2023 Star Measure Tips

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

Breast Cancer Screening (BCS)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of women who were screened for breast cancer.

Measure population (denominator)

Female patients ages 50–74 during the measurement year.

Measure compliance (numerator)

Bilateral mammogram screening performed any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year, as evidenced by either of the following:

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

Note: A breast thermogram **does not** meet criteria for this measure.

Did you know?

- Many women with breast cancer do not have symptoms, which is why regular breast cancer screenings are so important.
- Breast cancer detection at an early stage has a 93% or higher survival rate.
- The accuracy of mammography improves as women age and has an overall detection rate of about 85%.

Exclusions

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

continued

Helpful HEDIS hints

- Review completed screening dates with patients at all visits, including virtual care.
- Obtain mammogram report with date and result.
- Follow up on outstanding orders when no report has been received.
- Patient reported mammogram is acceptable. Document date in the history and/or preventive service section of the medical record.
- If the exact date of the last mammogram is unknown, avoid using words such as "approximate" or "about" when documenting. Instead, document the month/year or year alone.
- Create a standing order to mail to patient for mammography.
- Provide a list of locations where mammogram screenings can be performed.
- Depending on risk factors, mammograms may need to be done more frequently.

Tips for coding

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

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

Resources

1. American Cancer Society. Jan 2022. "American Cancer Society Recommendations for the Early Detection of Breast Cancer." **www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html**
2. American Cancer Society. 2019. "Frequently Asked Questions About the American Cancer Society's Breast Cancer Screening Guideline." **https://www.cancer.org/cancer/breast-cancer/frequently-asked-questions-about-the-american-cancer-society-new-breast-cancer-screening-guideline.html**

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2023 Star Measure Tips

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

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

Member Perception Star Measure

Why is the CAHPS survey important?

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

CAHPS survey questions and provider impact

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

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

Tips for success

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

continued

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

Tips for success

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

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

Tips for success

- Survey your patients, asking how you can improve their health care experience.
- Create a council of patient volunteers to obtain regular feedback on practice processes/procedures.
- Review patient feedback and implement changes for suggested improvements.

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

continued

Tips for success

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

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

Tips for success

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

Resources

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

2023 Star Measure Tips

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

Controlling High Blood Pressure (CBP)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of patients with hypertension whose blood pressure was adequately controlled.

Measure population (denominator)

Patients 18-85 years of age with a diagnosis of hypertension on at least 2 different dates of service between January 1 of the year prior and June 30 of the measurement year.

Did you know?

- Hypertension (high blood pressure) increases the risk of heart disease and stroke, which are the leading causes of death in the United States.
- Controlling high blood pressure is important in preventing heart attacks, stroke, and kidney disease.
- Approximately only one in four adults with hypertension have their condition under control.
- Lifestyle changes such as diet, exercise, smoking cessation and stress reduction can significantly impact blood pressure.

Measure compliance (numerator)

The **final** blood pressure reading of the measurement year is adequately controlled (≤ 139/89 mm Hg).

Note: The BP reading must occur *on or after* the date of the second diagnosis of hypertension.

Exclusions

- Nonacute inpatient admission during the measurement year
- End-stage renal disease, dialysis, nephrectomy, or kidney transplant
- Pregnancy diagnosis during the measurement year
- Are age 81 or older with frailty during the measurement year
- Are age 66 - 80 with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)

continued

Exclusions *(continued)*

- Received hospice services anytime during the measurement year
- Received palliative care during the measurement year
- Deceased during the measurement year

Helpful HEDIS hints

- Document all blood pressure readings and the dates they were obtained.
  - Report the lowest systolic and lowest diastolic pressures if more than one reading is taken on the same date.
- The final blood pressure reading of the year will be used to determine HEDIS measure compliance.
- Document exact readings; do not round up blood pressure readings. Ranges and thresholds are not acceptable.
- A BP noted as an "average BP" (e.g., "average BP: 139/70") is eligible for use. Must be documented as a distinct value.
- Blood pressure readings can be captured during a virtual care visit.
- Patient reported blood pressures taken with a digital device are acceptable and should be documented in the medical record. The provider does not need to see the digital reading.
- Prescribe single-pill combination medications whenever possible to assist with medication compliance.
- BP readings can be captured from a specialty or urgent care visit if the consult note is part of the patient's medical record.

  Note: BP readings taken from an acute inpatient stay, ED visit, or the same day as a diagnostic test are not acceptable.

Tips for coding

Blood pressure CPT® II codes should be billed as a $0.01 claim.

- BP readings should be reported with each office visit, this includes telehealth, telephone, e-visits, or virtual visits.
- BP readings can also be billed alone if taken outside of a visit (nurse visits, etc.).

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

continued

Tips for taking a blood pressure

- Ensure proper cuff size (placed on bare arm), feet flat on the floor, back supported and elbow is at the level of the heart. Advise patient not to talk during the measurement.
- Improper positioning can raise the systolic pressure up to 12 mm Hg.
- Take it twice. If the blood pressure is greater than 139/89, retake and record it at the end of the visit. Consider switching arms for subsequent readings.

Tips for patient education

One of the biggest challenges is convincing patients of the importance of maintaining a healthy blood pressure.

- Educate patients on the importance of blood pressure control and the risks when blood pressure is not controlled.
- Encourage blood pressure monitoring at home and ask patients to bring a log of their readings to all office visits. Educate patients on how to properly measure blood pressure at home.
- If the patient does not own a digital blood pressure cuff, instruct them to use their local pharmacy for a blood pressure reading.
- Discuss the importance of medication adherence at every visit. According to the Centers for Disease Control and Prevention (CDC):
  - Approximately one in four adults with hypertension have their condition controlled.
  - Many patients with Medicare Part D prescription coverage are not taking their blood pressure medication as prescribed.
- Advise patients not to discontinue blood pressure medication before contacting your office. If they experience side effects, another medication can be prescribed.
- If patients have an abnormal reading, schedule follow-up appointments for blood pressure management.
- Encourage lifestyle changes such as diet, exercise, smoking cessation and stress reduction.

Resources

1. National Committee for Quality Assurance (NCQA). 2022. "Controlling High Blood Pressure (CBP)." **ncqa.org/hedis/measures/controlling-high-blood-pressure/**
2. Centers for Disease Control and Prevention (CDC). 2022. "High Blood Pressure." **cdc.gov/bloodpressure/index.htm**
3. Centers for Disease Control and Prevention (CDC). 2022. "Facts About Hypertension." Facts About Hypertension | **cdc.gov**
4. American Medical Association (AMA). 2021. "The one graphic you need for accurate blood pressure reading." **ama-assn.org/delivering-care/hypertension/one-graphic-you-need-accurate-blood-pressure-reading**

2023 Star Measure Tips

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

Health Outcomes Survey (HOS)

Member perception star measures

Why is the HOS important?

