### 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.

**Measure 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 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.

**Exclusions:**
- Hx bilateral mastectomy or unilateral mastectomy
  - **ICD-10:** Z90.13 or Z90.11 Right, Z90.12 Left
- **ICD-10 PCS:** 0HTV02Z, 0HTU02Z, 0HTTO2Z
  - **CPT:** 19180, 19200, 19220, 19240, 19303-19307
- Age 66 or older with advanced illness and frailty (see details on page 8)
- Hospice or palliative care during the measurement year

### Colorectal Cancer Screening (COL)

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

**Measure Compliance:**
- **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 measurement year or the four years prior to measurement year**
  - **CPT:** 74261, 74262, 74263

**Exclusions:**
- 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:
  - **CPT:** 44150-44153, 44155-44158, 44210-44212
  - **ICD-10:** ODTE02Z, ODTE42Z, ODTE72Z, ODTE82Z
  - **ICD-9:** 45.81, 45.82, 45.83
- Age 66 or older with advanced illness and frailty (see details on page 8)
- Hospice or palliative care during the measurement year

(continued next page)

**Note:** Codes listed are not all inclusive; codes may be changed, added or removed. We have 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)

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.

Exclusions:
- Gestational diabetes or steroid-induced diabetes during measurement year or the year prior to measurement year
- Age 66 or older with advanced illness and frailty (see details on page 8)
- Hospice or palliative care during the measurement year

HgbA1c Good Control

The percentage of members age 18-75 with diabetes whose most recent HgbA1c test during the measurement year < 9%.

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

HgbA1c Test Coding: CPT: 83036, 83037 CPT II: 3044F, 3046F, 3051F, 3052F

Dilated or Retinal Eye Exam

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

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:
- 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 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 or results were read by a system that provides an artificial intelligence (AI) interpretation
- Documentation of a negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year; 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

HCPCS: S0620, S0621, S3000 CPT II (with evidence of retinopathy): 2022F, 2024F, 2026F CPT II (without evidence of retinopathy): 2023F; 2025F; 2033F

Dilated Retinal Screening – Negative in prior year: CPT II: 3072F

Unilateral Eye Enucleation: CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 ICD-10: (Left) 08T1XZ (Right) 08T0XZ

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.

Measure 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 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; timed 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

Urinary 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

Stage 4 Chronic Kidney Disease: ICD-10: N18.4 ESRD: N18.5, N18.6, Z99.2

Nephrectomy: CPT: 50340, 50370 ICD-10: 0TB02ZX, 0TB02ZZ, 0TB03ZX, 0TB03ZZ, 0TB042X, 0TB04ZX, 0TB07ZX, 0TB07ZZ, 0TB08ZX, 0TB08ZZ, 0TB10ZX, 0TB10ZZ, 0TB13ZX, 0TB13ZZ, 0TB14ZX, 0TB14ZZ, 0TB17ZX, 0TB17ZZ, 0TB18ZX, 0TB18ZZ


(continued next page)
### 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.

<table>
<thead>
<tr>
<th>Identifying Event</th>
<th>Measure Compliance:</th>
<th>Exclusions:</th>
</tr>
</thead>
</table>
| Woman, age 67-85 years, who suffered a fracture | Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following:  
- BMD test or osteoporosis therapy in any setting within 180-days (6 months) after the fracture |  
- 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 81 or older with frailty (see details on page 8)  
- Hospice or palliative care during the measurement year |

### 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, BQ00ZZ1, BQ02ZZ1, BQ07ZZ1, BR09ZZ1, BR0GZZ1

### Osteoporosis Medication: HCPCS:

- J0897, J1740, J3110, J3489

Rx Claims information for osteoporosis therapy:

- Bisphosphonates: alendronate, alendronate–cholecalciferol, risedronate, zoledronic acid, ibandronate
- Other agents: abaloparatide, denosumab, raloxifene, teriparatide, romosozumab

### 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

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Prescription (Formulary Tier applies to generic formulation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-intensity statin therapy</td>
<td>atorvastatin 40-80 mg, amiodipine–atorvastatin 40-80 mg</td>
</tr>
<tr>
<td></td>
<td>simvastatin 80 mg, rosvastatin 20-40 mg, ezetimibe–simvastatin 80 mg</td>
</tr>
<tr>
<td>Moderate-intensity statin therapy</td>
<td>atorvastatin 10-20 mg, lovastatin 40 mg, amiodipine–atorvastatin 10-20 mg, ezetimibe–simvastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>simvastatin 20-40 mg, rosvastatin 5-10 mg, pravastatin 40-80 mg, pitavastatin 2-4 mg</td>
</tr>
</tbody>
</table>

