Provider Reference Guide

HEDIS® 2025

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Introduction

The Centers for Medicare and Medicaid Services (CMS) created the 5-Star Quality Rating System to help consumers compare and evaluate the quality of health plans. The rating system gives each individual quality measure a rating between 1 and 5 stars. Some CMS Star Measures are for measures in the Healthcare Effectiveness Data and Information Set (HEDIS®), a national performance measurement tool established by the National Committee for Quality Assurance (NCQA) to assess the effectiveness of providers and health plans on specific clinical measures. HealthTeam Advantage wants to make sure that your office demonstrates the quality of care you provide through provision of necessary medical services and correct submission of claims data.

This guide is provided to help you:

- Know the types of conditions HealthTeam Advantage reviews to assess clinical performance based on HEDIS® measurement standards. For more information visit *www.ncqa.org* and *www.cms.gov*.
- Become familiar with the diagnosis and procedures codes most frequently reviewed to assess clinical performance as associated with CMS 5 Star/HEDIS.
- Review your practice to determine changes you may need to make to provide and bill needed services.

Contents

Controlling Blood Pressure (CBP)

Ages 18-85. The percentage of members who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mm Hg).

Measure Requirements

January 1, 2025 – December 31, 2025
Blood Pressure reading <140/90mm Hg

If multiple blood pressures occur on the same date, use the lowest reading of systolic and lowest reading of the diastolic.

Measure Exclusions

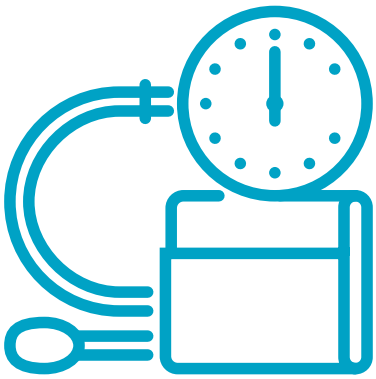
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year. Do not include laboratory claims.
- Members with evidence of end-stage renal disease, dialysis anytime during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims.
- Members with a procedure that indicates ESRD: dialysis, nephrectomy, or kidney transplant anytime during the member's history on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy during the measurement year.
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: Enrolled in an Institutional SNP (I-SNP) anytime during the measurement year OR living long-term in an institution anytime during the measurement year.
- Members 66-80 years of age as of December 31 of the measurement year with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded.
- Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims.

CPT II Codes

CPT II 3074F 3075F 3077F 3078F 3079F 3080F*
ICD-10- CM Diagnosis
I10 I11.9 I12.9

Documentation Requirements

- BP must be latest reading in the MY and must occur on or after the diagnosis of HTN.
- BP readings taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the test or procedure, with the exception of fasting blood tests, are not used.
- BP readings taken during an inpatient stay or ED visit are not used.
- When multiple BP measurements occur on the same date, the lowest systolic and lowest diastolic BP reading will be used.
- If no BP is recorded during the MY, the member is "not controlled."
- Services provided during a telephone visit, e-visit, or virtual check-in are acceptable.
- Member-reported data documented in medical record is acceptable if BP captured with a digital device and documented in the medical record with date BP taken.



Statin Therapy for Patients with Cardiovascular Disease (SPC)

Males 21-75 years of age and females 40-75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Measure Requirements

- 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 90-100 day prescriptions for maintenance drugs.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year. Do not include laboratory claims.
- In vitro fertilization in the measurement year or the year prior to the measurement year.
- Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year.
- ESRD during the measurement year or the year prior to the measurement year. Do not include laboratory claims.
- Dialysis during the measurement year or the year prior to the measurement year.
- Cirrhosis during the measurement year or the year prior to the measurement year. Do not include laboratory claims.
- Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. Do not include laboratory claims.
- Myalgia or rhabdomyolysis caused by a statin any time during the member's history through December 31 of the measurement year.
- Members who die anytime during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year. Do not include laboratory claims.
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: Enrolled in an Institutional SNP anytime during the measurement year. OR Living long-term in an institution anytime during the measurement year as identified by the LTI flag in the Monthly Membeship Derail Data File.
- Members 66 years of age and older as of December 31 of the measurement year with family and advanced illness.
- Members must meet both frailty and advanced illness criteria to be excluded.

