoporosis-screening

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Plan All-cause Readmissions (PCR)

Risk-Adjusted Utilization HEDIS® Measure

Measurement definition

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

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Died during the hospital stay.
- Were diagnosed with pregnancy or a condition originating in the perinatal period.

Tips for success

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of their discharge.
- When scheduling the post-discharge visit, ask patients to bring in all of their prescription medications and over-the-counter medications and supplements so that the medication reconciliation can be performed.
- Obtain and review patients' discharge summary.
- Obtain any test results that were not available when patients were discharged and track tests that are still pending.
- Connect with your state's automated electronic admission, discharge and transfer, or ADT system to receive admission, discharge and transfer notifications for your patients.

continued

- If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
- Consider implementing:
  - A post-discharge process to track, monitor and follow up with patients.
  - Perform transitional care management for recently discharged patients. TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period to be submitted on a claim.
- This measure is based on discharges. Members may appear in the denominator more than once.

Tips for talking with patients

- Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and/or caregivers to describe their new medication regimen back to you.
- Document and date the medication reconciliation in the outpatient medical record.
  - Submit an 1111F claim as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.
  - Provide the patient with a current list of medications
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
  - Start as-needed, or PRN, medications.
  - Call his or her doctor (during or after office hours).
  - Go to the emergency room.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.
- Ask patients if they completed or scheduled prescribed outpatient work-ups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment.

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Statin therapy for patients with cardiovascular disease (SPC)

Effectiveness of Care HEDIS® Measure

Measurement definition

Male patients ages 21–75 and female patients ages 40–75 who are identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

1. **Received Statin Therapy** – Dispensed at least one high-intensity or moderate-intensity statin medication
2. **Statin Adherence 80%** – Remained on the high or moderate-intensity statin medication for at least 80% of the treatment period.

Exclusions

Patients are excluded if they:

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

continued

Information that patient medical records must include

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

Condition	ICD-10-CM Codes
Myalgia	M79.1, M79.10–M79.12, M79.18
Myositis	M60.80–M60.819; M60.821–M60.829; M60.831–M60.839; M60.841–M60.849; M60.851–M60.859; M60.861–M60.869; M60.871–M60.879; M60.88–M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82

Tips for success

- Prescribe at least one high-intensity or moderate-intensity statin medication during the measurement year to patients diagnosed with ASCVD
- Instruct patients to fill prescriptions using their pharmacy benefit. Claims filled through pharmacy discount programs, cash claims, and medication samples would not count. Gap closure is dependent on pharmacy claims.

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

Tips for talking with patients

- Educate your patients on the importance of statin medication adherence.
- Remind patients to contact you if they think they are experiencing adverse effects. If the patient experiences any of the excluded symptoms/conditions, submit an office visit claim with the appropriate ICD-10 code listed on page 1.
- Once patients demonstrate they can tolerate statin therapy, encourage them to obtain 90-day supplies at their pharmacy.

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Statin use in persons with diabetes (SUPD)

Pharmacy Quality Alliance-endorsed performance measures

Measurement definition

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

Exclusions

Patients are excluded if they:

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

Information that patient claims should include

If patients meet any of the criteria listed below, they can be excluded from the measure by submitting a claim using the appropriate ICD-10-CM code:

Condition	ICD-10-CM code
Liver Disease	Numerous > 50
Pregnancy and/or Lactation	Numerous > 1k
Polycystic Ovarian Syndrome	E28.2
Pre-diabetes	R73.03
Other abnormal blood glucose	R73.09

continued

Condition	ICD-10-CM code
Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter*	T46.6X5A
Rhabdomyolysis/myopathy/myositis*:	
Drug-induced myopathy	G72.0
Other specified myopathies	G72.89
Myopathy, unspecified	G72.9
Other myositis, unspecified site	M60.80
Myositis, unspecified	M60.9
Rhabdomyolysis	M62.82

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

Tips for success

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

Tips for talking with patients

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

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measurement definition

The percentage of discharges for patients 18 years of age or older, as of December 31 of the measurement year, who had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year, who had each of the following:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation post-discharge

Exclusions

Patients are excluded if they:

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

continued

Information that patient medical records must include

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

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

continued

Component	Criteria	Outpatient medical record requirements
3. Patient engagement after inpatient discharge	Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.	Must include the date of engagement with any of the following criteria: • An outpatient visit including office visits and home visits. • Telehealth visits meet criteria with acceptable coding (audio and/or video, e-visits, virtual check-ins). • Documentation indicating a live conversation occurred with the patient will meet criteria, regardless of provider type. For example, medical assistants and registered nurses may perform the patient engagement. • If the patient is unable to communicate with the practitioner, interaction between the patient's caregiver and the provider meets criteria.
4. Medication reconciliation post-discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days). • Must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse. Other staff members (MA or LPN) may conduct the medication reconciliation, but it must be signed off by the required provider type. • Must be the outpatient medical record, but an outpatient face-to-face visit isn't required	Must include the date performed with any of the following criteria: • Current medication list with a notation that the provider reconciled the current and discharge medications. • Current medication list with reference to discharge medications (e.g., no changes in meds post discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed) • Current medication list and discharge medication list with evidence both lists reviewed on same date of service. • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • Discharge summary medication list indicates reconciled with current meds. Must be filed in the outpatient record within 30 days after discharge. • No medications were prescribed or ordered upon discharge.

Tips for success

- Utilize Michigan Health Information Network's (MiHIN) admission, discharge, transfer (ADT) notifications to support TRC components.
  - Request discharge summary from facility when discharge ADT notification is received.
- You can reduce errors at time of discharge by using the computer order entry system to generate a list of medication used before and during the hospital admission.

continued

- Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with **patient comprehension of his or her discharge instructions**.
- Documentation of notification must include a date when the document was received.
- **Examples of documentation that are not acceptable:**
  - Documentation that the member or the member's family notified the member's PCP or managing specialist of the admission or discharge.
  - Documentation of notification that doesn't include a date when the documentation was received.

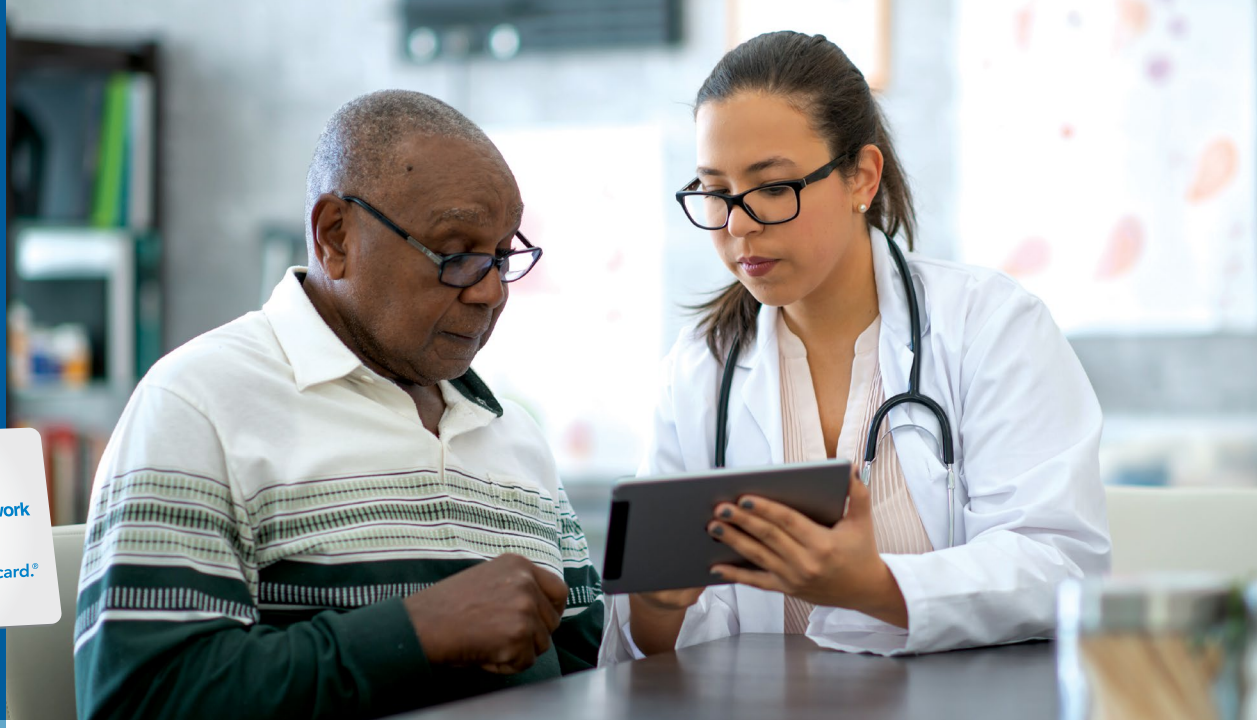
Tips for coding

- This measure is based on discharges. Members may appear in the denominator more than once.
- Visits with a practitioner can be with or without a telehealth modifier (see telehealth guide).
- Bill 1111F as soon as medication reconciliation is completed. It is not necessary to wait for all components of TCM or care planning service codes to be met.
- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.

