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

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

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 used by the NCQA for compliance and accreditation. The HEDIS measures listed here are part of the Medicare Star Rating Program governed by CMS.

Measure	Service needed	What to report *(sample of codes)*
Breast Cancer Screening (BCS) **Weight = 1** Percentage of women 52–74 years old who had a mammogram (including digital breast tomosynthesis). **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, using hospice services or receiving palliative care • 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	Mammogram between Oct. 1 two years prior to the measurement year and Dec. 31 of the current measurement year (27-month period) Dated notation in the medical record of: • Most recent mammogram with date of service (minimum month and year) • Mastectomy status and date of service (minimum year performed) **Note:** Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.	**Radiology codes** • CPT: 77061–77063, 77065–77067 **Note:** Listed below are codes within the HEDIS value set for this measure that are considered obsolete and may be denied for payment processing, if received on claims/encounters submission. • CPT: 77055, 77056 and 77057 • HCPCS: G0202, G0204 and G0206 **Medical record documentation** Patients are excluded if medical record documentation supports history of bilateral mastectomy or history of both a unilateral left and a unilateral right mastectomy. Unilateral mastectomy code and bilateral modifier must be from the same procedure.

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

Healthcare Effectiveness Data and Information Set (HEDIS)

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)
  - SNPs are a type of Medicare Advantage (MA) plan designed for certain people with Medicare.
  - Some SNPs 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

Measure	Service needed	What to report *(sample of codes)*
COA – Functional Status Assessment (COA–FSA) **Weight = N/A, display measure (MY20-22), 1 (MY23)** Percentage of COA eligible patients who had documentation in the medical record of at least one completed functional status assessment in the current measurement year.	**Functional status assessment** • At least one complete functional status assessment completed in an outpatient setting in the current measurement year • Document the type of assessment and the date it was performed in the medical record **Note:** Functional status assessment limited to an acute or single condition, event or body system does not meet criteria. **Note:** Assessments can occur via all telehealth methods including audio-only telephone visit, e-visit and virtual check-in.	**Physician codes** • CPT: 99483 • CPT II: 1170F • HCPCS: G0438, G0439 **Additional information** Notations for a complete functional status assessment may include: • Assessment of instrumental activities of daily living (IADL) or activities of daily living (ADL) **or** • Results using a standardized functional status assessment tool

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
COA – Medication Review (COA–MDR) **Weight = 1** Percentage of COA-eligible patients whose prescribing practitioner or clinical pharmacist reviewed all of the patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies. **Note:** A review of side effects for a single medication at the time of prescription alone is not sufficient.	**Medication review** • Documentation of a dated and signed medication review conducted by a healthcare provider with prescribing authority or clinical pharmacist in the current measurement year **and** • A medication list present in the same medical record with a dated notation **or** • If the patient is not taking medication, dated notation of this should be documented in the chart in the current measurement year ***Note:** Medication reviews can be completed via all telehealth methods including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. An outpatient visit or member presence are not required.	**Physician codes** Medication review • CPT: 90863, 99483, 99605, 99606 • CPT II: 1160F Medication list • CPT II: 1159F • HCPCS: G8427 Both a medication review and medication list code must be billed with the same date of service for a patient to be compliant. Transitional care management services • CPT: 99495, 99496 A transitional care management services code counts for both the medication review and medication list.
COA – Pain Screening (COA–PNS) **Weight = 1** Percentage of COA eligible patients who had documentation in the medical record of at least one pain screening assessment for more than one system in the current measurement year. Notation alone of the following activities does **not** meet criteria: • Pain management plan • Pain treatment plan • Screening for or presence of chest pain	**Pain assessment** Dated notation in the medical record of one pain assessment or screening performed in an outpatient setting in the current measurement year, which may include: • Documentation that the patient was assessed for pain (may include positive or negative findings) • Result of assessment using a standardized pain assessment tool ***Note:** Pain screenings can be addressed via all telehealth methods including audio-only telephone visit, e-visit and virtual check-in.	**Physician code** • CPT II: 1125F, 1126F

