



HEDIS Stars Measures Reference Guide for 2019-2020



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Here's a handy guide to help you check criteria, codes and exceptions of HEDISSM Stars measures. For questions about HEDIS measures, contact medicarestarsteam@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 and December 31 of the measurement year (MY).

<p>Measure Compliance:</p> <p>CPT: 77055–77057, 77061–77063, 77065–77067 HCPCS: G0202, G0204, G0206</p> <p>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 may be indicated for evaluating women with higher risk for breast cancer or for diagnostic purposes. These procedures are performed as an adjunct to mammography and they do not count alone.</p>	<p>Exclusions:</p> <ul style="list-style-type: none"> Hx bilateral mastectomy or unilateral mastectomy ICD-10: Z90.13 or Z90.11 Right, Z90.12 Left IDC-10 PCS: OHTV0ZZ, OHTU0ZZ, OHTT0ZZ CPT: 19180, 19200, 19220, 19240, 19303 - 19307 Age 66 or older with a dvanced illness and frailty (see details on page 8) Hospice
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Colorectal Cancer Screening (COL) The percentage of members age 50–75 who had appropriate screening for colorectal cancer.

<p>Measure Compliance:</p> <table border="1"> <tr> <td data-bbox="71 730 735 828">Colonoscopy during measurement years or the 9 years prior to the measurement year</td> <td data-bbox="735 730 1218 828">CPT: 44388- 44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121</td> </tr> <tr> <td data-bbox="71 828 735 876">FOBT (gFOBT or FIT) during measurement year</td> <td data-bbox="735 828 1218 876">CPT: 82270, 82274 HCPCS: G0328</td> </tr> <tr> <td data-bbox="71 876 735 958">FIT-DNA (Cologuard[®]) during measurement year or the two years prior to measurement year</td> <td data-bbox="735 876 1218 958">CPT: 81528 HCPCS: G0464</td> </tr> <tr> <td data-bbox="71 958 735 1039">Flexible Sigmoidoscopy during measurement year or the four years prior to measurement year</td> <td data-bbox="735 958 1218 1039">CPT: 45330– 45335, 45337–45342, 45345-45347, 45349, 45350 HCPCS: G0104</td> </tr> <tr> <td data-bbox="71 1039 735 1110">CT colonography during the measurmeent year or the four years prior to measurement year</td> <td data-bbox="735 1039 1218 1110">CPT: 74261, 74262, 74263</td> </tr> </table>	Colonoscopy during measurement years or the 9 years prior to the measurement year	CPT: 44388- 44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121	FOBT (gFOBT or FIT) during measurement year	CPT: 82270, 82274 HCPCS: G0328	FIT-DNA (Cologuard [®]) during measurement year or the two years prior to measurement year	CPT: 81528 HCPCS: G0464	Flexible Sigmoidoscopy during measurement year or the four years prior to measurement year	CPT: 45330– 45335, 45337–45342, 45345-45347, 45349, 45350 HCPCS: G0104	CT colonography during the measurmeent year or the four years prior to measurement year	CPT: 74261, 74262, 74263	<p>Exclusions:</p> <ul style="list-style-type: none"> Colorectal cancer: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> CPT: 44150 – 44153, 44155 – 44158, 44210 – 44212 ICD-10: ODTE0ZZ, ODTE4ZZ, ODTE7ZZ, ODTE8ZZ ICD-9: 45.81, 45.82, 45.83 Age 66 or older with a dvanced illness and frailty (see details on page 8) Hospice
Colonoscopy during measurement years or the 9 years prior to the measurement year	CPT: 44388- 44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121										
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Adult Body Mass Index (ABA) The percentage of members 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.

<p>Measure Compliance: Body mass index (BMI) is a statistical measure of the weight of a person scaled according to height. Documented BMI is during the measurement year or the year prior to measurement year.</p> <ul style="list-style-type: none"> Age 20 and older: Documentation must include weight and calculated BMI value. ICD-10: Z68.1, Z68.20-Z68.39, Z68.41-Z68.45 Age 19 and younger: Documentation must include weight, height and BMI percentile (either as a percentile or plotted on an age-growth chart): ICD-10: Z68.51-Z68.54 <p>Note: Weight and height without BMI value calculation will not meet this measure.</p>	<p>Exclusions:</p> <ul style="list-style-type: none"> Pregnancy during the measurement year or year prior to the measurement year Hospice
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Note: Codes listed are not all inclusive; codes may be changed, added or removed. Florida Blue has listed the most commonly used codes seen in primary care, but there may be additional codes that meet exclusion criteria or numerator compliance. Eligible HEDIS codes are used ultimately in assessing performance of care according to the measure.

