Medicare Advantage, the Affordable Care Act
and Medicaid Managed Care

Closing gaps in quality measures

Including HEDIS®, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Health Outcomes Survey (HOS)

Optum

The Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is one of the most widely used standardized set of health care performance measures in the United States. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA), which has expanded the size and scope of HEDIS to include measures for physicians, Preferred Provider Organizations (PPOs) and other organizations. More than 90 percent of America's health plans participate in HEDIS, in which several state laws currently mandate the use of HEDIS measures for various managed care plans. Health plans use HEDIS performance results to evaluate quality of care and service, evaluate provider performance, develop performance improvement initiatives, perform outreach to providers and members, and compare performance with other health plans to measure these important dimensions of care and service. HEDIS measure year (MY) 2024 consists of 90 measures across 6 domains of care (see official 2024 NCQA listing).

Some HEDIS measures have parameter requirements such as age, sex, race, ethnicity or condition; some have documentation requirements; others have claims reporting requirements. In addition to documenting these measure requirements, providers can report some of these measures via Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. Speak with your Optum representative regarding further questions on HEDIS reporting specific to your organization.

CMS Five-Star Quality Rating System

One of the Centers for Medicare & Medicaid Services' (CMS) important goals for the Star Rating system is to improve the quality of care and general health status for Medicare beneficiaries. CMS publishes the Star Ratings each year to: measure the collaborative partnership between health plans and CMS to promote patient-centered, value-based care, assist beneficiaries in finding the best plan for them and determine quality bonus payments. Moreover, the ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals and other providers. Star Ratings are driving improvements stemming from the reporting of health care performance measures (HEDIS data), allowing health plans to effectively and efficiently evaluate their populations and the efficacy of member programs to improve upon their identified service quality scores.

The following references were used in the creation of this document at time of publication:

- Optum360. *ICD-10-CM: Professional for Physicians 2024*. Salt Lake City, UT: Optum360; 2023.
- American Medical Association. *Current Procedural Terminology Professional 2024*. Chicago, IL: AMA; 2023.
- Optum360. *2024 HCPCS Level II Professional*. Salt Lake City, UT: Optum360; 2023.
- HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
- CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
- For additional information about the Medicare Advantage Five-Star Quality Rating System, please visit: https://go.cms.gov/partcanddstarrating.
- For additional information on the Consumer Assessment of Healthcare Providers & Systems (CAHPS), please visit: cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS.
- For additional information on the Medicare Health Outcomes Survey (HOS), please visit: cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/.

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2024: "A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required."

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CMS Five-Star Quality Rating System documentation guidelines

The Healthcare Effectiveness Data and Information Set (HEDIS) and the CMS Five-Star Quality Rating System, or Star Ratings, documentation guidelines are provided to assist you in your ongoing participation in the Optum program offerings. Medical records can be used to support our clients' HEDIS and Star Ratings data collection efforts. This tool may help ensure you have included all the necessary documentation. **Documentation in the medical record should include date/results as defined by specific measure criteria.**

Measures specific to the Medicare Advantage population

Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Breast cancer screening - Electronic (BCS-E)	Screening is recommended for female patients ages 50–74, who have not had a mammogram in the 27 months prior to December 31 of the current year.	Medical record stating the date that the mammogram was completed or a copy of the diagnostic report. *Documented exclusions: two unilateral mastectomies or bilateral mastectomy.*
Colorectal cancer screening (COL-E)	Screening is recommended for patients ages 45–75, who have not had any of the following: • FOBT in the current calendar year • FIT-DNA test (Cologuard®) during current year or two prior calendar years • CT colonography during current or four prior calendar years • Flexible sigmoidoscopy during current or four prior calendar years • Colonoscopy during current or nine prior calendar years	Medical record stating the screening was completed on a specified date with/without result or radiology/lab report. • Result or finding must also be present, which ensures that the screening was performed and not merely ordered. • Member refusal will not make them ineligible for this measure. • Digital rectal exam (DRE) and FOBT tests performed in an office setting or performed on a sample collected via DRE does not count as evidence of colorectal screening *Documented exclusions: colorectal cancer or total colectomy.*
Controlling high blood pressure (CBP)	Patients with a diagnosis of hypertension whose blood pressure was adequately controlled during the measurement year: • <140/90 mmHg for patients 18–85 years of age Patient must have at least two visits on different dates of service with a hypertension diagnosis during the measurement year or the year prior.	Medical record stating hypertension diagnosis and that blood pressure was completed on a specified date with result. • The BP reading must occur on or after the date of the second diagnosis of hypertension. The most recent BP counts toward measure. • Diagnosis and BP reading can come from different care providers or member reporting, providing BP criteria is met in the provider's note. • If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date of service. *Documented exclusions: patients with ESRD (dialysis), nephrectomy (total/partial) or kidney transplant; a diagnosis of pregnancy during year; or inpatient admission during year.*
Osteoporosis management in women who had a fracture (OMW)	For female patients 67–85 years of age, bone mineral density (BMD) testing or a dispensed prescription drug to treat osteoporosis is recommended within 180 days (6 months) of a fracture.	Medical record with result of bone mineral density test or documentation of the prescription that was given to the patient. HEDIS compliance stipulates that the prescription be dispensed. Documented exclusions: BMD within past 24 months or osteoporosis prescription therapy within past 12 months. Fractures of the finger, toe, face and skull are not included in this measure.