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Colorectal Cancer Screening (COL) **Weight = 1** Percentage of patients 50– 75 years old who had an appropriate screening for colorectal cancer. **Exclusions** • Patients in hospice, using hospice services or receiving palliative care • 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	**Any one of the following:** • Fecal occult blood test (FOBT, guaiac FOBT or immunochemical FOBT) during the current measurement year • Cologuard test during the current measurement year or the two years prior • Flexible sigmoidoscopy or computed tomography (CT) colonography during the current measurement year or four years prior • Colonoscopy during the current measurement year or the nine years prior **Note:** Clear documentation of previous colonoscopy, CT colonography or sigmoidoscopy, including year performed, is required. Note: Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.	**Pathology/laboratory codes** Fecal occult blood test Jan. 1 through Dec. 31 of the current measurement year (one year) • CPT: 82270, 82274 • HCPCS: G0328 Cologuard test Jan. 1 two years prior through Dec. 31 of the current measurement year (three years) • CPT: 81528 • HCPCS: G0464 **Surgery/hospital codes** Flexible sigmoidoscopy Jan. 1 four years prior through Dec. 31 of the current year (five years) • CPT: 45330-45335, 45337, 45338, 45340–45342, 45346, 45347, 45349, 45350 • HCPCS: G0104 CT colonography Jan. 1 four years prior through Dec. 31 of the current year (five years) • CPT: 74261–74263 Colonoscopy Jan. 1 nine years prior through Dec. 31 of the current year (10 years) • CPT: 44388–44392, 44394, 44401–44408, 45378–45382, 45384–45386, 45388–45393, 45398 • HCPCS: G0105, G0121 **Note:** The codes below within the HEDIS value set for this measure are considered obsolete and may be denied for payment processing, if received on claims/encounters submission: • CPT: 44393, 44397, 45339, 45345, 45355, 45383, 45387 • ICD-9 Procedure: 45.22, 45.23, 45.25, 45.42 and 45.43

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report (sample of codes)**
Controlling Blood Pressure (CBP) **Weight = 3** Percentage of hypertensive patients 18–85 years old whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the current measurement year. **Exclusions** • Patients in hospice, using hospice services or receiving palliative care • Patients 66–85 years old in long-term or institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) • Patients 66–80 years old with frailty and advanced illness or 81–85 years old with frailty only • Patients with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant • Patients who had a non-acute inpatient admission during the measurement year • Pregnant women	• 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 BP readings can be collected via outpatient and telehealth visits including real-time, interactive audio/video visits, audio-only and online assessments, as well as remote monitoring devices that transmit results to your office. Your patients can also report their results to you. **NOTE:** Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.	**Note:** Document the actual blood pressure reading. To pass administratively, the most recent adequately controlled blood pressure reading of the year must be documented and reported. If there are multiple BPs on the same date of service, record the lowest systolic and diastolic BP on that date as the representative BP. **Physician codes** • CPT II codes: – Systolic: 3074F, 3075F, 3077F* – Diastolic: 3078F, 3079F, 3080F* • ICD-10 diagnosis: I10 • CPT: 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474 *These results do not meet Star measure control levels and will not fully address care opportunities. However, these codes should be used to verify that the test was performed and for monitoring/reporting of results.

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

Healthcare Effectiveness Data and Information Set (HEDIS)

Measure	Service needed	What to report *(sample of codes)*
Diabetes Care • 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 activity 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, telehealth, observation, emergency department or non-acute inpatient visits – Telehealth visits include real-time, interactive audio/video visits, audio-only and online assessments – Can be any combination of visit types that occurred on different dates of service **Exclusions** • Patients in hospice, using hospice services or receiving palliative care • Patients with polycystic ovary syndrome (PCOS) • Patients with gestational or steroid-induced diabetes • 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 **NOTE:** Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.		
Measure	**Service needed**	**What to report** *(sample of codes)*
Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes (HBD) **Weight = 3** Percentage of eligible diabetic patients who have evidence of an HbA1c test with a level of 9% or less.	• 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	**Physician codes** • CPT II: 3044F (< 7%), 3051F (≥ 7% and < 8%), 3052F (≥ 8% and ≤ 9%), 3046F (> 9%) **Pathology/laboratory codes** • CPT: 83036, 83037 Note: Listed below are codes within the HEDIS value set for this measure that are considered obsolete and may be denied for payment processing, if received on claims/encounters submission. • CPT: 3045F A copy of all lab results should be kept in the patient's medical record. Only the most recent result is counted for the measure and a patient's clinical opportunity may reopen if the test has a noncompliant or missing result.