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Comprehensive Diabetes Care (CDC)	
<p>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 measurement year or the year prior to the measurement year.</p>	<p>Exclusions:</p> <ul style="list-style-type: none"> • Gestational diabetes or steroid-induced diabetes during measurement year or the year prior to measurement year • Hospice • Age 66 or older with advanced illness and frailty (see details on page 8)
<p>HgbA1c Good Control The percentage of members age 18-75 with diabetes whose most recent HbA1c test during the measurement year ≤ 9%.</p>	
<p>Measure 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, 3051F, 3052F</p>	
<p>Dilated or Retinal Eye Exam The percentage of members age 18-75 with diabetes who had screening or monitoring for diabetic retinal disease.</p>	
<p>Measure Compliance: Screening or monitoring for diabetic retinal disease, including diabetics who have had a retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year, or had a negative retinal or dilated eye exam (negative for retinopathy) by an optometrist or ophthalmologist in the year prior to the measurement year. Documentation in the medical record must include one of the following:</p> <ul style="list-style-type: none"> • A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that a non-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 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. <p>Dilated Retinal Screening: CPT: 67028-67113, 67121-67221, 67227-67228, 92002-92014, 92018, 92019, 92134, 92225-92240, 92250-92260 CPT II: 2022F, 2023F, 2024F, 2025F, 2026F, 2033F HCPCS: S0620, S0621, S3000</p> <p>Dilated Retinal Screening – Negative: CPT II: 3072F</p> <p>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, 08B03ZZ, 08B0XZX, 08B0XZZ</p>	
<p>Nephropathy Screening The percentage of members age 18-75 with diabetes (type 1 and type 2) who had nephropathy screening or monitoring test during the measurement year or evidence of nephropathy during the measurement year.</p>	
<p>Measure Compliance: Any of the following meets criteria for a nephropathy screening or monitoring test or evidence of nephropathy:</p> <ul style="list-style-type: none"> • A <i>urine</i> test for albumin or protein during the measurement year; 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 strip) 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 nephropathy includes any of the following documented in the measurement year: Nephropathy, end-stage renal disease (ESRD), chronic renal failure, stage 4 chronic kidney disease, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure, dialysis, nephrectomy kidney transplant • Documentation includes a note that member received a prescription for an ACE inhibitor/ARB or has taken an ACE inhibitor/ARB in the measurement year <p>Urine Protein Test: CPT: 81000-81005, 82042-82044, 84156 CPT II: 3060F, 3061F, 3062F 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</p> <p>Stage 4 Chronic Kidney Disease: ICD-10: N18.4 ESRD: N18.5, N18.6, Z99.2 Nephrectomy: CPT: 50340, 50370 ICD-10: 0TB00ZX, 0TB00ZZ, 0TB03ZX, 0TB03ZZ, 0TB04ZX, 0TB04ZZ, 0TB07ZX, 0TB07ZZ, 0TB08ZX, 0TB08ZZ, 0TB10ZX, 0TB10ZZ, 0TB13ZX, 0TB13ZZ, 0TB14ZX, 0TB14ZZ, 0TB17ZX, 0TB17ZZ, 0TB18ZX, 0TB18ZZ</p> <p>Dialysis: CPT: 90935, 90937, 90945, 90947, 90997, 90999, 99512 HCPCS: G0257, S9339 ICD-10: 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z</p>	

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DMARD therapy for Rheumatoid Arthritis (ART)		
The percentage of members age 18 and older as of December 31 of the measurement year, who were diagnosed with rheumatoid arthritis (RA) 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 measurement year. The visit type does not need to be the same. <ul style="list-style-type: none"> OP visit with any diagnosis of RA Non-acute IP with any diagnosis of RA Telephone visit or online assessment with any RA diagnosis Rheumatoid Arthritis ICD-10: M05.00-M06.39 M06.80-M06.9	Measure 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 <ul style="list-style-type: none"> HCPCS: J0129, J0135, J0717, J1438, , J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, J9311, J9312, Q5102, Q5103, Q5014, Q5109 Rx claims information for the following medications: sulfasalazine, cyclophosphamide, hydroxychloroquine, auranofin, leflunomide, penicillamine, methotrexate, abatacept, adalimumab, anakinra, certolizumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, sarilumab, tocilizumab, azathioprine, cyclosporine, mycophenolate, tofacitinib, minocycline, baricitinib 	Exclusions: <ul style="list-style-type: none"> HIV anytime during the member's history through December 31 of measurement year Pregnancy anytime during measurement year Hospice Age 66 or older with advanced illness and frailty (see details on page 8)