* The table above provides a summary only. Please refer to the NCQA technical specifications for complete details.

Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Osteoporosis screening in older women (OSW)	Female patients ages 65–75 years of age who received an osteoporosis screening on or between their 65th birthday and December 31 of the measurement year.	Documentation of acceptable test such as: • Ultrasound bone density measurement (76977) • CT, bone mineral density study , one or more sites; axial skeleton (77078) • Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites, axial skeleton (77080) • DXA, bone density study, one or more sites; appendicular skeleton (77081) • DXA, bone density study, one or more sites; axial skeleton, including vertebral fracture assessment (77085)
Eye exam for patients with diabetes (EED)	For patients ages 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam as of December 31 of the measurement year or the year prior. • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilateral or unilateral eye enucleation any time during the member's history through December 31 of the measurement year.	Medical record stating a confirmed diagnosis of diabetes to include the following retinal eye exam documentation: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that a retinal or dilated eye exam was completed by an eye care professional (optometrist or ophthalmologist). • A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results or that results were read by a qualified reading center. • Evidence of a bilateral or unilateral eye enucleation anytime during the patient's history through 12/31 of the current calendar year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care specialist in the year prior.
Kidney health evaluation for patients with diabetes (KED)	For patients ages 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by the following during the measurement year: An estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year on the same or different dates of service.	Medical record stating a confirmed diagnosis of diabetes and include the following kidney health evaluation documentation with a date and results: • At least one eGFR and • At least one uACR, which may include the following: – Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart – A uACR
Glycemic status assessment for patients with diabetes (GSD)	For patients ages 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: • Glycemic Status <8.0% • Glycemic Status >9.0%	Medical record stating a confirmed diagnosis of diabetes to include the following (HbA1c or GMI) screening documentation: • Document the date and result(s) or provide a copy of the lab report with the most recent (HbA1c or GMI) control indicator used regardless of data source.
Blood pressure control for patient with diabetes (BPD)	For patients ages 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	Medical record stating a confirmed diagnosis of diabetes to include the following blood pressure (BP) screening documentation: • Date and most recent results of the BP reading. • Documentation must be from a provider managing the condition. The BP reading can be abstracted from different care providers, but must be incorporated into the record by the provider. • Diagnosis and BP reading can come from different care providers, providing BP criteria is met in the managing provider's note. • If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date of service.

* The table above provides a summary only. Please refer to the NCQA technical specifications for complete details.

Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Care for older adults (COA) Applies only to Medicare Special Needs Plans (SNP) & Medicare-Medicaid Plans (MMP)	Recommended during the calendar year for adults 66 years and older. • Functional status: Patient to have at least one functional status assessment during the calendar year • Medication review: Annual review of all medications (prescriptions, OTC, herbal/ supplemental therapies) • Pain assessment: Patient to have at least one pain assessment during the calendar year	• Functional status: Notation that at least 5 activities of daily living (bathing, dressing, eating, walking, etc.) or at least 4 instrumental activities of daily living (grocery shopping, driving, meal preparation, laundry, taking medications, etc.) were assessed or documentation of result of assessment using a standardized functional status assessment • Medication review: Medication list and evidence of medication review by prescribing practitioner or clinical pharmacist, including date when performed or notation that member is not taking any medication and date when noted, which may include transitional care management services during the same outpatient visit • Pain assessment: Medical record with documentation of pain assessment or result of assessment using a standardized pain assessment tool, which may include positive or negative findings for pain. Documentation or screening of chest pain alone is not compliant. Pain management visits or pain treatment alone will meet compliance.
Advanced illness and frailty exclusion	Quality measures that were designed and intended for a general adult population may not always be appropriate for those with a limited life expectancy or advanced illness and frailty. As such, NCQA has implemented corresponding exclusions across selected HEDIS measures to help focus on the population who are most likely to benefit from preventive health screenings.	For additional information, please see the Advanced Illness and Frailty Exclusions tool.
Advance care planning (ACP)	For patients 66-80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning as of December 31 of the measurement year. • This is a discussion or documentation about preferences or resuscitation, life-sustaining treatment and end of life care.	Medical record should include the following discussions between a qualified health care professional and the patient: • Discuss the patient's health care wishes if they become unable to make decisions about their care with or without completing legal forms. This may include living wills, instruction directives, health care proxy or health care power of attorney.
Transitions of care-medication reconciliation post-discharge (TRCMRP)	Medication reconciliation post-discharge for patients 18 years of age and older to include documentation of medication on the date of discharge through 30 days after discharge (31 total days).	Medical record should include a medication reconciliation by a qualified health care professional (e.g. prescribing practitioner, clinical pharmacist, physician assistant or registered nurse) post-discharge in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. • The medication list may include medication names only or may include medications names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
Plan all-cause readmissions (PCR)	For Medicare patients 18 years of age and older, the number of acute inpatient and observations stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. (Also applies to commercial and Medicaid patients 18 to 64 years of age)	Identify and document all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. 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 stays. This measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

* The table above provides a summary only. Please refer to the NCQA technical specifications for complete details.

Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Follow-up after emergency department visit for people with multiple high-risk chronic conditions (FMC)	For patients 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of emergency department (ED) visit.	Document if the member had multiple high-risk chronic conditions (e.g. COPD, Alzheimer's, CKD, depression, CHF, AMI, atrial fibrillation, stroke, etc.) and who had a follow-up service within 7 days after the ED visit (8 total days) and identify all ED visits between January 1 and December 24 of the measurement year. • The following meet criteria for follow-up: outpatient visit, telephone or telehealth visit, an e-visit or virtual check-in, transitional care management services, care management visits, outpatient or telehealth behavioral health visit, an intensive outpatient encounter or partial hospitalization, a community mental health center visit, etc.

* The table above provides a summary only. Please refer to the NCQA technical specifications for complete details.

Prescription drug measures	CMS Five-Star Quality Rating requirements	Documentation guidelines
Medication adherence for diabetes medications (MAD)	Percentage of patients with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. Members who take insulin are not included in this measure.	Provider should document prescriptions in patient's medical record to include active management with medication, and include one or more dispensing events for the following therapy documentation: • Indexing the prescription start date or earliest dispensing date. • Reconcile the patent's medication list to determine if medications are current, and represent the most recent prescriptions if multiple scripts have been dispensed. *Star Rating is based on pharmacy data. Medications received at the VA or through discount programs where insurance is not billed are excluded from pharmacy data. This may result in the member being non-compliant in the measure.*
Medication adherence for hypertension (RAS antagonists) (MAH)	Percentage of patients with a prescription for blood pressure medication (ACE, ARB or direct renin inhibitor) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	
Medication adherence for cholesterol (statins) (MAC)	Percentage of patients with a prescription for cholesterol (a statin drug) medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	
Statin therapy for patients with diabetes (SPD)	For patients ages 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: • Received Statin Therapy. Patients who were dispensed at least one statin medication of any intensity during the measurement year. • Statin Adherence 80%. Patients who remained on a statin medication of any intensity for at least 80% of the treatment period.	
Statin therapy for patients with cardiovascular disease (SPC)	Percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD), who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year and who remained on the statin medication for at least 80% of the treatment period.	
Use of high-risk medications in the elderly (DAE)	The percentage of Medicare members 67 years of age and older that are dispensed a high-risk medication.	

Measures specific to the Affordable Care Act (ACA) and Medicaid population

Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Cervical cancer screening (CCS-E)	Screening is recommended for: • Women 21–64 years of age who had cervical cytology performed during the current calendar year or two years prior. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing or cervical cytology/hrHPV co-testing during the current calendar year or four years prior.	Documentation should include a notation indicating the date and type of screening performed. This quality measure or gap can also be closed via claims as permitted by the health plan.
Chlamydia screening (CHL)	Screening is recommended for women ages 16–24 who are sexually active (at least one test for chlamydia during the measurement year).	Documentation should include that a screening test was completed with date. This measure can be closed via claims when the lab test has been billed through the patient's health plan.

* The table above provides a summary only. Please refer to the NCQA technical specifications for complete details.

Documentation and coding tips: CPT Category II codes

Current Procedural Terminology (CPT®) Category II codes are non-reimbursable codes which provide supplemental tracking for certain Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures. By including CPT Category II codes on a claim form, the health plan(s) may request fewer medical records, reducing the disruption to provider offices.

Closing HEDIS measures can lead to better HEDIS performance by addressing conditions of high prevalence and can reduce the number of screening reminders sent to patients by the health plan(s). Please note this tool contains a partial listing of some of the most common measures. For additional information about HEDIS, please visit the National Committee for Quality Assurance (NCQA) website at ncqa.org.

Category II codes are:

- Alphanumeric and consist of four digits followed by the letter "F" that are in the American Medical Association (AMA) CPT codebook
- Supplemental and do not replace CPT Category I codes which describe services such as evaluation and management (E/M) services, medical procedures or surgeries
- Non-revenue codes that can be included on a claim form to notify the health plan(s) of specific services and/or test results
  - Note: The codes help support the provider's plan of care and may assist the health plan in referring patients to appropriate programs

