Quality Indicator Physician Medicare HEDIS®, HOS, CAHPS® and Part D Safety Measures Guide for 2018 (Measurement Year 2017)

Note: HEDIS codes can change from year to year. The codes in this document are from the HEDIS 2017 specifications.

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 those areas where a stronger focus could lead to improvements in member health. HEDIS reporting is mandated by the NCQA for compliance and accreditation. Current ICD-10, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology® (CPT) manuals should be used at all times.

Measure	Service needed	What to report *(sample of codes)*
Breast cancer screening (BCS) **Weight = 1** Percentage of women 50 to 74 years old who had a mammogram	• Mammogram between Oct. 1, 2015, and Dec. 31, 2017	**Radiology codes** • **CPT:** 77065 – 77067 • **HCPCS:** G0202 **Hospital codes** • **UB revenue:** 0403 **Medical record documentation** • Members excluded if medical record documentation supports history of bilateral mastectomy
Controlling blood pressure (CBP) **Weight = 3** Percentage of members 18 to 85 years old diagnosed with hypertension whose blood pressure was adequately controlled during the measurement year based on the following criteria**:** • Members 18 to 59 years old whose blood pressure was less than 140/90 mmHg • Members 60 to 85 years old with a diagnosis of diabetes whose blood pressure was less than 140/90 mmHg • Members 60 to 85 years old without a diagnosis of diabetes whose blood pressure was less than 150/90 mmHg	**Documentation in the member's medical record of:** • Hypertension diagnosis **between Jan. 1, 2017, and June 30, 2017** **and** • The most recent blood pressure reading in 2017 based on age and diabetes diagnosis	**Medical record documentation** • Hypertension diagnosis documented on or before June 30, 2016 • Document the actual blood pressure reading. To pass, the most recent adequately controlled blood pressure reading of the year must be documented. **Additional information** • Providers are able to submit the following CPT Category II codes**:** o Systolic: 3074F, 3075F, 3077F o Diastolic: 3078F, 3079F, 3080F **Note:** CPT category II codes for systolic blood pressure greater than 140 currently do not exist. • ICD-10-CM diagnosis for hypertension I10 places the member in the measure.

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Healthcare Effectiveness Data and Information Set (HEDIS®)		
Measure	**What service is needed**	**What to report** *(sample of codes)*
Colorectal cancer screening (COL) Weight = 1 Percentage of members 50 to 75 years old who have evidence of one of the following five screenings: • Fecal occult blood test • Flexible sigmoidoscopy • Colonoscopy • CT colonography • FIT-DNA Test	• Fecal occult blood test (FOBT, gFOBT or iFOBT) in **2017** **and/or** • Flexible sigmoidoscopy or CT colonography in the **past 5 years** **and/or** • Colonoscopy in the **past 10 years** **and/or** • FIT-DNA in the **past 3 years** **Note:** Clear documentation of previous colonoscopy or sigmoidoscopy, including year performed, is required.	**Pathology/laboratory codes** Fecal occult blood test between Jan. 1, 2017, and Dec. 31, 2017. • **CPT:** 82270, 82274 • **HCPCS:** G0328 • **LOINC:** 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6 **Surgery/hospital codes** Flexible sigmoidoscopy between Jan. 1, 2013, and Dec. 31, 2017. • **CPT:** 45330 – 45335, 45337 – 45342, 45345 – 45350 • **HCPCS:** G0104 CT colonography between Jan. 1, 2013, and Dec. 31, 2017. • **CPT:** 74263 Colonoscopy between Jan. 1, 2008, and Dec. 31, 2017. • **CPT:** 44388 – 44394, 44397, 44401 – 44408, 45355, 45378 – 45393, 45398 • **HCPCS:** G0105, G0121 FIT-DNA test between Jan. 1, 2015, and Dec. 31, 2017. • **CPT:** 81528 • **HCPCS:** G0464 • **LOINC:** 77353-1, 77354-9 **Medical record documentation** • Chart documentation as part of the medical history of colorectal screening performed within the required time frame

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** ***(sample of codes)***
Diabetes – dilated or retinal eye exam (CDC2-EYE) **Weight = 1** Percentage of diabetic members 18 to 75 years old who have received a comprehensive eye exam	• Encourage and/or refer member to see an eye care professional for a **comprehensive eye exam during 2017**.	**Physician codes** *Obtain the record of an eye exam performed in **2017** by an ophthalmologist or optometrist. Retain a copy of the exam in the member's medical record.* • **CPT Category II:** 2022F, 2024F, 2026F *Obtain the record of an eye exam performed in **2016** by an ophthalmologist or optometrist. **The eye exam must be clear that the member had a dilated/retinal eye exam by an eye care professional and retinopathy was not present.** Retain a copy of the exam in the member's medical record.* • **CPT Category II:** 3072F* *You may use ICD-10-CM code Z02.89 in conjunction with this CPT II code to demonstrate review of the 2016 medical chart. **Eye professional codes** *The following codes must be submitted by an ophthalmologist or an optometrist.* • **CPT:** 67028, 67030, 67031, 67036, 67039 – 67043, 67101, 67105, 67107, 67108, 67110, 67112, 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 • **CPT Category II:** 2022F, 2024F, 2026F, 3072F • **ICD-10-CM diagnosis code:** E10.9, E11.9, E13.9