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.		
Identifying Event Woman, age 67-85 years, who suffered a fracture	Measure Compliance: Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following: <ul style="list-style-type: none"> BMD test or osteoporosis therapy in any setting within 180-days (6 months) after the fracture Bone Mineral Density Test CPT: 76977, 77078, 77080, 77081, 77082, 77085, 77086 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: J0897, J1740, J3110, J3489 Rx Claims information for osteoporosis therapy: <ul style="list-style-type: none"> Bisphosphonates: alendronate, alendronate-cholecalciferol, risedronate, zoledronic acid, ibandronate Other agents: abaloparatide, denosumab, raloxifene, teriparatide 	Exclusions: <ul style="list-style-type: none"> Had BMD test within the 24 months prior to the fracture Received osteoporosis therapy during the 12 months prior to the fracture Received a dispensed Rx or had an active Rx to treat osteoporosis during the 365 days prior to the fracture Age 67-80 with advanced illness and frailty (see details on page 8) Hospice

Flu Shot		
The percentage of sampled Medicare members 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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Statin Therapy for Members 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.

Measure Compliance: Dispensed at least one high or moderate intensity statin medication during the measurement year.

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

Exclusions:

- Myalgia, myositis, or rhabdomyolysis during the measurement year
- ICD-10: G72.0, G72.2, G72.9, M60.8-M60.9, M62.82, M79.1-M79.18
- ESRD during measurement year or the year prior
- Cirrhosis during measurement year or the year prior
- Pregnancy, IVF or dispensed at least one Rx for clomiphene during the measurement year or the year prior
- Age 66 or older with a advanced illness and frailty (see details on page 8)
- Hospice

Statin Therapy for Persons with Diabetes (SUPD) The percentage of members 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

Statin Medications		
lovastatin	atorvastatin	simvastatin
pravastatin	rosuvastatin	
pitavastatin	fluvastatin	
Statin Combination Products		
atorvastatin and amlodipine	ezetimibe and simvastatin	

Exclusions:

- ESRD
- Hospice

Note: Unlike the Part C HEDIS measure *Statin Use for Patients with Cardiovascular Disease*, the SUPD measure does not allow for exclusions for myalgia, myositis or rhabdomyolysis.

Medication Adherence: Part D Pharmacy Quality Alliance measure

Eligible Population: The number of members who were dispensed two or more diabetes prescriptions, who received statin medication for the measurement year.

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

Exclusions:

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

Supplemental data use is not permitted for Part D measures.

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4 **Note:** Codes listed are not all inclusive; codes may be changed, added or removed. Florida Blue has listed the most commonly used codes seen in primary care, but there may be additional codes that meet exclusion criteria or numerator compliance. Eligible HEDIS codes are used ultimately in assessing performance of care according to the measure.



Medication Reconciliation Post-Discharge (MRP), a Transitions of Care measure	The percentage of discharges from an inpatient facility stay between January 1 and December 1 of the measurement year for members age 18 and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).
<p>Measure Compliance: Documentation in the outpatient medical record of a medication reconciliation occurring from the day of discharge through 30 days after discharge.</p> <p>Medication reconciliation is a review where the discharge medications are reconciled with the most recent medication list in the outpatient medical record. 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 pharmacist or RN.</p> <p>Note: Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.</p> <p>Medication Reconciliation: CPT II: 1111F CPT: 99483, 99495, 99496</p>	<p>If the member was transferred from one inpatient facility to another (e.g., hospital to a skilled nursing facility (SNF)), the medication reconciliation will be upon patient discharge from final inpatient facility stay (e.g., upon discharge from SNF).</p> <p>Exclusion: Hospice</p>