HEDIS measure and documentation guidelines	CPT II	CPT Category II code description
Transitions of Care – Medication Reconciliation Post-Discharge (TRCMRP) Medical record should include a medication reconciliation by a qualified health care professional post-discharge in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.	1111F	Discharge medications reconciled with the current medication list in outpatient medical record *Note:* • *The medication reconciliation must be documented on the date of discharge through 30 days after the discharge (31 days total)* • *1111F can be reported when the post-discharge medication reconciliation is done during a telephone call or during the transitional care management (TCM)* – *Please refer to the TCM section of the Optum Closing gaps in quality measure toolbook for additional information*
Advance care planning (ACP) Medical record should include the following discussions between a qualified health care professional and the patient: Discuss the patient's health care wishes if they become unable to make decisions about their care with or without completing legal forms. This may include living wills, instruction directives, health care proxy, health care power of attorney.	1123F	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
	1124F	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
	1157F	Advance care plan or similar legal document present in the medical record
	1158F	Advance care planning discussion documented in the medical record
Care for older adults (COA) (three components) • **Functional status:** Notation that activities of daily living (bathing, dressing, eating, walking, etc.) or instrumental activities of daily living (grocery shopping, driving, meal preparation, laundry, taking medications, etc.) were assessed or documentation of result of assessment using a standardized functional status assessment. • **Medication review:** Medication list and evidence of medication review by prescribing practitioner or clinical pharmacist, including date when performed or notation that member is not taking any medication and date when noted, which may include transitional care management services during the same outpatient visit. • **Pain assessment:** Medical record with documentation of pain assessment or result of assessment using a standardized pain assessment tool, which may include positive or negative findings for pain. *Note: Both 1159F and 1160F must be reported to satisfy the medication review component of COA measure.*	1125F	Pain severity quantified; pain present
	1126F	Pain severity quantified; no pain present
	1159F	Medication list documented in medical record
	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record
	1170F	Functional status assessed

HEDIS measure and documentation guidelines	CPT II	CPT Category II code description
Eye exam for patients with diabetes (EED) Medical record stating a confirmed diagnosis of diabetes to include the following retinal eye exam documentation: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that a retinal or dilated eye exam was completed by an eye care professional (optometrist or ophthalmologist) showing the type of exam, results of the exam and the date it was completed. • Evidence of a bilateral or unilateral eye enucleation anytime during the patient's history through 12/31 of the current calendar year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care specialist in the year prior. *Note: Any provider can report the appropriate CPT II code. Report 2022F-2033F with date of the eye exam, not the date of service (DOS) when the report was reviewed. Report 3072F with the current year DOS.*	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Glycemic Status Assessment for Patients With Diabetes (GSD) Medical record stating a confirmed diagnosis of diabetes to include the following (HbA1c or GMI) screening documentation: • Document the date and result(s) or provide a copy of the lab report with the most recent (HbA1c or GMI) control indicator used control indicator used regardless of data source. *Note: Report CPT II code with the date of the test, not the date of the office visit when the test was reviewed.*	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
	3046F	Most recent hemoglobin A1c level greater than 9.0%
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
Controlling high blood pressure (CBP) and blood pressure control for patients with diabetes (BPD) For CBP, medical record stating hypertension diagnosis and the following BP screening documentation: • Date and most recent results of the BP reading. • The BP reading must occur on or after the date of the second diagnosis of hypertension. • Documentation must be from provider managing the condition. For BPD, medical record stating a confirmed diagnosis of diabetes and the following BP screening documentation: • Date and most recent results of the BP reading. • Documentation must be from a provider managing the condition. *Note: Two codes (one from 3074F-3077F and one from 3078F-3080F) must be reported to identify the lowest systolic and lowest diastolic reading on that date of service.*	3074F	Most recent systolic blood pressure less than 130 mm Hg
	3075F	Most recent systolic blood pressure 130-139 mm Hg
	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg
	3078F	Most recent diastolic blood pressure less than 80 mm Hg
	3079F	Most recent diastolic blood pressure 80-89 mm Hg
	3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Consider reviewing Optum tools related to quality measures such as Advanced illness and frailty.

- Current Procedural Terminology CPT 2024. Professional ed. Chicago, IL: American Medical Association, 2023. Print.
- The National Committee for Quality Assurance. HEDIS Measures and Technical Resources. Accessed December 8,2023.
- American Medical Association. Alphabetical Clinical Topical Listing. Published January 2020. Accessed December 8,2023.

Breast cancer screening (BCS-E)

Description: Measures the percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer in the prior 27 reported months.

Population: Women 52–74 years of age as of December 31 of the measurement year. Include members that meet the following criteria at anytime in member's history:

- Administrative gender of female
  - Sex assigned at birth of female
  - Sex parameter for clinical use of female

CMS Star Rating Weight

1

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

Medical record stating that screening was completed and/or mammography report.

- Date screening was completed.
- Result/mammography report may be submitted in lieu of progress note.
- Documentation of exclusion, if applicable.
- A referral for a mammogram is not sufficient to close the quality gap.

Exclusions

Bilateral or unilateral mastectomy with a bilateral modifier (CPT codes: 19180, 19200, 19220, 19240, 19303–19307 with modifier RT or LT as applicable or ICD-10-CM: Z90.13 or Z90.11 & Z90.12) anytime during the member's history through December 31 of the measurement year.