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Measure	**Service needed**	**What to report** ***(sample of codes)***
Diabetes – HbA1c screening and control (CDC2-HBATEST and CDC2-HBAPOOR) **Test weight = N/A** **Poor control weight = 3** Percentage of diabetic members 18 to 75 years old who have evidence of: • HbA1c testing • HbA1c poor control (greater than 9 percent)	• At least one HbA1c test in 2017 for all eligible members • The goal is for the **most recent** HbA1c level in **2017** to be less than **9 percent.**	**Physician codes** • **CPT Category II:** 3044F, 3045F, 3046F *Note: These codes count for both the HbA1c test AND HbA1c level.* **Pathology/laboratory codes** • **CPT:** 83036, 83037 • **LOINC:** 4548-4, 4549-2, 17856-6 ***Note:*** *Pathology/laboratory codes count for the HbA1c test measure. They must include the result value to count for the HbA1c poor control measure.* A copy of all lab results should be kept in the member's medical record.

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Diabetes – nephropathy (CDC2-NPH) **Weight = 1** Percentage of diabetic members 18 to 75 years old who received medical attention for nephropathy (nephropathy screening test or evidence of nephropathy)	• Nephropathy screening **testing on all diabetic members in 2017 with:** - Urine protein test **and/or** • Documented evidence of nephropathy with: - Medical attention for nephropathy in 2017 **and/or** • Nephrology **consult in 2017** (include if primary care physician also is a nephrologist) **and/or** • A dispensed prescription for angiotensin-converting enzyme (ACE) inhibitor/angiotensin receptor blockers (ARB) therapy in **2017**	**Physician codes** *Nephropathy screening tests:* • **CPT Category II:** 3060F, 3061F, 3062F *Evidence of ACE/ARB therapy:* • **CPT Category II:** 4010F *Treatment for nephropathy:* • **CPT Category II:** 3066F • **ICD-10-CM diagnosis:** E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0 – N08, N14.0-4, N17.0-2, N17.8, N17.9, N18.1-6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0-6, Q61.00-02, Q61.11, Q61.19, Q61.2-5, Q61.8, Q61.9, R80.0-3, R80.8, R80.9 *Evidence of nephropathy – CKD stage 4:* • **ICD-10-CM diagnosis:** N18.4 *Evidence of nephropathy – kidney transplant:* • **ICD-10-CM diagnosis:** Z94.0 *Evidence of nephropathy – ESRD:* • **ICD-10-CM diagnosis:** N18.5, N18.6, Z91.15, Z99.2 **Pathology/laboratory codes** *Nephropathy screening tests:* • **CPT:** 82042, 82043, 82044, 84156 • **LOINC:** 1754-1, 1755-8, 1757-4, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13705-9, 13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1 *The following codes are for urine macroalbumin tests.* **CPT**: 81000 – 81003, 81005 • **LOINC**: 5804-0, 20454-5, 50561-0, 53525-2, 57735-3

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** ***(sample of codes)***
Diabetes – nephropathy (CDC2-NPH) **Continued**		**<u>Surgery/hospital codes/specialist codes</u>** *Evidence of nephropathy – kidney transplant:* • **CPT:** 50300, 50320, 50340, 50360, 50365, 50370, 50380 • **HCPCS:** S2065 • **UB revenue:** 0367 • **ICD-10-CM procedure:** 0TY00Z0 – 0TY00Z2, OTY10Z0 – OTY10Z2 *Evidence of nephropathy – ESRD:* • **CPT:** 36147, 36800, 36810, 36815, 36818 – 36821, 36831 – 36833, 90935, 90937, 90940, 90945, 90947, 90957 – 90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512 • **HCPCS:** G0257, S9339 • **ICD-10-CM procedure:** 3E1M39Z, 5A1D00Z, 5A1D60Z • **POS:** 65 • **UB revenue:** 0800 – 0804, 0809, 0820 – 0825, 0829 – 0835, 0839 – 0845, 0849 – 0855, 0859, 0880 – 0882, 0889 • **UB TOB:** 0720 – 0725, 0727, 0728, 072A – 072K, 072M, 072O, 072X – 072Z **<u>NDC codes</u>** There are several NDC codes for ACE/ARB therapy that indicate compliance (based on pharmacy claims received by CarePlus NCQA posts a comprehensive list of these NDC codes on its website each year. **<u>Specialist visit</u>** Any visit with a nephrologist would make a member compliant with the measure. CarePlus will identify these claims by the type of provider rendering the service (no specific codes are needed on the claim).