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Diabetes Care – Eye Exam for Patients with Diabetes (EED) **Weight = 1** Percentage of eligible diabetic patients who have received a screening or monitoring for diabetic retinal disease.	• 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 any time during the patient's history or the current measurement year **Note:** Obtain the record of an eye exam performed in the current year by an ophthalmologist or optometrist and retain in the patient's medical record.	**Physician codes** • CPT II – Without retinopathy – 2023F, 2025F, 2033F and 3072F – With retinopathy – 2022F, 2024F, 2026F **Eye professional codes** Must be submitted by an ophthalmologist or an optometrist: • CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114, 67028, 67030, 67031, 67036, 67039–67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002†, 92004†, 92012†, 92014†, 92018, 92019, 92134†, 92225–92228†, 92230†, 92235†, 92240†, 92250†, 92260†, 99203–99205, 99213–99215, 99242–99245 • HCPCS: S0620, S0621, S3000 • ICD-10 Procedure: 08T0XZZ, 08T1XZZ † Cost share will apply if not billed with diabetes diagnosis codes E08–E13
Diabetes Care Nephropathy (NPH) **Weight = 1** NCQA retired the NPH measure as of MY22 but as of 01/06/2022, CMS has not clarified the potential retirement of this measure (anticipating replacement by new Kidney Disease Measure – KED). Percentage of eligible diabetic patients who received a nephropathy screening or monitoring test, or have evidence of nephropathy in the current measurement year.	• Nephropathy screening or monitoring test for albumin or protein • Angiotensin converting enzyme inhibitor or angiotensin receptor blocker (ACE/ARB) therapy or dispensed medication • A visit with a nephrologist • Evidence of or treatment for kidney disease or kidney transplant	**Physician codes** *Nephropathy screening tests:* • CPT: 81000–81003, 81005, 82042–82044, 84156 • CPT II: 3060F, 3061F, 3062F *Treatment for nephropathy:* • CPT II: 3066F, 4010F (ACE/ARB therapy) *Dialysis, kidney disease or transplant* • CPT: 50340, 50360, 50365, 50370, 50380 • HCPCS: S2065, S9339 • ICD-10 Diagnosis: N18.4, N18.5, N18.6, Z99.2 • ICD-10 Procedure: 0TB00ZX, 0TB00ZZ, 0TB03ZX, 0TB03ZZ, 0TB04ZX, 0TB04ZZ, 0TB07ZX, 0TB07ZZ, 0TB08ZX, 0TB08ZZ, 0TB10ZX, 0TB10ZZ, 0TB13ZX, 0TB13ZZ, 0TB14ZX, 0TB14ZZ, 0TB17ZX, 0TB17ZZ, 0TB18ZX, 0TB18ZZ, 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

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

Healthcare Effectiveness Data and Information Set (HEDIS)

Measure	Service needed	What to report *(sample of codes)*
Osteoporosis Management in Women who had a Fracture (OMW) **Weight = 1** Percentage of females 67–85 years old who suffered a fracture* and who had either a bone mineral density (BMD) test or prescription to treat or prevent osteoporosis in the six months after the fracture. *Fractures of face, skull, fingers or toes are excluded **Exclusions** • Patients in hospice, using hospice services or receiving palliative care • Patients 67–85 years old living long-term in an institutional setting or 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 only	Within six months of fracture date or date of discharge (if hospitalized for a fracture): • A BMD test in any setting including tests administered during inpatient stay for fracture **or** • Dispensed osteoporosis medication therapy including any long-acting treatment provided during inpatient stay for fracture Patients are removed from the eligible population if they have had any one of the following: • BMD test within 24 months prior to the fracture • Dispensed osteoporosis medication therapy including any long-acting treatment provided during inpatient stay for fracture • NOTE: Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments	**Physician codes** *Osteoporosis therapy – medication injections* • HCPCS: J0897, J1740, J3110, J3111, J3489 **Radiology codes** *Bone mineral density test* • CPT: 76977, 77078, 77080, 77081, 77085, 77086 • ICD-10 Procedure: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **Note:** The codes within the HEDIS value set for this measure listed below are considered obsolete and may be denied for payment processing, if received on claims/encounters submission: • CPT: 77082 **Osteoporosis medications** *Bisphosphonates, with HCPCS if applicable* • Alendronate • Ibandronate, J1740 • Zoledronic acid, J3489 • Risedronate *Other agents* • Denosumab, J0897 • Raloxifene • Romosozumab, J3111 • Abaloparatide • Teriparatide, J3110