#### Exclusions:

- Myalgia, myositis, myopathy 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 or dialysis during measurement year or the year prior  
- Cirrhosis during measurement year or the year prior  
- Pregnancy, IVF or dispensed at last one Rx for clomiphene during the measurement year or the year prior  
- Age 66 or older with advanced illness and frailty (see details on page 8)  
- Hospice or palliative care during the measurement year

### 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 a Pharmacy Quality Alliance measure.*

#### Numerator Compliance:

At least one statin prescription (any intensity) dispensed in the measurement year.

#### Statin Medications:

- lovastatin  
- pravastatin  
- pitavastatin

#### Statin Combination Products:

- atorvastatin and amiodipine  
- ezetimibe and simvastatin

#### Exclusions:

- ESRD  
- Hospice care

**Note:** Unlike the HEDIS measure Statin Use for Patients with Cardiovascular Disease (which applies to Medicare Part C), the SUPD measure (which applies to Medicare Part D) does not allow for exclusions for myalgia, myositis or rhabdomyolysis.

(continued next page)
### Transitions of Care

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 for Medication Reconciliation Post-Discharge (next section below).  

**Note:** All documentation must come from the same outpatient medical record.

<table>
<thead>
<tr>
<th>Notification of Admission</th>
<th>Documentation in the outpatient medical record of receipt of notification of inpatient admission on the day of admission through two days after admission (total of three days).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure Compliance:</strong></td>
<td>Documentation in the outpatient medical record must include evidence of receipt of notification (time/date stamped) of inpatient admission on the day of admission through two days after admission.</td>
</tr>
</tbody>
</table>
| **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. |

**Receipt of Discharge Information**

Documentation in the outpatient medical record of receipt of discharge information on the day of discharge through two days after discharge (total of three days).

**Measure Compliance:** Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through two days after discharge.

**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.

**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, synchronous telehealth visit, e-visit or virtual check-in.

**Note:** If the member is unable to communicate with the provider, interaction between the member’s caregiver and the provider meets criteria

**CPT:**
- Telephone visit: 98966–98968, 99441–99443;  
- Transition of care management: 99496, 99495

**HCPCS:**
- G0402, G0438, G0439, G0463, T1015

**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).

**Measure Compliance:**
- Documentation in the outpatient medical record of a medication reconciliation completed by a prescribing practitioner, clinical pharmacist or registered nurse occurring from the day of discharge through 30 days after discharge.  
- 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 outpatient 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.  
- **Note:** Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.  