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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 to 85 years old who suffered a fracture and had either a bone mineral density (BMD) test or prescription to treat or prevent osteoporosis in the six months after the fracture ***To exclude***: Either a BMD within 24 months or drug treatment for osteoporosis within 12 months prior to the fracture date	• Perform **bone mineral density testing within 180 days of fracture date.** **and/or** • Prescribe a **medication to treat or prevent osteoporosis within 180 days (six months) after the fracture.**	**Physician codes** *Osteoporosis therapy – medication injections* • **HCPCS:** J0630, J0897, J1740, J3110, J3487, J3488, J3489 **Radiology codes** *Bone mineral density test* • **CPT:** 76977, 77078, 77080, 77081, 77082, 77085, 77086 • **HCPCS:** G0130 • **ICD-10-CM procedure:** BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **NDC codes** There are several NDC codes for prescriptions to treat osteoporosis based on pharmacy claims received by CarePlus. NCQA posts a comprehensive list of these NDC codes on its website each year. • **Description: Bisphosphonates** ▪ Alendronate ▪ Alendronate-cholecalciferol ▪ Calcium carbonate-risedronate ▪ Ibandronate ▪ Risedronate ▪ Zoledronic acid • **Description: Other agents** ▪ Calcitonin ▪ Denosumab ▪ Raloxifene ▪ Teriparatide **Additional information** ***The following codes identify fractures (eligible members)*** • **HCPCS:** S2360

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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) **Continued**		**ICD-10-CM diagnosis:** M48.4 Fatigue fracture of vertebra M84.3 Stress fracture, unspecified site **S12 Fracture of cervical vertebra and other parts of neck** S12.0 Fracture of first cervical vertebra S12.1 Fracture of second cervical vertebra S12.2 Fracture of third cervical vertebra S12.3 Fracture of fourth cervical vertebra S12.4 Fracture of fifth cervical vertebra S12.5 Fracture of sixth cervical vertebra S12.6 Fracture of seventh cervical vertebra S12.8 Fracture of other parts of neck S12.9 Fracture of neck, unspecified **S22 Fracture of rib(s), sternum and thoracic spine** S22.0 Fracture of thoracic vertebra S22.2 Fracture of sternum S22.3 Fracture of one rib S22.4 Multiple fractures of ribs S22.5 Flail chest S22.9 Fracture of bony thorax, part unspecified **S32 Fracture of lumbar spine and pelvis** S32.0 Fracture of lumbar vertebra S32.1 Fracture of sacrum S32.2 Fracture of coccyx S32.3 Fracture of ilium S32.4 Fracture of acetabulum S32.5 Fracture of pubis S32.6 Fracture of ischium S32.8 Fracture of other parts of pelvis S32.9 Fracture of unspecified parts of lumbosacral spine and pelvis **S42 Fracture of shoulder and upper arm** S42.0 Fracture of clavicle S42.1 Fracture of scapula S42.2 Fracture of upper end of humerus S42.3 Fracture of shaft of humerus S42.4 Fracture of lower end of humerus S42.9 Fracture of shoulder girdle, part unspecified **S49 Other and unspecified injuries of shoulder and upper arm** S49.0 Physeal fracture of upper end of humerus S49.1 Physeal fracture of lower end of humerus **S52 Fracture of forearm**

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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) **Continued**		S52.0 Fracture of upper end of ulna S52.1 Fracture of upper end of radius S52.2 Fracture of shaft of ulna S52.3 Fracture of shaft of radius S52.5 Fracture of lower end of radius S52.6 Fracture of lower end of ulna S52.9 Unspecified fracture of forearm **S59 Other and unspecified injuries of elbow and forearm** S59.0 Physeal fracture of lower end of ulna S59.1 Physeal fracture of upper end of radius S59.2 Physeal fracture of lower end of radius **S62 Fracture at wrist and hand level** S62.0 Fracture of navicular (scaphoid) bone of wrist S62.1 Fracture of other and unspecified carpal bone(s) S62.2 Fracture of first metacarpal bone S62.3 Fracture of other and unspecified metacarpal bone S62.9 Unspecified fracture of wrist and hand **S72 Fracture of femur** S72.0 Fracture of head and neck of femur S72.1 Pertrochanteric fracture S72.2 Subtrochanteric fracture of femur S72.3 Fracture of shaft of femur S72.4 Fracture of lower end of femur S72.8 Other fracture of femur S72.9 Unspecified fracture of femur **S79 Other and unspecified injuries of hip and thigh** S79.0 Physeal fracture of upper end of femur S79.1 Physeal fracture of lower end of femur **S82 Fracture of lower leg, including ankle** S82.0 Fracture of patella S82.1 Fracture of upper end of tibia S82.2 Fracture of shaft of tibia S82.3 Fracture of lower end of tibia S82.4 Fracture of shaft of fibula S82.5 Fracture of medial malleolus S82.6 Fracture of lateral malleolus S82.8 Other fractures of lower leg S82.9 Unspecified fracture of lower leg **S89 Other and unspecified injuries of lower leg** S89.0 Physeal fracture of upper end of tibia S89.1 Physeal fracture of lower end of tibia S89.2 Physeal fracture of upper end of fibula S89.3 Physeal fracture of lower end of fibula