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

HOS questions and provider impact

Practitioners can significantly impact how patients assess their health care experience in response to HOS questions.

Examples of HOS questions and tips for success are listed in the table below:

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

Tips for success

- Ask patients if they have pain and if it is affecting their ability to complete daily activities. Ask what goals the patient has, then identify ways to improve the patient's pain.
- Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist, or other specialist.
- Consider physical therapy and cardiac or pulmonary rehab when appropriate.

continued

Measure	Sample survey questions to patient
Improving or maintaining mental health	• During the past four weeks have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems? – Accomplished less than you would like – Didn't do work or other activities as carefully as usual • How much of the time during the past four weeks: – Have you felt calm and peaceful? – Did you have a lot of energy? – Have you felt downhearted or blue? • During the past four weeks how much of the time have your physical or emotional problems interfered with your social activities?

Tips for success

- Empathize with the patient.
- Incorporate annual depression screening into visits such as PHQ-2 or PHQ-9.
- Discuss options for therapy with a mental health provider, when appropriate.
- Develop a plan with your patient to take steps to improve mental health. Consider exercise, sleep habits, volunteering, attending religious services, identifying stress triggers, reducing alcohol or caffeine intake, meditation, connecting with supportive family and friends.
- Schedule a check-in to discuss progress with this plan.
- Consider a hearing test when appropriate, as loss of hearing can feel isolating.
- Provide patients the *988 Suicide & Crisis Lifeline* information (formerly known as the *National Suicide Prevention Lifeline*, 1-800-273-TALK).

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

Tips for success

- Talk to patients about their physical activity and the health benefits of staying active. Studies show that having patients fill out a questionnaire is not enough to gauge their activity level. Show interest in ensuring patients remain active.
- Develop a plan with your patient to take steps to start or increase physical activity. Offer suggestions based on the patient's physical ability, interests, and access.
  - Schedule a check-in to discuss progress on this plan.
- Refer patients with limited mobility to physical therapy to learn safe and effective exercises.

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

continued

Measure	Sample survey questions to patient
Tips for success • Ask patients if they have any trouble holding their urine. If yes, ask the following questions: – When do you notice leaking (exercise, coughing, after urinating)? – Is there urgency associated with the leaking? – Do you have any issues emptying your bladder (incomplete, takes too long, pain)? – How often do you empty your bladder at night? During the day? – Do you have pain when you urinate? – Have you noticed a change in color, smell, appearance or volume of your urine? – How impactful are your urinary issues to your daily life? • For men, ask all the same questions, plus: – Is there any change in stream? – Any sexual dysfunction (new, historical, or changing)? • Urinary problems can be common as we grow older, but there are treatments that can help. Discuss potential treatment options such as behavioral therapy, exercises, medications, medical devices, and surgery. • Use informational brochures and materials as discussion starters for this sensitive topic.	
Reducing the risk of falling	• In the past 12 months, did you talk with your doctor or other health practitioner about falling or problems with balance or walking? • Did you fall in the past 12 months? • In the past 12 months, have you had a problem with balance or walking? • Has your doctor or health practitioner done anything to help you prevent falls or treat problems with balance or walking?
Tips for success • Promote exercise, physical therapy and strengthening and balance activities (tai chi, yoga). • Review medications for any that increase fall risk. • Discuss home safety tips such as removing trip hazards, installing handrails, and using nightlights. • Suggest the use of a cane or walker, if needed. • Recommend a vision or hearing test.	

Resources

1. Health Services Advisory Group (HSAG). 2022. "Welcome to the Medicare Health Outcomes Survey (HOS) Website." **hosonline.org**
2. Substance Abuse and Mental Health Services Administration (SAMHSA). 2022. "988 Suicide & Crisis Lifeline." **samhsa.gov/find-help/988**

2023 Star Measure Tips

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

Medication Adherence

Pharmacy Quality Alliance-endorsed performance measures

Measure description

Percentage of patients with a prescription for diabetes, hypertension, or cholesterol medications and who were adherent with their prescribed course of treatment.

The three measures are:

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

Did you know?

- Medication adherence can reduce total annual health care spending primarily through decreased inpatient hospital days and emergency department visits.
- Medications are arguably the single most important health care technology to prevent illness, disability, and death in the older population.
- The consequences of medication nonadherence in older adults may be more serious, less easily detected, and less easily resolved than in younger age groups.

Measure population (denominator)

Patients 18 years and older who were dispensed at least 2 prescriptions on different dates of service during the measurement year.

Medications included in each measure

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

continued

Measure compliance (numerator)

Patients who filled their prescribed medication often enough to cover 80% or more of the treatment period.

Note: Patients must use their pharmacy benefit to close this measure.

Exclusions

- Received hospice services anytime during the measurement year
- Patients with end-stage renal disease diagnosis
- Diabetes measure only: Prescription for insulin
- Hypertension measure only: Prescription for sacubitril/valsartan

Helpful HEDIS hints

- Instruct patients to fill prescriptions using their pharmacy benefit.
  - Claims filled through pharmacy discount programs, cash claims, and medication samples will not count.
  - Gap closure is dependent on pharmacy claims.
  - Medication costs are often less when they use their pharmacy benefit.
- Provide short and clear instructions for all prescriptions.
- Emphasize the benefits of taking the medication and the risks of not taking the medication. The benefits should outweigh the risks.
- At each visit, ask your patients about their medication habits:
  - What side effects have you had from the medication, if any?
  - How many doses have you forgotten to take?
  - What financial barriers prevent you from obtaining your prescriptions?
  - What issues prevent you from refilling your prescription?
- Offer recommendations for adherence improvement:
  - Suggest the use of weekly or monthly pillboxes, smart phone apps with medication reminder alerts and placing medications in a visible area (in properly closed containers and safely out of reach of children or pets).
  - Instruct patients to contact their practitioner if experiencing side effects. Discuss alternative medications when appropriate.
  - Encourage patients to enroll in auto-refill program or utilize mail-order options.
- Once patients are stable on regimen, write 90-day supplies of maintenance medications.
- Schedule a follow-up visit within 30 days when prescribing a new medication to assess effectiveness and any barriers.

Resources

1. Pharmacy Quality Alliance (PQA). 2022. "Proportion of Days Covered: Diabetes All Class." **pqaalliance.org/measures-overview#pdc-dr**
2. Adult Meducation. 2012. "Improving Medication Adherence in Older Adults." **adultmeducation.com**

2023 Star Measure Tips

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

Osteoporosis Management in Women Who Had a Fracture (OMW)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of women who suffered a fracture and received appropriate testing or treatment for osteoporosis.

