Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

2024 HEDIS® PROVIDER GUIDE

MEDICARE

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Table of Contents

Introduction

NCQA developed a set of standardized performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® allows for comparison across health plans. Through HEDIS®, NCQA holds Arkansas Blue Cross and Blue Shield accountable for the quality of healthcare services delivered to its diverse membership.

What are the Medicare Star Ratings?

Medicare uses a Star Rating System to measure how well Medicare Advantage plans perform in several categories, including quality of care. Ratings range from one to five, with five being the highest.

Best practice and Measure Tips

- Encourage your patients to schedule preventive exams
- Reminding your patients to follow-up with ordered tests and procedures
- Making sure necessary services are being performed in a timely manner
- Submitting claims with appropriate HEDIS codes
- Accurately document all services and results in the patient's medical record

HEDIS and HIPAA

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/members.

Breast Cancer Screening (BCS-E)

Why it Matters

Breast cancer is the second leading cause of cancer death in women. The American Cancer Society estimates in 2023:

- There will be approximately 353,000 women diagnosed with new cases of breast cancer.
- There will be approximately 44,000 women who will die from breast cancer.

Half of the women who develop breast cancer are 62 years of age or younger at the time of diagnosis. Breast cancer rates have been increasing by 0.05% annually. Early detection with screening mammography means that treatment can be started earlier in the course of the disease, possibly before it has spread, and therefore decreasing cancer deaths.[I]

Description of Measure

Percentage of female patients ages 52-74 who had a mammogram screening completed on or by Oct. 1, two years prior to the measurement year through Dec. 31 of the measurement year (MY).[II]

To satisfy the measure, the patient must have one of more mammograms (screening, diagnostic, and film, digital or digital breast tomosynthesis) between October 1, two years prior(PY) and December 31, MY. If one breast has been removed and the other is present, a screening or initial diagnostic mammography is required for the remaining breast.

Documentation

Bilateral or **unilateral** mammogram reports are acceptable such as:

- Screening or Diagnostic mammogram.
- Digital mammogram or digital breast tomosynthesis

Documentation can include the following and results are not required.

- Notation of a completed mammogram with DOS as part of the medical history. Health Maintenance or preventive care sections are considered 'history" sections.
- Transgender members (male to female) are eligible for BCS reporting.
- Member reported completed mammogram with DOS.

Exclusions

<table>
<tr><th>Exclusions</th><th>Timeframe</th></tr>
<tr><td>■ Members in hospice or using hospice services
■ Member who died
■ Members receiving palliative care</td><td>Any time during MY</td></tr>
<tr><td>Members 66 years of age and older by Dec. 31 MY with Advanced Illness and Frailty.

Members must meet BOTH frailty and advanced illness criteria to be excluded.</td><td>■ Frailty diagnosis on 2 different DOS during the MY
■ Advanced Illness: Either of the following during the MY or PY
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<tr><td>Bilateral Mastectomy
■ History of bilateral mastectomy
■ Unilateral mastectomy with a bilateral modifier</td><td>Anytime in a member’s history through Dec. 31, MY</td></tr>
<tr><td>Members who had gender-affirming chest surgery with a diagnosis of dysphoria</td><td>Anytime in a member’s history through Dec. 31, MY</td></tr>
</table>

Exclusion Codes

Code	Definition
Z90.11	Acquired absence of right breast
Z90.12	Acquired absence of left breast
Z90.13	Acquired absence of bilateral breast
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Strategies for Success	■ Scheduling a mammogram appointment for your patient. ■ Use Annual Wellness Visits to schedule screenings. ■ Add screenings to your annual assessment form and/or EMR template. ■ Address mammography at every visit, even when patient has refused. ■ Provide a list of locations and phone numbers where mammogram services can be performed. ■ Send reminder letters to patients signed by the provider. ■ Establish a system to for telephone reminder calls. ■ Establish a system for mailed reminders. ■ Document medical and surgical history in the medical record with dates. ■ Code for exclusions, such as history of mastectomy. ■ Educate women regarding the benefit of early detection of breast cancer through routine mammograms. - Mammograms are the most effective method for detecting breast cancer in the early stages when it is most treatable. - Many women with breast cancer do not have symptoms, which underscores the importance of regular breast cancer screening. - The recommended frequency of routine mammograms is at least once every 24 months for all women aged 50 -74. Depending on risk factors, mammograms may be done more frequently. ■ **MRI's, ultrasounds, or biopsies do not count in this measure.** Although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count towards the compliance.

Resources

I. American Cancer Society, 2023, *Key Statistics for Breast Cancer*, www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html

II. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Colorectal Cancer Screening (COL-E)

Description of Measure

Percentage of patients 45 – 75 years of age as of Dec. 31, measurement year (MY), as of who had appropriate screening for colorectal cancer: colonoscopy, CT colonography, flexible sigmoidoscopy, FIT-DNA, or fecal occult blood test (FOBT).[II]

Documentation

Screening Test	Frequency
Fecal Occult Blood (FOBT)	Annually
Cologuard/ FIT-DNA	Every three years, 2 years prior through MY
Flexible Sigmoidoscopy	Every five years, 4 years prior through MY
CT Colonography	Every five years, 4 years prior through MY
Colonoscopy	Every ten years, 9 years prior through MY

- Member reported completed specified colon cancer screening with DOS
- Colorectal or colon cancer screening documentation dated in the MY is acceptable as an unknown FOBT.
- Notation of a completed specified colon cancer screening with DOS as part of the medical history. Health maintenance and preventive care sections are considered "history" sections.
- A pathology report that indicates the type of screening and the date meets criteria.
- A pathology report that does not indicate the type of screening:
  - Colonoscopy- Evidence that the scope advanced to the cecum or further (e.g., ileum, terminal ileum, ileocecal valve, appendiceal orifice)
  - Flexible Sigmoidoscopy- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy (e.g., sigmoid flexure, descending colon, splenic flexure, transverse colon, ascending colon)
- Member refusal will **not** make them ineligible for this measure.
- Digital rectal exams (DRE) or FOBT test performed in the office setting will **not** meet compliance.