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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) **Continued**		**S92 Fracture of foot and toe, except ankle** S92.0 Fracture of calcaneus S92.1 Fracture of talus S92.2 Fracture of other and unspecified tarsal bone(s) S92.3 Fracture of metatarsal bone(s) S92.9 Unspecified fracture of foot and toe Please specify ICD-10 code(s) to the highest level of specificity, using fourth, fifth and sixth digits as appropriate and a seventh character when required as appropriate with ICD-10 guidelines. (See appendix for the complete listing of OMW ICD-10 codes.) • **CPT:** 21800, 21805, 21810 – 21813, 21820, 21825, 22305, 22310, 22318, 22319, 22520, 22521, 22523, 22524, 23500, 23505, 23515, 23570, 23575, 23585, 23600, 23605, 23615, 23616, 23620, 23625, 23630, 23665, 23670, 23675, 23680, 24500, 24505, 24515, 24516, 24530, 24535, 24538, 24545, 24546, 24560, 24565, 24566, 24575 – 24577, 24579, 24582, 24620, 24635, 24650, 24655, 24665, 24666, 24670, 24675, 24685, 25500, 25505, 25515, 25520, 25525, 25526, 25530, 25535, 25545, 25560, 25565, 25574, 25575, 25600, 25605 – 25609, 25622, 25624, 25628, 25630, 25635, 25645, 25650, 25651, 25652, 25680, 25685, 26600, 26605, 26607, 26608, 26615, 27193, 27194, 27200, 27202, 27215 – 27218, 27220, 27222, 27226 – 27228, 27230, 27232, 27235, 27236, 27238, 27240, 27244 – 27246, 27248, 27254, 27267 – 27269, 27500 – 27503, 27506 – 27511, 27513, 27514, 27520, 27524, 27530, 27532, 27535, 27536, 27538, 27540, 27750, 27752, 27756, 27758 – 27760, 27762, 27766 – 27769, 27780, 27781, 27784, 27786, 27788, 27792, 27808, 27810, 27814, 27816, 27818, 27822 – 27828, 28400, 28405, 28406, 28415, 28420, 28430, 28435, 28436, 28445, 28450, 28455, 28456, 28465, 28470, 28475, 28476, 28485, 29850, 29851, 29855, 29856

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Measure	**Service needed**	**What to report** *(sample of codes)*
Disease-modifying antirheumatic drug (DMARD) therapy for rheumatoid arthritis (ART) **Weight = 1** Percentage of members who were diagnosed with rheumatoid arthritis and were dispensed at least one ambulatory prescription for a DMARD in 2017 *Codes that identify rheumatoid arthritis:* ICD-10-CM diagnosis: M05.00 – M05.9, M06.00 – M06.9	• Assess all patients with diagnosis of rheumatoid arthritis for DMARD treatment in 2017. • Refer all patients *not* currently treated with a DMARD for rheumatology consultation to confirm diagnosis and assess for DMARD therapy. • Complete and return a rheumatoid arthritis verification form on any patient identified as not having rheumatoid arthritis *or* not currently treated with a DMARD. (Contraindications to DMARD therapy is not considered an exclusion, per NCQA.)	**<u>Physician codes</u>** *DMARD therapy – medication injections* • **HCPCS:** J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515, J7516, J7517, J7518, J9250, J9260, J9310 **<u>Medical record review</u>** • Rheumatoid arthritis verification via medical record and claim review. Identify any misdiagnosed with rheumatoid arthritis. • Identify reasons for not treating with a DMARD on all patients confirmed to have rheumatoid arthritis. Include findings and recommendations of rheumatology consultant. **<u>NDC codes</u>** There are several NDC codes for prescriptions to treat rheumatoid arthritis based on pharmacy claims received by CarePlus. NCQA posts a comprehensive list of these NDC codes on its website each year. DMARDs include the following: • **Description: 5-aminosalicylates** ▪ Sulfasalazine • **Description: Alkylating agents** ▪ Cyclophosphamide • **Description: Aminoquinolines** ▪ Hydroxychloroquine • **Description: Antirheumatics** ▪ Auranofin ▪ Gold sodium thiomalate ▪ Leflunomide ▪ Methotrexate ▪ Penicillamine • **Description: Immunomodulators** ▪ Abatacept ▪ Adalimumab ▪ Anakinra ▪ Certolizumab ▪ Etanercept ▪ Golimumab ▪ Infliximab ▪ Rituximab