- Do not count breast biopsies, ultrasounds or MRIs. They are not appropriate methods for primary breast cancer screening.
- Ensure that the mammogram and documentation of mammogram screening date occur within the appropriate time frame, 27 months prior to December 31 of the measurement year.
- Documentation of "next screening due" does not meet evidence of completion of breast cancer screening.
- Mastectomy must be specified as "bilateral" (by one operative session or two operative sessions) to be an acceptable exclusion. Mastectomies can be defined as simple, extended simple, radical or extended radical.

Claims-only exclusions

Members 66 years of age and older who are enrolled in an Institutional SNP (I-SNP) or, living long-term in an institution any time during the measurement year.

Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

- At least two indications of frailty with different dates of service during the measurement period
- Either of the following during the measurement period or the year prior to the measurement period:
  - Advanced illness on at least two different dates of service
  - Dispensed a dementia medication

Members in hospice, using hospice services or receiving palliative care any time during the measurement period.

Members who die any time during measurement period.

Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.

Description	CPT
Breast cancer screening	77061, 77062, 77063, 77065, 77066, 77067

Colorectal cancer screening (COL-E)

Description: Measures the percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Population: Members 45–75 years of age as of December 31 of the measurement year.

CMS Star Rating Weight

1

Requirements for compliance

One or more screenings for colorectal cancer. Any of the following meet the criteria:

- Fecal occult blood test (FOBT) during the measurement year. iFOBT (immunological fecal occult blood test) or gFOBT (guaiac fecal occult blood test) are acceptable. Documentation of one or more samples is acceptable.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (Cologuard®) during the measurement year or the two years prior to the measurement year.

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation:

- Medical record stating that screening was completed.
- Date screening was completed. A result is not required if the documentation is clearly part of the Medical History section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).
- Documentation of exclusion, if applicable.

Exclusions

- Colorectal cancer
- Total colectomy

- Digital rectal exam (DRE) and FOBT tests performed in an office setting or performed on a sample collected via DRE does not count as evidence of colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.
- Ensure that the test occurs within the appropriate time frame. The main reasons that the screening gap does not close from medical record documentation are:
  - The screening date is missing.
  - The screening date is outside of the HEDIS time frame.
- Must be documented as total colectomy to count as an exclusion.

Claims-only exclusions

Members 66 years of age and older who are enrolled in an Institutional SNP (I-SNP) OR, living long-term in an institution any time during the measurement year

Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

- At least two indications of frailty with different dates of service during the measurement period
- Either of the following during the measurement period or the year prior to the measurement period:
  - Advanced illness on at least two different dates of service
  - Dispensed a dementia medication

Members who use hospice services or receive palliative care any time during measurement year.

Members who die any time during the measurement year.

Description	CPT	HCPCS
FOBT (every year)	82270, 82274	G0328
FIT-DNA (every 3 years)	81528	
Flexible sigmoidoscopy (every 5 years)	45330–45335, 45537, 45538, 45340-45342, 45346, 45347, 45349, 45350	G0104
CT colonography (every 5 years)	74261, 74262, 74263	
Colonoscopy (every 10 years)	44388–44394,44397, 44401–44408, 45355, 45378–45393, 45398	G0105, G0121

Controlling high blood pressure (CBP)

Description: Measures the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Population: Members ages 18 to 85 years as of December 31 of the measurement year.

CMS Star Rating Weight

3

What to report for compliance

This screening can be closed by using the appropriate CPT II codes on claims submission or by medical record review.

What you need to include in medical record documentation

- Date of service
- BP reading at each visit. BP readings taken by the member and documented in the member's medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist. If there are multiple BP readings on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP for reporting.
- Documentation and coding of exclusion, if applicable

Exclusions

Pregnancy (reporting an appropriate pregnancy diagnosis on the claim and in your documentation is necessary, if applicable)

Patients with ESRD (dialysis), nephrectomy, kidney transplant, or nonacute inpatient admission during the measurement year

- Member-reported results are acceptable if BP readings were obtained using a digital device.
- Most recent BP reading should be used.
- Reasons the measure is not closed from medical record documentation:
  - Screening date is missing.
  - BP reading is 140/90 or greater.

Claims-only exclusions

Members 66 years of age and older who are enrolled in an Institutional SNP (I-SNP) OR, living long-term in an institution any time during the measurement year

Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

- At least two indications of frailty with different dates of service during the measurement period
- Either of the following during the measurement period or the year prior to the measurement period:
  - Advanced illness on at least two different dates of service
  - Dispensed a dementia medication

Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty during measurement year

Members in hospice, using hospice services or receiving palliative care any time during the measurement period

Members who die any time during the measurement year

Please see the Optum tool: Advanced illness and frailty exclusions for further details.

ICD-10-CM code	CPT	CPTII	HCPCS
I10	99202–99205, 99211–99215, 99242–99245, 99341–99342, 99344-99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483	3074F, 3075F, 3077F, 3078F, 3079F, 3080F	G0402, G0438, G0439, G0463, T1015

Osteoporosis management in women who had a fracture (OMW)

Description: Measures the percentage of women ages 67–85 who suffered a fracture and had either a bone mineral density test (BMD) or a prescription for a drug to treat osteoporosis within six months (180 days) after the fracture.