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

Healthcare Effectiveness Data and Information Set (HEDIS)

Measure	Service needed	What to report *(sample of codes)*
Statin Therapy for Patients with Cardiovascular Disease (SPC) **Weight = 1** 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 in the current measurement year. **Exclusions** • Patients in hospice, using hospice or receiving palliative care • Patients 66–75 years old who: – Live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP) **or** – Have frailty and advanced illness • Patients with the following diagnoses or services in the current or prior measurement year: – Pregnancy or in-vitro fertilization (IVF) – Cirrhosis – Dispensed clomiphene medication – End-stage renal disease (ESRD) or dialysis • Patients with myalgia, myositis, myopathy or rhabdomyolysis during the current measurement year	At least one dispensing event for a high- or moderate-intensity statin medication in the measurement year 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** – during the current or prior measurement year: At least one acute inpatient or outpatient visit with a diagnosis of ischemic vascular disease (IVD) **NOTE**: Frailty can be diagnosed via a real-time, interactive audio/video telehealth visit. Advanced illness can be diagnosed via telehealth visits including audio-only and online assessments.	**Statin medications** The statin medications listed below will address your patient's open SPC opportunities with a processed pharmacy claim. • **Moderate-intensity statin therapy** – Atorvastatin 10–20 mg* – Pitavastatin 1–4 mg – Simvastatin 20–40 mg – Rosuvastatin 5–10 mg – Pravastatin 40–80 mg – Lovastatin 40 mg – Fluvastatin 40 mg – Fluvastatin XL 80 mg • **High-intensity statin therapy** – Atorvastatin 40–80 mg – Rosuvastatin 20–40 mg – Simvastatin 80 mg** *Evidence from one randomized controlled trials (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.

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

Healthcare Effectiveness Data and Information Set (HEDIS)

Care Coordination Measures

There is a group of four HEDIS Star measures that comprise HEDIS Care Coordination measures:

- Follow-Up after Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC)
- Medication Reconciliation Post-Discharge (MRP)
- Plan All-Cause Readmissions (PCR)
- Transitions of Care (TRC) which is an average of four display measures:
  - Notification of Inpatient Admission (TRC–NIA) (Display)
  - Receipt of Discharge Information (TRC–RDI) (Display)
  - Patient Engagement after Inpatient Discharge (TRC–PED) (Display)
  - Medication Reconciliation Post-Discharge (TRC–MRP) (Display)

Note: There is a CAHPS measure that is also referred to as Care Coordination (CC).

Measure	Service needed	What to report *(sample of codes)*
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) **Weight = 1** The eligible population for this measure includes Medicare Advantage patients 18 years old and older with multiple high-risk chronic conditions who visit an ED on or between Jan. 1–Dec. 24 of the measurement year. **Exclusions** • Patients in hospice or using hospice services • Any ED visit that results in an inpatient admission on the day of, or within seven days following, the ED visit • ED visits occurring within the same eight-day period Example: An ED visit on April 1 is in scope, but subsequent visits occurring April 2–8 are not. If the same member visits an ED on April 9, this would be a new event requiring follow-up.	Members must have a follow-up visit or service within seven days of the ED visit via: • An outpatient or telehealth visit, including those for behavioral health (BH) services in a clinic, at home or at a community mental health center • An outpatient or partial hospitalization stay including observation visits • Transitional care management services • A case management visit • Complex care management services • Monitored electroconvulsive therapy in an outpatient, ambulatory surgical or partial hospitalization setting	**Note:** FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed by a physician.

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Medication Reconciliation Post-Discharge (MRP) **Weight = 1** Percentage of discharges from Jan. 1–Dec. 1 of the current measurement year for patients 18 years old and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). **Exclusions** • Patients in hospice or using hospice services	• Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse (RN) on the patient's date of discharge through 30 days after discharge (31 total days) • Document all medication reconciliations with a dated notation in outpatient medical records **Additional considerations:** • Medication name is required; while dose and frequency are not required, their inclusion is highly recommended. • The reconciled medication list should be communicated to the discharged patient by a clinician. • Medication reconciliation may be done via office visit, home visit or telehealth visits including real-time, interactive audio/video visits and audio-only.	**Physician codes** • CPT: 99483, 99495, 99496 • CPT II: 1111F **Notations for a complete medication reconciliation may include:** • Current medications with a notation that a 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 discharge summary that discharge medications were reconciled with most recent medication list in outpatient record; must include 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

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Plan All-Cause Readmissions (PCR) **Weight = 1 (MY22), 3 (MY23)** 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. *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. **Exclusions** • Pregnant women • Patients in hospice or using hospice services • Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1 of the current measurement year • For stays that included a direct transfer, exclude original admission's discharge date. Only the last discharge should be considered.	No particular service is needed. 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.	No reporting is needed from healthcare providers.