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Measure	**Service needed**	**What to report** *(sample of codes)*
Disease-modifying antirheumatic drug (DMARD) therapy for rheumatoid arthritis (ART) **Continued**		**Description: Immunomodulators** ▪ Certolizumab pegol ▪ Tocilizumab **Description: Immunosuppressive agents** ▪ Azathioprine ▪ Cyclosporine ▪ Mycophenolate **Description: Janus kinase (JAK) inhibitor** ▪ Tofacitinib **Description: Tetracyclines** ▪ Minocycline
Adult body mass index (BMI) assessment (ABA) **Weight = 1** Percentage of members 18 to 74 years old who had an outpatient visit and who had a BMI documented during the measurement year or the year prior to the measurement year ***Note:*** *The weight and BMI must be from the same data source.*	• Documented BMI for outpatient visits in **2016 or 2017**	**Physician codes** **Codes to identify BMI assessment** • **ICD-10-CM diagnosis:** Z68.1, Z68.20-39, Z68.41-45, Z68.51 – Z68.54

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Measure	**Service needed**	**What to report** *(sample of codes)*
Care for older adults advanced care planning (COA–ACP) **Weight = N/A** *(Medicare SNP only)* Percentage of adults 66 years old and older who had advance care planning (advance directive, living will, power of attorney, health care proxy, actionable medical decision-maker or surrogate decision-maker) during the measurement year	**Advance care planning** Documentation of advance care planning in **2017** Evidence of advance care planning **must include:** • An advance care plan in the medical record **or** • Advance care planning discussion with the provider documented and dated in the medical record **or** • Notation that the member has previously executed an advance care plan that meets criteria	**Physician codes** • **CPT:** 99497 • **CPT Category II:** 1157F, 1158F • **HCPCS:** S0257

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** ***(sample of codes)***
Care for older adults medication review (COA–MDR) **Weight = 1** *(Medicare SNP only)* Percentage of adults 66 years old and older who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist **along** with a medication list or documentation of no medications	**Medication review** • Documentation of at least one dated and signed medication review conducted by a prescribing practitioner or clinical pharmacist in 2017 **and** • A medication list present in the same medical record. If patient is not taking any medication, dated notation should be documented in the chart in **2017**. A review of side effects for a single medication at the time of prescription alone is not sufficient.	**Physician codes** *Both a medication review and medication list code must be billed for a member to be compliant.* **Medication review** • **CPT:** 90863, 99605, 99606 • **CPT Category II:** 1160F **Medication list** • **CPT Category II:** 1159F • **HCPCS:** G8427 *A transitional care management services code counts for both the medication review and medication list.* **Transitional care management services** • **CPT:** 99495, 99496

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Care for older adults functional status (COA–FSA) **Weight = 1** *(Medicare SNP only)* Percentage of adults 66 years old and older who had documentation in the medical record of at least one complete functional status assessment in 2017	**Functional status** • At least one complete functional status assessment in 2017 • The functional status assessment **must include the date it was performed**. • Reference "Additional information" for detailed requirements.	**Physician codes** • **CPT Category II:** 1170F **Additional information** Notations for a complete functional status assessment may include: • Assessment of instrumental activities of daily living (IADL), such as shopping for groceries, driving, using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications or handling finances **or** • Assessment of activities of daily living (ADL), such as bathing, dressing, eating, transferring, using the toilet, walking **or** • Results using a standardized functional status assessment tool **or** Documentation that **three of the four** following components were assessed: • Cognitive status • Ambulation status • Sensory ability (must include hearing, vision and speech) • Other functional independence (e.g., exercise, ability to perform job) A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment.