Test Type	Unknown	Guaiac (gFOBT)	FIT (iFOBT)	Unknown
Samples Returned	Unknown or 3 or >	Documented 3 or >	Any # or unknown	Documented 1 -2
Status	Compliant	Compliant	Compliant	Unacceptable Non-compliant

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Exclusions

<table>
<tr><th>Exclusions</th><th>Time limit</th></tr>
<tr><td>■ Members in hospice or using hospice services
■ Member deceased
■ Members receiving palliative care</td><td>Any time during measurement year (MY)</td></tr>
<tr><td>■ Colorectal cancer
■ Total colectomy</td><td>Anytime in member's history through Dec. 31 MY</td></tr>
<tr><td>Members 66 years of age and older by Dec. 31 MY with Advanced Illness and Frailty.

Members must meet BOTH frailty and advanced illness criteria to be excluded.</td><td>■ Frailty diagnosis on 2 different DOS during the MY
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Exclusion Codes

CPTII Code	Definition
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
C18.0-9, C19-20, C21.2, C21.8, C78.5	Colorectal cancer, active

Strategies for Success	■ If a patient has family history of colon cancer, encourage a colonoscopy instead of a Cologuard. ■ Use the Annual Wellness visit to schedule screenings. ■ Add screenings to annual assessment form/ EMR template. ■ Implement a referral tracking process. ■ For patients refusing colonoscopy, recommend a FIT-DNA or FOBT kit. ■ Educate patients on preparation for the ordered tests.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Controlling Blood Pressure (CBP)

Description of Measure

Percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (< 140/90 mm Hg) as of December 31 of the measurement year (MY).[I]

Members are identified by having had at least two visits on two different dates of service with a diagnosis of hypertension (I10) on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Documentation

- The most recent BP reading during the measurement year on or after the second diagnosis of hypertension.
- If multiple BP measurements occur on the same date of service, use the lowest systolic and lowest diastolic BP reading. The systolic and diastolic results do not need to be from the same reading or from the same encounter.
- Member reported BP readings must be taken with a digital device.
- A distinct number result for the BP is required. Average BP reading is acceptable. Ranges do not meet criteria.
- BP's can be abstracted from a BP log with dates of BP taken.
- BP readings taken on the same day that the member receives a common-low intensity or preventive procedure are eligible. Examples of what is considered low- intensity but this is not inclusive:
  - Injections (e.g., vaccinations allergy shots or skin testing, Vit. B-12, insulin, steroid, Toradol, Depo-Provera, testosterone, lidocaine)
  - TB test
  - Eye exam with dilating agents
  - Biopsies, wart, or mole removal with lidocaine only
  - Procedure with no documentation of diet changes or change in medications, (Cardiac Stress test, Exercise Stress test, EKG, X-ray, Mammogram, IUD insertion, Fasting blood test, Eye exam with dilating agents)

Codes

Code	Definition
I10	Essential Hypertension (only diagnosis to place member in denominator)
3074F	Systolic blood pressure < 130mm Hg
3075F	Systolic blood pressure 130 – 139mm Hg
3077F	Systolic blood pressure ≥ 140mm Hg
3078F	Diastolic blood pressure < 80mm Hg
3079F	Diastolic blood pressure 80 -89mm Hg
3080F	Diastolic blood pressure ≥ 90mm Hg

Exclusions

<table>
<tr><th>Exclusions</th><th>Timeframe</th></tr>
<tr><td>■ Members in hospice or using hospice services
■ Member who died
■ Members receiving palliative care</td><td>Any time during MY</td></tr>
<tr><td>■ Dialysis
■ End-stage renal disease (ESRD)
■ Kidney transplant
■ Nephrectomy (total, partial)</td><td>Any time during the member's history on or prior to Dec. 31 MY</td></tr>
<tr><td>Members with a diagnosis of pregnancy</td><td>Any time during the MY</td></tr>
<tr><td>Members 66 – 80 years of age by Dec. 31 MY with Advanced Illness and Frailty.

Members must meet BOTH frailty and advanced illness criteria to be excluded.</td><td>■ Frailty diagnosis in MY on 2 different DOS during the MY
■ Advanced Illness: Either of the following during the MY or PY
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<tr><td>Members 81 years of age and older by Dec. 31 MY with at least two indications of frailty with different dates of service during the MY.</td><td>Indication of frailty with 2 different DOS in MY</td></tr>
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Exclusion Codes

Code	Definition
N18.5	Chronic kidney disease, Stage 5
N18.6	End stage renal disease
Z99.2	Dependence on renal dialysis
Z94.0	Kidney transplant status (History of kidney/renal transplant)

Disqualifying Events	If a blood pressure is taken in any of the following circumstances, the blood pressure may not be used. ■ Taken during an acute inpatient stay or an ED visit. ■ Taken by the member using a non-digital device, such as with a manual blood pressure cuff. ■ Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or a change in medication on or one day before the day of the test or procedure, except for fasting blood tests. The following list of examples of disqualifying events is not all inclusive: - Colonoscopy - Dialysis - Nebulizer treatment with albuterol - Lidocaine with epinephrine
Strategies for Success	■ If patient no longer has essential hypertension (e.g., I12, I13) remove essential hypertension from the problem list. If both are coded then member inappropriately moved to the denominator. ■ Record all blood pressures during visits, especially if multiple blood pressures are taken. ■ Educate staff on proper technique for taking blood pressures. ■ Implement process to re-take & document any systolic BP ≥ 140 or diastolic BP ≥ 90. - If initial BP is out of range, retake the BP, ensuring the patient is quiet, their feet are flat on the floor, arm is at heart level, and appropriate size cuff is being used. ■ Establish a plan to monitor patients with elevated blood pressures. ■ Initiate specialist, pharmacist consult and/ or care management referrals when appropriate. ■ Tailor treatment regimens to the patient's lifestyle and needs ■ Encourage patients use a digital BP monitor at home. ■ Educate members on the chronic nature of their disease, risk of hypertension and benefits of effective treatment. ■ Work to prevent medication nonadherence by providing health education, shared decision making, and promotion of self-care and self-management.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Osteoporosis Management in Women with a Fracture (OMW)

Description of Measure

Percentage of women 67 -85 years of age who suffered a fracture and had either a bone mineral density (BMD) or prescription for a drug to treat osteoporosis in the 180 days (6 months) after the fracture. Fractures of the fingers, toes, face, or skull are not included in this measure.[I]

Documentation

- BMD reports, dated with results, within 24 months before and/or 6 months after the fracture.
- Members who received a dispensed prescription or had an active prescription of osteoporosis medication, within 12 months before or 6 months after the fracture.
- Member reported screenings documented in the medical record with DOS are acceptable.
- Health maintenance and preventive care section of the medical record are considered a "history" section.