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)	<p>The percentage of discharges an inpatient facility stays between January 1 and December 1 of the measurement year for members 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.</p> <p>Note: All documentation must come from the same outpatient medical record.</p>
Notification of Inpatient Admission	Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
<p>Measure Compliance: Documentation in the outpatient medical record must include evidence of receipt of notification (time/date stamped) of inpatient admission on the day of admission or the following day.</p> <p>Examples: Communication between the emergency department (ED), inpatient providers or staff and the member's primary care physician (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 electronic medical record. 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 placed 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.</p>	
Receipt of Discharge Information	Documentation of receipt of discharge information on the day of discharge or the following day.
<p>Measure Compliance: Evidence of the date when the documentation was received. Information must include: practitioner responsible for member's care during the inpatient stay; procedure or treatment provided; diagnosis at discharge; current medication list; testing results or documentation of pending test or no test pending; instructions for patient care.</p> <p>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.</p>	
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.
<p>Measure Compliance: Documentation in the outpatient record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria: Outpatient visit (including office and home visits); telephone visit; or synchronous telehealth visit.</p> <p>Note: If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria</p> <p>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; Telephone visit: 98966–98968, 99441–99443; Transition of care management: 99496, 99495</p> <p>HCPCS: G0402, G0438, G0439, G0463, T1015 Rev Codes: 0510–0517, 0519–0523, 0526–0529, 0982, 0983</p>	

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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.
<p>Measure Compliance: Either of the following will meet the measure’s criteria:</p> <ul style="list-style-type: none"> 1) 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) Notation that the member is not taking any medication and the date when it was noted <p>Medication Review: CPT: 90863, 99483, 99605, 99606 CPT II: 1160F Medication List: CPT II: 1159F HCPCS: G8427</p> <p>Transitional Care Management Services during the measurement year: CPT: 99495, 99496</p>	
Functional Status Assessment	At least one functional status assessment during the measurement year, as documented through either administrative claim data or medical record review.
<p>Measure 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:</p> <ul style="list-style-type: none"> • 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 • 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) <p>Functional Status Assessment: CPT: 99483 CPT II: 1170F HCPCS: G0438, G0439</p>	
Pain Assessment	At least one pain assessment during the measurement year; documented through either administrative claims data or medical record review.
<p>Measure Compliance: Documentation in the medical record must include evidence of a pain assessment and the date it was performed. Notations for a pain assessment must include one of the following:</p> <ul style="list-style-type: none"> • Documentation that the member 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 <p>Pain Assessment: CPT II: 1125F, 1126F</p>	
Advance Care Planning	Evidence of advance care planning, as documented through either administrative claims data or medical record review.
<p>Measure Compliance: Documentation in the medical record of advance care planning. Evidence of a dvanice care planning must include one of the following:</p> <ul style="list-style-type: none"> • The presence of an advance care plan in the medical record during the measurement year • Documentation of an advance care planning discussion with the provider and the date it was discussed. The discussion must be noted during the measurement year. • Notation that the member previously executed an advance care plan. The notation must be dated during the measurement year. <p>Examples: Advance directive, actionable medical orders, living will, surrogate decision-maker</p> <p>HCPCS: S0257 ICD-10: Z66 Functional Assessment: CPT: 99483, 99497 CPT II: 1123F, 1124F, 1157F, 1158F</p>	

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The following measures are not included in Star ratings.

Plan All-Cause Readmission (PCR)	For members age 18 and older, the number of acute inpatient and observation stays (including behavioral healthcare facilities) during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	
<p>Plan all cause readmission assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.</p> <p>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.</p> <p>A lower rate indicates better performance.</p>		<p>Exclusions:</p> <ul style="list-style-type: none"> • Exclude an inpatient hospital stay if: <ul style="list-style-type: none"> ▪ The principal diagnosis of pregnancy or a condition originating in the perinatal period is documented on the discharge claim ▪ The member died during the stay • Any first hospital stay if it is for: <ul style="list-style-type: none"> ▪ Principal diagnosis of maintenance chemotherapy or rehabilitation ▪ Organ transplant ▪ Certain potentially planned procedures without a principal acute diagnosis ▪ Hospice