CPT II Codes

HCPCS: G9664 (current statin users)***

Documentation Requirements

The Index Prescription Start DATE (IPSD) is the earliest dispensing date for any statin medication of at least moderate intensity during the MY. The Treatment Period (TP) is the period beginning on the ISPD through 12/31 of the MY.

Common codes for exclusions ***
Myopathy: G72.0 G72.9
Myositis: M60.80 M60.9
Rhabdomyolysis: M62.82
Cirrhosis: K70.30 K70.31 K71.7 K74.3 K74.5 K74.60
K74.69 P78.81
ESRD: N18.5 N18.6 Z99
Confirm diagnosis of cardiovascular disease

Breast Cancer Screening (BCS-E)

The percentage of women ages 50-74 who had one or more mammograms to screen for breast cancer anytime on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Measure Requirements

Mammogram completed from October 1, 2023 – December 31, 2025.

Measure Exclusions

- Members who have a bilateral mastectomy or both right and left unilateral mastectomies anytime during the member's history through the end of measurement period.
- Members who are in hospice or die during measurement year.

CPT II Codes/ICD Categories

CPT 77061 77062 77063 77065 77066 77067 ** CPT II: 3014F***

Documentation Requirements

All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance.

Note: Biopsies, breast ultrasounds, and MRIs do not count toward this measure.

Colorectal Cancer Screening (COL-E)

The percent of members ages 45 to 75 who had one or more appropriate screenings for colorectal cancer.

Measure Requirements

- FOBT (fecal occult blood test) January 1, 2025 – December 31, 2025
- Flexible Sigmoidoscopy - January 1, 2021 – December 31, 2025
- Colonoscopy January 1, 2016 – December 31, 2025
- CT Colonography January 1, 2021 – December 31, 2025
- Stool DNA (Cologuard) January 1, 2022 – December 31, 2025

Measure Exclusions

- Members who had colorectal cancer.
- Members who had total colectomy.
- Members receiving palliative care anytime during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year.
- In hospice or using hospice services anytime during the measurement year.
- Members who died during the measurement year.
- Medicare members 66 years of age and older by the end of the measurement period who meet either the following: Enrolled in an Institutional SNP (I-SNP) anytime during the measurement period OR living long-term in an institution anytime during the measurement period.
- Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:
  - At least two indications/diagnoses of frailty with different dates of service during the measurement year.
  - At least two diagnoses of advanced illness on different dates of service during the measurement year or year prior, or dispensed a dementia medication (memantine, galantamine, rivastigmine, donepezil, donepezil-memantine).

CPT II Codes

*FOBT CPT: 82270 82274
*HCPCS: G0328
*FIT sDNA CPT: 81528
CT Colonography
CPT: 74261 74262 74263
Flexible Sigmoidoscopy CPT: 45330 45331 45332 45333 45334 45335 45337 45338 45340 45341 45342

Documentation Requirements

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present. (This ensures that the screening was performed and not merely ordered.)

- Colonoscopy in past 10 years (the MY and 9 years prior).
- Flexible Sigmoidoscopy in past 5 years (the MY and 4 years prior).
- CT Colonography in past 5 years (the MY and 4 years prior).
- Stool DNA (sDNA) with FIT test in past 3 years (the MY and 2 years prior).
- Fecal Occult Blood Test (FOBT) in the MY.

Osteoporosis Management in Women who had a Fracture (OMW)

The percentage of women 67 to 85 who suffered a fracture and who had a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Measure Requirements

Bone Density Scan in the 180 days (6 months) after the fracture or Osteoporosis Medication in the 180 days (6 months) afer the fracture July 1, 2023 – June 30, 2025.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.
- Members who receive palliative care anytime enduring the intake period through the end of the measurement year.
- Members who are 66 or older as of December 31 of the measurement period with frailty and advanced illness.
- Members must meet both of the following frailty and advance illness criteria to be excluded:
  - At least two indications/diagnoses of frailty with different dates of service during the measurement year.
  - At least two diagnoses of advanced illness on different dates of service during the measurement year or year prior, or dispensed a dementia medication (memantine, galantamine, rivastigmine, donepezil, or donepezil-memantine).