Measure population (denominator)

Female patients age 67–85 who suffered a fracture from July 1 of the year prior through December 31 of the measurement year.

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

Measure compliance (numerator)

Received appropriate treatment or testing within six months after the fracture, as defined by either of the below:

- A bone mineral density (BMD) test on the fracture date or within 180 days (six months) after the fracture.
  - BMD tests during an inpatient stay are acceptable.
- A prescription to treat osteoporosis that's filled on the fracture date or within 180 days (six months) after the fracture. Patients must use their pharmacy benefit to close this measure.

Did you know?

- The U.S. Preventive Services Task Force recommends BMD screening for women starting at age 65 to reduce the risk of fractures and postmenopausal women < 65 if they are at high risk.
- Osteoporosis is a bone disease characterized by low bone mass, which leads to bone fragility and increased susceptibility to fractures.
- Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life and increased mortality.

continued

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

Exclusions

- Had a bone mineral density test within the 24 months prior to the fracture.
- Received osteoporosis therapy within the 12 months prior to the fracture.
- Received hospice services anytime during the measurement year
- Received palliative care from July 1 of the prior year through December 31 of the measurement year.
- Are deceased during the measurement year.
- Are age 67–80 with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).
- Are age 81 or older with frailty within the measurement year.

Helpful HEDIS hints

- Discuss osteoporosis prevention, including calcium and vitamin D supplements, weight-bearing exercises and modifiable risk factors.
- Ask patients if they have had any recent falls or fractures, since treatment may have been received elsewhere.
- Discuss the need for a bone mineral density test and mail an order to the patient that contains the location and phone number of a testing site.
- Encourage patients to obtain the screening and follow up with the patient to ensure the test was completed.
- Provide patients with a prescription to treat or prevent osteoporosis when appropriate.
  - Patients should fill prescriptions using their pharmacy benefit.
  - Gap closure is dependent on pharmacy claims.
  - Discount programs, cash claims, and medication samples will not count.
- If virtual care is used instead of in-person visits:
  - Discuss the need for a bone mineral density test and mail an order to the patient that contains the location and phone number of a testing site.
  - Mail or e-scribe a prescription for an osteoporosis medication if applicable.
- Discuss fall prevention such as:
  - The need for assistive devices, e.g., cane, walker.
  - Removing trip hazards, using night lights, and installing grab bars.
- Promote exercise, physical therapy, strengthening and balance activities (e.g., yoga, tai chi).

Tips for coding

- Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).
- Bill the ICD-10 code to identify how the fracture happened (e.g., fall).

Resources

1. National Institutes of Health (NIH). 2019. "Osteoporosis Overview." **bones.nih.gov/health-info/bone/osteoporosis/overview**
2. U.S. Preventive Services Task Force. June 2018. "Final Recommendation Statement: Osteoporosis to Prevent Fractures: Screening." **uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening**

2023 Star Measure Tips

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

Plan All-cause Readmissions (PCR)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients that were readmitted to the hospital within 30 days of discharge.

Measure population (denominator)

Patients 18 years and older who had an acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year.

- This measure is based on discharges.
- Patients may appear in the denominator more than once.
- Includes acute discharges from any type of facility.

Did you know?

- Unplanned readmissions are associated with increased mortality and higher health care costs.
- Readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.

Measure compliance (numerator)

The number of patients who had an unplanned acute readmission for any diagnosis within 30 days following an acute discharge.

Exclusions

- Diagnosed with pregnancy or a condition originating in the perinatal period.
- Received hospice services anytime during the measurement year
- Deceased during the hospital stay.

continued

Helpful HEDIS hints

- Keep open appointments so patients who are discharged from the hospital can be seen within 7 days of discharge.
  - If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
  - Request patients bring all prescriptions, over-the-counter medications, and supplements to the post-discharge visit and complete the medication reconciliation.
- Connect with your state's automated electronic admission, discharge, and transfer (ADT) system to receive admission, discharge and transfer notifications for your patients. Michigan Health Information Network (MiHIN). **https://mihin.org/**
- Perform transitional care management for recently discharged patients.
- Consider implementing a post-discharge process to track, monitor and follow up with patients.
  - Obtain and review patients' discharge summary.
  - Obtain any test results that were not available when patients were discharged and track tests that are still pending.
  - Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and/or caregivers to describe their new medication regimen back to you.
- Document and date the medication reconciliation in the outpatient medical record.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future
- Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
  - Start as-needed or PRN medications.
  - Call his or her doctor (during or after office hours).
  - Go to the emergency room.

Tips for coding

- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period to be submitted on a claim.
- Document and date the medication reconciliation in the outpatient medical record.
  - Submit an 1111F claim as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.

Resources

1. Institute for Healthcare Improvement (IHI). 2009. "Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions." **ihi.org/resources/Pages/Changes/EffectiveInterventionstoReduceRehospitalizationsCompendium15PromisingInterventions.aspx**
2. Centers for Medicare and Medicaid Services (CMS). August 2022. "Hospital Readmissions Reduction Program (HRRP)." **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program**

2023 Star Measure Tips

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

Statin therapy for patients with cardiovascular disease (SPC)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients with clinical atherosclerotic cardiovascular disease (ASCVD) receiving statin therapy.

Measure population (denominator)

Males 21–75 years of age and females 40–75 years of age during the measurement year and identified as having clinical ASCVD such as:

- Myocardial infarction (MI)
- Coronary artery bypass graft (CABG)
- Ischemic vascular disease (IVD)
- Percutaneous coronary intervention (PCI)
- Other revascularization procedure

Did you know?

- Cardiovascular disease is the leading cause of death in the United States.
- Unhealthy cholesterol levels places patients at a significant risk for developing ASCVD.
- Effective statin therapy can dramatically reduce deaths from coronary artery diseases.

Measure compliance (numerator)

Patients dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

continued

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

Note: Patients must use their pharmacy benefit to close this measure.

Exclusions

- Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year
- Received hospice services anytime during the measurement year
- Received palliative care during the measurement year
- Deceased during the measurement year.
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the Advanced Illness and Frailty Guide).
- Any of the following during the **measurement year or the year prior**
  - Pregnancy diagnosis, IVF or at least one prescription for clomiphene (estrogen agonists)
  - End stage renal disease or dialysis
  - Cirrhosis

Helpful HEDIS hints

- Educate your patients on the importance of statin medication adherence.
- Instruct patients to contact their practitioner if they are experiencing adverse effects.
  - Document any adverse effects from statin therapy.
  - Determine if the signs/symptoms qualify as an exclusion.
  - Try reducing the dose or frequency.
  - Consider trying a different statin and/or
- Once patients demonstrate they can tolerate statin therapy, encourage them to obtain 90-day supplies at their pharmacy.
- Instruct patients to fill prescriptions using their pharmacy benefit.
  - Gap closure is dependent on pharmacy claims.
  - Discount programs, cash claims, and medication samples will not count

Tips for coding

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

- These codes are intended to close Star measure gaps and do not apply to payment or reimbursement. Only the codes listed below will exclude the patient from the SPC measure.