Controlling High Blood Pressure (CBP)		
The percentage of members age 18- 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.		
<p>Identifying Event: Two or more visits on different dates of service with a diagnosis of HTN during the measurement year or the year prior.</p> <p>Any of the following code combinations meet criteria:</p> <ul style="list-style-type: none"> • Outpatient visit with a diagnosis of hypertension • A telephone visit with a diagnosis of hypertension • An online assessment with a diagnosis of hypertension 	<p>Measure Compliance: Adequate control: For BP to be identified as controlled, the systolic and diastolic BP must be lower than 140/90 mm HG.</p> <p>Note: SBP of 140 mm Hg and DBP of 90 mm Hg do not meet compliance.</p> <p>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.</p> <p>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!</p> <p>BP readings from acute inpatient stay, ED visit, day of major diagnostic or surgical procedures, or member-reported do not count toward meeting the measure.</p> <p>BP readings can be captured through codes reported on claims or through medical record review.</p> <p>Systolic: CPT II: 3074F, 3075F, 3077F Diastolic: CPT II: 3078F, 3079F, 3080F</p>	<p>Exclusions:</p> <ul style="list-style-type: none"> • ESRD • Kidney transplant • Pregnancy during measurement year • Age 66 or older with advanced illness and frailty (see details on page 8) • Hospice

(continued next page)

7 **Note:** Codes listed are not all inclusive; codes may be changed, added or removed. Florida Blue has listed the most commonly used codes seen in primary care, but there may be additional codes that meet exclusion criteria or numerator compliance. Eligible HEDIS codes are used ultimately in assessing performance of care according to the measure.



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 Stars measures shown below with designated age group:	
<ul style="list-style-type: none"> • Age 66 or older with frailty and advanced illness: <i>Breast Cancer Screening, Colorectal Cancer Screening, Statin Therapy for Members with Cardiovascular Disease, and Comprehensive Diabetes Care</i> (HbA1c control, diabetes eye exam, nephropathy screening) • Age 66-80 with frailty and advanced illness: <i>Controlling High Blood Pressure, Osteoporosis Management in Women with Fractures, and DMARD Therapy for Rheumatoid Arthritis</i> 	
Advanced Illness	<p>Diagnosis of advanced illness during measurement year or year prior to measurement year found in:</p> <ul style="list-style-type: none"> • two outpatient visits, 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)
<p>Creutzfeldt-Jakob disease (A81.00-01, A81.09); Malignant neoplasm of pancreas (C25.0-4,7-9); Malignant neoplasm of brain, unspecified (C71.0 – C71.9) Secondary and unspecified malignant neoplasm of: lymph nodes (C77.0- C77.5, C77.8-C77.9); unspecified lung (C78.00–C78.02); mediastinum (C78.1); pleura (C78.2); other respiratory organs (C78.30, 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 (C78.80, C78.89); unspecified kidney and renal pelvis (C79.00 – C79.02); bladder (C79.10, C79.11); other urinary organs (C79.19); skin (C79.2); brain (C79.31); cerebral meninges (C79.32); other parts of nervous system (C79.40, C79.49); bone (C79.51); bone marrow (C79.52); unspecified ovary (C79.60 – C79.62); unspecified adrenal gland (C79.70 – C79.82; breast (C79.81); genital organs (79.82) 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); amnesic disorder due to known physiological condition (F04); alcohol-induced persisting amnesic 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); ESRD (N18.6) Pressure Ulcer (L89.000 – L89.004, L89.009 – L89.014, L89.019 – L89.024, L89.029, L89.100 – L89.104, L89.109 – L89.114, L89.119–L89.124, L89.129 – L89.134, L89.139 – L89.144, L89.149 – L89.154, L89.159, L89.200 – L89.204, L89.209 – L89.214, L89.219 – L89.224, L89.229, L89.300 – L89.304, L89.309 – L89.314, L89.319 – L89.324, L89.329, L89.40 – L89.45, L89.500 – L89.504, L89.509 – L89.514, L89.519 – L89.524, L89.529, L89.600 – L89.601 – L89.604, L89.609 – L89.614, L89.619, L89.624, L89.629, L89.810 – L89.814, L89.819, L89.890–L89.894, L89.899–L89.95</p>	
Frailty	<p>Frailty coded once during the measurement year.</p> <p>Home visit for mechanical care (99504); Home visit for stoma care and maintenance including colostomy and cystostomy (99505) Cane (E0100, E0105); Walker (E0130, E0135, E0140, E0141, E0143, 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-E0297, E301-E0304); Oxygen (E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-E0444) Rocking bed (E0462); Home ventilator (E0465, E0466); Respiratory assist device (E0470-E0472); Humidifier used with positive airway pressure device (E0561-E0562) 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, S9123, S9124, T1000 – T1005, T1019 – T1022, T1030, T1031) Physician management of member home care, hospice (S0271) Comprehensive management (S0311) 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)</p>