CPT II Codes

CPT: 76977, 77078, 77080, 77081, 77085, 77086 ICD10PCS: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
Osteoporosis Medication Therapy: HCPCS: JO897, J1740, J3110, J3111, J3489
Long-Acting Osteoporosis Medications: HCPCS: J0897, J1740, J3489

Documentation Requirements

- HEDIS rates are based on pharmacy claims/BMD testing
- Bone Mineral Density Test
- Osteoporosis Medications List: Bisphosphonates: Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid
- Other Agents: Abaloparatide, Denosumab, Raloxifene, Romosozumab, Teriparatide

Blood Pressure Control for Patients with Diabetes (BPD)

The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Measure Requirements

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest dyastolic BP on that date as the representative BP.

Measure Exclusions

- Members who did not have a diagnosis of diabetes.
- Members in hospice or using hospice services.
- Members who died during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year. Do not include laboratory claims.
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) anytime during the measurement year. OR Living long-term in an institution anytime during the measurement year.
  - Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness.

CPT II Codes

CPT II: 3074F 3075F 3077F 3088F 3079F 3080F
ICD -10- CM I10 I11.9 I12.9

Documentation Requirements

Documentation must confirm member is a diabetic and blood pressure is most recent for the measurement year.

Glycemic Status Assessment for Patients with Diabetes (GSD)

The percentage of members with diabetes (Type 1 and Type 2) ages 18 to 75 whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: Glycemic status <8.0% or Glycemic Status >9.0%.

Measure Requirements

Glycemic Status <8.0% January 1, 2025 – December 31, 2025

Measure Exclusions

- Members in hospice or using hospice services.
- Members who died during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year. Do not include laboratory claims.
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: Enrolled in an Institutional SNP (I-SNP) anytime during the measurement year OR Living long-term in an instutution anytime during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year with frailty AND advanced illness.
- Members must meet both frailty and advanced illness crieria to be excluded:
  1. Frailty—at least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims.
  2. Advanced Illness—Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness on at least two different dates of service. Do not include laboratory claims.
     - Dispensed dementia medication.

CPT II Codes

* CPT II: 3044F 3051F 3052F 3046F
*** CPT: 83036 (A1c test)

Documentation Requirements

At a minimum, the documentation in the medical record must include a note indicating the date when the most recent HbA1c test was performed in the MY and the result or findings. Ranges and thresholds DO NOT meet criteria—a distinct numeric result is required.

Eye Exam for Patients with Diabetes (EED)

The percentage of members ages 18 to 75 with diabetes (Type 1 and Type 2) who were adequately screened for diabetic retinopathy by an eye care professional (optometrist or ophthalmologist)

Measure Requirements

Retinal Eye Exam by optometrist or ophthalmologist.

NEGATIVE Retinal Exam
January 1, 2024 – December 30, 2025.

POSITIVE Retinal Exam
January 1, 2025 – December 30, 2025.

Measure Exclusions

- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year:
  - Unilateral eye enucleation with a bilateral modifier.
  - Two unilateral eye enucleations with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
  - Left unilateral eye enucleation and right unilateral eye enucleation on the same or different dates of service.
  - A unilateral eye enucleation and a left unilateral eye enucleation with service dates 14 days or more apart.
  - A unilateral eye enucleation and a right unilateral eye enucleation with service dates 14 days or more apart.
- Members who did not have a diagnosis of diabetes.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year. (If only unilateral eye enucleation for one eye, member must complete a diabetic eye exam for the other eye)
- Members in hospice or using hospice services.
- Members who died during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year. Do not include laboratory claims.
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: Enrolled in an Institutional SNP (I-SNP) anytime during the measurement year OR living long-term in an institution anytime during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness.

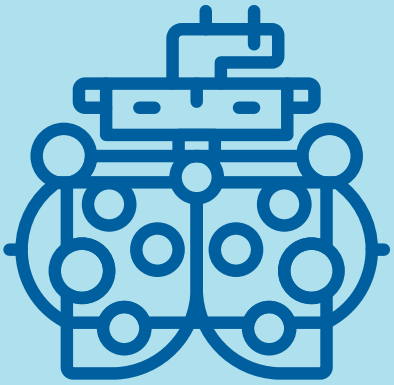
CPT II Codes

CPT II: 2022F 2023F 2024F 2025F 2026F 2033F 3072F* 3017F***

Documentation Requirements

Documentation can include any of the following noted in the medical record:

- A note or letter during the MY prepared by an ophthalmologist, optometrist, PCP, or other health care provider indicating that an ophthalmoscopic exam was completed by an eye care provider, the date when the procedure was performed and the results.
- Documentation of a negative (or normal) retinal or dilated exam by



an eye care provider in the year prior to the MY, where results indicate retinopathy was not present and the date when the exam was performed.

- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) or qualified reading center reviewed the results, or that results were read by a system that provides artificial intelligence (AI) interpretation.

Kidney Health Evaluation for Patients with Diabetes (KED)

The percentage of members with diabetes (Type 1 and Type 2) ages 18 to 85 who received kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR)

Measure Requirements

eGFR (blood test - creatinine) AND uACR (urine creatinine albumin ratio or urine creatine and urine albumin)
January 1, 2025 – December 31, 2025

Measure Exclusions

- Members who did not have a diagnosis of diabetes.
- Members with evidence of ESRD or dialysis anytime during the member's history on or prior to December 31 of the measurement year.
- Members in hospice or using hospice services.
- Members who died during the measurement year.
- Members receiving palliative care anytime during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year. Do not include laboratory claims.
- Enrolled in an Institutional SNP (U-SNP) anytime during the measurement year.
- Living long-term in an institution anytime during the measurement year.
- Members 60-88 years of age as of December 31 of the measurement year with frailty and advanced illness. Do not include laboratory claims.
- Advanced illness on at least two different dates of service. Do not include laboratory claims.
- Dispensed dementia medication. Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims.

CPT II Codes

Estimated Glomerular Filtration Rate Lab Test: CPT: 80047, 80048, 80050, 80053, 80069, 82565
Quantitative Urine Albumin Lab Test CPT: 82043
Urine creatine lab test CPT: 82570

Documentation Requirements

All three are required. Service dates of Quantitative Urine Albumin lab test and Urine Creatinine lab test must be four or less days apart.

Care of Older Adults - Medication Review (COA-Med)

Ages 66 and older. A review of all member's medications, including prescription medication, OTC medication, herbal/supplemental therapies.

Measure Requirements

January 1, 2025 – December 31, 2025. Medication list AND evidence of a review by a prescribing practitioner or pharmacist OR evidence that a member is not on any medications.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

CPT II Codes

CPT II: 1160F*
* Medication review CPT 90863 99843 99605 99606
*Medication List HCPCS G8427

Documentation Requirements

Any of the following are acceptable:

- The presence of a medication listed on the medical record with notation of date reviewed
- Dated notation that member is not taking any medications
- Transitional care mgt. services documented during MY Criteria is NOT met if review is performed by an RN

Care of Older Adults - Functional Status Assessment (COA-FSA)

Ages 66 and older as of December 31 of the measurement year.

Measure Requirements

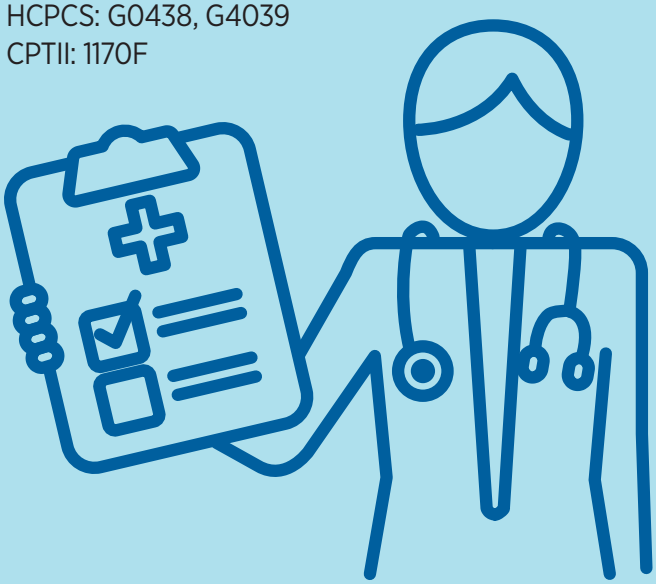
Documentation in the medical record must show evidence of a complete functional status assessment and the date when it was performed.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

CPT II Codes

**CPT II: 1159F
Transitional Care Management CPT: 99495
CPT: 99496, 99483
HCPCS: G0438, G4039
CPTII: 1170F



Documentation Requirements

- At least one functional status assessment during the MY and the date it was performed. Functional status assessment must include one of the following:
  - Notation that Activities of Daily Living (ADLs) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking.
  - Notation that Instrumental Activities of Daily Living (IADLs) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
  - Result of an assessment using a standardized functional status assessment tool.
  - Criteria is not met by a fall assessment.