Population: Women 67–85 years of age as of December 31 of the measurement year.

Intake period: Time frame used to capture the first fracture. This is a 12-month window that begins July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

Index episode start date (IESD): The earliest episode date during the intake period that meets all eligible population criteria.

CMS Star Rating Weight

1

Requirements for compliance

Screening/test required: Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:

- A bone mineral density (BMD) test on the IESD or in the six-month period after the IESD
- A BMD test during the inpatient stay for the fracture (applies only to fractures requiring hospitalization)
- Osteoporosis therapy on the IESD or in the six-month period after the IESD
- Long-acting osteoporosis therapy during inpatient stay (applies only to fractures requiring hospitalization)
- A dispensed prescription to treat osteoporosis on the IESD or in the six-month period after the IESD

What to report for compliance

This screening is typically closed by claims data.

What you need to include in medical record documentation

- Evidence of completed BMD test (date DXA, ultrasound or CT bone mineral density test was completed)
- Osteoporosis therapies (prescription must be dispensed by pharmacy)
- Documentation of exclusion, if applicable

- Fractures of finger, toe, face and skull are not included in this measure.
- If exceptions require use of documentation, include the screening date. Screening date must be within the HEDIS time frame.
- Member must have prescription filled through their Medicare Advantage Part D pharmacy benefit to close gap using claims data.
- A referral is not sufficient to close the gap.

Exclusions

- Members who had a BMD test during the 24 months prior to fracture
- Members with a claim/encounter for osteoporosis therapy during the 12 months prior to the IESD
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the fracture
- Members who die any time during measurement year

Claims-only exclusions

Members 67 years and older who are enrolled in an Institutional SNP (I-SNP) OR, living long-term in an institution any time during the measurement year

Members 67–80 years of age or older as of December 31 of measurement year with both frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

- At least two indications of frailty with different dates of service during the measurement period
- Either of the following during the measurement period or the year prior to the measurement period:
  - Advanced illness on at least two different dates of service
  - Dispensed a dementia medication

Members 81 years of age and older as of December 31 of the measurement year with two indications of frailty during the intake period through the end of the measurement year

Members in hospice or using hospice services or receiving palliative care any time during the measurement year

Description	CPT	HCPCS
DXA, ultrasound and CT bone mineral density tests	76977, 77078, 77080, 77081, 77085, 77086	N/A
Osteoporosis medications (injectables) and long-acting osteoporosis medications		J0897, J1740, J3110, J3111, J3489

Description	Drug name	
Osteoporosis therapies, identified through pharmacy data *Medications received at the VA or through discount programs where insurance is not billed are excluded from pharmacy data.*	• Abaloparatide • Alendronate • Alendronate-cholecalciferol • Denosumab • Ibandronate	• Raloxifene • Risedronate • Romosozumab • Teriparatide • Zoledronic acid

Eye exam for patients with diabetes (EED)

Description: Measures the percentage of plan members with diabetes (Type 1 or Type 2) who had a retinal or dilated eye exam by an eye care professional during measurement year or a negative retinal or dilated eye exam the prior year.

Population: Members ages 18–75 years as of December 31 of the measurement year

CMS Star Rating Weight

1

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, primary care physician or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional and includes:
  - Date procedure was performed
  - Results of exam
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
  - Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year (CPT II: 3072F), where results indicate retinopathy was not present (e.g., documentation of normal findings).
  - Documentation does not have to state specifically “no diabetic retinopathy” to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates “diabetes without complications” does not meet criteria.
- Evidence that the member had bilateral or unilateral with a bilateral modifier eye enucleation or acquired absence of both eyes. Look as far back as possible in the member’s history through December 31 of the measurement year.

- To show evidence that a diabetic retinal eye exam was performed, an eye exam from a licensed eye care professional (optometrist or ophthalmologist) must be included in the medical record.
- Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.
- If not specified, verify that the eye exam performed was “retinal” or “dilated.”
- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

Claims-only exclusions

Members 66 years of age and older who are enrolled in an Institutional SNP (I-SNP) or, living long-term in an institution any time during the measurement year

Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

- At least two indications of frailty with different dates of service during the measurement period
- Either of the following during the measurement period or the year prior to the measurement period:
  - Advanced illness on at least two different dates of service
  - Dispensed a dementia medication

Members in hospice or using hospice services or receiving palliative care any time during the measurement year

Members who die any time during measurement year

Description	CPT	CPT II	HCPCS
Eye exam	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114, 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225, 92226, 92227, 92228, 92229, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F 2023F 2024F 2025F 2026F 2033F 3072F	S0620 S0621 S3000

- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.