Osteoporosis therapies:

Description	Medication Name	Brand Name
Bisphosphonates	Alendronate	Fosamax
	Alendronate-cholecalciferol	Fosamax Plus D
	Ibandronate	Boniva
	Risedronate	Actonel
	Zoledronic acid	Zometa Reclast
Parathyroid Hormone Analogs	Abaloparatide	Tymlos
RANK ligand inhibitors	Denosumab	Xgeva Prolia
Selective estrogen receptor modulators	Raloxifene	Evista

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Description	Medication Name	Brand Name
Sclerostin inhibitors	Romosozumab	Evinity
Parathyroid hormone (PTH)	Teriparatide	Forteo

Exclusions

<table>
<tr><th>Exclusions</th><th>Timeframe</th></tr>
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- Member who died
- Members receiving palliative care

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Tips for Success	■ Provide patients who have had a fracture with a referral for BMD testing and encourage them to obtain the screening. Follow up with the patient to ensure the test was completed. - Review bone mineral density results and prescribe osteoporosis treatment when appropriate. ■ If patients are unable or unwilling to have the BMD testing, prescribe osteoporosis medications, if appropriate. ■ Discuss fall prevention annually: - Ask if your patient has any problems with balance or walking. If so, evaluate if they need an assistive device such as a cane or walker. - Suggest an exercise or balance program. - Ask if your patient has fallen in the past 12 months. If so, evaluate what led to the fall. - Discuss trip hazards such as loose carpets, poor lighting, uneven flooring, and cluttered walkways - Discuss fall preventative measures such as using night lights, wearing supportive shoes with grips or no slip socks, and installing grab bars. - Review medications to identify side effects that can increase risk. - Encourage annual vision and hearing checks. ■ Discuss osteoporosis prevention with our patients including calcium and Vitamin D supplements, weight bearing exercises, and modifying risk factors. ■ Remind patients to always tell their primary care provider about a fracture, even if they have received treatment elsewhere. ■ Screen female patients starting at age 65 to reduce the risk of osteoporosis. ■ Consider screening women younger than 65, if they are high risk. Some risk factors include low body weight, current tobacco use, excessive alcohol consumption, history of fractures, and glucocorticoid use.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

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Eye Exam for Patients with Diabetes (EED)

Description of Measure

The percentage of members 18 -75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.[I]

Members may be identified as having diabetes in the year prior (PY) or during the measurement year. Members are identified by the following:

- Claims/encounter data- Members had at least two diagnoses of diabetes on different dates of service during the prior year (PY) or measurement year (MY).
- Pharmacy data – Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the MY or PY **and** at least one diagnosis of diabetes during the MY or PY.

Documentation

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the MY.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the PY.
- Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy.
- Dilation confirmation is not necessary when retina and vessels are examined.
- Health maintenance or preventive care sections are considered as a "history section" and can be used for reporting when all EED data elements are present (eye care provider, date of service, and an eye exam result).
- An eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy.
- If one eye is not examined this leads to an indeterminate result, this is not considered a result/finding.
- Blindness is not an exclusion.

Codes

CPTII Code	Definition
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**

Exclusions

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Strategies for Success	■ Build care gap alerts in your EHR and include when diabetic patients are due for care. ■ Review diabetic services needed at each office visit. ■ Refer patients to an optometrist or ophthalmologist for dilated retinal exam annually and explain why it is different than a screening for glasses or contacts. ■ Incorporate a retinal camera in primary care with results interpreted by an optometrist or ophthalmologist.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Glycemic Status Assessment for Patients With Diabetes (GSD) Formerly HBD

Description of Measure

The percentage members ages 18-75 years of age with Type 1 and Type 2 diabetes, who most recent glycemic status (hemoglobin A1c or glucose management indicator) was at the following levels during the measurement year (MY).[1]

- Glycemic Status ≤ 9.0%

Members may be identified as having diabetes in the year prior (PY) or during the MY. Members are identified by the following:

- Claims/encounter data – Members had at least two diagnoses of diabetes on different dates of service during the PY or MY.
- Pharmacy data – Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the MY or PY **and** at least one diagnosis of diabetes during the MY or PY.

Documentation

- Documentation in the medication record must include a date when the glycemic status assessment (HbA1c or GMI) was performed and resulted.
- GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.
- Members reported glycemic status assessment (HbA1c or GMI) are eligible for reporting.
- Ranges and thresholds do not meet criteria. A distinct numeric result is required.

CPTII Code	A1c Value
3044F	< 7.0%
3051F	7.0% - 7.9%
3052F	8.0% - 9.0%
3046F	> 9.0%

Exclusions

<table>
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■ Members who died
■ Members receiving palliative care</td><td>Any time during MY</td></tr>
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Tips for Success	■ HbA1c testing should be completed 2 -4 times annually with result date and distinct numeric result ■ If test results are documented in the progress note, please include the date and result of the A1c ■ Review diabetic services needed at each office visit ■ Order labs to be completed prior to patient appointments ■ Refer patients to disease management or a certified diabetic educator as needed ■ Utilize the Annual Wellness Visit to document a screening schedule ■ Appointment frequency protocol for patients with diabetes every 3 – 6 months ■ Utilize a diabetic EMR template that includes A1c, Med Adh, Statin use, Eye exam, urine protein and foot exam elements ■ Recommend earlier follow up appointments after treatment plan changes

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Kidney Health Evaluation for Patient with Diabetes (KED)

Description of Measure

The percentage of members18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year (MY).[I]

Members are identified by one or both of the following:

- Have two diagnoses of diabetes on different dates of service during the measurement year (MY) or prior year (PY)
- Dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (MY) or prior year (PY)