Transitions of Care (TRC)

The percentage of discharges for ages 18 and older that had each of the following. (4 rates reported):

1. Notification of Inpatient Admission - Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
2. Receipt of discharge information. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
3. Patient engagement after inpatient discharge. Documentation of patient engagement (e.g. office visits, visits to the home, telehealth) provided within 30 days after discharge.
4. Medication Reconciliation Post-discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

#1

Notification of Inpatient Admission

Measure Requirements

Notification of Inpatient Admission - Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days)

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

Documentation Requirements

- The Notification of Inpatient Admission and Receipt of Discharge Information has no administrative reporting option. They are based on medical record review only. Documentation sent to the member's PCP or OCP must include dated evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total). Compliance through Medical Record Review only. Ensure admission/discharge notifications are in member's outpatient chart.
- If member has an observation stay and then admitted as an inpatient, the date of the admission stay is used for compliance. Observation stays are considered outpatient.

#2

Receipt of Discharge Information

Measure Requirements

- Receipt of discharge information.
- Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

Documentation Requirements

The Notification of Inpatient Admission and Receipt of Discharge Information has no administrative reporting option. They are based on medical record review only. Patients transferring from a hospital to a skilled nursing facility or other inpatient setting require notification of discharge from the skilled nursing facility or other inpatient setting.

#3

Patient Engagement

Measure Requirements

Patient engagement after inpatient discharge. Documentation of patient engagement (e.g. office visits, visits to the home, telehealth) provided within 30 days after discharge.

Measure Exclusions

Members in hospice or using hospice services anytime during the measurement year. Members who died anytime during the measurement year.

CPT II Codes

Patient Engagement Indicator:

Outpatient: CPT: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483

HCPCS: G0402, G0438, G0439, G0463, T1015

Telephone Visits: CPT: 98966, 98967, 98968, 99441, 99442, 99443

Transitional Care Management Services: CPT: 99495, 99496

Online Assessments: CPT: 98969, 98970, 98971, 98972, 98980, 98981, 99421, 99422, 99423, 99444, 99457, 99458 HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Documentation Requirements

Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria. (HYBRID: Compliance via claims or Medical Record Review.) Note: Patients transferring from a hospital to a skilled nursing facility or other inpatient setting require engagement after discharge from the skilled nursing facility or other inpatient setting.

#4

Medication Reconciliation Post-Discharge

Measure Requirements

Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

CPT II Codes

CPT II: 1111F*
CPT: 99843 99495 99496

Documentation Requirements

- Evidence discharge medications were reconciled with the most recent medication list in the PCP/OCP outpatient medical record on the date of discharge through 30 days after discharge (31 days total). (HYBRID: Compliance via claims or Medical Record Review). Note: Patients transferring from a hospital to a skilled nursing facility or other inpatient setting DO NOT require medication reconciliation until they are discharged from the inpatient setting.
- Evidence of medication reconciliation and the date when it was performed by either:
  - prescribing practitioner
  - clinical pharmacist
  - physician's assistant
  - registered nurse

Plan All-Cause Readmission (PCR)

Members 18 years of age and older, the number of acute inpatient and observation stays between January 1 and December 1 of the measurement year that were followed by unplanned acute readmission for any diagnosis within 30 days, either for the same condition as their recent hospital stay or for a different reason.

Measure Requirements

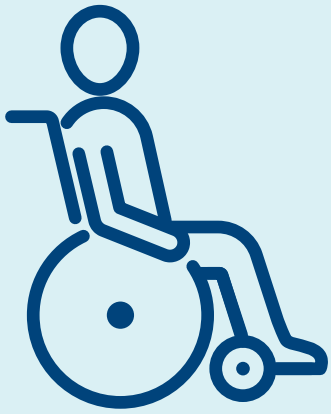
No specific services are needed, other than efforts from the plan and health care providers supporting coordination of care and prevention of all readmissions.

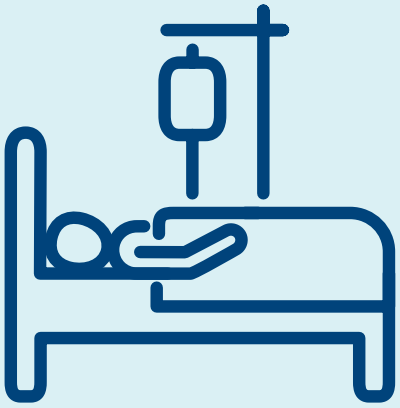
Measure Exclusions

Members in hospice or using hospice services anytime during the measurement year.