CPT® codes	Description
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face (in-person or telehealth) visit within **14 days** of discharge.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face (in-person or telehealth) visit within **7 days** of discharge.

2022 Custom Measure Tips



Medicare Wellness Visits (MWV)

Medicare Plus Blue℠ and BCN Advantage℠ Custom Measure

Measure description

The percentage of members that had a Medicare Wellness Visit (MWV) during the measurement year.

Measure population (denominator)

Members continuously enrolled in Medicare Plus Blue℠ or BCN Advantage℠ plans during the measurement year.

Measure compliance (numerator)

This measure can be met through coding one of the following visits during the measurement year:

- **Initial Preventive Physical Exam (IPPE):** also known as a **Welcome to Medicare** visit and includes the review of medical and social health history and preventive services education.
  - For **NEW** Medicare members within the first 12 months of enrollment in Medicare Part B
  - Medicare members are eligible for an IPPE visit once per lifetime

Did you know?

- Research has shown that adults who recalled receiving advice from a physician or health care professional were more likely to change their eating habits, exercise, maintain a healthy weight, and/or reduce sodium and alcohol intake.
- Failure to evaluate memory or cognitive complaints is likely to hinder treatment of underlying disease and comorbid conditions and may present safety issues for the patient and others.
- More than one third of those older than 65 fall each year. The risk of falling and fall-related problems rises with age.

This measure applies to Medicare members only.

continued

- **Annual Wellness Visit (AWV):** to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA).
  - For **EXISTING** Medicare members that have been enrolled in Medicare Part B for >12 months
  - Medicare members are eligible for an AWV once every 12 months (i.e., 12 months after their IPPE or last AWV)
  - Telehealth visits meet criteria with acceptable coding. This includes audio-only interactions.

Exclusions

- Deceased members during the measurement year
- Members receiving palliative care during the measurement year
- Members in hospice or using hospice services anytime during the measurement year

Tips for coding

This measure can only be met through appropriate coding and claims. Submitting a claim for a service date within the measurement year with one of the following three codes will close the MWV gap:

HCPCS code	Description
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0438	Annual wellness visit, includes a personalized prevention plan of service (PPS); initial visit
G0439	Annual wellness visit, includes a personalize prevention plan of service (PPS); subsequent visit

Helpful hints

- Document and code for any active conditions during the visit
- Implement a system for automated reminders to patients encouraging wellness visit scheduling
- Educate patients on the importance of Medicare Wellness Visits regardless of health status
- Review the member's Medicare coverage and wellness visit history to determine which type of wellness visit is appropriate
- Consult the Michigan Automated Prescription System (MAPS) to view complete medication profiles for patients and to confirm the current cumulative dosage of opioid medications being prescribed. **michigan.pmpaware.net/login**
  - If outside of Michigan, please consult your state's Prescription Drug Monitoring Program (PDMP).
- A routine physical exam is not the same service as an IPPE or AWV, nor do they have the same coverages.

continued

Documentation in the medical record must indicate the date the visit occurred and evidence of the components below:

Wellness Visit Components	
AWV:	**IPPE:**
• Health risk assessment (HRA) • Medical and family history • Medication review and reconciliation (including supplements) • Height, weight, BMI, blood pressure, and other routine measurements deemed appropriate based on history • List of current providers and specialists providing medical care • Detect any cognitive impairment • Potential depression risk factors, including current or past experiences with depression or other mood disorders • Functional ability and level of safety • Established written screening schedule • List of risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway • Review of current opioid prescriptions • Screen for potential Substance Use Disorders (SUDs) • Personalized health advice and appropriate referrals to educational or counseling services or programs • Advance care planning services at the member's discretion	• Height, weight, Body Mass Index (BMI), visual acuity screen, and other factors deemed appropriate based on history and clinical standards • Medical and social history • Medication review and reconciliation (including supplements) • Potential depression risk factors including current or past experiences with depression or other mood disorders • Functional ability and level of safety • Review of current opioid prescriptions • Screening for potential Substance Use Disorders (SUDs) • Educate, counsel, and refer based on above components • Educate, counsel, and refer for other preventive services • End-of-life planning with patient agreement

Note: *For additional information on components, see **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html**

Resources

1. Medicare Learning Network (MLN). 2021. "Medicare Wellness Visits." **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html**
2. National Institutes of Health (NIH). 2021. "Assessing Cognitive Impairment in Older Patients." **nia.nih.gov/health/assessing-cognitive-impairment-older-patients#17**
3. Centers for Medicare and Medicaid Services (CMS). 2021. "List of Telehealth Services." **cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes**
4. Musich, S., Wang, S., Hawkins, K., & Klemes, A. (2016). "The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures." Population health management, 19(6), 389–397. **ncbi.nlm.nih.gov/pmc/articles/PMC5296930/**
5. National Institutes of Health (NIH). 2017. "Prevent Falls and Fractures." **nia.nih.gov/health/prevent-falls-and-fractures**

2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

HEDIS® Advanced Illness and Frailty Guide

The National Committee for Quality Assurance allows additional exclusions to Healthcare Effectiveness Data and Information Set, or HEDIS®, star measures for patients with advanced illness and frailty.