Condition	ICD-10-CM Codes
Myalgia	M79.10–M79.12, M79.18
Myositis	M60.80, M60.811-M60.819, M60.821–M60.829, M60.831–M60.839, M60.841–M60.849, M60.851–M60.859, M60.861–M60.869, M60.871–M60.879, M60.88–M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82
Cirrhosis	K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
End stage renal disease (ESRD)	N18.5, N18.6, Z99.2
Pregnancy	Numerous > 1k
Condition	**CPT® Codes**
Dialysis	90935, 90937, 90945, 90947, 90997, 90999, 99512
Condition	**HCPCS Codes**
In vitro fertilization (IVF)	S4015, S4016, S4018, S4020, S4021

Resources

1. American Heart Association (AHA). 2021. "2021 Heart Disease and Stroke Statistics Update Fact Sheet." **heart.org/-/media/phd-files-2/science-news/2/2021-heart-and-stroke-stat update/2021_heart_disease_and_stroke_statistics_update_fact_sheet_at_a_glance.pdf**
2. American College of Cardiology. 2019. "Statin Use in Primary Prevention of ASCVD According to 5 Guidelines." **acc.org/Latest-in-Cardiology/Journal-Scans/2019/10/08/11/49/Statin-Use-in-Primary-Prevention-of-Atherosclerotic**

2023 Star Measure Tips

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

Medication Reconciliation Post-Discharge (TRC-M)

A component of Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients who had their medications reconciled following an inpatient discharge.

Measure population (denominator)

Patients 18 years and older with an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

Note: If patients have multiple discharges, they could appear in the measure more than once.

Measure compliance (numerator)

Medications reconciled on the date of discharge through 30 days after (31 days total).

Did you know?

- Inadequate care coordination and poor care transitions result in billions of unnecessary medical expenses.
- Lack of communication between inpatient and outpatient providers may result in unintentional medication changes, incomplete diagnostic workups and inadequate patient, caregiver, and provider understanding of diagnoses, medication, and follow up needs.
- Patient safety is compromised and medication errors result from inadequate medication reconciliation during care transitions.

Exclusions

- Received hospice services anytime during the measurement year
- Received palliative care during the measurement year
- Deceased during the measurement year

continued

Helpful HEDIS hints

- Medication reconciliation must be conducted or cosigned by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse.
  - Medication reconciliation may be performed by other medical professionals (e.g., MA, LPN) if signed off by an acceptable practitioner.
- Evidence of medication reconciliation must be in the outpatient medical record, but an outpatient face-to face visit is not required.
- Performing medication reconciliation after every discharge ensures that patients understand all their medications; new, current, and discontinued.
- Request patients' discharge summary with medication list and any discharge instructions from the inpatient facility.
- A post discharge visit is encouraged to support patient engagement (office, home, or virtual care visit). Ask patients to bring all medications (prescription, over-the counter, herbal, topical, etc.).
- Documentation of medication reconciliation **must** include the date performed, current medication list, and evidence of any of the following:
  - Notation that the practitioner reconciled the current and discharge medications.
  - Notation that references the discharge medications (e.g., no change in medications since discharge, same medications at discharge, discontinue all discharge medications).
  - Evidence the practitioner was aware of the patient's hospitalization and a post-discharge hospital follow-up with medication reconciliation or review.
  - Discharge medication list with evidence that both lists were reviewed on the same date of service
  - Notation that no medications were prescribed or ordered upon discharge.

Tips for coding

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

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
CPT® codes	**Description**
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **moderate** complexity and a face-to-face visit within **14 days** of discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **high** complexity and a face-to-face visit within **7 days** of discharge.

continued

Tips for coding *(continued)*

- Bill 1111F as soon as medication reconciliation is completed.
  - 1111F can be billed alone ***OR*** with an associated visit.
  - The allowable amount for an 1111F claim is $35 for Medicare Plus Blue and BCN Advantage.

    Note: There is no member cost share associated with 1111F for Medicare Plus Blue and BCN Advantage.
- Visits with a practitioner can be with or without a telehealth modifier.
- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

Resources

1. National Committee for Quality Assurance (NCQA). 2022. "Transitions of Care (TRC)." **ncqa.org/hedis/measures/transitions-of-care/**
2. National Institutes of Health (NIH). 2018. "Impact of medication reconciliation for improving transitions of care." **ncbi.nlm.nih.gov/pmc/articles/PMC6513651/**

2023 Star Measure Tips

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

HEDIS® Advanced Illness and Frailty Guide

The National Committee for Quality Assurance (NCQA) allows additional exclusions to Healthcare Effectiveness Data and Information Set (HEDIS®) Star measures for patients with advanced illness and frailty.

- Services measured by NCQA may not benefit older adults with limited life expectancy and advanced illness.
- Unnecessary tests or treatments could burden these patients or even be harmful.
- NCQA encourages practitioners to focus on appropriate care for their patients.

This guide includes:

- Measure specific ages
- Billing codes and definitions for advanced illness and frailty exclusions
- Dementia medications

Tips for coding

- Advanced illness and frailty must be documented in the medical record and billed with the appropriate exclusion codes.
- Virtual care visits are acceptable when used to exclude a patient.
- Appropriate coding on different dates of service must be billed to meet exclusion criteria:
  - **Advanced illness:**
    - Two outpatient visits with an advanced illness diagnosis during the **measurement year or the year prior**

    Or
    - A dispensed dementia medication during the **measurement year or the year prior**
  - **Frailty:**
    - Two indications of frailty during the **measurement year**

Note: Appropriate billing and coding can substantially reduce medical record requests for HEDIS® data collection purposes.

continued

Star Measure exclusion criteria	Applicable HEDIS® Star Measure
66 years and older with **both** advanced illness and frailty	• Breast Cancer Screening (BCS) • Colorectal Cancer Screening (COL) • Eye Exam for Patients with Diabetes (EED) • Hemoglobin A1C Control for Patients with Diabetes (HBD) • Statin Therapy for Patients with Cardiovascular Disease (SPC)
66 - 80 years old with **both** advanced illness and frailty	• Controlling High Blood Pressure (CBP) • Kidney Health Evaluation for Patients with Diabetes (KED)
67 - 80 years old with **both** advanced illness and frailty	• Osteoporosis Management in Women Who Had a Fracture (OMW)
81 years and older with frailty alone	• Controlling High Blood Pressure (CBP) • Kidney Health Evaluation for Patients with Diabetes (KED) • Osteoporosis Management in Women Who Had a Fracture (OMW)