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

Care Coordination: Transitions of Care (TRC) 1.0

The Transitions of Care measure evaluates patient engagement provided within 30 days after an acute or non-acute discharge. This 1.0 weighted measure is an average of four display submeasures: MRP, NIA, PED, RDI

Exclusions

- Patients in hospice or using hospice services
- Discharges occurring after Dec. 1 of the measurement year

Note: There is a CAHPS measure that is also referred to as Care Coordination (CC).

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Transitions of Care – Notification of Inpatient Admission (TRC–NIA) **Weight = Display**	• Documentation of receipt of notification of inpatient admission on the day of admission or the two following days • To address the measure, the patient's outpatient medical record must include documentation by his/her primary care physician (PCP) practice of receipt of notification of inpatient admission on the day of admission or within the two following days • Evidence must include the date the documentation was received. This evidence can only be collected via medical record review; there are no claim codes for TRC–NIA • If the discharge is preceded by an observation stay, use the admit date from the acute or nonacute inpatient stay. If an observation stay turns into an inpatient admission, the admit notification must be documented as being received on the admit date of the observation stay or within the two following days • Notification of admission by the patient or the patient's family to the PCP or ongoing care provider does not meet criteria • Any documentation that does not include a timeframe or date stamp does not meet criteria	For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable and: • Must clearly apply to the admission event and include the time frame for the planned inpatient admission • Is not limited to the admit date or the two following days

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Transitions of Care – Receipt of Discharge Information (TRC–RDI) **Weight = Display**	• Documentation of receipt of notification of inpatient discharge on the day of discharge or the two following days • To address the measure, the patient's outpatient medical record must include documentation by his/her PCP practice that discharge information was received on the day of discharge or within the two following days. Evidence must include a date stamp when the documentation was received. Any documentation that does not include a time frame or date stamp does not meet criteria • Evidence must include the date the documentation was received. This evidence can only be collected via medical record review; there are no claim codes for TRC–RDI • Discharge information may be included in: – A discharge summary – A summary of care record • Structured fields in an electronic health record (EHR)	

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Transitions of Care – Patient Engagement after Inpatient Discharge (TRC–PED) **Weight = Display**	• Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge • To address the measure, the patient must be engaged within 30 days of discharge via: – Outpatient visits, including office or home visits – A telephone visit – A synchronous telehealth visit where real-time interaction occurred between the patient and his/her PCP with audio and video communication – An e-visit or virtual check-in (asynchronous where two-way interaction, which was not real-time, occurred between the member and provider) **Note:** If a patient is unable to communicate, his/her PCP can interact with a caregiver.	Physician codes CPT: 98966–98968, 99442–99443, 99495, 99496, and modifier 95

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

Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Transitions of Care – Medication Reconciliation Post-Discharge (TRC–MRP) **Weight = Display**	• Documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse (RN) on the day the patient is discharged from the hospital through 30 days after discharge (31 total days) • 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 • When patients are directly transferred to another facility, perform reconciliation for final discharge	

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

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.

Measure	Best practices	Survey questions
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 a urine leakage problem in the past six months and who discussed treatment options with a healthcare provider. **Exclusions** • Patients in hospice	• Discuss bladder control issues and symptoms with your older patients, including during telehealth visits. • Ask patients to keep a daily diary tracking when they urinate and when they experience urine leakage. • Assist patients with 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.	• 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?
Improving or Maintaining Mental Health (IMMH) **Weight = 0** Percentage of surveyed patients 65 years old and older whose mental health status was better than expected or remained the same after two years. **No member/patient exclusions exist for this measure.**	• Administer PHQ-2 and PHQ-9 Mental Health Assessments. • 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. Try to have these discussions during all visits, including telehealth. • Provide written materials regarding mental well-being and identify local resources. • Listen to patients' stories and suggest activities or recommend medication, when necessary.	• During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? – Accomplished less than you would like as a result of any emotional problems – Didn't do work or other activities as carefully as usual as a result of any emotional problems • How much of the time during the past four weeks: – Have you felt calm and peaceful? – Did you have a lot of energy? – Have you felt downhearted and blue? • During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