Kidney health evaluation for patients with diabetes (KED)

Description: Measures the percentage of plan members 18–85 years of age with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Population: Members ages 18–85 as of December 31 of the measurement year

CMS Star Rating Weight

1

What to report for compliance

These screenings are typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

Members who received both an eGFR and a uACR during the measurement year on the same or different dates of service:

- At least one eGFR and
- At least one uACR identified by either of the following:
  - **Both** a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart. *For example,* if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
  - A uACR

Claims-only exclusions

Members with a diagnosis of ESRD or dialysis any time during the member's history on or prior to December 31 of the measurement year

Members 66-80 years of age as of December 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

- At least two indications of frailty with different dates of service during the measurement period
- Either of the following during the measurement period or the year prior to the measurement period:
  - Advanced illness on at least two different dates of service
  - Dispensed a dementia medication

Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year

- Ensure that the lab reports with results of GFR and uACR tests are included in the medical record.
- A screening or monitoring test meets criteria, whether result is in range, out of range, positive or negative.

Claims-only exclusions (continued)

Members in hospice or using hospice services or receiving palliative care any time during the measurement year

Members who die any time during measurement year

Description	CPT
Estimated Glomerular Filtration Rate Lab Test	80047, 80048, 80050, 80053, 80069, 82565
Quantitative Urine Albumin Lab Test	82043
Urine Creatinine Lab Test	82570

Glycemic Status Assessment for Patients With Diabetes (GSD)

Description: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) showed their blood sugar is under control during the measurement year adequate control is < 8.0%, poor control is > 9.0%).

Population: Members ages 18–75 years as of December 31 of the measurement year

CMS Star Rating Weight

3

Requirements for compliance

Hemoglobin A1c or GMI screening test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

HbA1c control is based on the last test value of the year.

Glucose management indicator (GMI) was added as an option to meet gap closure criteria.

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

- HbA1c or GMI test performed during the measurement year
- Date the HbA1c test was performed
- Result

HEDIS specifies that HbA1c or GMI control for this population is <8.0%. The member is compliant if the result for the most recent HbA1c level during the measurement year is <8.0%. HEDIS defines poor control for this measure as >9.0%. Missing test result (HbA1c value or GMI) is considered not compliant for GSD control for HEDIS and Five-Star Quality Ratings.

- Document the date the HbA1c or GMI test was performed and not the date the test result was reviewed or the current date of service.
- HbA1c or glucose management indicator (GMI) test must be performed during the measurement year. If multiple tests were performed in the measurement year, the most recent result is reported.
- If using CPT category II codes to report the result, a copy of the lab results must be included in the medical record.

Claims-only exclusions

Members 66 years of age and older who are enrolled in an Institutional SNP (I-SNP) or, living long-term in an institution any time during the measurement year

Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

- At least two indications of frailty with different dates of service during the measurement period
- Either of the following during the measurement period or the year prior to the measurement period:
  - Advanced illness on at least two different dates of service
  - Dispensed a dementia medication

Members in hospice or using hospice services or receiving palliative care any time during the measurement year

Members who die any time during measurement year

Description	CPT	CPT II
HbA1c test	83036, 83037	
HbA1c level less than 7.0%		3044F
HbA1c level 7.0–7.9%		3051F
HbA1c level 8.0–9.0%		3052F
HbA1c level greater than 9.0%		3046F

Care for Older Adults (COA)

COA measures are only reported for Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) members. The three components of this measure include the following:

- Functional status assessment
- Medication review
- Pain screening

COA – Functional status assessment

Description: The percentage of Medicare Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) enrollees 66 years of age and older who had a functional assessment in the measurement year.

Population: Members 66 years and older as of December 31 of the measurement year

CMS Star Rating Weight

—

Medical record

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

What to report for compliance (includes evidence in medical record, other actions provider needs to take)

To comply, the following must be included:

- Evidence of functional assessment and date of service
- Date of service

Notations for a complete functional status assessment 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 (that is, 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®
  - Assessment of Living Skills and Resources (ALSAR)
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
  - Bayer ADL (B-ADL) Scale
  - Barthel Index
  - Edmonton Frail Scale
  - Extended ADL (EADL) Scale
  - Groningen Frailty Index
  - Independent Living Scale (ILS)
  - Katz Index of Independence in ADL
  - Kenny Self-Care Evaluation
  - Klein-Bell ADL Scale
  - Kohlman Evaluation of Living Skills (KELS)
  - Lawton and Brody's IADL scales
  - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

Description	CPT	CPT II	HCPCS
Functional status	99483	1170F	G0438, G0439

A functional status assessment limited to an acute or single condition, event or body system (for example, lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

Activities of daily living (ADL)

Please circle the appropriate response for each activity, based on what the member actually does rather than what he/she could do.

For the functional assessment, at least five of the following must be assessed: toilet use, bathing, eating, dressing, mobility (walking) and/or transferring.