Advanced illness	
ICD-10-CM code	**Definition**
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0-4, C25.7-9	Malignant neoplasm of pancreas
C71.0-9	Malignant neoplasm of brain
C77.0-5, C77.8-9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00-02	Secondary malignant neoplasm of lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30, C78.39	Secondary malignant neoplasm of unspecified or other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80, C78.89	Secondary malignant neoplasm of unspecified or other digestive organs
C79.00-02	Secondary malignant neoplasm of kidney and renal pelvis
C79.10-11, C79.19	Secondary malignant neoplasm of bladder and other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40, C79.49	Secondary malignant neoplasm of unspecified or other parts of nervous system
C79.51-52	Secondary malignant neoplasm of bone or bone marrow
C79.60-63	Secondary malignant neoplasm of ovary

continued

Advanced illness	
ICD-10-CM code	**Definition**
C79.70-72	Secondary malignant neoplasm of adrenal gland
C79.81-82	Secondary malignant neoplasm of breast or genital organs
C79.89, C79.9	Secondary malignant neoplasm of unspecified or other sites
C91.00, C92.00, C93.00, C93.90, C93.Z0, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse
F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27, F10.97, G31.09, G31.83	Dementia
F04	Amnestic disorder due to known physiological condition
F10.96	Alcohol-induced persisting amnestic disorder
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G31.01	Picks disease
G35	Multiple sclerosis
I09.81, I11.0, I13.0, I13.2, I50.1, I50.20-23, I50.30-33, I50.40-43, I50.810-814, I50.82-84, I50.89, I50.9	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage 5
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes, and vapers
J84.10, J84.112, J84.17, J84.170, J84.178	Pulmonary fibrosis
J96.10-12, J96.20-22, J96.90-92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.00-02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
N18.6	End stage renal disease

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

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

continued

Frailty	
HCPCS code	**Definition**
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147-9	Walker
E0163, E0165, E0167, E0168, E0170, E0171	Commode chair
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-7, E0301-4	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-2	Respiratory assist device
E1130, E1140, E1150, E1160, E1161, E1170, E1171, E1172, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-8	Wheelchair
G0162, G0299, G0300, G0493, G0494	Skilled RN/LPN services related to home health/hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124, T1000-5, T1019-22, T1030, T1031	Nursing, respite care and personal care services

Frailty	
ICD-10-CM code	**Definition**
L89.000 - L89.96	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified state
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.2	Difficultly in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R53.1	Weakness
R53.81	Other malaise
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA-W01.198S, W06.XXXA-W06.XXXS, W07.XXXA-W07.XXXS, W08.XXXA-W08.XXXS, W10.0XXA-W10.9XXS, W18.00XA-W18.39XS, W19.XXXA-W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution

continued

Frailty	
ICD-10-CM code	**Definition**
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator (ventilator) status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

Resources

1. National Committee for Quality Assurance (NCQA). July 2018. "Improving care for those with advanced illness and frailty."
   www.ncqa.org/blog/improving-care-advanced-illness-frailty/

2023 Star Measure Tips

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

Colorectal Cancer Screening (COL)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients who had a colorectal cancer screening.

Measure population (denominator)

Patients 45–75 years of age during the measurement year.

Measure compliance (numerator)

Patients who had any of the following:

Type of Screening	Compliant for:
Colonoscopy	10 years
Flexible Sigmoidoscopy	5 years
sDNA (stool DNA + FIT test) also known as Cologuard®	3 years
FIT (Fecal Immunochemical Test) **FOBT** (Fecal Occult Blood Test)	1 year
CT-Colonography (virtual colonoscopy)	5 years

Exclusions

- History of colorectal cancer (cancer of the small intestine doesn't count).
- Total colectomy (partial or hemicolectomies don't count).
- Received hospice services anytime during the measurement year.

Did you know?

- A screening test is used to look for a disease when a person doesn't have symptoms.
- Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate.
- Colorectal cancer screening can detect polyps before they become cancerous or in early stages when treatment is most effective.
- Many adults have not been screened as recommended. Lower screening rates directly contribute to higher death rates from colorectal cancer.

continued

Exclusions *(continued)*

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

Helpful HEDIS hints

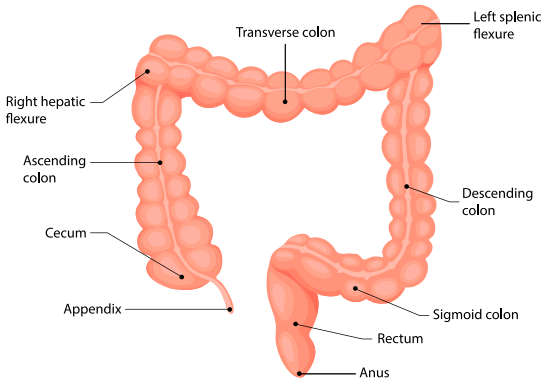
- Discuss the benefits and risks of different screening options and make a plan that offers the best health outcomes for your patient.
- Document the date, result, and type of colorectal screenings or if the patient met exclusion criteria.
  - Pathology reports that indicate the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.
  - Pathology or procedure reports that do NOT indicate type of screening are acceptable, IF there is evidence the scope advanced:

    * "**TO** the Cecum" = completed colonoscopy

    * "**INTO** the Sigmoid Colon" = completed flex sigmoidoscopy

    Note: if the scope advanced anywhere between the cecum and sigmoid colon, it would be considered a flexible sigmoidoscopy.

Anatomy of colon



- Inquire about and document any patient reported completed screenings. Be sure to document the type of screening, date, and result in their medical history.
  - Simply documenting "colorectal screening" or "UTD" does not meet criteria.
- For patients who refuse a colonoscopy, discuss options of noninvasive screenings such as Cologuard® or FIT.
- Have FIT kits readily available to give patients during the visit.
- Samples taken from a digital rectal exam (DRE) or collected in an office setting do not meet screening criteria by the American Cancer Society or HEDIS®.
  - If a patient brings a completed sample into the office, be sure to document this so it's clear it wasn't collected in the office.
- Fecal Immunochemical Test (FIT) and Cologuard® (sDNA + FIT) tests are NOT the same screening.
  - FIT uses antibodies to detect blood in the stool (completed annually).
  - sDNA combines the FIT with a test that detects altered DNA in the stool (completed every 3 years).
- If virtual care is used, discuss current screening status, and encourage in-home testing if applicable.

continued

Tips for coding

For exclusions, use the appropriate ICD-10-CM code. Document and bill exclusions annually.