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

Health Outcomes Survey (HOS)		
Measure	**Best practices**	**Survey questions**
Improving or Maintaining Physical Health (IMPH) **Weight = 0** Percentage of surveyed patients 65 years old and older whose physical health status was better than expected or remained the same. **No member/patient exclusions exist for this measure.**	• 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.	• The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? – Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? – Climbing several flights of stairs? • During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? – Accomplished less than you would like as a result of your physical health? – Were limited in the kind of work or other activities as result of your physical health? • During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
Monitoring Physical Activity – Physical Activity in Older Adults (PAO) **Weight = 1** Percentage of surveyed patients 65 years old and older who 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. **Exclusions** • Patients in hospice • Patients responding "I had no visits in the past 12 months"	• Explain to patients that an exercise regimen could increase their 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.	• In the past 12 months, did you talk with a doctor or other healthcare provider about your level of exercise or physical activity? For example, a doctor or other healthcare provider may ask if you exercise regularly or take part in physical exercise. • In the past 12 months, did a doctor or other healthcare 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 healthcare 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.

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

Health Outcomes Survey (HOS)		
Measure	**Best practices**	**Survey questions**
Fall Risk Management (FRM) **Weight = 1** Percentage of patients 65 years old and older who in the past 12 months had a fall or had problems with balance or walking, were seen by a practitioner in the past 12 months and received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner. **Exclusions** • Patients in hospice and answering "I had no visits in the past 12 months"	• Take advantage of and share the Centers for Disease Control and Prevention's (CDC) Stopping Elderly Accidents, Deaths & Injuries (STEADI) online training and materials. • Educate your patients to discuss fear of falling or feelings of imbalance and have discussions with them about any existing fears or feelings of unsteadiness. Discuss during all visits including telehealth. • Assess patients' risk factors and share information and resources that might assist in reducing the risk of falls in their homes and daily lives such as recommending shoes that provide extra security. • Advise your Humana-covered patients to use their over-the-counter (OTC) benefits and Humana Pharmacy's OTC product catalog to purchase items that may help, such as canes or night lights.	• A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other healthcare 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 that might be suggested 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 – Patient survey questions

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

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 patient experience with his or her physicians and other healthcare providers, the remaining three correlate to patient experience with their MA plan. There are no member/patient exclusions for CAHPS® measures.

Measure	Best practices	Survey questions
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 through June each year). **No member/patient exclusions exist for this measure**	• Stress the importance of flu vaccination for all patients in your practice, as it can increase the herd immunity effect. • Talk to patients about getting vaccinated during regularly scheduled visits 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 scheduling appointments is 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.	• Have you had a flu shot since July 1 (prior year)?

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)		
Measure	**Best practices**	**Survey questions**
Care Coordination (CC) **Weight = 4** Assesses how well patient care is coordinated including whether or not doctors had the records and information they needed about patients' care and how quickly patients got their test results. **Note:** There are four HEDIS Star measures that are also referred to as Care Coordination measures. See Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC), Medication Reconciliation Post-Discharge (MRP), Plan All-Cause Readmissions (PCR) and Transitions of Care (TRC). **No member/patient exclusions exist for this measure**	• 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 the 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 patient is in your office, give them the names and phone numbers to call specialists. • Schedule follow-up with patient within one month of the specialist visit to discuss 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. Have your Humana-covered patients use their over-the-counter (OTC) benefits and Humana Pharmacy's OTC product catalog to purchase items that may help them organize medication, such as medication pill boxes. • Review all of your patient's medications, including prescription medicines, over-the-counter medications and herbal or supplemental therapies. This review can occur during telehealth visits. • Complete and provide a medication action plan and/or personal medication list to educate and help patients organize medication-related information.	• 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?

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)		
Measure	**Best practices**	**Survey questions**
Getting Appointments and Care Quickly (GACQ) **Weight = 4** Assesses how quickly the patients were able to get appointments and care. **No member/patient exclusions exist for this measure**	• If possible, schedule patients' follow-up visits and provide discharge summary in the exam room before patients leave their 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. Suggest they arrive a few minutes early to complete any required intake forms. • 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.	• In the last six months, when you needed care right away, how often did you get care as soon as you thought 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?
Getting Needed Care (GNC) **Weight = 4** Assesses how easy it was for patients to get needed care and see specialists. **No member/patient exclusions exist for this measure**	• 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 for an appointment. • Use specialist appointment reminder cards so patients remember that your office assisted in scheduling the follow-up appointment. • Check the current preauthorization and notification list(s) at **Humana.com/PAL** to determine if the service requires preauthorization before being administered. • If a service requires preauthorization, obtain approval from Humana before performing or ordering it.	• 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?