Diabetes Medication

Screening Test	Prescription		
Alpha-glucosidase inhibitors	▪ Acarbose	▪ Miglitol	
Amylin analogs	▪ Pramlintide		
Antidiabetic combinations	▪ Alogliptin-metformin ▪ Alogliptin-pioglitazone ▪ Canagliflozin-metformin ▪ Dapagliflozin-metformin ▪ Dapagliflozin-saxagliptin ▪ Empagliflozin-linagliptin ▪ Empagliflozin-linagliptin-metformin	▪ Empagliflozin-metformin ▪ Ertugliflozin-metformin ▪ Ertugliflozin-sitagliptin ▪ Glimepiride-pioglitazone ▪ Glipizide-metformin ▪ Glyburide-metformin	▪ Metformin-pioglitazone ▪ Metformin-repaglinide ▪ Metformin-rosiglitazone ▪ Metformin-saxagliptin ▪ Metformin-sitagliptin ▪ Linagliptin-metformin
Insulin	▪ Insulin aspart ▪ Insulin aspart-insulin aspart protamine ▪ Insulin degludec ▪ Insulin degludec-liraglutide ▪ Insulin detemir ▪ Insulin glargine ▪ Insulin glargine-lixisenatide	▪ Insulin glulisine ▪ Insulin isophane human ▪ Insulin isophane-insulin regular ▪ Insulin lispro ▪ Insulin lispro-insulin lispro protamine ▪ Insulin human inhaled	
Meglitinides	▪ Nateglinide	▪ Repaglinide	
Biguanides	▪ Metformin		
Glucagon-like peptide-1 (GLP1) agonists	▪ Albiglutide ▪ Lixisenatide	▪ Liraglutide ▪ Exenatide	▪ Dulaglutide ▪ Semaglutide
Sodium glucose cotransporter 2 (SGLT2) Inhibitor	▪ Canagliflozin ▪ Empagliflozin	▪ Ertugliflozin	▪ Dapagliflozin
Sulfonylureas	▪ Chlorpropamide ▪ Glimepiride	▪ Glipizide ▪ Glyburide	▪ Tolazamide ▪ Tolbutamide
Thiazolidinediones	▪ Pioglitazone	▪ Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	▪ Alogliptin ▪ Sitagliptin	▪ Saxagliptin	▪ Linagliptin

Documentation

Members who receive ***both*** an eGFR and a uACR during the measurement year on the same or different dates of service.

- At least one eGFR
- At least one uACR identified by either of the following:
  - ***Both*** a quantitative urine albumin test ***and*** a urine creatinine test ***with*** services dates four days or less apart.
  - A uACR

Exclusions

Exclusions	Timeframe
▪ Members 81 years of age and older Dec. 31, MY with at least two indications of frailty with different dates of service during the MY.	Indications of frailty with 2 different DOS in MY
▪ Members in hospice or using hospice services ▪ Member who died ▪ Members receiving palliative care	Any time during MY
▪ ESRD ▪ Dialysis	Any time during MY
Members 66 – 80 years of age by Dec. 31 MY with Advanced Illness and Frailty. Members must meet **BOTH** frailty and advanced illness criteria to be excluded.	▪ Frailty diagnosis in MY on 2 different DOS during the MY ▪ Advanced Illness: Either of the following during the MY or PY - Advanced illness on 2 different DOS - **OR** Dispensed a dementia medication

Dementia Med Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Misc. Central Nervous System Agents	• Memantine
Dementia Combinations	• Donepezil-memantine

Exclusions

Exclusion Codes	Definitions
N18.5	Chronic kidney disease Stage 5
N18.6	End stage renal disease
Z99.2	Dependence on renal dialysis

Tips for Success	■ Education patients that some complications from diabetes may be asymptomatic. Routine testing may help prevent/delay some life-threatening complications. ■ Testing should be completed annually. ■ Review diabetic services needed at each visit ■ Order labs to be completed prior to patient appointments ■ Utilize the Annual Wellness Visit to document a screening schedule ■ Utilize a diabetic EMR template

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plan

Y0083_24ABM_HEDIS_KED_C Last Reviewed November 21, 2023 00882.04.13-1123

Transitions of Care (TRC)

Description of Measure

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

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

Documentation

The following codes are for medication reconciliation post-discharge:

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.
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 or 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.

Component	Timing	Outpatient medical record requirements
Notification of Inpatient Admission (NIA)	Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total)	Documentation in the PCP or OCP EMR's with a date stamp, of when the following information was received: ■ Information from the facility, admitting provider or a specialist that the patient was admitted ■ The PCP or OCP ordering tests or treatments during the inpatient stay also meets criteria. ■ A pre-admission exam, which documents that the planned admission, not just a procedure, by the PCP or OCP also meets Criteria (this does not use the NIA date ranges)
Receipt of discharge information (RDI)	Receipt of discharge information on the day of the discharge through 2 days after the discharge (3 days total)	Documentation in the PCP or OCP medical record with a date stamp, of when the following information was received from the discharging facility the date of discharge to 2 days after: ■ Practitioner responsible for patient's care during the inpatient stay ■ Procedures or treatment provided ■ Diagnosis at discharge ■ Current medication list ■ Testing results, notation of pending tests or no tests pending ■ Instructions for patient care post discharge
Patient engagement after inpatient discharge (PED)	Patient engagement provided within 30 days after discharge	Type of visit: Outpatient, Telehealth, Telephone Visits can be performed by medical assistants, LPN's, RN's to meet criteria
Medication reconciliation post-discharge (MRPD)	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days)	Medications to be reconciled with discharge medications to current medication list. Documentation of medications reconciled, reviewed, or statement that no medications were prescribed/ordered upon discharged, meets criteria.