**Medication Reconciliation:**
- **CPT II:** 1111F  
- **CPT:** 99483, 99495, 99496

**Exclusion:** Hospice care

(continued on next page)
<table>
<thead>
<tr>
<th>Care for Older Adults</th>
<th><em><strong>Applies to Florida Blue HMO Special Needs Plan (SNP) members only</strong></em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Population:</strong></td>
<td>Medicare Special Needs Plan members, 66 years and older as of December 31 of the measurement year.</td>
</tr>
<tr>
<td></td>
<td><strong>Exclusions:</strong> Hospice</td>
</tr>
<tr>
<td><strong>Medication Review</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Measure Compliance:</strong></td>
<td>Either of the following documented in the measurement year will meet the measure’s criteria:</td>
</tr>
<tr>
<td></td>
<td>1) Medication list and medication review – Documentation of a medication review done by a prescribing practitioner or clinical pharmacist during the measurement year and a medication list in the medical record</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Notation that the member is not taking any medication and the date when it was noted</td>
</tr>
<tr>
<td></td>
<td>2) Documentation of transitional care management services during the measurement year</td>
</tr>
<tr>
<td><strong>Medication Review:</strong></td>
<td>CPT: 90863, 99483, 99605, 99606  CPT II: 1160F  Medication List: CPT II: 1159F  HCPCS: G8427</td>
</tr>
<tr>
<td><strong>Transitional Care Management Services</strong></td>
<td>during the measurement year: CPT: 99495, 99496</td>
</tr>
<tr>
<td><strong>Functional Status Assessment</strong></td>
<td>At least one functional status assessment during the measurement year, as documented through either administrative claim data or medical record review.</td>
</tr>
<tr>
<td><strong>Measure Compliance:</strong></td>
<td>Documentation in the medical record must include evidence of a functional assessment completed during the measurement year, with the date it was performed.</td>
</tr>
<tr>
<td></td>
<td>Documentation in the medical record must include one of the following:</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• 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 &amp; Brody’s IADL, PROMIS</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
</tr>
<tr>
<td><strong>Functional Status Assessment:</strong></td>
<td>CPT: 99483  CPT II: 1170F  HCPCS: G0438, G0439</td>
</tr>
<tr>
<td><strong>Pain Assessment</strong></td>
<td>At least one pain assessment during the measurement year; documented through either administrative claims data or medical record review.</td>
</tr>
<tr>
<td><strong>Measure Compliance:</strong></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• Documentation that the member was assessed for pain (which may include positive or negative findings for pain)</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td><strong>Pain Assessment:</strong></td>
<td>CPT: 99483  CPT II: 1125F, 1126F</td>
</tr>
<tr>
<td><strong>Advance Care Planning</strong></td>
<td>Evidence of advance care planning, as documented through either administrative claims data or medical record review.</td>
</tr>
<tr>
<td><strong>Measure Compliance:</strong></td>
<td>Documentation in the medical record of advance care planning in the measurement year. Evidence of advance care planning must include one of the following:</td>
</tr>
<tr>
<td></td>
<td>• The presence of an advance care plan in the medical record during the measurement year</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• Notation that the member previously executed an advance care plan. The notation must be dated on or before December 31 of the measurement year.</td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td>Advance directive, actionable medical orders, living will, surrogate decision-maker</td>
</tr>
<tr>
<td><strong>HCPCS:</strong></td>
<td>50257  ICD-10: 266  Functional Assessment: CPT: 99483, 99497  CPT II: 1123F, 1124F, 1157F, 1158F</td>
</tr>
</tbody>
</table>

5 | **Note:** Codes listed are not all inclusive; codes may be changed, added or removed. We have 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. |
**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.

**Identifying Event:**
Two or more visits on different dates of service with a diagnosis of HTN on or between January 1 of the prior measurement year and June 30 of the measurement year.

Any of the following code combinations meet criteria:
- Outpatient visit with a diagnosis of hypertension
- A telephone visit with a diagnosis of hypertension
- An e-visit or virtual check-in with a diagnosis of hypertension

**Measure Compliance:**
Adequate control:
For BP to be identified as controlled, the systolic and diastolic BP must be lower than 140/90 mm HG.

**Note:** SBP of 140 mm 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, on the same dates of service, 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 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:**
- ESRD
- Kidney transplant
- Pregnancy during measurement year
- Age 66-88 with advanced illness and frailty (see details on page 8)
- Age 81 or older with frailty (see page 8)
- Hospice or palliative care during the measurement year

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**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, 202X?  Survey administration period is a sample from March through early June, each year.

(continued next page)
### Pharmacy Quality Alliance (PQA) Measures for Medication Adherence

**Medication Adherence: Cholesterol**

**Eligible Population:** Members who received at least two prescriptions of cholesterol medication (statins) during the measurement period.

**Numerator Compliant:** Members who adhere to their cholesterol (statin) medication 80 percent or more of the time they are supposed to be taking the medication.

**Exclusions:**
- ESRD diagnosis
- Hospice care

**Medication Adherence: Diabetes**

**Eligible Population:** Members who received at least two prescriptions of diabetes medication during the measurement period.

**Numerator Compliant:** Members who adhere to their diabetes medication 80 percent or more of the time they are supposed to be taking the medication.

**Exclusions:**
- ESRD diagnosis
- One or more prescriptions for insulin
- Hospice care

**Medication Adherence: Hypertension**

**Eligible Population:** Members who received at least two prescriptions of hypertension medication during the measurement period.

**Numerator Compliant:** Members who adhere to their hypertension medication 80 percent or more of the time they are supposed to be taking the medication.

**Exclusions:**
- ESRD diagnosis
- One or more prescriptions for sacubitril/valsartan
- Hospice care

### 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.

Plan all-cause readmission (PCR) assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.

**Note:** Inpatient and observation 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.**

**Exclusions:**
- Exclude acute inpatient hospitalizations if:
  - 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
  - Planned admission using any of the following:
    - Principal diagnosis of maintenance chemotherapy or rehabilitation
    - Organ transplant
    - Certain potentially planned procedures without a principal acute diagnosis
    - Hospice care

Advanced Illness and Frailty exclusions and codes follow on page 8.
This exclusion must come from claims (see specific codes below). Medical record documentation is NOT sufficient to apply the exclusion. This exclusion must come from claims (see specific codes below).