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)		
Measure	**Best practices**	**Survey questions**
Getting Needed Prescription Drugs (GNRx) **Weight = 4** Assesses how easy it is for patients to get the medicines their doctor prescribed. **No member/patient exclusions exist for this measure.**	• Consult the Humana formulary at **Humana.com/MedicareDrugList** prior to prescribing a new medication. • Check the current preauthorization and notification list(s) at **Humana.com/PAL** to determine if a medication requires preauthorization before it can be dispensed or administered. • If available and clinically appropriate, consider a generic or lower-cost brand alternative drug or therapeutic equivalent. • Recommend switching to 90-day supplies from their community pharmacy or via a mail-order pharmacy.	• 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?
Rating of Health Care Quality (RHCQ) **Weight = 4** Assesses patients' view of the quality of the healthcare they received. **No member/patient exclusions exist for this measure**	• Ask questions to gauge the patient's current experience and perception of the care they are receiving from your practice, specialists and other healthcare providers. • Based on feedback, discuss options to improve the perception of their healthcare. • 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	• Using any number from 0 to 10, in which 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all of your healthcare in the last six months?

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

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 MA organizations such as Humana. 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 the 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.
- Refer patients to **Humana.com/TakeMyMedicine** for adherence tips and tools.

Medication adherence measure	Exclusions
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.	• 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, DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors.	• Patients in hospice • Patients with end-stage renal disease (ESRD) • Prescription(s) filled for insulin

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

Patient Safety

Medication adherence measure	Exclusions
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.	• Patients in hospice • Patients with end-stage renal disease (ESRD) • Prescription(s) filled for Entresto® (sacubitril/valsartan)

Measure	Activity needed	Best practices
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. MTM eligibility criteria: • Have three of the following five chronic diseases: – Diabetes mellitus – Congestive heart failure – Dyslipidemia – Rheumatoid arthritis – Asthma • Minimum of eight Part D medications • Anticipated Part D drug cost of more than $4,430 per year Eligibility is determined by looking back at the most recent three months' calculation. **Exclusions** • Patients in hospice	• An interactive, person-to-person or telehealth medication review and consultation of all medications must be 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. • Medication reviews can be completed via all telehealth methods including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals.	• 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 – Provide contact information for 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 • Inform patients with Humana coverage that they can schedule a CMR by calling Humana Pharmacy at **855-202-2510**, Monday – Friday, 8 a.m. – 7 p.m., Eastern time.

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

Patient Safety		
Measure	**Activity needed**	**Best practices**
Statin Use in Persons With Diabetes (SUPD) **Weight = 1** 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. **Exclusions** • Patients in hospice care • Patients with a diagnosis of end-stage renal disease (ESRD) • Patients with rhabdomyolysis or myopathy • Patients who are pregnant, lactating or undergoing therapy for fertility • Patients with liver disease • Patients with prediabetes • Patients with polycystic ovary syndrome (PCOS)	• At least one fill for a statin medication of any intensity in the measurement year. • Use lists of SUPD eligible patients to review medications and evaluate addition of statin therapy to existing regimen in alignment with the 2018 American College of Cardiology and American Heart Association (ACC/AHA) guidelines.	• Use noncompliant patient lists to review medications and evaluate addition of statin therapy to regimen. • Assess patients with cardiovascular disease for statin therapy in alignment with the 2018 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. • Cross-reference patients qualifying for SUPD with members qualifying for SPC. If the member qualifies for both measures, consider a moderate or high-intensity statin as you deem medically appropriate.

Please ensure that all telehealth or telephone/virtual visits are billed in accordance with Humana's telehealth guidance. For more information, visit **Humana.com/provider/telehealth-faq**.

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® Current Procedural Terminology and Current Procedural Terminology Category II (CPT II) codes are developed by the American Medical Association. CPT codes are used to communicate services and procedures rendered to patients. CPT II codes are supplemental tracking codes used for quality performance measurement.

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

ICD-10 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).