Services measured by NCQA may not benefit older adults with limited life expectancy and advanced illness. Also, unnecessary tests or treatments could burden these patients or even be harmful. NCQA wants providers to focus on appropriate care for their patients.

Billing codes

Telehealth, telephone visits, e-visits and virtual check-ins are acceptable when used to exclude a patient using the advanced illness and frailty category when documented and the exclusion code is billed properly. Other components of the specification must be met, such as claims with advanced illness diagnosis on two different dates of service in the prior year or measurement year **and** frailty claim in the measurement year, as well as measure-specific ages.

This guide includes:

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

Remember that use of HEDIS-approved billing codes can substantially reduce medical record requests for HEDIS data collection purposes.

continued

Star Measure exclusion criteria

Codes must be billed in the measurement year or the year prior to exclude the patient from the star measures in the table below.

Patients 66 and older with BOTH advanced illness and frailty	Patients 66 to 80 with BOTH advanced illness and frailty	Patients 67 to 80 with BOTH advanced illness and frailty	Patients 81 and older with frailty ONLY
• Breast cancer screening (BCS) • Colorectal cancer screening (COL) • Eye Exam for Patients with Diabetes (EED) • Hemoglobin A1c Control for Patients with Diabetes (HBD) • Kidney Health Evaluation for Patients with Diabetes (KED) • Statin therapy for patients with cardiovascular disease (SPC)	Controlling high blood pressure (CBP)	Osteoporosis management in women who had a fracture (OMW)	• Controlling high blood pressure (CBP) • Kidney Health Evaluation for Patients with Diabetes (KED) • Osteoporosis management in women who had a fracture (OMW)

Advanced illness	
ICD-10-CM code	**Definition**
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0-4, C25.7-9	Malignant neoplasm of pancreas
C71.0-9	Malignant neoplasm of brain
C77.0-5, C77.8-9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00-02	Secondary malignant neoplasm of lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30, C78.39	Secondary malignant neoplasm of unspecified or other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80, C78.89	Secondary malignant neoplasm of unspecified or other digestive organs
C79.00-02	Secondary malignant neoplasm of kidney and renal pelvis
C79.10-11, C79.19	Secondary malignant neoplasm of bladder and other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges

continued

C79.40, C79.49	Secondary malignant neoplasm of unspecified or other parts of nervous system
C79.51-52	Secondary malignant neoplasm of bone or bone marrow
C79.60-62	Secondary malignant neoplasm of ovary
C79.70-72	Secondary malignant neoplasm of adrenal gland
C79.81-82	Secondary malignant neoplasm of breast or genital organs
C79.89, C79.9	Secondary malignant neoplasm of unspecified or other sites
C91.00, C92.00, C93.00, C93.90, C93. Z0, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse
F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27, F10.97, G31.09, G31.83	Dementia
F04	Amnestic disorder due to known physiological condition
F10.96	Alcohol-induced persisting amnestic disorder
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G31.01	Pick's disease
I09.81, I11.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage 5
I50.1	Left ventricular failure, unspecified
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J84.10, J84.112, J84.17, J84.170, J84.178	Pulmonary fibrosis
J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
N18.6	End stage renal disease

Dementia medications	
Description	**Prescription**
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

continued

Frailty	
CPT® code*	**Definition**
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care

Frailty	
HCPCS code	**Definition**
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147-9	Walker
E0163, E0165, E0167-71	Commode chair
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-7, E0301-4	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-2	Respiratory assist device
E0561, E0562	Humidifier used with positive airway pressure device
E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-8	Wheelchair
G0162, G0299, G0300, G0493, G0494	Skilled RN services related to home health/hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124, T1000-5, T1019-22, T1030, T1031	Nursing, respite care and personal care services

continued

Frailty	
ICD-10-CM code	**Definition**
L89.000 - L89.96	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified state
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.0	Ataxic gait
R26.1	Paralytic gait
R26.2	Difficultly in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R41.81	Age-related cognitive decline
R53.1	Weakness
R53.81	Other malaise
R53.83	Other fatigue
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA – W01.198S, W06.XXXA – W10.9XXS, W18.00XA – W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator [ventilator] status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices