HEDIS Stars Measures Reference Guide for 2018-2019

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Here's a handy guide to help you check criteria, codes and exceptions of HEDIS® Stars measures.
For questions about HEDIS measures, contact *carole.wright@floridablue.com* .

Breast cancer screening (BCS)

The percentage of women age 50–74 who had a mammogram to screen for breast cancer. One or more mammograms anytime on or between October 1 two years prior to the measurement year (MY) and December 31 of the MY.

Numerator Compliance:

CPT: 77055–77057, 77061–77063, 77065 –77067 **HCPCS:** G0202, G0204, G0206

Note: The goal of the measure is the use of imaging to detect breast cancer in women. All types and methods of mammograms qualify, however, MRIs, ultrasounds and biopsies do not count unless these procedures are performed as an adjunct to mammography; they do not count alone.

Hx bilateral mastectomy: **ICD 10:** Z90.13 or Z90.11 Right + Z90.12 Left

Various procedure codes indicating bilateral mastectomy or code combination indicating mastectomy on both sides.

Exclusions: Hospice, advanced illness and frailty

Colorectal cancer screening (COL)

The percentage of patients age 50–75 who had appropriate screening for colorectal cancer.

Numerator Compliance:

Screening	Codes
Colonoscopy during measurement year (MY) or the 9 yrs prior to the MY	**CPT:** 44388- 44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **HCPCS:** G0105, G0121
FOBT (gFOBT or FIT) during MY	**CPT:** 82270, 82274 **HCPCS:** G0328
FIT-DNA (Cologuard®) during MY or the 2 yrs prior to MY	**CPT:** 81528 **HCPCS:** G0464
Flexible Sigmoidoscopy during MY or the 4 yrs prior to MY	**CPT:** 45330– 45335, 45337–45342, 45345-45347, 45349, 45350 **HCPCS:** G0104
CT colonography during the MY or the 4 yrs prior to MY	**CPT:** 74261, 74262, 74263

Colorectal Cancer:

- **ICD 10:** Z85.038 (Personal hx of other malignant neoplasm of large intestine)
- **ICD 10:** Z85.048 (Personal hx of other malignant neoplasm of rectum, rectosigmoid junction, and anus)
- **ICD 10:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5,
- **ICD 9:** 153.0-154.1, 197.5, V10.05, V10.06
- **HCPCS:** G0213-G0215, G0231

Total colectomy: Florida Blue will assess claims history for colectomy surgical procedures. Medical record documentation of total colectomy will be accepted if *total* colectomy is specified in the note.

Exclusions: Hospice, advanced illness and frailty

Adult Body Mass Index (ABA)

The percentage of patients age 18-74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Numerator Compliance: Body mass index (BMI) is a statistical measure of the weight of a person scaled according to height. Documented BMI is during the MY or the year prior to the MY.

- Patients ≥ age 20 years: documentation must include weight and calculated BMI value. Wt and ht without BMI value calculation will not meet this measure.
  ICD 10: Z68.1. Z68.20-Z68.39, Z68.41-Z68.45
- Patients <20 years: documentation must include weight, height and BMI percentile (either as a percentile or ht/wt plotted on an age-growth chart):
  ICD10: Z68.51-Z68.54

Exclusions:

- Hospice
- Pregnancy during the measurement year or year prior to the MY

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Comprehensive Diabetes Care (CDC)

Diabetes (type 1 and 2): Population identified by two outpatient visits with a diabetes diagnosis, or one acute inpatient encounter with a diabetes diagnosis; or pharmacy claims for insulin or oral anti-diabetic agents during the MY or the year prior to the MY.	**Exclusions:** Hospice; advanced illness and frailty; gestational diabetes or steroid-induced diabetes during MY or the year prior to MY.

HgbA1c Good Control

The percentage of patients age 18-75 with diabetes whose most recent HbA1c test during the measurement year ≤ 9%.

Numerator Compliance: The most recent HgbA1c value ≤ 9%. Medical record must include a note with date when HbA1c test was done with a distinct numeric result.

HbA1c Test Coding: CPT: 83036, 83037 **CPT II:** 3044F, 3045F, 3046F

Dilated or Retinal Eye Exam

The percentage of patients age 18-75 with diabetes who had screening or monitoring for diabetic retinal disease.

Numerator Compliance: Screening or monitoring for diabetic retinal disease, this includes diabetics who have had a retinal or dilated eye exam by an optometrist or ophthalmologist in the MY, **or** had a negative retinal or dilated eye exam (negative for retinopathy) by an optometrist or ophthalmologist in the year prior to the MY.

Documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was done and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Documentation of a negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the MY, results indicating retinopathy was not present.
- Documentation anytime in the member's history of evidence that the member had bilateral eye enucleation or acquired absence of both eyes.

Dilated Retinal Screening: CPT: 67028-67113, 67121-67221, 67227-67228, 92002-92014, 92018, 92019, 92134, 92225-92240, 92250-92260
CPT II: 2022F, 2024F, 2026F **HCPCS:** S0620, S0621, S3000

Dilated Retinal Screening- Negative: CPT II: 3072F

Unilateral Eye Enucleation: CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
ICD 10: (Left) 08B10ZX, 08B10ZZ, 08B13ZX, 08B13ZZ, 08B1XZX, 08B1XZZ **(Right)** 08B00ZX, 08B00ZZ, 08B03ZX, O8B03ZZ, 08B0XZX, 08B0XZZ

Nephropathy Screening

The percentage of patients age 18-75 with diabetes (type1 and type 2) who had nephropathy screening or monitoring test during the measurement year or evidence of nephropathy during the measurement year.

Numerator Compliance:
Any of the following meets criteria for a nephropathy screening or monitoring test or evidence of nephropathy:

- A urine test for albumin or protein. Documentation must include a note indicating the date the urine test was done and the result or finding. One of the following will meet criteria: 24-hour urine for albumin or protein; time urine for albumin or protein; spot urine (urine dipstick or urine test) for albumin or protein; urine for albumin/creatinine ratio; 24-hour urine for total protein; random urine for protein/creatinine ratio
- Documentation of a visit to a nephrologist
- Documentation of a renal transplant
- Documentation of medical attention for any of the following: Diabetic nephropathy, ESRD, chronic renal failure (CRF), chronic kidney disease (CKD), renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), dialysis
- Documentation includes a note that patient received an ambulatory Rx for ACEi/ARBs or member has taken ACEi/ARB in the MY

Nephropathy Treatment: CPT II: 3066F, 4010F
ICD 10: E08.21-E08.29, E09.21-E09.29, E10.21-E10.29, E11.21-E11.29, E13.21-E13.29, I12.0-I15.1, N00.0-N08, N14.0-N14.4, N17.0-N19, N25.0-N26.9, Q60.0-Q61.9, R80.0-R80.9

Urine Protein Test: CPT: 81000-81005, 82042-82044, 84156 **CPT II:** 3060F, 3061F, 3062F

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DMARD therapy for Rheumatoid Arthritis (ART)	The percentage of patients age 18 and older as of December 31of the measurement year, who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).	
Identifying Event Two of the following with different dates of service on or between January 1 and November 30 of MY. The visit type does not need to be the same. • OP visit with any diagnosis of RA • Non-acute IP with any dx of RA • Telephone visit or online assessment with any RA diagnosis **Rheumatoid Arthritis** **ICD 10:** M05.00-M06.39 M06.80-M06.9	**Numerator Compliance:** Dispensed at least one ambulatory prescription for DMARD. Note: This measure requires proof that the member received the medication, which can be through a prescription claim or documentation indicating dispensing or infusion administration date. Prescribing intent in medical record is not sufficient to meet the requirement for this measure. **DMARD** • **HCPCS:** J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, Q5102-4 • Rx claims information for the following medications: sulfasalazine, cyclophosphamide, hydroxychloroquine, auranofin, leflunomide, penicillamine, methotrexate, abatacept, adalimumab, anakinra, certolizumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab, azathioprine, cyclosporine, mycophenolate, tofacitinib, minocycline	**Exclusions:** - Hospice - Advanced illness and frailty - HIV, anytime during the patient's history through December 31 of MY - Pregnancy anytime during MY.

Osteoporosis Management in Women with Fractures (OMW)	The percentage of women age 67-85 who suffered a fracture and who had either a bone mineral density test (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	
Woman, age 67-85 years, who suffered a fracture	**Numerator Compliance:** Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following: • A BMD or osteoporosis therapy in any setting within the 180-day (6 months) period after the fracture. **Bone Mineral Density Test** **CPT:** 76977, 77078-77086 **HCPCS:** G0130 **ICD 9:** 88.98 **ICD 10 PCS:** BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **Osteoporosis Medication** **HCPCS:** J0630, J0897, J1740, J3110, J3489 Rx Claims information for osteoporosis therapy: • Bisphosphonates: alendronate, alendronate-cholecalciferol, risedronate, zoledronic acid, ibandronate • Other agents: albandronate, calcitonin, denosumab, raloxifene, teriparatide	**Exclusions:** - Hospice - Advanced illness and frailty - Patients who had a BMD test within the 24 months prior to the fracture - Patients who received osteoporosis therapy during the 12 months prior to the fracture - Patients who received a dispensed Rx or had an active Rx to treat osteoporosis during the 365 days prior to the fracture

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Controlling High Blood Pressure (CBP)

The percentage of patients age 18-85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.

Identifying Event:
Two or more visits on different dates of service with a diagnosis of HTN during the MY or the year prior.

Any of the following code combinations meet criteria:

- Outpatient visit (with or without a telehealth modifier), with a diagnosis of hypertension
- A telephone visit with a diagnosis of hypertension
- An online assessment with a diagnosis of hypertension

Numerator Compliance:
Adequate control:
Both representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Note: SBP of 140 mmg Hg and DBP of 90 mm Hg do **not** meet compliance.

The representative BP is the most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple blood pressures are recorded during an eligible visit, the lowest systolic and lowest diastolic BP reading will count toward the measure.

If you recheck a blood pressure during a visit due to an original elevated reading, please be sure to record the reading in the medical record!

BP readings from acute inpatient stay, ED visit, day of major diagnostic or surgical procedures, or patient-reported **do not** count toward meeting the measure.

BP readings can be captured through codes reported on claims or through medical record review.

Systolic: CPT II: 3074F, 3075F, 3077F
Diastolic: CPT II: 3078F, 3079F, 3080F

Exclusions:

- Hospice
- Advanced illness and frailty
- End Stage Renal Disease
- Kidney transplant
- Pregnancy during MY

Plan All-Cause Readmission (PCR)

For patients age 18 and older, the number of acute inpatient stays (including behavioral healthcare facilities) during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days

For members age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Note: Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays.

A lower rate indicates better performance.

Exclude hospital stays for the following reasons:

- Hospice
- The member died during the stay
- A principal dx of pregnancy or a condition in the perinatal period

The measure excludes any first hospital stay if it is for:

- principal dx of maintenance chemotherapy or rehabilitation
- organ transplant
- certain potentially planned procedures without a principal acute dx

Flu Shot

The percentage of sampled Medicare patients who received an influenza vaccination in the measurement year.

Health Plan CAHPS question: Have you had a flu shot since July 1, 201X? Survey administration period is a sample from March through early June, each year.

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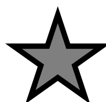

HEDIS Stars Measures Reference Guide 2018-2019

Florida Blue

Statin Therapy for Patients with Cardiovascular Disease (SPC)

The percentage of males age 21-75 and females age 40-75 during the measurement year, who were identified as having atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high - or moderate–intensity statin medication during the measurement year.

Numerator compliance: Dispensed at least one high or moderate intensity statin medication during the MY.

Intensity	Prescription (Formulary Tier applies to generic formulation)	
High-intensity statin therapy	atorvastatin 40-80 mg (tier 6)* amlodipine–atorvastatin 40-80 mg (tier 6)* ezetimibe–atorvastatin 40-80 mg (NF)	simvastatin 80 mg (tier 6)* rosuvastatin 20-40 mg (tier 6)* ezetimibe–simvastatin 80 mg (tier 6)*
Moderate-intensity statin therapy	atorvastatin 10-20 mg (tier 6)* lovastatin 40 mg (tier 6)* amlodipine–atorvastatin 10-20 mg (tier 6)* ezetimibe–simvastatin 20-40 mg (tier 6)* sitagliptin–simvastatin 20-40 mg (NF) ezetimibe–atorvastatin 10-20 mg (NF) niacin–simvastatin 20-40 mg (NF)	simvastatin 20-40 mg (tier 6)* rosuvastatin 5-10 mg (tier 6)* pravastatin 40-80 mg (tier 6)* niacin–lovastatin 40 mg (NF) fluvastatin XL 80 mg (NF) fluvastatin 40 mg bid (NF) pitavastatin 2-4 mg (NF)

* Tier 6 Select Care drugs for generic formulation. $0 copay after any deductible met.
NF = not on Florida Blue formulary

Exclusions:

- Hospice
- Advanced illness and frailty
- Myalgia, myositis, or rhabdomyolysis during the MY
- **ICD 10:** G72.0, G72.2, G72.9, M60.8-M60.9, M62.82, M79.1-M79.18
- ESRD during MY or the year prior
- Cirrhosis during MY or the year prior
- Pregnancy, IVF or dispensed at last one Rx for clomiphene during the MY or the year prior

Statin Therapy for Persons with Diabetes (SUPD)

The percentage of patients age 40-75 who were dispensed at least two diabetes medication (oral hypoglycemic or insulin) fills and also a statin medication fill during the measurement year. This is Part D Pharmacy Quality Alliance measure.

Numerator compliance: At least one statin prescription (any intensity) dispensed in the measurement year:

- Florida Blue Tier 6 Select Care Statin medications: amlodipine–atorvastatin, atorvastatin, ezetimibe – simvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin

Note: Unlike the SPC measure, this measure is calculated based upon pharmacy claims information only. Therefore, medical records or exclusions are not taken into consideration for performance.

Medication Adherence: Part D Pharmacy Quality Alliance measure

Eligible Population: The number of patients who were dispensed two or more prescriptions in the drug category listed, for the measurement year.

Note: Adherence is calculated and benchmarked solely on pharmacy claims.

Exclusions: - Hospice
- Patients with ESRD, identified using the ICD-9/10 codes and/or by the RxHCC for dialysis status

Supplemental data use is not permitted for Part D measures.

Oral Diabetic Meds	Patients who achieved a proportion of days covered (PDC) threshold of 80% for hypoglycemic agent during the MY. **Tier 6 drugs:** glimepiride, glipizide, glipizide ER, glipizide XL, glipizide–metformin, metformin, metformin ER, nateglinide, pioglitazone, pioglitazone–metformin, pioglitazone–glimepiride, repaglinide
Hypertension Meds (RAS antagonists)	Patients who achieved a PDC threshold of 80% for ACEI/ARB/direct renin inhibitor (or combination) during the MY. **Tier 6 drugs:** amlodipine–benazepril, benazepril–HCTZ, candesartan, candesartan–HCTZ, captopril, enalapril, enalapril–HCTZ, fosinopril, fosinopril–HCTZ, irbesartan, irbesartan–HCTZ, , lisinopril, lisinopril–HCTZ, losartan, losartan–HCTZ, moexipril, moexipril–HCTZ, perindopril, quinapril, quinapril–HCTZ, rampiril, telmisartan, amlodipine–benazepril, amlodipine–valsartan, amlodipine –valsartan–HCTZ, telmisartan–HCTZ, trandolapril, valsartan, valsartan–HCTZ, olmesartan
Cholesterol Meds (statins)	Patients who achieved a PDC threshold of 80% for a statin or statin combination during the MY. (see SPC or SUPD for tier 6 drugs)

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Medication Reconciliation Post-Discharge (MRP), a Transitions of Care measure	The percentage of discharges from acute inpatient or subacute inpatient facility stays between January 1 and December 1 of the measurement year for patients age 18 and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
Numerator Compliance: A medication reconciliation occurring from discharge through 30 days after discharge. Medication reconciliation is a review where the discharge meds are reconciled with the most recent medication list in the outpatient medical record. Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required. Documentation in the medical record must include evidence of medication reconciliation and the date performed. The medication reconciliation can be performed by a prescribing practitioner (including specialist), clinical RPh, or RN. **Medication Reconciliation: CPT II:** 1111F **CPT:** 99483, 99495, 99496	If the patient was transferred from one inpatient facility to another (e.g., hospital to SNF), the med reconciliation will be upon patient discharge from final inpatient facility stay (e.g., upon discharge from SNF). **Exclusion:** Hospice

The following measure is not included in Star ratings. TRC and MRP documentation of compliance must come from the same medical record.

Transitions of Care (TRC)	The percentage of discharges from acute inpatient or subacute inpatient facility stays between January 1 and December 1 of the measurement year for patients age 18 and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). This is the same denominator as MRP.
Notification of Inpatient Admission	**Documentation of receipt of notification of inpatient admission on the day of admission or the following day.**
Numerator Compliance: Medical record documentation with receipt of notification (time/date stamped) of inpatient admission on the day of admission or the following day. **Examples:** Communication between the Emergency department, inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax). Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via ADT alert system; or a shared EMR. Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. Indication that the PCP or ongoing care provider place orders for tests and treatments during the member's inpatient stay. Indication that the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam.	
Receipt of Discharge Information	**Documentation of receipt of discharge information on the day of discharge or the following day.**
Numerator Compliance: Medical record documentation with receipt of discharge information on the day of discharge or the following day. Information must include: practitioner responsible for member's care during the inpatient stay; procedure or treatment at discharge; diagnosis at discharge; current medication list (including allergies); testing results or documentation of pending test or no test pending; instructions for patient care. **Examples:** Discharge information may be included in a discharge summary or summary of care record or be located in structured fields in an electronic health record.	
Patient Engagement After Inpatient Discharge	**Documentation of patient engagement (e.g., office visit, visit to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.**
Numerator Compliance: **CPT:** outpatient visits: 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483; telehealth modifiers: 95 and GT; telephone visit: 98966-98968, 99441-99443; transition of care management: 99496, 99495 **HCPCS:** G0402, G0438, G0439, G0463, T1015 **Rev Codes:** 0510-0517, 0519-0523, 0526-0529, 0982, 0983 Documentation of outpatient visit or synchronous telehealth visit with real-time interaction between the member and provider by phone or video conference.	

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Care for Older Adults ***Applies to Florida Blue HMO Special Needs Plan (SNP) members only***

Eligible Population: Medicare Special Needs Plan members, 66 years and older as of December 31 of the measurement year.

Exclusions: Hospice

Medication Review

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.

Numerator Compliance: Either of the following will meet the measure's criteria:

1) A medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist with the date it was performed (must be in the same medical record)
2) A notation that the member is not taking any medication and the date when it was noted.

Medication Review: CPT: 90863, 99483, 99605, 99606 **CPT II:** 1160F **Medication List: CPT II:** 1159F **HCPCS:** G8427
Transitional care management services during the measurement year: **CPT:** 99495, 99496

Functional Status Assessment

At least one functional status assessment during the measurement year, as documented through either administrative claim data or medical record review.

Numerator Compliance: Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.
Documentation in the medical record must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking, continence
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
- Result of assessment using a standardized functional status assessment tool, not limited to: SF-36®, ALSAR, ADLS, B-ADL, Barthel Index, EADL, ILS, Katz Index of Independence in ADL, Kenny Self-Care Evaluation, Klein-Bell ADL Scale, KELS, Lawton & Brody's IADL, PROMIS
- Notation that at least three of the following four components were assessed: Cognitive status, ambulation status, hearing, vision and speech (i.e., sensory ability), other functional independence (e.g., exercise, ability to perform job)

Functional Status Assessment: CPT: 99483 **CPT II:** 1170F **HCPCS:** G0438, G0439

Pain Assessment

At least one pain assessment during the measurement year; documented through either administrative claims data or medical record rreview.

Numerator Compliance: Documentation in the medical record must include evidence of a pain assessment and the date when it was performed. Notations for a pain assessment must include one of the following:

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain)
- Result of assessment using a standardized pain assessment tool, not limited to: numeric rating scales (verbal or written), FLACC, Verbal descriptor scales, pain thermometer, pictorial pain scales, visual analogue scale, brief pain inventory, chronic pain grade, PROMIS pain intensity scale, PAINAD

Pain Assessment: CPT II: 1125F, 1126F

Advance Care Planning

Evidence of advance care planning, as documented through either administrative claims data or medical record review.
ADVANCE CARE PLANNING IS NOT A STAR MEASURE BUT INCLUDED AS PART OF THE CARE FOR OLDER ADULT MEASURE SUITE.

Numerator Compliance: Documentation in the medical record of advance care planning. Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record.
- Documentation of an advance care planning discussion with the provider and the date when it was discussed. The discussion must be noted during the measurement year.
- Notation that the member previously executed an advance care plan.

Examples: Advance directive, actionable medical orders, living will, surrogate decision maker
HCPS: S0257 **ICD-10:** Z66 **Functional Assessment: CPT:** 99483, 99497 **CPT II:** 1123F, 1124F, 1157F, 1158F

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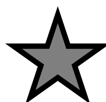

HEDIS Stars Measures Reference Guide 2018-2019

Florida Blue

Advanced Illness and Frailty Exclusion

This exclusion must come from claims (see specific codes below). Medical record documentation is NOT sufficient to apply the exclusion.

This exclusion applies to the following Stars measures: Breast Cancer Screening; Colorectal Cancer Screening; Statin Therapy for Patients with Cardiovascular Disease; Diabetes Care (HbA1c control, diabetes eye exam, nephropathy screening); Controlling High Blood Pressure *; Osteoporosis Management in Women with Fractures*; DMARD therapy for Rheumatoid Arthritis*	Patients age 66-80 must have advanced illness and frailty for exclusion *Patients age ≥ age 81 qualify for exclusion with frailty alone

Advanced Illness

Diagnosis of advanced iilness from MY or year prior to MY found in:
- **one outpatient visit, observation visit, ED visit, or non-acute inpatient encounter on different dates of service with an advanced illness diagnosis**
- ***-or-* one acute inpatient encounter with an advanced illness diagnosis**
- ***-or-* dispensed dementia medication (donepezil, galantamine, rivastigmine, memantine)**

Creutzfeldt-Jakob disease (A81.00-01, A81.09); Malignant neoplasm of pancreas (C25.0-4,7-9), Malignant neoplasm of brain, unspecified (C71.9)
Secondary and unspecified malignant neoplasm of: lymph nodes (C77.0-5,8-9), unspecified lung (C78.00), mediastinum (C78.1), pleura (C78.2), other respiratory organs (C78.39), small intestine (C78.4), large intestine and rectum (C78.5), retroperitoneum and peritoneum (C78.6), liver and intrahepatic bile duct (C78.7)
Secondary malignant neoplasm of other digestive organs (C78.89); unspecified kidney and renal pelvis (C79.00), bladder (C79.11); other urinary organs (C79.19); skin (C79.2); brain (C79.31); cerebral meninges (C79.32); other parts of nervous system (C79.49)
Leukemia not having achieved remission (C91.00, C92.00, C93.00, C93.90, C93.Z0, C94.30), in relapse (C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32)
Dementia: (F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27, F10.97, G31.83); Amnestic disorder due to known physiological condition (F04); alcohol-induced persisting amnestic disorder (F10.96)
Alzheimer's disease (G30.0, G30.1, G30.8, G30.9); Huntington's disease (G10); Amyotrophic lateral sclerosis (G12.21); Parkinson's disease (G20);
Pick's disease (G31.01); other frontotemporal dementia (G31.09)
Heart failure (I09.81, I11.0, I13.0, I13.2, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9)
Chronic kidney disease, stage 5 (I12.0, I13.11, I13.2, N18.5); Left ventricular failure, unspecified (I50.1)
Emphysema (J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3); Chronic respiratory conditions due to chemicals, gases, fumes and vapors (J68.4)
Pulmonary fibrosis (J84.10, J84.112, J84.17); Respiratory failure (J96.10 , J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92);
Alcoholic hepatic disease (K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9); Hepatic disease (K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69); End stage renal disease (N18.6)

Frailty

Frailty coded once during the measurement year.

99504 Home visit for mechanical care; 99505 Home visit for stoma care and maintenance including colostomy and cystostomy
Cane (E0100,E0105); Walker (E0130, E0135, E0140, E0141, E0144, E0147, E0148, E0149); Commode chair (E0163, E0165, E0167, E0168, E0169, E0170, E0171)
Hospital bed (E0250,E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-7, E301-4); Oxygen (E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4)
Rocking bed (E0462); Home ventilator (E0465, E0466); Respiratory assist device (E0470-2); Humidifier used with positive airway pressure device (E0561-2)
Wheelchair (E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298)
Skilled RN services related to home health/hospice setting (G0162, G0299, G0300, G0493, G0494)
Physician management of patient home care, hospice (S0271)
Pressure ulcer (L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90)
Muscle wasting and atrophy, not elsewhere classified, unspecified site (M62.50); Muscle weakness (generalized) (M62.81); Sarcopenia (M62.84)
Ataxic gait (R26.0); Paralytic gait (R26.1); Difficulty in walking, not elsewhere classified (R26.2); Other abnormalities of gait & mobility (R26.89); Unspecified abnormalities of gait & mobility (R26.9)
Age-related cognitive decline (R41.81); Weakness (R53.1); Other malaise (R53.81); Other fatigue (R53.83); Age-related physical debility (R54)
Adult failure to thrive (R62.7); Abnormal weight loss (R63.4); Underweight (R63.6); Cachexia (R64)
Fall (W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS,W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S,W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS,W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS)
Unspecified place in other specified residential institution as the place of occurrence of the external cause (Y92.199)
Problems related to living in residential institution (Z59.3); Limitation of activities due to disability (Z73.6); Bed confinement status (Z74.01); Other reduced mobility (Z74.09)
Need for assistance with personal care (Z74.1); Need for assistance at home and no other household member able to render care (Z74.2);
Need for continuous supervision (Z74.3); Other problems related to care provider dependency (Z74.8); [Z74.9] Problem related to care provider dependency, unspecified (Z74.9)
History of falling (Z91.81); Dependence on respirator [ventilator] status (Z99.11); Dependence on wheelchair (Z99.3); Dependence on supplemental oxygen (Z99.81)
Dependence on other enabling machines and devices (Z99.89)

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