CPT II Codes

Refer to UBREV codes





Documentation Requirements

- The denominator for this measure is based on discharges and not members specifically.
- An acute discharge can be from any type of facility, including behavioral health facilities.
- Discharges are excluded if a direct transfer takes place after Dec. 1 of the measurement year.
- A lower readmission rate and comprehensive diagnosis documentation will drive better scores for this measure.
- Patients with multiple comorbidities are expected to return post inpatient or observation discharge at a higher rate. Ensure all suspect conditions are appropriately identified in the patient's medical record and claims.
- Discuss palliative care or hospice programs and assist with referral as appropriate.

Follow-up after Emergency Room Visit for People with High-Risk Multiple Chronic Conditions (FMC)

Age 18 and older. The percentage of emergency department visits for members who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the emergency department visit.

Measure Requirements

January 1, 2025 – December 31, 2025 Date dependent on encounter and has to be within 7 days of the discharge.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

CPT II Codes

Outpatient visit : CPT: 99202-99205, 99212-99215, 99241-99245, 99341-99345, 99347-99349, 99350, 99381-00387, 99391-99397, 99401, 99411-99412, 99429, 99455-99456, 99483
HCPCS: G0402, G0438/, G0439, G0463, GT1015
UBREV: 0510-05129, 0982, 0983
phone visits, transitional care mgt. visits, case mgt. encounter, complex care mgt., visit setting unspecified

Documentation Requirements

Refer to coding of the chronic conditions present. Only EMR systems and medical records accessible to the PCP/OCP (ongoing care provider) are eligible for use in reporting.

- Ensure all admission/discharge notifications are received and saved in the member's outpatient chart.
- Be sure to include any admission/discharge notifications from Skilled Nursing Facilities.
- Ensure appropriate engagement and medication reconciliation occur for all discharges including when discharged to home from Skilled Nursing Facilities. Members may be in the measure more than once in the measurement year!

Statin Therapy for Patients with Diabetes (SUPD)

The percent of members 40-75 years of age during the measurement year who were dispensed medications for diabetes and received a statin medication.

Measure Requirements

- Measure is closed with a paid claim on the insurance for a statin medication.
- 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 100 day prescriptions for maintenance drugs.

Measure Exclusions

- Members who have elected to receive hospice care with at least one day of hospice coverage during the measurement year.
- Members diagnosed with ESRD anytime during the measurement year.
- Members diagnosed with rhabdomyolysis or myopathy anytime during the measurement year.
- Members who are pregnant or breast-feeding anytime during the measurement year or at least one prescription claim for a medication indicated for fertility during the measurement year.
- Members diagnosed with cirrhosis anytime during the measurement period.
- Members diagnosed with pre-diabetes anytime during the measurement period.
- Members diagnosed with polycystic ovarian syndrome during the measurement year.

CPT II Codes/ICD Categories

HCPCS: G9664

EXCLUSION CODES

ICD-10-CM Categories:

ESRD including N19 Z91.15 Z99.2

Hypertensive Heart Diease with CKD Stage (5 or 6)

Cirrhosis

Prediabetes

Pregnancy and Breast Feeding

Polycystic Overian Syndrome (PCOS)

Myopathy

Drug - induced myopathy

Other specified myopathy

Myopathy unspecified Myositis

Unspecified Rhabomyolysis

Documentation Requirements

*Common codes for **exclusions***

Myopathy: G72.0 G72.9

Myositis: M60.80 M60.9

Rhabdomyolysis: M62.82

Cirrhosis: K70.30 K70.31 K71.7 K74.3 K74.5 K74.60 K74.69

ESRD: N18.5 N18.6 Z99

Not all inclusive

The Index Prescription Start DATE (IPSD) is the earliest date of service (DOS) for a diabetes medication during the measurement year. The Treatment Period (TP) is the period beginning on the ISPD through 12/31 of the MY.

Medication Adherence for Diabetes Medications

The percent of members 18 years and older with a prescription for a diabetic medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

Measure Requirements

- 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 90-100 day prescriptions for maintenance drugs.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members with an end stage renal diagnosis.
- Members who have prescription for insulin.