Exclusions	■ In hospice or using hospice services in measurement year ■ Members who have died in measurement year
Tips for Success	■ Documentation of notification must include a date when the document was received. ■ Develop a centralized team or assigned roles to communicate with patients post-discharge. ■ Implement a standard post-discharge call template to reduce patient risk and readmissions that incorporates: - Medication reconciliation - Confirms a follow-up appointment is scheduled and kept - Assesses patient comprehension of his or her diagnosis and discharge instructions - Assesses patient's or caregiver's ability to self-manage medications - Incorporates knowledge of the "red flags" of a worsening condition and what to do or who to contact - Whom to contact for questions or concerns about their care going forward - Summary of the conversation through a medical record accessible by the patient or caregiver, or sent to the patient and caregiver ■ Include non-acute (surgical) admissions in post-discharge outreach and medication reconciliation, even if post-surgical treatment is being performed through a specialist. ■ Reduce errors at time of discharge by using a computer order entry system to generate a list of medications used before and during the hospital admission. ■ Ensure the medication list that was the result of reconciliation is in the chart note or can be pulled up in reference to the reconciliation later. EMR medication lists that update upon prescribing are not sufficient to demonstrate the medications that were in place upon reconciliation.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Medication Reconciliation Post-Discharge (MRP)

Description of Measure

The percentage of members 18 and older, with an acute or non-acute inpatient discharge on or between January 1 – December 1 of the measurement year (MY), who have a medication reconciliation documented on the date of discharge through 30 days after the discharge (31 days total).[I]

Documentation

Documentation in the PCP's or ongoing care provider's (OCP) outpatient medical record must include one of the following:

- Outpatient hospital follow-up visit
- Discharge summary
- MRP must be completed by an appropriate provider type:
  - Prescribing practitioner (MD, DO, NP, APRN, PA)
  - Pharmacist
  - RN

Documentation of a hospital follow-up visit must reference the acute hospitalization (hospital or rehab), admission, or discharge.

Reference only of post-op or post-surgical visit does not indicate an inpatient hospitalization.

Documentation must include the medication list resulted from the reconciliation, the date performed and note anyone of the following:

- An embedded medication list on the same DOS of the hospital follow-up
- Provider reconciled the current and discharge medications
- Reference to the discharge medications (e.g., no changes in medication post discharge, or discharge medications reviewed)
- Discharge summary indicates medication list reconciled with current medication and is filed in the outpatient record within 30 days post-discharge
- List of current medications with evidence patient was seen for post-discharge hospital follow-up
- Freestanding medication list in the outpatient medical record with a medication review statement in the hospital follow-up visit

Medication reconciliation performed without the patient present meets criteria.

These codes will close MRP.

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.
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 or 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.

Exclusions

Patients are excluded if they are in hospice or using hospice services or die during the measurement year.

Tips for Success	■ Develop a centralized team or assigned roles to communicate with patients post-discharge and ensure records are reviewed and signed by appropriate provider for measure compliance. ■ Implement a standard post-discharge call template to reduce patient risk and readmissions that incorporates: - Medication reconciliation - Confirms a follow-up appointment is scheduled and kept - Assesses patient's or caregiver's ability to self-manage medications ■ Include non-acute (surgical) admissions in post-discharge outreach and medication reconciliation, even if post-surgical treatment is being performed through a specialist. Ensure the medication list that was the result of reconciliation is in the chart note or can be pulled up in the reference to the reconciliation later. EMR medication lists that update upon prescribing are not sufficient to demonstrate the medications that were in place upon reconciliation.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Plan All-Cause Readmissions (PCR)

Description of Measure

The number of acute inpatient and observation stays for patients 18 years of age and older between January 1st and December 1st, followed by an acute readmission, for any diagnosis, within 30 days of discharge and the predicted probability of an acute readmission.

Note: This measure is based on discharges, not patients, and includes behavioral health facilities.

Exclusions

Patients are excluded if they:

- In hospice or using hospice services anytime during the measurement year (MY)
- Members who died during the hospital stay
- Members with primary diagnosis of pregnancy
- Members with a principal diagnosis of a condition originating in the perinatal period
- A planned hospital stay using any of the following:
  - Principle diagnosis of maintenance chemotherapy
  - Principal diagnosis of rehabilitation
  - An organ transplant
  - A potentially planned procedure without a principal acute diagnosis

Tips for Success	■ Please help members avoid readmission by:
	- Following up with them within 1 week of their discharge
	- Making sure they filled their new prescriptions post-discharge.
	- Implementing a robust, safe discharge plan that includes a post-discharge plan that includes a phone call to discuss these questions:
	  - Do you completely understand all the instructions you were given at discharge?
	  - Do you complete understand the medications and your medication instructions? Have you filled all your medications?
	  - Have you made your follow-up appointments? Do you need help scheduling them?
	  - Do you have transportation to the appointment and/or do you need help arranging transportation?
	  - Do you have any questions?

Tips for Success	■ Implement an appointment frequency protocol for patients at high-risk for admission. ■ Utilize telehealth appoints for patients who are not able to come to the office for appointments. ■ Obtain any test results that were not available when patients were discharged. ■ Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future. ■ Consider outreach calls to members that are prone to readmission. ■ Educate patients that are non-adherent to treatment plans on the risk to hospitalization, as appropriate. ■ Educate patients to call their PCP prior to going to the emergency/ hospital, if appropriate. ■ 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. ■ Encourage members to engage in palliative care or hospice programs as appropriate.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

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

Description of Measure

Percentage of emergency department (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions and had a follow-up service within 7 days of the ED visit.[I]

Note:

- **ED visits between January 1 and December 24 of the measurement year (MY).**
- **If a member has more than one ED visit in an eight-day period, the first eligible ED visit date is counted as the start of the 7-day period.**

Eligible Chronic Conditions

A patient with multiple high-risk chronic conditions is defined as anyone who was diagnosed with two or more of the following conditions during the measurement year (MY) or the prior year (PY), **but prior to the ED visit:**

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

Documentation

- A follow-up service on the day of the ED visit to 7 days after.
- The following type of visits or services meet criteria:
  - Outpatient visit, telephone visit, telehealth, e-visit, or virtual check-in
  - Transitional care management, Complex care management, Case management
  - Behavioral health or Substance abuse

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Exclusion

Description	Timeframe
ED visits that resulted in an inpatient stay	Any time during the MY
ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission	Any time during the MY
Members in hospice or using hospice services	Any time during the MY
Members who died	Any time during the MY

Tips for Success	■ Keep open appointments so patients with an ED visit can be seen within 7 days ■ Schedule follow-up visits within 2 – 5 days of ED visit ■ In addition to an office visit follow-up can be provided via a telephone or virtual care/telehealth visit ■ Create provider alerts of ED visits and tracking for follow-up ■ Flag patients with comorbidities that would require a follow-up after an ED visit ■ Develop a process to communicate with patient's after ED visits ■ Implement a standard post-ED visit template to reduce patient risk and readmissions that: - Assesses patient comprehension of his or her diagnosis and discharge instructions - Assesses patient's or a caregiver's ability to self-manage medications - Asks about barriers or issues that might have contributed to the ED visit and discuss how to prevent them in the future - Incorporate knowledge of the 'red flags' of a worsening condition and what to do or who to contact - Establishes who the patient is to contact for questions or concerns about their care going forward ■ Encourage patients to have regular office visits with their primary care physician to monitor and manage chronic conditions

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Advanced Illness and Frailty (AI/F)

Description of Exclusion

Patients with frailty and/or advanced illness are excluded from specific measures because of their conditions and health status. Excluding these patients will help ensure they are included with only the appropriate measures for their circumstances. The measures below require exclusions for advanced illness and frailty. The age ranges and requirements differ by measure and are included in the table below.

Applicable Measure	Frailty and Advanced Illness Both Required	Frailty Only
(BCS) Breast Cancer Screening	66 years and older as of Dec. 31 measurement year (MY)	
(CBP) Controlling Blood Pressure	66 – 80 years as of Dec. 31 MY	81 years of age and older as of Dec 31 MY
(COL) Colorectal Cancer Screening	66 years and older as of Dec. 31 MY	
(GSD) Glycemic Status Assessment for Patients with Diabetes	66 years and older as of Dec. 31 MY	
(EED) Eye Exam for Patients with Diabetes	66 years and older as of Dec. 31 MY	
(KED) Kidney Health Evaluation for Patients and Diabetes	66 – 80 years as of Dec. 31 MY	81 years of age and older as of Dec 31 MY
(OMW) Osteoporosis Management for Women With a Fracture	66 – 80 years as of Dec. 31 MY	81 years of age and older as of Dec 31 MY
(SPC) Statin Therapy for Patients with Cardiovascular Disease	66 years and older as of Dec. 31 MY	

Documentation

Beginning 2024 Advanced Illness and Frailty documentation can be submitted via supplemental data.

Inpatient and outpatient documentation is acceptable.

Advanced Illness	▪ 66 years of age and older (varies by measure) as of December 31 MY. Either of the following during the MY or the year prior (PY) to the measurement year: ▪ Advanced illness on at least two different DOS. ▪ Dispensed a dementia medication: donepezil, donepezil-memantine, galantamine, rivastigmine or memantine
Common Advanced Illness Examples	▪ Respiratory – emphysema, pulmonary fibrosis, acute respiratory failure ▪ Renal – CKD stage V or ESRD ▪ Hypertensive Heart Disease with heart failure ▪ Heart Disease – chronic or acute heart failure, rheumatic ▪ Hepatic – hepatitis, cirrhosis, fibrosis ▪ Neurologic – Parkinson's, Alzheimer's, ALS, Huntington's Disease, MS ▪ Malignancy – primary (brain, pancreatic, leukemia) and secondary (bone marrow, breast, lung, lymph nodes, kidney)
Frailty	▪ There must be at least two indications of frailty with two (2) different dates of service during MY. ▪ Patients with Frailty must be 66 years of age and older (varies by measure) as of December 31 measurement year and have Advanced Illness. ▪ Three measures (CBP, KED, OMW) exclude patients 81 years of age and older as of December 31 MY, with frailty only.
Common Frailty Examples	▪ Durable Medical Equipment (DME) – cane, walker, hospital bed, oxygen, etc. ▪ Home Care – Skilled nursing, private duty nursing, personal care, physician ▪ Comprehensive management and care coordination for advanced illness ▪ Pressure ulcers ▪ Musculoskeletal – weakness, atrophy, cachexia, sarcopenia ▪ Age related cognitive decline ▪ Falls – a fall or history of falling ▪ Bed confinement ▪ Gait abnormality – paralytic, difficulty walking, other reduced mobility ▪ Need for assistance – at home w/no help in the home, asst. w/ personal care, continuous supervision, problems related to care dependency ▪ Dependent on ventilator ▪ Dependent on wheelchair ▪ Dependent on supplemental oxygen ▪ Dependent on other enabling machine or devices
Resources	National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plan

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Description of Measure

The percentage of males aged 21 – 75 and females aged 40-75 who are identified as having clinical atherosclerotic cardiovascular disease (ASCVD), and who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year (MY) and who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.[I]

The treatment period starts with the date of the first fill of the statin medication thru 31 Dec. MY.

Eligible Population

Members are identified by either of these two methods.

Event: Any of the following during Prior Year	Setting
Myocardial Infarction (MI)	Inpatient discharge claim
CABG	Any setting
PCI	Any setting
Other revascularization	Any setting
IVD Diagnosis who had least one encounter both in prior year and measurement year	
ICD10	Setting
I20.0, I20.2 -.9, I24.0, I24.8-.9, I25.10, I25.110 - .119, I25.5 - .6, I25.00 - .799, I25.810 - .84, I25.89 - .9, I63.20 - .39, I63.50, I63.511 –I65.29, I66.01 - .9, I67.2, I70.1 - .799, I70.92, I75.011 - .89, T82.855A - .8565	Outpatient, Telehealth, Acute Inpatient

Documentation

Required documentation of a statin being dispensed:

- Member name and DOB
- Dispensed date or shipped date within MY
- Medication name, dose, route, days supply, doses per day (sig) and quantity

Office visit with documentation of an exclusion.

Exclusions

<table>
<tr><th>Exclusions</th><th>Timeframe</th></tr>
<tr><td>

- Members in hospice or using hospice services
- Members who died
- Members receiving palliative care

</td><td>Any time during the MY</td></tr>
<tr><td>

- Pregnancy
- In vitro fertilization
- Clomiphene – 1 dispensing event

</td><td>Any time during the PY or MY</td></tr>
<tr><td>

- ESRD
- Dialysis
- Cirrhosis

</td><td>Any time during the PY or MY</td></tr>
<tr><td>

- Myalgia
- Myositis
- Myopathy
- Rhabdomyolysis

</td><td>Any time during the MY</td></tr>
<tr><td>Members 66 years and older by Dec. 31 MY with Advanced Illness and Frailty.

Members must meet BOTH advanced illness and frailty criteria to be excluded.</td><td>

- Frailty diagnosis in MY on 2 different DOS during the MY
- Advanced Illness: Either of the following during the MY or PY
  - Advanced illness on 2 different DOS
  - **OR** Dispensed a dementia medication

<table>
<tr><th>Dementia Med Description</th><th>Prescription</th></tr>
<tr><td>Cholinesterase inhibitors</td><td>• Donepezil
• Galantamine
• Rivastigmine</td></tr>
<tr><td>Misc. Central Nervous System Agents</td><td>• Memantine</td></tr>
<tr><td>Dementia Combinations</td><td>• Donepezil-memantine</td></tr>
</table>

</td></tr>
</table>

Condition	ICD-10-Code
Myalgia	M79.10 – M79.12; M79.18
Myositis	M60.80 – M60.819; M60.821 – M60.829; M60.831 – M60.839; M60.841 – M60.849; M60.851 – M60.859; M60.861- M60.869, M60.871 – M60.879; M60.88; M60.89
Myopathy	G72.0; G72.2; G72.9
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; Z99.2

Medications

High-intensity Statin Therapy	Moderate-intensity statin therapy	
▪ Atorvastatin 40 – 80mg ▪ Amlodipine-atorvastatin 40 – 80mg ▪ Rosuvastatin 20 - 40mg ▪ Simvastatin 80mg ▪ Ezetimibe- simvastatin 80mg	▪ Atorvastatin 10 - 20mg ▪ Amlodipine-atorvastatin 10 - 20mg ▪ Rosuvastatin 5 - 10mg ▪ Simvastatin 20 - 40mg ▪ Ezetimibe-simvastatin 20 - 40mg	▪ Pravastatin 40 - 80mg ▪ Lovastatin 40mg ▪ Fluvastatin 40 – 80mg ▪ Pitavastatin 1 – 4mg

Tips for Success	▪ Education patients on the importance of statin medications in reducing cardiovascular risk, regardless of cholesterol levels. ▪ Start low, go slow' when starting patients on a statin to reduce potential for side effects and improve adherence. - Consider decreasing the frequency of long-acting statins, rosuvastatin and atorvastatin, to every other day if the patient is unable to tolerate daily statin due to side effects. - If it is desired to keep the patient on a statin, consider switching to pravastatin or fluvastatin as they are the least likely to cause muscle toxicity. ▪ In patients with chronic liver disease, who require a statin because of high ▪ cardiovascular risk, low dose pravastatin and abstinence from alcohol is recommended. ▪ Atorvastatin and fluvastatin are preferred in patients with severe renal impairment.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans

Statin use in Patients with Diabetes (SUPD)

Why it Matters

Diabetes is manageable but even when glucose levels are under control, these patients have a significantly increased risk of heart disease and stroke. Individuals with insulin resistance or diabetes in combination with one or more risk factors (e.g., obesity, smoking, high blood pressure, lack of physical activity) are at even greater risk. With the combination of statin use and management of risk factors, patients may delay or avoid the development of heart and blood vessel disease.[I]

Description of Measure

Percentage of patients 40 – 75 years of age with diabetes, who receive at least 1 fill of a statin medication in the measurement year.[II]

Statins	▪ Atorvastatin (+/ - amlodipine) ▪ Lovastatin (+/- niacin) ▪ Pitavastatin ▪ Simvastatin (+/- ezetimibe, niacin)	▪ Pravastatin ▪ Rosuvastatin (+/- ezetimibe) ▪ Fluvastatin
Exclusions	Patients are excluded if they: ▪ Received hospice care during the measurement year ▪ ESRD / dialysis ▪ Pregnancy, lactation, or fertility	▪ Pre-diabetes ▪ PCOS ▪ Cirrhosis ▪ Rhabdomyolysis or myopathy

Exclusion	ICD 10
Myopathy	G72.0, G72.89, G72.9
Myositis	M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9
Rhabdomyolysis	M62.82
Cirrhosis	K70.30, K70.31, K71.7, K74.3 -5, K74.60, K74.69
ESRD	I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2

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Tips for Success	■ 'Start low, go slow' when starting patients on a statin to reduce potential for side effects and improve adherence. ■ Look for unwanted side effects of statins, such as myalgias or drug-to-drug interactions. If it is desired to keep the patient on a statin, consider switching to pravastatin or Fluvastatin.

Resources

I. American Heart Association, Cardiovascular Disease and Diabetes, www.heart.org/en/health-topics/diabetes/diabetes-complications-and-risks/cardiovascular-disease-diabetes

II. Pharmacy Quality Alliance, April 19, 2022, *PQA Measure Overview*, November 22, 2023, www.pqaalliance.org

Medication Adherence

Why it Matters

Adherence to medication is a primary determinant of treatment success. Medication non-adherence in patients leads to substantial worsening of disease, death, and increased health care costs. The Centers for Disease Control and Prevention (CDC) estimates that non-adherence causes 30 to 50% of chronic disease treatment failures and 125,000 deaths each year in the United States. Additionally, 25 – 50% of patients being treated with statins who stop their therapy within 1 year have up to a 25% increased risk of death.[I]

A variety of factors are likely to affect adherence. Identifying specific barriers for each patient and adopting techniques to overcome them is necessary to improve medication adherence.

Description of Measure

Percentage of members 18 years of age and older with a prescription for diabetes, hypertension, or cholesterol medications who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.[II] The three measures are:

- Medication Adherence for Diabetes Medications: Biguanides, DPP-4 inhibitors, GLP-1 Receptor agents, Meglitinides, SGLT2 inhibitors, Sulfonylureas, and Thiazolidinediones
- Medication Adherence for Hypertension – ACE/ARB's and DRI's
- Medication Adherence for Cholesterol - Statins

Patients qualifying for the measure on the second medication fill date, but the measurement period begins with the date of the first dispense.

Exclusions

Patients are excluded if they:

- In hospice or using hospice services
- Have end stage renal disease (ESRD)
- Diabetes only: Have a prescription for insulin.
- Hypertension only: Have a prescription for sacubitril/valsartan.

Tips for Success	■ Schedule a 30-day follow-up when prescribing a new medication to assess how the medication is working. Schedule this visit while the patient is still in the office. ■ Provide short and clear instructions for all prescriptions. Include reason they are taking the statin medication, and how it's important to take their medication as prescribed and get timely refills. ■ Write 90-day supplies of maintenance medications and have your patients use a mail order pharmacy with automatic refills. ■ Emphasize the benefits of taking the medication outweigh the risks. ■ Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and costs. ■ If ongoing therapy is appropriate, talk with members about timely refills to prevent large gaps between fills. This is particularly important between the first and second fills to set up good habits. ■ Offer recommendations for improvement: - Recommend weekly or monthly pillboxes, smart phone apps with medication reminder alerts, and placing medications in a visible area (but in properly closed containers and safely out of reach of children or pets) for patients who forget to take their medications. - Encourage patients to call your office if they experience side effects to discuss alternative medications. - Encourage patients to use mail-order for their prescriptions. ■ Statin intolerance and statin associated muscle symptoms can be barriers to statin therapy. Clinicians should: - Partner with the patient to gain a thorough symptom history and determine if he or she is truly statin intolerant. - Walk through the steps of treating and managing a patient who reports muscle symptoms, including cycles of statin discontinuation and rechallenged to identify a tolerated statin and dose.

Resources

I. Why You Need to Take Your Medications as Prescribed or Instructed, U.S. Food & Drug, 11/22/2023, [fda.gov/drugs/specisal-features/why-you-need-take-your-medications-prescribed-or-instructed]

II. Pharmacy Quality Alliance, April 19, 2022, *PQA Measure Overview*, November 22, 2023, www.pqaallliance.org

Frequently used Codes for HEDIS® measures

CPT II and ICD 10 codes make it easier to track quality of care. The codes also simplify how quality performance measures are reported and eliminate the need for chart abstraction. Providers and hospitals can use these codes to report specific services that contribute to positive health outcomes and high-quality care.

Why use CPT II and diagnosis codes?

- Supply more accurate medical data and decrease requests for members' record to review
- Identify and close gaps in care more accurately and quickly – this drives HEDIS®
- Supports a proactive approach to addressing clinical care opportunities

Listed are HEDIS® measures and applicable codes.

HEDIS Measure	Codes
Controlling Blood Pressure (CBP)	**3074F** – Systolic BP < 130mmHg **3075F** – Systolic BP 130 – 139mmHg **3077F** – Systolic BP ≥ 140mmHg **3078F** – Diastolic BP < 80mmHg **3079F** – Diastolic BP 80 - 89mmHg **3080F** – Diastolic BP ≥ 90mmHg
Breast Cancer Screening (BCS-E)	**77061** – provider performs unilateral digital tomosynthesis for diagnostic **77062** – provider performs bilateral digital tomosynthesis for diagnostic **Exclusions** **Z90.11** – Absence of Right Breast **Z90.12** – Absence of Left Breast **Z90.13** – Absence of both Breasts
Colon Cancer Screening (COL-E)	**82270, 82274** – FOBT **HCPCS G0328** – FOBT **81528** – Cologuard (sDNA FIT) **Exclusions** **Z85.038** – History of other malignant neoplasm of large intestine **Z85.048** – History of other malignant neoplasm of rectum, rectosigmoid junction, and anus **C18.0 – C18.9, C19, C20, C21.2, C21.8** – Active colon cancer **C78.5** – Secondary malignant neoplasm of large intestine and rectum

<table>
<tr><th>HEDIS Measure</th><th>CPTII Codes / ICD Codes</th></tr>
<tr><td>Eye Exam for Patients with Diabetes (EED)</td><td>2022F – Dilated retinal exam interpreted by an eye care professional documented/ reviewed, with evidence of retinopathy
2023F – Dilated retinal eye exam interpreted by an eye care professional documented/ reviewed, without evidence of retinopathy
3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year)</td></tr>
<tr><td>Glycemic Status Assessment for Patients with Diabetes (GSD)</td><td>3044F – A1c < 7.0%
3051F – A1c 7.0% - 7.9%
3052F – A1c 8.0% - 9.0%
3046F – A1c > 9.0%</td></tr>
<tr><td>Osteoporosis Management in Women who had a Fracture (OMW)</td><td>J0897 – Injection, Denosumab 1mg
J1740 – Injection, Ibandronate sodium, 1mg
J3489 – injection, Zoledronic acid, 1mg</td></tr>
<tr><td>Statin Therapy for Patients with Cardiovascular Disease (SPC)</td><td><table><tr><th colspan="2">Exclusions</th></tr><tr><td>Myalgia</td><td>M79.10 – M479.12, M79.18</td></tr><tr><td>Myositis</td><td>M60.80 – M60.819, M60.821 – M60.829, M60.831 – M60.839, M60.841 – M60.849, M60.851 – M60.859, M60.861 – M60.869, M60.871 – M60.88, M60.89, M60.9</td></tr><tr><td>Myopathy</td><td>G72.0, G72.2, G72.9</td></tr><tr><td>Rhabdomyolysis</td><td>M62.82</td></tr><tr><td>Cirrhosis</td><td>K70.30, K70.31, K71.7, K74.3 -K74.5, K74.60, K74.69, P78.81</td></tr><tr><td>ESRD</td><td>N18.5, N18.6, Z99.2</td></tr></table></td></tr>
<tr><td>Statin Use in Patients with Diabetes (SUPD)</td><td><table><tr><th colspan="2">Exclusions</th></tr><tr><td>Myopathy</td><td>G72.0, G72.89, G72.9</td></tr><tr><td>Rhabdomyolysis</td><td>M62.82</td></tr><tr><td>Cirrhosis</td><td>K70.30, K70.31, K71.7, K74.3-5, K74.60, K74.69</td></tr><tr><td>ESRD</td><td>N18.5, N18.6, N19, Z91.15, Z99.2</td></tr></table></td></tr>
<tr><td>Medication Reconciliation Post-discharge (MRP)</td><td>1111F – discharge medications reconciled with current medication list
99483, 99495, 99496 – Transitional Care Management Services (TCM) includes medication reconciliation</td></tr>
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