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Care for older adults pain screening (COA–PNS) Weight = 1 *(Medicare SNP only)* Percentage of adults 66 years old and older who had documentation in the medical record of at least one pain screening assessment for more than one system in 2017	**Pain assessment** Documentation in the medical record of at least one pain assessment or pain management plan in 2017, including the date it was performed. Notations can include: • A comprehensive pain assessment or results of a screening using a standardized tool (may include positive or negative findings) • Evidence of a pain management plan, such as notation of no pain intervention and the rationale, notation of plan for pain treatment (pain meds, psychological support and /family education) or notation of plan for reassessment of pain, including time interval A pain assessment or management plan limited to an acute or single condition, event or body system does not meet criteria.	**Physician codes** • **CPT Category II:** 1125F, 1126F

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Plan all-cause readmissions (PCR) Weight = 3 Readmission to a hospital within 30 days of being discharged Percent of members 18 years old and older discharged from a hospital stay and readmitted to a hospital within 30 days, either for the same condition or for a different reason Patients may have been readmitted to the same hospital or a different one Rates of readmission are risk-adjusted and account for how sick patients were on the first admission	No specific services are needed, other than efforts from the plan and health care providers supporting coordination of care and prevention of all readmissions.	No reporting is needed from the health care providers as data for this measure are taken from health plan data.

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Healthcare Effectiveness Data and Information Set (HEDIS)		
Measure	**Service needed**	**What to report** *(sample of codes)*
Hospitalization for potentially preventable complications (HPC) Weight = 1 For members 67 years old and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members. ACSC is an acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this measure are: **Chronic ACSC** - Diabetes short-term complications - Diabetes long-term complications - Uncontrolled diabetes - Lower-extremity amputation among patients with diabetes - Chronic obstructive pulmonary disease (COPD) - Asthma - Hypertension - Heart failure **Acute ACSC** - Bacterial pneumonia - Urinary tract infection - Cellulitis - Pressure ulcer CarePlus will rate the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.	• Ensure appropriate outpatient management of the conditions under ACSC. • Coordinate efforts with specialists and other health care providers to prevent complications and subsequent admissions. • Provide prompt follow-up care post discharge to prevent complications and subsequent readmissions.	No reporting is needed from the health care providers as data for this measure are taken from health plan data.

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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 measurement year for members 18 years old and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the patient's date of discharge through 30 days after discharge (31 total days) **Note:** Evidence of the reconciliation and the date it was done **must be documented** in the outpatient record.	**Physician codes** **CPT code:** 99495, 99496 **CPT Category II:** 1111F **Notations for a complete medication reconciliation may include:** • Documentation such as a copy of the discharge summary that includes the list of discharged medications, signed and dated by the PCP, with a notation that "medications were reviewed and reconciled" • Documentation of the current medications with a notation that cites that discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications) • Documentation of the member's current medications with a notation that the discharge medications were reviewed • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service • Notation that no medications were prescribed or ordered upon discharge **Additional considerations:** • Dose and frequency do not have to be noted to meet the intent of the measure, but their inclusion is highly recommended. • The final (post-reconciliation) medication list should be communicated to the discharged patient by a clinician. Medication reconciliation may be done via home visit or telephonically; no outpatient visit is necessary.

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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 to 75 years old and females 40 to 75 years old during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: 1. Dispensed at least one high or moderate-intensity statin medication during the measurement year. 2. Remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.	• Assess patients with ASCVD for statin therapy in alignment with the 2013 American College of Cardiology/American Heart Association (ACC/AHA) guidelines. • Use noncompliant member lists to review medications and evaluate addition of statin therapy to regimen.	**No reporting required from providers. The health plan evaluates prescription claims data for this measure.**

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Health Outcomes Survey (HOS)

HOS is an annual -reported outcome survey, conducted by a vendor contracted by the Centers for Medicare & Medicaid Services (CMS), for Medicare Advantage plans. 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. Six of the survey areas are included in the CMS Star quality measures.

Measure	Services needed	Member survey questions
Physical activity assessment (Weight = 1) is part of the following **Star measures** • Percentage of plan members 65 years old or 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	Complete/document **functional assessment**. Encourage member to start, increase or maintain physical activity and document communication. Discuss member's: • Level of exercise or physical activity • Loss of independence/performance • Activities of daily living • Level of assistance needed • Social activities Advise member to: • Consult his/her health care provider to determine what level of physical activity is safe and appropriate. • Begin physical activity with short intervals of moderate activity (five to 10 minutes). • Perform flexibility training, such as stretching and yoga every day. • Perform strength training, such as carrying laundry or groceries, doing chair exercises or working in the yard two to three days per week. • Perform cardiorespiratory activities, such as walking, rolling a wheelchair or swimming three to five days a week for at least 30 minutes. Make efforts to ensure the member understands services rendered.	• In the past 12 months, did you talk with a doctor or other practitioner about your level of exercise or physical activity? • In the past 12 months, did a doctor or other practitioner advise you to start, increase or maintain your level of exercise or physical activity?