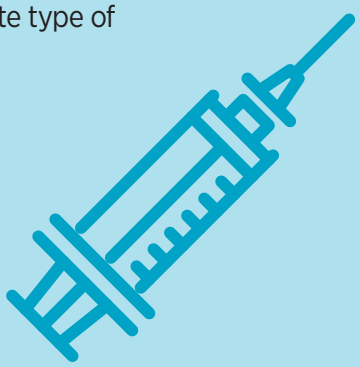
CPT II Codes

Refer to ICD-10-CM, CPT, HCPCS

Be aware of type of diabetes, I or II

Documentation Requirements

Members qualify for the measure with the second fill, but the measurement period starts with the date of the first fill. To be included in the measure, the first fill of medication must occur at least 91 days before the end of the enrollment period. Note type of diabetes.



Medication Adherence for Hypertension (RAS Antagonists)

The percent of members 18 years and older with a prescription for a high blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Measure Requirements

- 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 90-100 day prescriptions for maintenance drugs.

Measure Exclusions

The following beneficiaries are also excluded from the denominator anytime during the measurement period:

- Hospice enrollment
- ESRD disease or dialysis coverage dates
- One or more prescription for sacubitril/valsartan.

CPT II Codes

Refer to ICD-10-codes, CPT codes

Documentation Requirements

The first fill of medication must occur at least 91 days before the end of the enrollment period.

Medication Adherence for Cholesterol (Statins)

The percent of continuously enrolled members, 18 years and older, with a prescription for a statin, who fill their prescription often enough to cover 80% of more of the time they are supposed to be taking the medication.

Measure Requirements

- 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 100 day prescriptions for maintenance drugs.

Measure Exclusions

The following beneficiaries are also excluded from the denominator if anytime during the measurement period:

- Hospice enrollment
- ESRD diagnosis or dialysis coverage dates

CPT II Codes/ICD Categories

HCPCS: G9664 (current statin users)

EXCLUSION CODES

ICD-10-CM Categories:

ESRD including N19 Z91.15 Z99.2

Hypertensive Heart Disease with CKD Stage (5 or 6)

Documentation Requirements

- The member must be 18 years of age or older as of January 1 of the measurement year.
- The member must have at least two prescription claims on different dates of service in the targeted drug class(es).
- The first fill of medication must occur at least 91 days before the end of the enrollment period.
- Common codes for exclusions: Hospice, ESRD, dialysis. Please ensure the documentation states the reason the member cannot take a statin medication. Please make sure this is updated on an annual basis.

Polypharmacy of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

The percentage of continuously enrolled members, age 65 years or older, with concurrent use of two or more different anticholinergic medications.

Measure Requirements:

- Medications involved in this measure include (list is not all inclusive):
  - Antihistamines (hydroxyzine, meclizine, cyproheptadine)
  - Antiparkinsonian agents (benztropine, trihexyphenidyl)
  - Skeletal muscle relaxants (cyclobenzaprine, orphenadrine)
  - Antidepressants (amitriptyline, paroxetine, imipramine, nortriptyline)
  - Antipsychotics (chlorpromazine, olanzapine, perphenazine, clozapine)
  - Antimuscarinics (oxybutynin, tolterodine, solifenacin, trospium)
  - Antispasmodics (dicyclomine, scopolamine (excludes ophthalmic)
  - Antiemetics (prochlorperazine, promethazine)
- Complete medication review regularly
- Education members about risks with polypharmacy
- Use non-pharmacologic alternatives when appropriate

Measure Exclusions:

Hospice enrollment

Documentation Requirements:

Concurrent use is defined as 30 or more cumulative overlapping days' supply of two or more unique anticholinergic medications, each with two or more prescription claims on different dates of service.

Concurrent Use of Opioids and Benzodiazepines (ACH-COB)

The percentage of continually enrolled members 18 years or older with concurrent use of prescription opioids and benzodiazepines.

Measure Requirements:

- Assess medications regularly
- Evaluate concomitant use of opioids and benzodiazepines
- Educate patients on risk with combined therapy

Measure Exclusions:

- The following beneficiaries are excluded from the denominator if anytime during the measurement period:
  - Hospice enrollment
  - Cancer diagnosis
  - Sickle Cell Disease
  - Palliative Care

CPT II Codes/ICD Categories

- ICD-10-CM Categories
  - Cancer
  - Palliative Care
  - Sickle Cell Disease

Documentation Requirements:

- The prescription date of service and days' supply are utilized to count the number of overlapping days the member was "covered" by an opioid and benzodiazepine prescription.
- Overlapping supply is the days covered by both a benzodiazepine and opioid.
- Concurrent use is an overlapping supply of at least 30 cumulative days of opioids and benzodiazepines.