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

For screenings use the appropriate codes:

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

Resources

1. American Cancer Society. 2017. "Colorectal Cancer Facts & Figures 2017-2019." **cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2017-2019.pdf**
2. Centers for Disease Control and Prevention (CDC). February 2022. "What Should I Know About Screening." **cdc.gov/cancer/colorectal/basic_info/screening/index.htm**
3. Centers for Disease Control and Prevention (CDC). February 2022. "Colorectal Cancer Control Program (CRCCP)." **cdc.gov/cancer/crccp/about.htm**

2023 Star Measure Tips

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

Eye Exam for Patients with Diabetes (EED)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of diabetic patients who had a dilated or retinal eye exam.

Measure population (denominator)

Patients 18 - 75 years old with diabetes (type 1 or type 2).

Any of the following during the measurement year or the year prior to the measurement year:

- Two or more outpatient visits on different dates of service with a diagnosis of diabetes
- One acute inpatient stay with a diagnosis of diabetes
- Patients dispensed insulin or hypoglycemics/antihyperglycemics
  - This includes Semaglutides (except for Wegovy® given for weight loss).
  - Glucophage/Metformin as a solo agent is not included because it's used to treat conditions other than diabetes. Patients with diabetes on these medications are identified through diagnosis codes only.

Did you know?

- Diabetic retinopathy is the leading cause of blindness among adults.
- Anyone with diabetes is at risk for diabetic-related eye disease such as diabetic retinopathy, macular edema, glaucoma, and cataracts.
- The prevalence of diabetic retinopathy is more than twice as common in Mexican Americans, and almost three times as common in African Americans, than in the Caucasian population.

Measure compliance (numerator)

- Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist).
  - Negative eye exam during the measurement year or year prior
  - Positive eye exam during the measurement year (must be done **annually**).
- Bilateral eye enucleation any time during the patient's history

continued

Exclusions

- Patients who did not have a diagnosis of diabetes during the measurement year or the year prior **and** who had a diagnosis of:
  - Polycystic ovarian syndrome **or**
  - Gestational diabetes **or**
  - Steroid-induced diabetes
- Received hospice services anytime during the measurement year
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)
- Deceased during the measurement year
- Received palliative care during the measurement year

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

Helpful HEDIS hints

- A retinal or dilated eye exam must be performed by an eye care professional **annually** for patients with **positive retinopathy**, and every two years for patients without evidence of retinopathy.
  - Date of service, eye exam results, and eye care professional's name with credentials are required.
  - Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure.
- Review the report and document abnormalities in the active problem list.
- Eye exam result documented as unknown does not meet criteria.
- Document patient reported eye exams with date, result, and eye care provider with credentials in the medical history.
  - If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.
- Evidence of prosthetic eye(s) is acceptable for enucleation.
  - Unilateral enucleation would still require an exam on the other eye.
- Refer patients to an optometrist or ophthalmologist for a dilated or retinal eye exam annually and explain why this is different than a routine eye exam.
  - Routine eye exams for glasses, glaucoma or cataracts do not count. Must be a dilated/retinal exam.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- Diabetic eye exams are covered under the patient's medical insurance and may be subject to copays and deductibles.
- Optical coherence tomography is considered imaging and is eligible for use. The fundus/retinal photography must have the date, result and eye care professional with credentials documented.

continued

Tips for coding

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

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

- If a primary care practitioner's office has equipment to complete retinal imaging with interpretation by artificial intelligence (AI) in their office, the practitioner can report completion of the eye exam by submitting a claim with CPT code 92229, for the services provided **AND** the appropriate CPT II code to report the exam results.
- Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).

Resources

1. Medical News Today. 2022. "Why is diabetic eye screening important?" **medicalnewstoday.com/articles/diabetic-eye-exam**
2. American Diabetes Association (ADA). May 2022. "May is Healthy Vision Month…Did you Know?" **diabetes.org/sites/default/files/2022-04/FOD_HVM_0.pdf**
3. Centers for Disease Control and Prevention. August 2021 "Diabetic Retinopathy." **cdc.gov/visionhealth/pdf/factsheet.pdf**

2023 Star Measure Tips

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

Hemoglobin A1c Control for Patients with Diabetes (HBD)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of diabetic patients whose HbA1c was adequately controlled.

Measure population (denominator)

Patients 18 - 75 years old with diabetes (type 1 or type 2).

Any of the following during the measurement year or the year prior to the measurement year:

- Two or more outpatient visits on different dates of service with a diagnosis of diabetes
- One acute inpatient stay with a diagnosis of diabetes
- Patients dispensed insulin or hypoglycemics/antihyperglycemics
  - This includes Semaglutides (except for Wegovy® given for weight loss).
  - Glucophage/Metformin as a solo agent is not included because it's used to treat conditions other than diabetes. Patients with diabetes on these medications are identified through diagnosis codes only.

Did you know?

- Small changes in diet and exercise can significantly impact diabetes.
- Diabetes is one of the nation's leading causes of death and disability.
- Type 1 diabetes occurs at every age and in people of every race, shape, and size.

Measure compliance (numerator)

The last HbA1c of the measurement year. The result must be ≤ 9% to show evidence of control.

Exclusions

- Patients who did not have a diagnosis of diabetes during the measurement year or the year prior and who had a diagnosis of:
  - Polycystic ovarian syndrome or
  - Gestational diabetes or
  - Steroid-induced diabetes

continued

Exclusions *(continued)*

- Received hospice services any time during the measurement year
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).
- Deceased during the measurement year
- Received palliative care during the measurement year

Helpful HEDIS hints

- HbA1c should be completed two to four times each year and include the result date and distinct numeric result.
- Order labs to be completed prior to patient appointments.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- Patient-reported HbA1c results are acceptable as long as the date and result are documented in the medical record.

  Note: HbA1c home kits (e.g., patient purchased from drug store) are not acceptable. The test must be processed in a lab.

Tips for coding

When HbA1c reports are received, or the patient reports their HbA1c results, submit the appropriate CPT® II code on a $0.01 claim.

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

Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).

Resources

1. American Diabetes Association (ADA). 2022. "The Path to Understanding Diabetes Starts Here." **diabetes.org/diabetes**
2. Centers for Disease Control and Prevention (CDC). July 2022. "About Chronic Diseases." **https://www.cdc.gov/chronicdisease/about/index.htm#:~:text=Chronic%20diseases%20such%20as%20heart,in%20annual%20health%20care%20costs**

2023 Star Measure Tips

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

Kidney Health Evaluation for Patients with Diabetes (KED)

Effectiveness of Care HEDIS® Measure

Measurement description

Percentage of diabetic patients who received a kidney health evaluation.