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Health Outcomes Survey (HOS)		
Measure	**Service needed**	**Member survey questions**
Physical health status assessment (Weight = 3) is part of the following **Star measure:** • Percentage of plan members whose physical health status was better than expected or remained the same	Assess current issues and identify interventions to improve physical health status and document communication. Discuss member's: • Loss of independence and/or performance • Activities of daily living • Level of assistance needed • Social activities Make efforts to ensure the member understands services rendered.	• During the past four weeks, have you accomplished less than you would like with your work or other regular activities as a result of your physical health? • During the past four weeks, how much of the time has physical health interfered with your social activities?
Mental health status assessment (Weight = 3) is part of the following **Star measure:** • Percentage of plan members whose mental health status was better than expected or remained the same	Assess current issues and identify interventions to improve mental health status and document communication. Make efforts to confirm the member understands services rendered.	• During the past four weeks, have you accomplished less or were you limited with your work or other regular daily activities as a result of your emotional health? • During the past four weeks, have you felt peaceful and calm or had a lot of energy or felt downhearted and blue? • During the past four weeks, how much of the time have emotional problems interfered with your social activities?

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Health Outcomes Survey (HOS)		
Measure	**Service needed**	**Member survey questions**
Fall risk and balance assessment (Weight = 1) is part of the following **Star measure**: • Percentage of members 65 years old or older who in the past 12 months had a fall or had problems with balance or walking, were seen by a practitioner and received fall-risk interventions from their current practitioner	Discuss member fall/balance problem and document prevention interventions. Prevention/interventions: • Regular exercise and exercise programs (e.g., tai chi) may increase strength and improve balance among older adults. • Regular medication reviews by physicians or pharmacists can help reduce side effects and drug interactions. • Regular eye exams at least once a year can help maintain eye health. • Home assessment and modifications may reduce hazards in the home (e.g., improper lighting) that can lead to falls. • Fall-prevention programs may be needed to provide and install safety devices to be effective in reducing environmental hazards. Make efforts to confirm the member understands services rendered.	• In the past 12 months, have you had a problem with balance or walking? • A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health care provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • Has your doctor or other health care provider done anything to help prevent falls or treat problems with balance or walking?

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Health Outcomes Survey (HOS)		
Measure	**Service needed**	**Member survey questions**
Urinary incontinence assessment and advice (Weight = 1) is part of the following **Star measure:** • Percentage of plan members 65 years old or older who reported having a urine leakage problem in the past six months and who received treatment for their current leakage problem	Assess all members to determine if they are having problems with urinary incontinence. Discuss urinary problem with member and document possible treatment options, such as: • Behavioral therapies, such as bladder training and techniques for pelvic muscle rehabilitation. (Low-intensity behavioral therapies are ideal first-line interventions that are inexpensive, pose a low risk and can be initiated effectively by primary care providers.) • Pharmacologic therapies • Surgical therapies (if indicated) Make efforts to confirm the member understands services rendered.	• Many people experience problems with urinary incontinence, the leakage of urine. In the past six months, have you leaked urine? • How much of a problem, if any, was the urine leakage for you? • Have you talked with your current doctor or other health care provider about your urine leakage problem? • There are many ways to treat urinary incontinence, including bladder-training exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problems?
Annual depression screening and follow-up monitoring	• Annual depression screening using either a PHQ2 or PHQ9 tool as applicable in **2017**.	**Physician codes** • **CPT:** 99420 in conjunction with **ICD-10-CM diagnosis code**: Z13.89 **or** • **CPT Category II:** 1220F, 3725F • **HCPCS:** G0444, G8431, G8510, G5811, G8940, G9393, G9395, G9509, G9573

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)		
CAHPS is an annual member survey conducted by a vendor contracted by CMS for Medicare Advantage plans. 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: http://www.medicare.gov. Eight areas of the member survey are included in the Star measures reporting.		
Measure	**Service needed**	**Survey questions**
Member satisfaction with getting needed care quickly (Weight = 1.5) **Member satisfaction with getting needed care without delay (Weight = 1.5)**	• Facilitate referral issuance and assist with the arrangement of specialist appointments, as appropriate. • Ensure limited wait times and the availability of urgent appointments.	• 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? • In the last six months, when you needed care right away, how often did you get care as soon 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?
Member satisfaction with his/her current health care (Weight = 1.5)	• Ask questions to gauge the member's current feeling about the care he/she is receiving. • Discuss options to improve health care. • Discuss options to improve the member's perception of health care delivery. • Make efforts to confirm the member understands services rendered.	• Using any number from zero to 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 of your health care in the last six months?

