

2024/25 Health Plan Coding Guide



Trinity Health Plan
New York

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We understand the challenges of working with multiple payers and meeting measurements, guidelines and documentation for Medicare beneficiaries. This Coding Guide is intended to make things easier for you and your staff when working with our health plan. The guide includes assistance in understanding:

- Star Ratings and the HEDIS reporting process.
- Your role in reporting and documenting care.
- Medical record requests (MRR).
- Star measure guidance and codes.

We always welcome your feedback on how we can make this guide better.

“Thank you for partnering with our health plan to improve the health and well-being of our members. We sincerely consider you our partner and recognize that we cannot succeed without the compassionate and high-quality care delivered by the providers in our network. Working together, we can have a positive impact on patient outcomes.”



Greg Wise, MD, FAAFP,
Chief Medical Officer

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Star Ratings, HEDIS Reporting and Documentation

What are Star Ratings?

All Medicare Advantage plans are awarded Star ratings annually by the Centers for Medicare & Medicaid Services (CMS). On a scale of one to five, a 5-Star rating is considered excellent. Our health plan's overall Star rating combines rankings of quality and performance, including how well we help our members to stay healthy and manage chronic conditions. This information is gathered from HEDIS® scores, HOS and CAHPS Survey data and CMS administrative data. This guide covers the HEDIS-related Star Measures, and the needed coding and documentation for those measures, used in our HEDIS scores.

HEDIS Reporting and the Role You Play

HEDIS, the acronym for Healthcare Effectiveness Data and Information Set, is a performance measurement tool for health plans, administered by the National Committee for Quality Assurance (NCQA). HEDIS measures are a significant component of Medicare Star Ratings and the NCQA accreditation process. The coding and documentation necessary to meet measures is collected from our claims database and review of medical records. In the eyes of measurement reporting, if it isn't documented, then it didn't happen. To meet requirements, it's important to make every visit count.

Useful tips include:

- Promote all patient's health and encourage an annual wellness visit before June 30 each year, when possible.
- Give patients reminder calls 48 hours before their appointments.
- Schedule follow-up visits before patients leave.
- Accurately code all claims.
- Thoroughly document all care in the patient's chart at the time service is provided, including date and provider's signature.
- Utilize our health plan's Gaps In Care report to close measures and strengthen patient relationships.

Feel free to request a gaps in care report for your office by emailing starsandhedis@mchs.com

What are CPT Category II codes?

Current Procedural Terminology (CPT) Category II codes were developed by the American Medical Association (AMA) as a supplemental performance tracking set of procedural codes in addition to the Category I and III code settings.

- Category I codes are used for tracking and billing common procedures.
- Category III codes are temporary codes for emerging technology.
- Category II codes are optional and intended to be used for measuring performance on quality metrics such as Healthcare Effectiveness Data and Information Set (HEDIS®)

<p>Category II codes are alphanumeric and consist of four digits followed by the letter 'F'.</p>	<p>Category II codes are NOT billing codes; they are used to track services on claims for performance measurement.</p>	<p>Category II codes are not to be used as a substitute for Category I codes.</p>
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What is the purpose of CPT Category II codes?

Category II codes are intended to facilitate the reporting of services or test results that support quality of care performance measures. MediGold highly encourages (and even incentivizes*) clinical office staff to utilize CPT II codes.

By accurately coding you can decrease the need for manual record abstraction and chart review, minimizing the burden on physicians and office staff to report this information through other methods.

CPT Category II codes are arranged according to the following categories:

Category	Code Range	Category	Code Range
Composite measures	0001F-0015F	Therapeutic, preventive or other interventions	4000F - 4306F
Patient management	0500F - 0575F	Follow-up or other outcomes	5005F - 5100F
Patient history	1000F - 1220F	Patient safety	6005F - 6045F
Physical examination	2000F - 2050F	Structural measures	7010F - 7025F
Diagnostic/screening processes or results	3006F - 3573F		

CPT II codes allow providers to measure and display the quality of care they provide.

CPT® is a registered trademark of the American Medical Association. Copyright 2016 American Medical Association (AMA). All rights reserved. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

	MEASURE	CATEGORY II CPT CODE	INCENTIVE
EED	Comprehensive Diabetes Care-Retinal Eye Exam <i>(One time per year.)</i>	2022F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$20
		2023F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$20
		2024F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$20
		2025F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$20
		2026F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$20
		2033F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$20
		3072F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$20
GSD	Comprehensive Diabetes Care-HbA1c level less than 7.0 <i>(Diabetic members only.)</i>	3044F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$10
	Comprehensive Diabetes Care-HbA1c level greater than 9.0 <i>(Diabetic members only.)</i>	3046F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$10
	Comprehensive Diabetes Care-HbA1c level greater than or equal to 7.0 and less than 8.0 <i>(Diabetic members only.)</i>	3051F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$10
	Comprehensive Diabetes Care-HbA1c level greater than or equal to 8.0 and less than 9.0 <i>(Diabetic members only.)</i>	3052F Filed with ICD-10 Diag Codes: ICD-10-E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83	\$10
CBP	Controlling Blood Pressure- Systolic <i>(Essential Hypertensive members only.)</i>	3074F Filed with ICD-10 Diag Code: I10	\$5
	Controlling Blood Pressure- Systolic <i>(Essential Hypertensive members only.)</i>	3075F Filed with ICD-10 Diag Code: I10	\$5
	Controlling Blood Pressure- Systolic <i>(Essential Hypertensive members only.)</i>	3077F Filed with ICD-10 Diag Code: I10	\$5
	Controlling Blood Pressure- Diastolic <i>(Essential Hypertensive members only.)</i>	3078F Filed with ICD-10 Diag Code: I10	\$5
	Controlling Blood Pressure- Diastolic <i>(Essential Hypertensive members only.)</i>	3079F Filed with ICD-10 Diag Code: I10	\$5
	Controlling Blood Pressure- Diastolic <i>(Essential Hypertensive members only.)</i>	3080F Filed with ICD-10 Diag Code: I10	\$5
MRP	Medication Reconciliation Post- Discharge	1111F	\$25

Documentation Requirements

Correctly documenting patient encounters is critical for quality reporting and accurate reimbursement. This is key as health care reform continues to move toward quality-driven reimbursement.

- Documentation is legible.
- Ensure correct CPT, CPT II and ICD-10 codes are used.
- Blood pressure diagnosis is documented prior to June 30.
- All patient encounters, including telephone, fax and electronic message exchanges are documented.

Common HEDIS Barriers and Obstacles

- Let us know if member attribution is incorrect (patient assigned to wrong PCP)
- Claim submitted without correct codes will not count toward the measure. This means we will be required to ask for the medical record.
- Claim submitted with inaccurate diagnosis code will incorrectly add to a measure.
- Not coding A1c or blood pressure values/results.
- Services not documented in the patient's medical chart.
- All required components of the measure not provided, e.g., diabetes diagnosis or hypertension without blood pressure reading.
- Records not transferred when patient changed PCP.
- Appointment availability when patient tries to schedule preventive services.
- Practice not seeing new patient in a timely manner.
- PCPs should include documentation received from specialists and other sources in outpatient chart i.e. eye exams, inpatient and discharge summaries, radiology, gastro, gaps summaries from health plan

Ways to improve Health Outcomes Survey and CAHPS Results

Access to care

- Ensure your patients get care quickly and efficiently by leaving open appointments on your schedule for sick/urgent needs
- Prompt patient to schedule their next routine care appointment after each visit
- If necessary, assist in the coordination of non-emergency transportation
- Provide a link to community resources to facilitate referrals
- Follow up with patients' specialists to confirm continuity of care

Educate your patients

- Ask your patients what their major health concerns are
- Communicate at a level appropriate to the education level and in preferred language of the patient
- Encourage your patients to get the annual flu vaccine
- Discuss fall prevention and tactics
- Make mental health questions part of your patient care routine
- Bring up health topics like urinary incontinence and improving and maintaining physical health

Member Rewards and Incentives – 2024

MediGold members have an opportunity to earn rewards for completing healthy activities.

Notification of personalized reward offerings will be received via mail throughout the year.

Healthy activities are incentivized with a \$25 reward per activity; one reward per activity per calendar year.

Offered to all enrollees:

Annual Wellness Visits or In-home Assessment (SNF/homebound)

Eligibility based Reward Activities:

Breast Cancer Screening: members who complete a mammogram.

Colorectal Cancer Screening: members who receive a colorectal cancer screening (colonoscopy, ColoGuard, FOBT, sigmoidoscopy).

Diabetes Care Eye Exam: diabetics who receive a retinal eye exam performed by an eye care provider

Diabetes Care A1c: diabetics who receive a Hemoglobin A1c (HbA1c) screening.

Medical Record Collection/Delivery Methods

Medical Record Confidentiality

Our health plan strictly maintains the confidentiality of any records, which are accessed only by authorized people adhering to the following guidelines. Records are:

- Kept in a safe and secure location.
- Appropriately destroyed when they are no longer needed for the purpose requested.
- Not further disclosed or otherwise distributed.

We are not asking for nor do we want any medical record information related to psychotherapy, HIV, substance abuse or developmental disabilities.

Further, your Provider Agreement stipulates that copies of members' medical records shall be provided to our health plan, or its respective designees, for quality improvement activities, e.g., HEDIS.

If you have questions concerning this request, please contact: StarsAndHEDIS@mchs.com.

Medical Record Collection/Delivery Methods

Data collection methods include the following, as long as they meet HIPAA guidelines:

- Remote electronic medical record (EMR) system. EMR submissions, which are highly recommended, result in fewer visits and emails from our health plan.
- Fax.
- Hard copy, flash or CD delivered via postal service certified mail, or other signature-required service.
- Email encrypted to HIPAA standards.
- Schedule time with one of our HEDIS coordinators to come into your office to collect a copy of the records on-site.
- Ask that one of our HEDIS coordinators come by to pick up the records.

Online Submission of Medical Records for Stars and HEDIS Gaps In Care

1. Access the provider portal at: MediGold.com/For-Providers/Provider-Portal.
(For first-time portal users, follow the easy steps at the link to set up an account and log in.
Please reach out to Provider Services for any issues with creating an account or account access.)
2. On the portal home page, select Close Gaps In Care.

Welcome to the MediGold Provider Portal!

This site will allow you to:

- [Verify eligibility and coverage](#)
- [View claims history and payment status](#)
- [Ask a Claim, Eligibility or Benefit Question](#)
- [Special Investigation Unit: upload requested medical records or documents](#)
- [Close Gaps In Care](#)

3. On the 'Gaps In Care Medical Records' page enter content in all required fields.

Gaps In Care Medical Records Attachments (0)

Gaps In Care Medical Records

Having trouble uploading documentation? Fax to: 614-234-8838.

*PCP Name:

*Provider Group:

*Provider NPI:

*Member First Name:

*Member Last Name:

*Member ID:

*Member Date of Birth:

Next Step: select the Attachments tab above to attach the medical records, then return here to Submit.

Note: do not hit the submit button at this point. Instead, select the Attachments tab above.

Gaps In Care Medical Records Attachments (0)

Gaps In Care Medical Records

Having trouble uploading documentation? Fax to: 614-234-8838.

Online Submission of Medical Records for Stars and HEDIS Gaps In Care (continued)

4. Select browse to select the file, then select the Add button.

Gaps In Care Medical Records Attachments (0)

Add Attachment

*File **Browse...** No file selected.
(maximum file size: 10 MB)

Note: Uploading from certain mobile devices is not supported, i.e. iOS < 6 and older Android.

Description

Add

5. After the file(s) finish uploading it will indicate the number of attachments in the Attachments tab. Now, click the Gaps In Care Medical Records tab.

Gaps In Care Medical Records Attachments (0)

6. Select Submit.

Gaps In Care Medical Records Attachments (0)

Gaps In Care Medical Records

Having trouble uploading documentation? Fax to: 614-234-8838.

*PCP Name:

*Provider Group:

*Provider NPI:

*Member First Name:

*Member Last Name:

*Member ID:

*Member Date of Birth:

Next Step: select the Attachments tab above to attach the medical records, then return here to Submit.

Submit

Frequently Asked Questions

Who reviews the medical records?

Our health plan uses our own professionals and/or partners with expert organizations working on our behalf. All professionals reviewing the medical records will treat your patient's protected health information (PHI) with total protection and confidentiality.

Is a review of medical records permitted by HIPAA without a signed member release?

HIPAA allows providers to disclose PHI to another covered entity without a signed release in reference to health care operations. These operations include activities such as quality assessment and improvement and health plan performance evaluations. HEDIS scores are a significant part of these activities.

When will I be asked to provide the records for HEDIS?

Records may be requested throughout the year. However, the majority of records are requested and reviewed between early February to middle April each year.

Is my participation in data collection mandatory and what am I required to do?

Yes. Network participants are contractually required to provide medical record information so we may fulfill our state and federal regulatory obligations. You and your staff are responsible for responding to our request for medical record documentation in a timely manner. You may provide the records yourself, or schedule time with one of our professionals to come into your office to collect a copy of the records on-site. If a patient included on the list is not part of your practice, you should notify us immediately.

Should I allow a record review for a patient who is no longer with the health plan or a patient who is deceased?

Yes. Medical record reviews may require data collection on the services obtained over multiple years when the patient was receiving benefits from our health plan.

Am I required to provide medical records for a patient who was seen by a provider who has retired, died or moved?

Yes. Data collection includes reviewing medical records as far back as 10 years (including before your patient was a health plan member). Archived medical records and data may be required to complete data collection.

If you have further questions, please contact: StarsAndHEDIS@mchs.com.

Star Measures

Breast Cancer Screening (BCS)	Percentage of members 50-74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year, and December 31 of the measurement year. This measure evaluates primary screening, not diagnostic screenings.
Star Weight:	1
Provider Actions:	Mammogram to screen for cancer in the time period listed in measure.
Coding:	
CPT4	77061-77063 77065-77067
Revenue	0401 0403
Exclusions:	Members with advanced illness and frailty. Members with a history of bilateral or two unilateral mastectomies. Members in hospice or palliative care. Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI). Members deceased within the measurement period. Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.

Plan All-Cause Readmission (PCR)

Plan All-Cause Readmissions (PCR)	Those with an acute inpatient stay during the measurement year that were followed-up by an unplanned acute readmission for any diagnosis within 30-days and the predicted probability of an acute readmission.
Star Weight:	3
Provider Action:	Outreach to your patient and see them within 7 days of discharge. Reconcile current and discharge medications, when applicable. If medications are prescribed, provide education to the patient, including side effects, importance of adherence, etc.
Exclusions:	None

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

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	<p>The percentage of emergency department visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. Chronic conditions include: COPD and Asthma, Alzheimer’s disease and related disorders, Chronic Kidney disease, Depression, Heart Failure, MI, A-FIB, TIA and or Strokes</p>
Weight:	<p>1</p>
Provider Action:	<p>Perform follow up within 7 days of an ED visit for members with multiple chronic conditions.</p>
Qualifying Follow-Up Encounters:	<ul style="list-style-type: none"> • Outpatient, telephone or telehealth visits • E-visit or virtual check-in • Transitional care management services • Case management visit • Complex care management service • Outpatient or telehealth behavioral health visit • Intensive outpatient encounter or partial hospitalization • Community mental health center visit • Electroconvulsive therapy • Observation visit • IET stand-alone visit • Behavior Health (BH) outpatient services • Substance use disorder services
Exclusions:	<p>Members in hospice, ED visits resulting in an inpatient stay. Members deceased within the measurement year.</p>

Colorectal Cancer Screening (COL)

Colorectal Cancer Screening (COL)	Percentage of members 45-75 years of age who had appropriate screening for colorectal cancer.
Star Weight:	1
Provider Actions:	Annual gFOBT or FIT during the measurement year.
	Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
	FIT-DNA every three years
	Colonoscopy during the measurement year or the nine years prior to the measurement year.
	CT Colonography during the measurement year or the four years prior.
Coding:	
LOINC	Noninvasive colorectal cancer DNA and occult blood screening [Interpretation] in Stool Narrative – 77353-1
	Noninvasive colorectal cancer DNA and occult blood screening [Presence] in Stool – 77354-9
CPT 4	FOBT – 82270, 82274
	Flexible Sigmoidoscopy – 45330-45335, 45337-45338, 45340-45342, 45346-45347, 45349-45350
	FIT-DNA - 81528
	Colonoscopy – 44388-44394, 44401-44408, 45378-45393, 45398
	CT Colonography – 74261-74263
HCPCS	FOBT – G0328
	Flexible Sigmoidoscopy – G0104
	Colonoscopy – G0105, G0121
SNOMED CT US Edition	Stool DNA-based colorectal cancer screening positive (finding) –708699002
	Fecal occult blood trace finding - 389076003
ICD-9-CM Procedures	Flexible Sigmoidoscopy – 45.24 Colonoscopy - 45.23
Exclusions:	Members receiving palliative care. Members with advanced illness and frailty. Members with a diagnosis of colorectal cancer or total colectomy. Members in hospice. Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI). Members deceased within the measurement year.

Controlling Blood Pressure (CBP)

Controlling Blood Pressure (CBP)	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	
Star Weight:	3	
Provider Actions:	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension	
Coding		
CPT 2	Systolic BP <130 mmHg.	3074F
	Systolic BP 130-139 mmHg.	3075F
	Systolic BP ≥140 mmHg.	3077F
	Diastolic BP <80 mmHg.	3078F
	Diastolic BP 80-89 mmHg.	3079F
	Diastolic BP ≥90 mmHg.	3080F
LOINC	Diastolic blood pressure--sitting	8453-3
	Diastolic blood pressure--standing	8454-1
	Diastolic blood pressure--supine	8455-8
	Diastolic blood pressure	8462-4
	Systolic blood pressure--sitting	8459-0
	Systolic blood pressure--standing	8460-8
	Systolic blood pressure--supine	8461-6
	Systolic blood pressure	8480-6
Exclusions:	Palliative Care Members with advanced illness and frailty. Members in hospice. Members with evidence of End-stage Renal Disease (ESRD) or kidney transplant on or prior to December 31 of the measurement year. Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI). Members deceased within the measurement year.*	

*If more than one BP reading is collected on the same date record lowest systolic and lowest diastolic readings.

Transitions of Care (TRC)

Transitions of Care (TRC)	Percentage of discharges for members 18 and older who had each of the following. Four rates are reported:	
Weight:	1	
Provider Action:	<ul style="list-style-type: none"> • Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days). • Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). • At a minimum, the discharge information must include all of the following: <ul style="list-style-type: none"> • The practitioner responsible for the member's care during the inpatient stay. • Procedures or treatment provided. • Diagnoses at discharge. • Current medication list. • Testing results, or documentation of pending tests or no test pending. • Instructions for patient care post-discharge • Patient Engagement After Inpatient Discharge. Documentation of patient engagement provided within 30 days after discharge. • Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). 	
Coding:		
CPT 2	1111F	
CPT 4	99495	
	99496	
Exclusions:	Members deceased within the measurement year. Members in hospice	

Medication Reconciliation Post Discharge (MRP)

Medication Reconciliation Post Discharge (MRP)	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).
Weight:	1
Provider Actions:	Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Coding:	
CPT 2	1111F
Exclusions:	Members deceased within the measurement year. Members in hospice.

Care for Patients with Diabetes

Glycemic Status Assessment for Patients with Diabetes (GSD) [formerly Hemoglobin A1c for Patients with Diabetes (HBD) measure]	The percentage of members 18–75 years of age with diabetes (types 1 and 2) 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%. Glycemic Status >9.0%.	
Provider Actions	The most recent glycemic status assessment, HbA1c test or GMI, performed in the measurement year.	
Star Weight:	1	
Provider Actions:	Annual documentation of the most recent date and result of the HbA1c test or GMI.	
Coding:		
CPT 2	Level <7.0%	3044F
	Level >9.0%	3046F
	Level >7.0<8.0%	3051F
	Level > 8.0%<9.0%	3052F
CPT4	83036-83037	
LOINC	97506-0	
Exclusions:	Members with advanced illness and frailty for all CDC measures. Member in hospice or palliative care. Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI). Members deceased within the measurement year.	
Eye Exam for Patients with Diabetes (EED)	The percentage of members 18-75 with diabetes (types 1 and 2) who had a retinal eye exam	
Retinal Eye Exam:		
Star Weight:	1	
Provider Actions:	Annual documentation of most recent retinal or dilated eye exam or Documentation of a negative retinal or dilated eye exam in prior year or Chart/photograph of retinal abnormalities indicating date when the fundus photography was performed and evidence it was reviewed by an eye care professional (optometrist or ophthalmologist) in current year.	
Coding:		
CPT 2	Diabetic Retinal Screening with Eye Care Professional:	2022F, 2024F, 2026F
	Negative Indicators for Diabetic Retinopathy	2023F, 2025F
	Diabetic Retinal Screening Negative:	2033F
Exclusions:	Member in hospice or palliative care. Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI). Members deceased within the measurement year. Members with advanced illness and frailty.	

Kidney Health Evaluation for Patients With Diabetes (KED)

Kidney Health Evaluation for Patients With Diabetes (KED)	The percentage of members 18–85 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.
Star Weight:	1
Provider Action:	Annual documentation of both an eGFR and a uACR during the measurement year on the same or different dates of service.
Reported Rates	Two elements are required during the measurement year on same or different dates of service: <ol style="list-style-type: none"> At least one estimated Glomerular Filtration Rate (eGFR) lab test. At least one uACR identified by both a quantitative urine albumin test and a urine creatinine test with service dates four or less days apart.
Coding:	
CPT - eGFR Lab Test	80047, 80048, 80050, 80053, 80069, 82565
CPT - Quantitative Urine Albumin lab test	82043
CPT - Urine creatinine lab test	82570
LOINC	50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6; 100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7; 20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5; 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7
Exclusions:	Members in hospice. Members with advanced illness and frailty. Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI). Members receiving palliative care during the measurement year. Members with a diagnosis of ESRD any time during the member's history on or prior to December 31 of the measurement year.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Osteoporosis Management in Women Who Had a Fracture (OMW)	The percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture. Note: Fractures of finger, face and skull are not included in this measure.	
Star Weight:	1	
Provider Action:	Perform Bone Mineral Density (BMD) test or prescribe medication therapy to treat osteoporosis within 6 months of a fracture. Allowable every 24 months.	
Coding:		
CPT4	Bone Mineral Density Test: 76977, 77078, 77080-77081, 77085 - 77086	
HCPCS	Injection, Denosumab, 1 mg	J0897
	Injection, Ibandronate sodium, 1 mg	J1740
	Injection, Teriparatide, 10 mg	J3110-J3111
	Injection, Zoledronic acid, 1 mg	J3489
	Injection, Zoledronic acid, not otherwise classified, 1 mg	Q2051
ICD10PCS	Ultrasonography of Right Shoulder, Densitometry	BP48ZZ1
	Ultrasonography of Left Shoulder, Densitometry	BP49ZZ1
	Ultrasonography of Right Elbow, Densitometry	BP4GZZ1
	Ultrasonography of Left Elbow, Densitometry	BP4HZZ1
	Ultrasonography of Right Wrist, Densitometry	BP4LZZ1
	Ultrasonography of Left Wrist, Densitometry	BP4MZZ1
	Ultrasonography of Right Hand, Densitometry	BP4NZZ1
	Ultrasonography of Left Hand, Densitometry	BP4PZZ1
	Plain Radiography of Right Hip, Densitometry	BQ00ZZ1
	Plain Radiography of Left Hip, Densitometry	BQ01ZZ1
	Plain Radiography of Right Femur, Densitometry	BQ03ZZ1
	Plain Radiography of Left Femur, Densitometry	BQ04ZZ1
	Plain Radiography of Cervical Spine, Densitometry	BR00ZZ1
	Plain Radiography of Thoracic Spine, Densitometry	BR07ZZ1
	Plain Radiography of Lumbar Spine, Densitometry	BR09ZZ1
Plain Radiography of Whole Spine, Densitometry	BR0GZZ1	
Medications	Notation of the following prescribed medications listed below:	
	Description	Prescription
	Bisphosphonates	<ul style="list-style-type: none"> • Alendronate • Alendronate-cholecalciferol • Ibandronate
Other agents	<ul style="list-style-type: none"> • Risedronate • Zoledronic acid • Romosozumab • Teriparatide 	
Exclusions:	<p>Members with advanced illness and frailty.</p> <p>Members who had a Bone Mineral Density Test during the 730 days (24 months) prior to the Index Episode Start Date (IESD).</p> <p>Members who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to the IESD.</p> <p>Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to the IESD.</p> <p>Member in hospice or palliative care.</p> <p>Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI).</p> <p>Hospice and palliative care</p> <p>Members deceased within the measurement year.</p>	

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Statin Therapy for Patients with Cardiovascular Disease (SPC)	The percentage of males 21-75 years of age and females 40-75 years of age with clinical atherosclerotic cardiovascular disease (ASCVD) who receive a high or moderate-intensity statin medication during the measurement year.																		
Star Weight:	1																		
Provider Action:	<p>Encourage the member to adhere to at least 80% or more to their statin medication. Prescribe at least one high-intensity or moderate-intensity statin medication during the measurement year:</p> <table border="1" data-bbox="505 443 1370 1024"> <thead> <tr> <th data-bbox="505 443 915 464">Description</th> <th data-bbox="915 443 1370 464">Prescription</th> </tr> </thead> <tbody> <tr> <td data-bbox="505 464 915 615" rowspan="5">High-intensity statin therapy</td> <td data-bbox="915 464 1370 485">• Atorvastatin 40-80 mg</td> </tr> <tr> <td data-bbox="915 485 1370 506">• Amlodipine-atorvastatin 40-80 mg</td> </tr> <tr> <td data-bbox="915 506 1370 527">• Rosuvastatin 20-40 mg</td> </tr> <tr> <td data-bbox="915 527 1370 548">• Simvastatin 80 mg</td> </tr> <tr> <td data-bbox="915 548 1370 615">• Ezetimibe-simvastatin 80 mg</td> </tr> <tr> <td data-bbox="505 615 915 1024" rowspan="9">Moderate-intensity statin therapy</td> <td data-bbox="915 615 1370 636">• Atorvastatin 10-20 mg</td> </tr> <tr> <td data-bbox="915 636 1370 657">• Amlodipine-atorvastatin 10-20 mg</td> </tr> <tr> <td data-bbox="915 657 1370 678">• Rosuvastatin 5-10 mg</td> </tr> <tr> <td data-bbox="915 678 1370 699">• Simvastatin 20-40 mg</td> </tr> <tr> <td data-bbox="915 699 1370 720">• Ezetimibe-simvastatin 20-40 mg</td> </tr> <tr> <td data-bbox="915 720 1370 741">• Pravastatin 40-80 mg</td> </tr> <tr> <td data-bbox="915 741 1370 762">• Lovastatin 40 mg</td> </tr> <tr> <td data-bbox="915 762 1370 783">• Fluvastatin 40-80 mg</td> </tr> <tr> <td data-bbox="915 783 1370 1024">• Pitavastatin 1-4 mg</td> </tr> </tbody> </table>	Description	Prescription	High-intensity statin therapy	• Atorvastatin 40-80 mg	• Amlodipine-atorvastatin 40-80 mg	• Rosuvastatin 20-40 mg	• Simvastatin 80 mg	• Ezetimibe-simvastatin 80 mg	Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	• Amlodipine-atorvastatin 10-20 mg	• Rosuvastatin 5-10 mg	• Simvastatin 20-40 mg	• Ezetimibe-simvastatin 20-40 mg	• Pravastatin 40-80 mg	• Lovastatin 40 mg	• Fluvastatin 40-80 mg	• Pitavastatin 1-4 mg
Description	Prescription																		
High-intensity statin therapy	• Atorvastatin 40-80 mg																		
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	• Pitavastatin 1-4 mg																		
Exclusions (With appropriate diagnosis code on claim):	<p>Members with advanced illness and frailty. Member diagnosed with Muscular Pain and Disease to include Myalgia, Myopathy, Rhabdomyolysis and End-stage Renal Disease (ESRD). Members dispensed with at least one prescription for clomiphene (Estrogen Agonist) during the measurement year or the year prior to the measurement year. Members diagnosed with Cirrhosis during the measurement year or the year prior to the measurement year. Member in hospice or palliative care. Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an I-SNP any time during the measurement year or living long term in an institution (LTI). Members deceased during the measurement year.</p>																		

Part D Measures

Medication Adherence - Cholesterol	The percentage of Part D beneficiaries aged 18 or older who had at least two fills of cholesterol medication (a statin drug) on unique dates of service who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.										
Star Weight:	3										
Provider Action:	<p>Always prescribe 90 days when possible. Encourage patients to adhere to their prescribed statin medication at 80% or more throughout the year for the following medications.</p> <p>Table STATINS: Statins^a</p> <table border="1" data-bbox="516 527 1383 695"> <thead> <tr> <th colspan="2">Statin Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td>atorvastatin (+/- amlodipine, ezetimibe)</td> <td>pravastatin</td> </tr> <tr> <td>fluvastatin</td> <td>rosuvastatin (+/- ezetimibe)</td> </tr> <tr> <td>lovastatin (+/- niacin)</td> <td>simvastatin (+/- ezetimibe, niacin)</td> </tr> <tr> <td>pitavastatin</td> <td></td> </tr> </tbody> </table> <p>^a The active ingredients are limited to oral formulations only.</p>	Statin Medications and Combinations		atorvastatin (+/- amlodipine, ezetimibe)	pravastatin	fluvastatin	rosuvastatin (+/- ezetimibe)	lovastatin (+/- niacin)	simvastatin (+/- ezetimibe, niacin)	pitavastatin	
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pitavastatin											
Exclusions:	Members enrolled in hospice any time during the measurement period										

Medication Adherence – Diabetes	The percentage of Medicare Part D beneficiaries, 18 years or older, with at least two diabetes medication fills on unique dates of service during the measurement period who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.																																												
Star Weight:	3																																												
Provider Action:	<p>Always prescribe 90 days when possible. Encourage patients to adhere to their prescribed drug therapy 80% or more throughout the year for the following medications: Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV inhibitors, Incretin Mimetics, Meglitinides, and SGLT2 inhibitors:</p> <p>Table BG: Biguanides^{a,b}</p> <table border="1" data-bbox="699 422 1287 495"> <thead> <tr> <th colspan="2">Biguanide Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td colspan="2">metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)</td> </tr> </tbody> </table> <p>a Active ingredients are limited to oral formulations only. b Excludes nutritional supplement/dietary management combination products.</p> <p>Table SFU: Sulfonylureas^a</p> <table border="1" data-bbox="699 573 1287 667"> <thead> <tr> <th colspan="2">Sulfonylurea Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td>chlorpropamide^b</td> <td>glyburide (+/- metformin)</td> </tr> <tr> <td>glimepiride (+/- pioglitazone, rosiglitazone^b)</td> <td>tolazamide</td> </tr> <tr> <td>glipizide (+/- metformin)</td> <td>tolbutamide^b</td> </tr> </tbody> </table> <p>a Active ingredients are limited to oral formulations only. b There are no active NDCs for chlorpropamide, glimepiride/rosiglitazone, or tolbutamide.</p> <p>Table TZD: Thiazolidinediones^a</p> <table border="1" data-bbox="699 745 1287 819"> <thead> <tr> <th colspan="2">Thiazolidinedione Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td>pioglitazone (+/- alogliptin, glimepiride, metformin)</td> <td>rosiglitazone (+/- glimepiride^b, metformin)</td> </tr> </tbody> </table> <p>a Active ingredients are limited to oral formulations only. b There are no active NDCs for rosiglitazone/glimepiride.</p> <p>Table DPP4: DPP-4 Inhibitors^a</p> <table border="1" data-bbox="699 896 1287 970"> <thead> <tr> <th colspan="2">DPP-4 Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td>alogliptin (+/- metformin, pioglitazone)</td> <td>saxagliptin (+/- metformin, dapagliflozin)</td> </tr> <tr> <td>linagliptin (+/- empagliflozin, metformin)</td> <td>sitagliptin (+/- metformin, ertugliflozin)</td> </tr> </tbody> </table> <p>a Active ingredients are limited to oral formulations only.</p> <p>Table GIP/GLP1: GLP-1 Receptor Agonists[†]</p> <table border="1" data-bbox="699 1031 1287 1146"> <thead> <tr> <th colspan="2">GIP/GLP-1 Receptor Agonists Medications</th> </tr> </thead> <tbody> <tr> <td>albiglutide^b</td> <td>lixisenatide</td> </tr> <tr> <td>dulaglutide</td> <td>semaglutide</td> </tr> <tr> <td>exenatide</td> <td>tirzepatide</td> </tr> <tr> <td>liraglutide</td> <td></td> </tr> </tbody> </table> <p>a Excludes products indicated for weight loss. b No active NDCs for albiglutide.</p> <p>Table MEG: Meglitinides^a</p> <table border="1" data-bbox="699 1224 1287 1276"> <thead> <tr> <th colspan="2">Meglitinides Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td>nateglinide</td> <td>repaglinide (+/-metformin)</td> </tr> </tbody> </table> <p>a Active ingredients are limited to oral formulations only.</p> <p>Table SGLT2: SGLT2 Inhibitors^a</p> <table border="1" data-bbox="699 1333 1287 1428"> <thead> <tr> <th colspan="2">SGLT2 Inhibitors Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td>bexagliflozin</td> <td>dapagliflozin (+/- metformin, saxagliptin)</td> </tr> <tr> <td>canagliflozin (+/- metformin)</td> <td>empagliflozin (+/- metformin, linagliptin)</td> </tr> <tr> <td>ertugliflozin (+/- sitagliptin, metformin)</td> <td></td> </tr> </tbody> </table> <p>a Active ingredients are limited to oral formulations only.</p>	Biguanide Medications and Combinations		metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)		Sulfonylurea Medications and Combinations		chlorpropamide ^b	glyburide (+/- metformin)	glimepiride (+/- pioglitazone, rosiglitazone ^b)	tolazamide	glipizide (+/- metformin)	tolbutamide ^b	Thiazolidinedione Medications and Combinations		pioglitazone (+/- alogliptin, glimepiride, metformin)	rosiglitazone (+/- glimepiride ^b , metformin)	DPP-4 Medications and Combinations		alogliptin (+/- metformin, pioglitazone)	saxagliptin (+/- metformin, dapagliflozin)	linagliptin (+/- empagliflozin, metformin)	sitagliptin (+/- metformin, ertugliflozin)	GIP/GLP-1 Receptor Agonists Medications		albiglutide ^b	lixisenatide	dulaglutide	semaglutide	exenatide	tirzepatide	liraglutide		Meglitinides Medications and Combinations		nateglinide	repaglinide (+/-metformin)	SGLT2 Inhibitors Medications and Combinations		bexagliflozin	dapagliflozin (+/- metformin, saxagliptin)	canagliflozin (+/- metformin)	empagliflozin (+/- metformin, linagliptin)	ertugliflozin (+/- sitagliptin, metformin)	
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Exclusions:	<p>Beneficiaries who have one or more of the following prescriptions for insulin in the measurement period listed below.</p> <p>Table INSULINS: Insulin Exclusion^{a,b}</p> <table border="1" data-bbox="699 1577 1287 1734"> <thead> <tr> <th colspan="2">Insulins</th> </tr> </thead> <tbody> <tr> <td>insulin aspart (+/- insulin aspart protamine, niacinamide)</td> <td>insulin glulisine</td> </tr> <tr> <td>insulin degludec (+/- liraglutide)</td> <td>insulin isophane (+/- regular insulin)</td> </tr> <tr> <td>insulin detemir</td> <td>insulin lispro (+/- insulin lispro protamine)</td> </tr> <tr> <td>insulin glargine (+/- lixisenatide)</td> <td>insulin regular (including inhalation powder)</td> </tr> </tbody> </table> <p>a Active ingredients are limited to inhaled and injectable formulations b Excludes insulin analogs that are not included in the table above.</p> <p>Beneficiaries enrolled in hospice any time during the measurement period. Beneficiaries that have ESRD</p>	Insulins		insulin aspart (+/- insulin aspart protamine, niacinamide)	insulin glulisine	insulin degludec (+/- liraglutide)	insulin isophane (+/- regular insulin)	insulin detemir	insulin lispro (+/- insulin lispro protamine)	insulin glargine (+/- lixisenatide)	insulin regular (including inhalation powder)																																		
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Medication Adherence - Hypertension-RAS Antagonists	The percentage of Medicare Part D beneficiaries, 18 years or older, with at least two RAS antagonist medication fills on unique dates of service during the measurement period, who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.																										
Star Weight:	3																										
Provider Action:	<p>Always prescribe 90 days when possible. Encourage patients to adhere to their prescribed ACE inhibitors, ARBs, or Direct Renin Inhibitors 80% or more throughout the year.</p> <p>Table RASA: Renin Angiotensin System (RAS) Antagonists a, b</p> <table border="1" data-bbox="527 504 1399 1108"> <thead> <tr> <th colspan="2" data-bbox="527 504 1399 550">Direct Renin Inhibitor Medications and Combinations</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="527 550 1399 592">aliskiren (+/- hydrochlorothiazide)</td> </tr> <tr> <th colspan="2" data-bbox="527 592 1399 634">ARB Medications and Combinations</th> </tr> <tr> <td data-bbox="527 634 971 676">azilsartan (+/- chlorthalidone)</td> <td data-bbox="971 634 1399 676">irbesartan (+/- hydrochlorothiazide)</td> </tr> <tr> <td data-bbox="527 676 971 718">candesartan (+/- hydrochlorothiazide)</td> <td data-bbox="971 676 1399 718">losartan (+/- hydrochlorothiazide)</td> </tr> <tr> <td data-bbox="527 718 971 787">eprosartan (+/- hydrochlorothiazide)</td> <td data-bbox="971 718 1399 787">olmesartan (+/- amlodipine, hydrochlorothiazide)</td> </tr> <tr> <td data-bbox="527 787 971 850">telmisartan (+/- amlodipine, hydrochlorothiazide)</td> <td data-bbox="971 787 1399 850">valsartan (+/- amlodipine, hydrochlorothiazide nebulolol)</td> </tr> <tr> <th colspan="2" data-bbox="527 850 1399 892">ACE Inhibitor Medications and Combination Products</th> </tr> <tr> <td data-bbox="527 892 971 955">benazepril (+/- amlodipine, hydrochlorothiazide)</td> <td data-bbox="971 892 1399 955">lisinopril (+/- hydrochlorothiazide)</td> </tr> <tr> <td data-bbox="527 955 971 997">captopril (+/- hydrochlorothiazide)</td> <td data-bbox="971 955 1399 997">moexipril (+/- hydrochlorothiazide)</td> </tr> <tr> <td data-bbox="527 997 971 1039">enalapril (+/- hydrochlorothiazide)</td> <td data-bbox="971 997 1399 1039">perindopril (+/- amlodipine)</td> </tr> <tr> <td data-bbox="527 1039 971 1081">fosinopril (+/- hydrochlorothiazide)</td> <td data-bbox="971 1039 1399 1081">quinapril (+/- hydrochlorothiazide)</td> </tr> <tr> <td data-bbox="527 1081 971 1108">ramipril</td> <td data-bbox="971 1081 1399 1108">trandolapril (+/- verapamil)</td> </tr> </tbody> </table> <p>a Active ingredients are limited to oral formulations only. b Excludes nutritional supplement/dietary management combination</p>	Direct Renin Inhibitor Medications and Combinations		aliskiren (+/- hydrochlorothiazide)		ARB Medications and Combinations		azilsartan (+/- chlorthalidone)	irbesartan (+/- hydrochlorothiazide)	candesartan (+/- hydrochlorothiazide)	losartan (+/- hydrochlorothiazide)	eprosartan (+/- hydrochlorothiazide)	olmesartan (+/- amlodipine, hydrochlorothiazide)	telmisartan (+/- amlodipine, hydrochlorothiazide)	valsartan (+/- amlodipine, hydrochlorothiazide nebulolol)	ACE Inhibitor Medications and Combination Products		benazepril (+/- amlodipine, hydrochlorothiazide)	lisinopril (+/- hydrochlorothiazide)	captopril (+/- hydrochlorothiazide)	moexipril (+/- hydrochlorothiazide)	enalapril (+/- hydrochlorothiazide)	perindopril (+/- amlodipine)	fosinopril (+/- hydrochlorothiazide)	quinapril (+/- hydrochlorothiazide)	ramipril	trandolapril (+/- verapamil)
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Exclusions:	<p>Beneficiaries that received one of more prescription claims for Sacubitril/Valsartan.</p> <p>Table SAC-VAL: Sacubitril/Valsartan Exclusion</p> <table border="1" data-bbox="527 1333 1399 1417"> <thead> <tr> <th data-bbox="527 1333 1399 1375">ARB/Nepriylsin Inhibitor Combination Medication</th> </tr> </thead> <tbody> <tr> <td data-bbox="527 1375 1399 1417">sacubitril/valsartan</td> </tr> </tbody> </table> <p>Beneficiaries enrolled in hospice any time during the measurement period Beneficiaries that have ESRD</p>	ARB/Nepriylsin Inhibitor Combination Medication	sacubitril/valsartan																								
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Statin Therapy for Patients with Diabetes (SUPD)	The percentage of Medicare Part D beneficiaries, ages 40-75 years, dispensed at least two diabetes medication fills who received a statin medication fill.																																																																																																
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indicated for weight loss.</p> <p>c Combination products including dapagliflozin or empagliflozin (and another diabetes medication from the table) are included.</p> <p>d For biologic reference product contained in the medication table, biosimilar associated with the reference product, regardless of interchangeable status, are also included in the associated value sets, unless otherwise noted.</p> <p>e There are no active NDCs for albiglutide, chlorpropamide, glimepiride/rosiglitazone or tolbutamide.</p> <p>f Dapagliflozin and empagliflozin single ingredient products are not included due to FDA-approved non-diabetes indications.</p> <table border="1"> <thead> <tr> <th colspan="2">Table STATINS: Statins^a</th> </tr> </thead> <tbody> <tr> <td colspan="2">Statin Medications and Combinations</td> </tr> <tr> <td>atorvastatin (+/- amlodipine, ezetimibe)</td> <td>pravastatin</td> </tr> <tr> <td>fluvastatin</td> <td>rosuvastatin (+/- ezetimibe)</td> </tr> <tr> <td>lovastatin (+/- niacin)</td> 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Display Measures

Newly Introduced Measures

Below are newly introduced measures. HEDIS measures are evaluated yearly. Measures may be updated, changed, or recommended for retirement.

Social Needs Screening and Intervention

Social Need Screening and Intervention (SNS-E)	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Star Weight:	Display
Measure indicators:	<ul style="list-style-type: none"> • Food screening: The percentage of members who were screened for unmet food needs. • Food intervention: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet food needs. • Housing screening: The percentage of members who were screened for unmet housing needs. • Housing intervention: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet housing needs. • Transportation screening: The percentage of members who were screened for unmet transportation needs. • Transportation intervention: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet transportation needs.
Provider Action:	Screen members for food, housing, and transportation needs using an eligible screening instrument with thresholds for positive findings; provide a corresponding intervention from the following categories when screening is positive: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.
Reporting and Coding:	Reported from Electronic Clinical Data Systems, e.g. EHR, clinical registry, case management database, admin/enrollment database Per NCQA technical specifications, an extensive list of codes is included in the value set, including CPT, HCPCS, and LOINC codes used to report screening instruments. For codes, please consult NCQA.org.
Exclusions:	Members in Hospice. Members deceased during the measurement period. Members enrolled in an I-SNP any time during the measurement year or living long-term in an institution (LTI).

Adult Immunization Status

Adult Immunization Status (AISE)	The percentage of members who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Star Weight:	Display
Measure indicators:	<ul style="list-style-type: none"> Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period. Members who received at least one Td vaccine or one Tdap vaccine between 9 years prior to the start of the measurement period and the end of the measurement period. Members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the measurement period. Members who were administered at least one dose of an adult pneumococcal vaccine during the measurement period.
Provider Action:	Use correct codes to capture vaccines given or identify anaphylaxis code to reflect contraindications.
Coding*:	
CPT 4	Adult Influenza Vaccine Procedure: 90630, 90653-90654, 90656, 90658, 90660-90662, 90672-90674, 90682, 90686, 90688-90689, 90694, 90756 Td Vaccine Procedure: 90714 Tdap Vaccine Procedure: 90715 Varicella Zoster (VZV) Vaccine Procedure: 90736, 90750 Adult Pneumococcal Vaccine Procedure: 90670-90671, 90677, 90732
Exclusions:	Members in Hospice. Members deceased during the measurement period. Members with a history of at least one of the following contraindications any time during the measurement period: <ul style="list-style-type: none"> Anaphylaxis due to the influenza vaccine Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine, or encephalitis due to the diphtheria, tetanus or pertussis vaccine Anaphylaxis due to the herpes zoster vaccine Anaphylaxis due to the pneumococcal vaccine
*Codes are subject to change.	

Depression Screening and Follow-Up

Depression Screening and Follow-Up (DSF-E)	The percentage of members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.
Star Weight:	Display
Measure indicators:	<ul style="list-style-type: none"> Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Provider Action:	Screen members for depression using an age appropriate, standardized screening instrument; provide follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: <ul style="list-style-type: none"> An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. A behavioral health encounter, including assessment, therapy, collaborative care or medication management. A dispensed antidepressant medication. Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
Reporting and Coding:	Reported from Electronic Clinical Data Systems, e.g. EHR, clinical registry, case management database, admin/enrollment database. Per NCQA HEDIS Specifications there are over 1,200 codes for this value set. For codes, please consult NCQA.org.
Exclusions:	Members in Hospice. Members deceased during the measurement period. Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period. Members with depression that starts during the year prior to the measurement period.

Advanced Illness and Frailty

Patients with an advanced illness diagnosis or limited life expectancy may not benefit from recommended services required to meet certain quality measures. Unnecessary tests and treatments may be burdensome or even harmful to these patients. To account for this the National Committee for Quality Assurance (NCQA) updated their specifications to allow exclusions for advanced illness and frailty.

To qualify, patients must have at least one of the following in the measurement year or year prior:

- Two outpatient claims on different dates of service with an advanced illness code OR
- One inpatient claim with an advanced illness code OR
- One filled prescription for a dementia medication

AND

- At least two indications of frailty (diagnosis or treatment claims) with different dates of service during the measurement year.

Exclusions can be applied to the following Star Measures:

Breast Cancer Screening (BCS)	Osteoporosis Management in Women with a
Colorectal Cancer Screening (COL)	Fracture (OMW)*
Care for Patients with Diabetes (GSD, EED, KED*)	Statin Therapy for Patients with Cardiovascular
Controlling Blood Pressure (CBP)*	Disease (SPC)

*Patients age 81 and older can be excluded with a frailty diagnosis or treatment alone.

For a complete listing of advanced illness and frailty codes please visit NCQA.org or MediGold.com.

Contact Us

Please send us an email at:
StarsAndHEDIS@mchs.com.

If you would like to receive gaps in care information specific to your patients, email us and provide the following:

1. **Practice name.**
2. **All associated primary care providers (PCPs).**
3. **Contact name.**
4. **Contact phone number.**