Measure population (denominator)

Patients 18 - 85 years old with diabetes (type 1 or type 2).

Any of the following during the measurement year or the year prior to the measurement year:

- Two or more outpatient visits on different dates of service with a diagnosis of diabetes
- One acute inpatient stay with a diagnosis of diabetes
- Patients dispensed insulin or hypoglycemics/ antihyperglycemics
  - This includes Semaglutides (except for Wegovy® given for weight loss).
  - Glucophage/Metformin as a solo agent is not included because it's used to treat conditions other than diabetes. Patients with diabetes on these medications are identified through diagnosis codes only.

Did you know?

- Diabetes and high blood pressure are the most common causes of kidney disease.
- Adequate control of blood sugar and blood pressure have been shown to lower the risk of developing kidney disease.
- Kidney disease often develops slowly, consequently many are unaware until the disease is advanced and requires dialysis or a kidney transplant.
- Kidney disease is more common in people over 65, as well as Black and Hispanic adults.

continued

Measure compliance (numerator)

Diabetic patients who received ***both*** of the following during the measurement year:

1. Serum estimated glomerular filtration rate (eGFR)
2. Urine albumin creatinine ratio (uACR) identified by *either* of the following:
   - **Both** a Quantitative Urine Albumin test **and** a Urine Creatinine test with service dates 4 days or less apart

Or

   - Urine Albumin Creatinine Ratio test (uACR)

Exclusions

- Patients who did not have a diagnosis of diabetes during the measurement year or the year prior **and** who had a diagnosis of:
  - Polycystic ovarian syndrome **or**
  - Gestational diabetes **or**
  - Steroid-induced diabetes
- Are age 66–80 with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).
- Received hospice services anytime during the measurement year
- Are age 81 and older with frailty during the measurement year.
- Received palliative care during the measurement year
- End stage renal disease (ESRD) or dialysis
- Deceased during the measurement year

Helpful HEDIS hints

- Lab test reports should indicate both an eGFR and uACR were performed during the measurement year on the same or different dates of service.
- Order labs to be completed prior to patient appointments.
- Ensure labs are ordered at least annually, preferably at the beginning of the year.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- If ordering a microalbumin, be sure that the albumin/creatinine ratio is being measured, reported and both codes are being billed (82043, 82570).

Tips for coding

To ensure gap closure, verify the practitioner orders and lab facilities include all 3 codes below.

Note: Measure can only be closed through claims.

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

Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).

Resources

1. Centers for Disease Control and Prevention (CDC). May 2021. "Diabetes and Chronic Kidney Disease." **cdc.gov/diabetes/managing/diabetes-kidney-disease.html**
2. Centers for Disease Control and Prevention (CDC). March 2021. "Chronic Kidney Disease in the United States, 2021". **cdc.gov/kidneydisease/pdf/Chronic-Kidney-Disease-in-the-US-2021-h.pdf**
3. Centers for Disease Control and Prevention (CDC). July 2022. "Prevention and Risk Management." **cdc.gov/kidneydisease/prevention-risk.html**

2023 Star Measure Tips

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

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

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients who had a follow-up service following an emergency department (ED) visit.

Measure population (denominator)

Patients 18 years of age and older with **two or more** different high-risk chronic conditions that had an ED visit between January 1 and December 24 of the measurement year.

Note: If a patient has more than one ED visit, they could be in the measure more than once.

Did you know?

- Patients are at a higher risk of complications following emergency department visits because of their functional limitations and multiple chronic conditions.
- Studies have found that older adults have increased mortality rates and readmissions rates within the first three months after the emergency department visit.

High-risk chronic conditions (diagnosed prior to ED visit during measurement year or year prior)		
Alzheimer's disease and related disorders	COPD and asthma	Myocardial infarction - acute
Atrial fibrillation	Depression	Stroke and transient ischemic attack
Chronic kidney disease	Heart failure	

continued

Measure compliance (numerator)

A follow-up service within 7 days on or after the emergency department visit (8 total days).

The following meet criteria for follow-up:

- Outpatient visit
- Observation visit
- Virtual care visit
- Behavioral health visit
- Case management visit
- Electroconvulsive therapy
- Substance use disorder service
- Community mental health center visit
- Complex Care Management Services
- Intensive outpatient or partial hospitalization
- Transitional care management (TCM) services
- Domiciliary or rest home visit (e.g., boarding home, assisted living visit, custodial care services)

Exclusions

- Admitted to an acute or nonacute inpatient facility on or within 7 days after the ED visit, regardless of the principal diagnosis for admission.
- Received hospice services anytime during the measurement year
- Deceased during the measurement year

Helpful HEDIS hints

- Contact patient as soon as ED discharge notification is received and schedule follow-up visit.
  - Discuss the discharge summary; verify understanding of instructions and that all new prescriptions were filled.
  - Complete a thorough medication reconciliation with the patient and/or caregiver.
- Virtual care visits are acceptable for follow-up.
- Keep open appointments so patients with an ED visit can be seen within 7 days of their discharge.
- Instruct patients to call health care practitioner with any concerns or worsening of symptoms.

Resources

1. Department of Health and Human Services (HHS). 2010. "Multiple Chronic Conditions: A Strategic Framework." **hhs.gov/sites/default/files/ash/initiatives/mcc/mcc_framework.pdf**
2. National Institutes of Health (NIH). October 2020. "Ambulatory Follow-up and Outcomes Among Medicare Beneficiaries After Emergency Department Discharge." **pubmed.ncbi.nlm.nih.gov/33034640/**
3. National Institutes of Health (NIH). 2019. "Emergency Department Interventions for Older Adults: A Systemic Review." **pubmed.ncbi.nlm.nih.gov/30875098/**

2023 Star Measure Tips

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

Statin Use in Persons with Diabetes (SUPD)

Pharmacy Quality Alliance-endorsed performance measures

Measure description

Percentage of patients with diabetes receiving statin therapy.

Measure population (denominator)

Patients with diabetes age 40–75 years old who were dispensed at least two diabetes medication fills during the measurement year.

Measure compliance (numerator)

Patient dispensed at least one statin medication of any intensity during the measurement year.

Did you know?

- Patients with diabetes have an increased prevalence of lipid abnormalities, which contributes to their increased risk of cardiovascular disease.
- Statins are effective at lowering cholesterol and protecting against a heart attack and/or stroke.
- The American College of Cardiology/American Heart Association (ACC/AHA) and the American Diabetes Association guidelines all recommend using statins in patients with diabetes.