**Advanced Illness Exclusion**

**Advanced Illness and Frailty Exclusion**

This exclusion applies to the Stars measures shown below with designated age group:
- **Age 66 or older with complex care and advanced illness**
- **Age 66-80 with frailty and advanced illness**

<table>
<thead>
<tr>
<th>Advanced Illness</th>
<th>Diagnosis of advanced Illness during measurement year or year prior to measurement year found in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• two outpatient visits, observation visit, ED visit or non-acute inpatient encounter on different dates with an advanced illness diagnosis</td>
<td></td>
</tr>
<tr>
<td>• or one acute inpatient encounter with an advanced illness diagnosis</td>
<td></td>
</tr>
<tr>
<td>• or dispensed medication: diabetics (diazepine, galantamine, rivastigmine, memantine)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frailty</th>
<th>Frailty coded once during the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visit for medical care (99504); Home visit procedures (99509)</td>
<td></td>
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<tr>
<td>Cane (E0100,E0105); Walker (E0130, E0135, E0140, E0141, E0144, E0147, E0148, E0149); Commode chair (E0163, E0165, E0167, E0168, E0169, E0170, E0171)</td>
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<tr>
<td>Hospital bed (E0250, E0251, Walker (E0255, E0256, E0260, E0261, E0265, E0266, E0267, E0290-E0297, E0300-E0304); Oxygen (E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-E0444)</td>
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<tr>
<td>Rocking bed (E0462); Home ventilator (E0465, E0466); Respiratory assist device (E0470-E0472); Humidifier used with positive airway pressure device (E0506-E0562)</td>
<td></td>
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<tr>
<td>Wheelchair (E0110, E0115, E0120, E0125, E0130, E0135, E0140, E0141, E0142, E0143, E0144, E0145, E0146, E0147, E0148, E0149); Commode chair (E0163, E0165, E0167, E0168, E0169, E0170, E0171)</td>
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<tr>
<td>Skilled RN services related to home health/hospice setting (G0162, G0299, G0300, G0493, G0494, G0649, G0912, G0913, T1000-T1005, T1019-T1021, T1030)</td>
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<tr>
<td>Physician management of member home care, hospice (S0271); Comprehensive management (S0310)</td>
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<tr>
<td>Pressure ulcer (L89.000-L89.009, L89.009-L89.014, L89.016, L89.019-L89.024, L89.026, L89.029, L89.100-L89.104, L89.106, L89.109-L89.114, L89.116, L89.120-L89.124, L89.126, L89.129-L89.134, L89.136, L89.140-L89.144, L89.146, L89.150-L89.154, L89.156, L89.200-L89.204, L89.206, L89.210-L89.214, L89.216, L89.219-L89.224, L89.226, L89.229, L89.300-L89.304, L89.306, L89.310-L89.314, L89.316, L89.319-L89.324, L89.326, L89.329, L89.40-L89.46, L89.500-L89.504, L89.506, L89.509-L89.514, L89.516, L89.519-L89.524, L89.526, L89.529, L89.600-L89.604, L89.606, L89.609-L89.614, L89.616, L89.619-L89.624, L89.626, L89.629, L89.810-L89.814, L89.816, L89.819, L89.890-L89.894, L89.896, L89.899, L89.90-L89.96)</td>
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</tr>
<tr>
<td>Muscle wasting and atrophy, not elsewhere classified, unspecified site (M62.50); Muscle weakness (generalized) (M62.81); Sarcopenia (M62.81); Nutritional deficiency, unspecified (M62.90); Malnutrition (M62.90); Protein-calorie malnutrition (M62.90); Arrhythmia: atrial (R05.90); Arrhythmia: other (R05.92); Ventricular tachycardia (R05.93); Ventricular fibrillation (R05.94); Ventricular flutter (R05.95); Unexpected death (R05.96); Bradycardia (R05.97); Tachycardia (R05.98); Ventricular tachycardia (R05.99); Atrial fibrillation (R06.00); Atrial flutter (R06.01); Arrhythmia: unspecified (R06.02); Arrhythmia: unspecified (R06.03); Arrhythmia: unspecified (R06.04); Arrhythmia: unspecified (R06.05); Arrhythmia: unspecified (R06.06)</td>
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</tbody>
</table>

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