Medicare Annual Wellness Visit (AWV)

The percent of members who had an ambulatory or preventive care visit

Measure Requirements

- Vital signs
- Pain assessment
- Cognitive function assessment
- Risk factors for depression or other mood disorders (depression screenings)
- End-of-life planning (if patient agrees)
- Cognitive impairment detection

Measure Exclusions

Members in hospice or using hospice services anytime during the measurement year. Members who died anytime during the measurement year.

CPT II Codes/ICD Categories

HCPCS: G0402, G0438, G0439
G0468 (1)

Documentation Requirements

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

1 Section 60.2 of the Medicare Claims Processing Manual, Chapter 9 has more information on how to bill HCPCS code G0468.

Physical Exam

A physical exam is an evaluation of the patient's overall health. It is performed by a clinical licensed practitioner. The exam focuses on preventative care so the patient maintains good health or gets to good health.

Measure Requirements

- Review medical and family history
- Take routine measurements such as height, weight and B/P
- Assess risk factors for preventable diseases
- Perform lung, head and neck, abdominal and neurological exams
- Check reflexes and vital signs
- Take urine samples and submit for lab testing.

CPT II Codes/ICD Categories

CPT : 99385-99387 for new patients
99395-99397 for established patients

Documentation Requirements

A physical exam is not a Medicare wellness exam. Here is what is done during a physical exam:

- Review your medical and family history
- Take routine measurements such as for height, weight and B/P
- Assess risk factors for preventable diseases
- Perform lung, head and neck abdominal and neurological exams
- Check reflexes and vital signs
- Take urine and blood samples and submit for lab testing

When an Annual Wellness Visit and a Annual Physical Exam occcur at the same date of service, no modifer is necessary.

Advanced Illness and Frailty Exclusion

Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded.

Measure Requirements

Frailty: At least two indications with different dates of service during the measurement year.

Measure Exclusions

- Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness.
- One or more acute inpatient encounter(s) with a diagnosis of advanced illness.
- One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim. NOTE: Advanced illness diagnosis must occur in the measurement year or year prior.
- Dispensed a dementia medication: Donepezil, Galantamine, Rivastigmine, Memantine or Donepezil-memantine.

CPT II Codes/ICD Categories

CPT/HCPCS/ICD-10-CM Inclusions:

CPT: Fraility: 99504-99509

HCPCS:

Ambulatory Equipment: E0100, E0105

Commode: E0163-E0171

Hospital Beds and Accessories: E0250-E0290-E0297, E0301-E0304

Oxygen and Related Respiratory Equipment: E0424, E0444, E0462, E0465, E0466, E0470-E0472

Wheelchairs: E1130, E1140, E1150, E1160, E1161, E1170-E1172, E1180, E1190, E1195, E1200 - E1298

Home Health/Hospice Services: G0162, G0299-G0300, G0493-G0494, T1000-T1005, T1019-T0122, T1030-T1031

PQRS Codes: G2090-G2127

ICD-10-CM Codes:

Do Not Resuscitate Z66

Documentation Requirements

A discussion or documentation about preferences for resuscitation, life-sustaining treatment, and end-of-life care. Please make sure to update this information on an annual basis.

Advanced Care Planning (ACP)

The percentage of members 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had Advance Care Planning during the measurement year.

Measure Requirements

Advance Care Planning documentation in the medical record, or documentation of discussion with provider about Advanced Care Planning, or notation that previously executed.

Measure Exclusions

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

CPT II Codes

CPT: 99483 99497
HCPCS: S0257
ICD-10-CM: Z66 Do NOT Resuscitate
CPT II: 1123F 1124F 1157F 1158F*

Documentation Requirements

Have a discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care.

References

The coding section is not an all inclusive section and you should also be aware some measures may require a modifier. Codes also have the potential to change each year in March and October.

*OPTUM

**Care Source 2022-2023MY

AmeriHealth Caritas+

Johns Hopkins++

*CMS Medicare 2024 Part C & D Start Ratings Technical Notes

*HEDIS Measurement year 2025 Volume 2: Technical Specifications for Health Plans

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Have questions about the information in this guide?

Contact HealthTeam Advantage's Quality Department
via email at *qualitydepartment@htanc.com*

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