Statin Medications: Generic and Brand Names			
Atorvastatin (Lipitor, Caduet)	**Lovastatin** (Altoprev)	**Pravastatin** (Pravachol)	**Simvastatin** (Zocor, Vytorin)
Fluvastatin (Lescol XL)	**Pitavastatin** (Livalo, Zypitamag)	**Rosuvastatin** (Crestor, Ezallor)	

Note: Patients must use their pharmacy benefit to close this measure. Statins found in combination medications (i.e., Caduet, Vytorin) meet the measure.

continued

Exclusions

- Myositis, myopathy, or rhabdomyolysis during the measurement year
- Pre-diabetes
- End stage renal disease (ESRD)
- Cirrhosis
- Pregnant, lactating, or undergoing fertility treatment.
- Polycystic Ovarian Syndrome (PCOS)
- Received hospice services anytime during the measurement year.

Helpful HEDIS hints

- Prescribe at least one statin medication during the measurement year to patients diagnosed with diabetes.
- Educate patients on the importance of statin medications for patients with diabetes over the age of 40, regardless of LDL levels.
- Discuss with patients the importance of taking their medications as prescribed.
- Once patients demonstrate that they tolerate statin therapy, encourage them to obtain 90-day supplies through their pharmacy or mail order pharmacy.
- Instruct patients to fill prescriptions using their pharmacy benefit.
  - Claims filled through pharmacy discount programs, cash claims, and medication samples will not count.
  - Gap closure is dependent on pharmacy claims.
  - Medication costs are often less when patients use their pharmacy benefit.
- This measure overlaps with other HEDIS® and PQA pharmacy measures
  - Statin Therapy for Patients with Cardiovascular Disease/Diabetes (SPC/SPD)
  - Medication Adherence for Cholesterol (Statins).
- For patients turning 76 years old during the measurement year, a statin must be filled no later than a month before their 76th birthday.
- Remind patients to contact practitioner if experiencing medication adverse effects.
- Consider trying a different statin and/or reducing the dose or frequency if patients are experiencing adverse effects.

Tips for coding

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

- These codes are intended to close Star measure gaps and do not apply to payment or reimbursement. Only the codes listed below will exclude the patient from the SUPD measure.

Condition	ICD-10-CM code
Cirrhosis	K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69
ESRD	I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
Pregnancy and/or Lactation	Numerous > 1k
Polycystic Ovarian Syndrome	E28.2
Pre-diabetes	R73.03
Other abnormal blood glucose	R73.09
Myopathy, drug induced *	G72.0
Myopathy, Other specified *	G72.89
Myopathy, unspecified *	G72.9
Myositis, other *	M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879
Myositis, unspecified *	M60.9
Rhabdomyolysis *	M62.82

**The condition the code refers to does not necessarily need to occur in the same year the code was billed. The member's medical chart should reflect 'history of'.*

Resources

1. American College of Cardiology (ACC) / American Heart Association (AHA). 2019. "ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease." **https://www.acc.org/Latest-in-Cardiology/ten-points-to-remember/2019/03/07/16/00/2019-ACC-AHA-Guideline-on-Primary-Prevention-gl-prevention**
2. Mangione, Carol M. (2022). "Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: US Preventive Services Task Force Recommendation Statement." JAMA : the Journal of the American Medical Association (0098-7484), 328 (8), p. 746. **https://jamanetwork.com/journals/jama/fullarticle/2795521**
3. Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes—2022. Diabetes Care 2022;45 (Supplement_1): S144–S174. **https://diabetesjournals.org/care/article/45/Supplement_1/S144/138910/10-Cardiovascular-Disease-and-Risk-Management**

Pharmacy Quality Alliance (PQA) is a national quality organization dedicated to improving medication safety, adherence and appropriate use. PQA measures are included in the Medicare Part D Star Ratings.

2023 Star Measure Tips

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

Medication Reconciliation Post-Discharge (TRC-M)

A component of Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients who had their medications reconciled following an inpatient discharge.

Measure population (denominator)

Patients 18 years and older with an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

Note: If patients have multiple discharges, they could appear in the measure more than once.

Measure compliance (numerator)

Medications reconciled on the date of discharge through 30 days after (31 days total).

Did you know?

- Inadequate care coordination and poor care transitions result in billions of unnecessary medical expenses.
- Lack of communication between inpatient and outpatient providers may result in unintentional medication changes, incomplete diagnostic workups and inadequate patient, caregiver, and provider understanding of diagnoses, medication, and follow up needs.
- Patient safety is compromised and medication errors result from inadequate medication reconciliation during care transitions.

Exclusions

- Received hospice services anytime during the measurement year
- Deceased during the measurement year

continued

Helpful HEDIS hints

- Medication reconciliation must be conducted or cosigned by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse.
  - Medication reconciliation may be performed by other medical professionals (e.g., MA, LPN) if signed off by an acceptable practitioner.
- Evidence of medication reconciliation must be in the outpatient medical record, but an outpatient face-to face visit is not required.
- Performing medication reconciliation after every discharge ensures that patients understand all their medications; new, current, and discontinued.
- Request patients' discharge summary with medication list and any discharge instructions from the inpatient facility.
- A post discharge visit is encouraged to support patient engagement (office, home, or virtual care visit). Ask patients to bring all medications (prescription, over-the counter, herbal, topical, etc.).
- Documentation of medication reconciliation **must** include the date performed, current medication list, and evidence of any of the following:
  - Notation that the practitioner reconciled the current and discharge medications.
  - Notation that references the discharge medications (e.g., no change in medications since discharge, same medications at discharge, discontinue all discharge medications).
  - Evidence the practitioner was aware of the patient's hospitalization and a post-discharge hospital follow-up with medication reconciliation or review.
  - Discharge medication list with evidence that both lists were reviewed on the same date of service
  - Notation that no medications were prescribed or ordered upon discharge.

Tips for coding

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

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
CPT® codes	**Description**
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **moderate** complexity and a face-to-face visit within **14 days** of discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **high** complexity and a face-to-face visit within **7 days** of discharge.

continued

Tips for coding *(continued)*

- Bill 1111F as soon as medication reconciliation is completed.
  - 1111F can be billed alone ***OR*** with an associated visit.
  - The allowable amount for an 1111F claim is $35 for Medicare Plus Blue and BCN Advantage.

    Note: There is no member cost share associated with 1111F for Medicare Plus Blue and BCN Advantage.
- Visits with a practitioner can be with or without a telehealth modifier.
- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

Resources

1. National Committee for Quality Assurance (NCQA). 2022. "Transitions of Care (TRC)." **ncqa.org/hedis/measures/transitions-of-care/**
2. National Institutes of Health (NIH). 2018. "Impact of medication reconciliation for improving transitions of care." **ncbi.nlm.nih.gov/pmc/articles/PMC6513651/**