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)		
Measure	**Factors**	**Survey questions**
Influenza vaccination status (Weight = 1) • Percentage of plan members who reported having received an influenza vaccination between July 2017 and the date when the Medicare CAHPS survey was completed (March through June 2018)	• Order influenza vaccine for your office in advance of flu season. • Identify options for purchasing additional vaccines and/or referring patients to alternative administration sites should demand exceed your supply of vaccines. • Make sure all eligible members are encouraged to receive an influenza vaccination between September and December each year. • Make efforts to confirm the member understands services rendered. **Note:** Make sure that claim/encounter is submitted and that it includes the appropriate CPT code for the flu shot administration date of service.	• Did you get a flu shot last year?

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)		
Measure	**Factors**	**Survey questions**
Care coordination (Weight = 1.5) • Percent of the best possible score the plan earned on how well the plan coordinates members' care. (This includes whether doctors had the records and information they need about members' care and how quickly members got their test results.)	• Whether the doctor had medical records and other information about the patient's care • Whether there was follow-up with the patient to provide test results • How quickly the patient got the test results • Whether the doctor spoke to the patient about prescription medicines • Whether the patient received help managing care • Whether the personal doctor is informed and up to date about specialist care	• 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? (Responses: never, sometimes, usually, always) • 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? (Responses: never, sometimes, usually, always) • 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? (Responses: never, sometimes, usually, always) • In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking? (Responses: never, sometimes, usually, always) • In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists? (Responses: never, sometimes, usually, always, I do not have a personal doctor, I did not visit my personal doctor in the last six months) • 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? (Responses: yes, definitely; yes, somewhat; no)

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Part D safety measures CMS includes several Part D measures in the Star measures reporting, including the following five safety measures.		
Measure	**Service needed**	**What to report**
Taking diabetes medication as directed (Weight = 3) Percentage of Medicare Part D beneficiaries 18 years old or older with a prescription for diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication **Note:** In this measure, "diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic or a meglitinide drug. Plan members who take insulin are not included.	• Assess proactively whether the patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription.	• No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.

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Part D safety measures CMS includes several Part D measures in the Star measures reporting, including those listed below.		
Measure	**Service needed**	**What to report**
Taking blood pressure medication as directed (Weight = 3) • Medicare Part D beneficiaries 18 years old or older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication. **Note:** In this measure, "blood pressure medication" means an ACE (angiotensin-converting enzyme) inhibitor or an ARB (angiotensin receptor blocker) drug, or a direct renin inhibitor drug.	• Assess proactively whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription.	• No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.
Taking cholesterol medication as directed (Weight = 3) • Percentage of Medicare Part D beneficiaries 18 years or older with a prescription for a cholesterol medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication **Note:** In this measure, "cholesterol medication" means a statin drug.	• Assess proactively whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription.	• No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.

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Part D safety measures CMS includes several Part D measures in the Star measures reporting, including those listed below.		
Measure	**Service needed**	**What to report**
Medication therapy management (MTM) program completion rate for Comprehensive Medication Review (CMR) (Weight = 1) • Percent of Medicare Part D beneficiaries 18 years old or older enrolled in the MTM program for at least 60 days who received a CMR in **2017** CarePlus MTM eligibility criteria: • Have three of the following five chronic diseases: - Diabetes - Congestive heart failure - Dyslipidemia - Chronic obstructive pulmonary disease - Bone disease: arthritis or osteoporosis • Minimum of eight Part D medications • Anticipated Part D drug cost of more than $3,919	• Conduct discussions with MTM-eligible members, explaining the importance and benefits of completing a comprehensive medication review annually. • Members interested in receiving a CMR may be referred to CarePlus' Member Services department at 1-800-794-5907 to have the service scheduled and rendered by a CarePlus pharmacist.	• No reporting required from providers.

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Part D safety measures CMS includes several Part D measures in the Star measures reporting, including those listed below.		
Measure	**Service needed**	**What to report**
Statin use in persons with diabetes (SUPD) **Weight = 1** Percentage of Medicare Part D beneficiaries 40 to 75 years old who were dispensed at least two medications for diabetes and also who received a statin medication.	• Assess diabetic patients for statin therapy in alignment with the 2013 American College of Cardiology/American Heart Association (ACC/AHA) guidelines. • Use noncompliant member lists to review medications and evaluate addition of statin therapy to regimen.	No reporting required from providers. The health plan evaluates prescription claims data for this measure.

HEDIS® is a set of standardized performance measures designed to help purchasers and consumers compare the performance of health plans on an "apples-to-apples" basis. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
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CAHPS® is the Consumer Assessment of Healthcare Providers and Systems on behalf of CMS.
CPT® codes are the Current Procedural Terminology codes developed by the American Medical Association.
HCPCS is the Healthcare Common Procedure Coding System used by CMS.
ICD is the International Classification of Diseases.
LOINC® (Logical Observation Identifiers Names and Codes) is a set of universal names and ID codes for identifying laboratory and clinical test results.