Activity	Independent	Needs some assistance	Requires assistance
Bladder	Continent (>7 days)	Occasional accidents (within 24 hours)	Incontinent; needs assistance with catheterization; needs assistance with ostomy care
Bowels	Continent	Occasional accidents (within one week)	Incontinent; needs assistance with bowel routine; needs assistance with ostomy care
Toilet use	Independent (on and off, dressing, wiping)	Needs help with some tasks	Dependent on assistance
Bathing	Independent	Needs help with some tasks (transfer, drying)	Dependent on assistance
Eating	Independent (using proper utensils to bring food to the mouth as well as chewing and swallowing)	Needs minimal assistance but can do most tasks unaided	Dependent on assistance
Dressing	Independent (buttons, zippers, laces)	Needs help but can do some tasks unaided	Dependent
Mobility	Independent	Walks with cane or needs minor assistance (verbal or one person)	Immobile, wheelchair/scooter-bound
Transferring	Independently transfers to and from sitting position	Needs minor assistance (verbal or one person)	No sitting balance or requires help of more than one person
Stairs	Independent both up and down stairs	Needs help (verbal, physical, bolstering aid)	Unable

- Based on the above, determine if the patient is a candidate for supervised care. ☐ Yes ☐ No
- Based on first three questions, determine if patient needs counseling for urinary and/or bowel incontinence. ☐ Yes ☐ No
- Based on the last three questions, determine if patient requires fall prevention counseling. ☐ Yes ☐ No

COA – Medication review

Description: The percentage of Medicare Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) enrollees 66 years of age and older who received at least one medication review in the measurement year.

Population: Members 66 years and older as of December 31 of the measurement year

CMS Star Rating Weight

1

Requirements for compliance

Both of the following on the same date of service during the measurement year:

- At least one medication review conducted by a prescribing practitioner or clinical pharmacist
- The presence of a medication list in the medical record or notation that no medications were prescribed and the date of service was noted

What to report for compliance

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, as documented through either administrative data or medical record review.

Medication list: A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).

Medical record: Documentation must come from the same medical record and must include the following:

- A medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed, or
- Notation that the member is not taking any medication and the date when it was noted
- The code 1159F (medication list documented) must be submitted with 1160F (review of all medications by a prescribing practitioner or clinical pharmacist documented) on the same date of service.

Description	CPT	CPT II	HCPCS
Medication review	90863, 99483, 99605, 99606	1160F	
Medication list		1159F	G8427
Transitional care management	99495, 99496		

- A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.
- A list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
- A review of side effects for a single medication at the time of prescription alone is not sufficient.
- An outpatient visit is not required to meet criteria.

COA – Pain screening

Description: The percentage of Medicare Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) enrollees 66 years of age and older who received at least one pain screening or pain management plan during the measurement year.

Population: Members 66 years and older as of December 31 of the measurement year

CMS Star Rating Weight

1

Medical record

Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

What to report for compliance

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)
  - Face, Legs, Activity, Cry, Consolability (FLACC) scale
  - Verbal descriptor scales (5–7 word scales, present pain inventory)
  - Pain thermometer
  - Pictorial pain scales (faces pain scale, Wong-Baker FACES® Pain Rating Scale)
  - Visual analogue scale
  - Brief pain inventory
  - Chronic pain grade
  - PROMIS Pain Intensity scale
  - Pain Assessment in Advanced Dementia (PAINAD) scale

Description	CPT II
Pain present	1125F
Pain not present	1126F

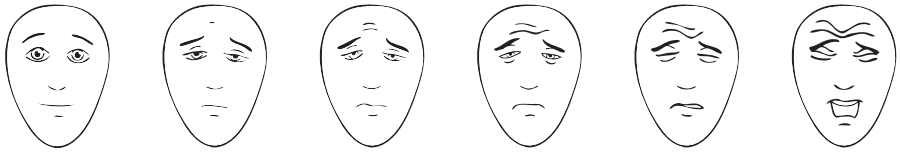
- Notation of a pain management or treatment plan alone does not meet criteria.
- Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.
- Do not include pain assessments performed in an acute inpatient setting.

Comprehensive pain screening[1]

1. Does the patient complain of any pain symptoms? ☐ Yes ☐ No
   If yes, circle the appropriate face in figure 1 below. If the score is 2 or higher, then document the following:
2. How long has the patient had the pain? _____
3. Describe the characteristics of the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Other: _____
4. The type of pain: ☐ Intermittent ☐ Variable (constant with intense breakthrough pain) ☐ Constant at a stable intensity
5. The location of the pain (indicate on figure 2 below): _____

Document, code and provide a treatment plan for the pain and its management.

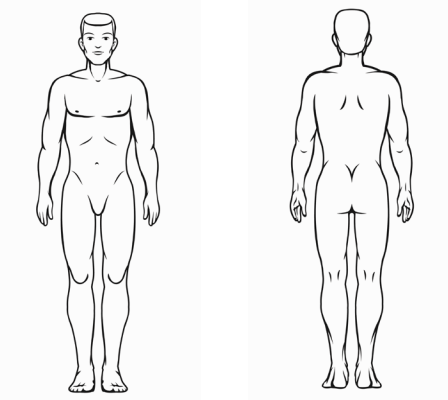
Figure 1: Faces pain scale-revised (FPS-R)*



"These faces show how much something can hurt. This face (point to face on far left) shows no pain. The faces show more and more pain (point to each from left to right) up to this one (point to face on far right) – it shows very much pain. Point to the face that shows how much you hurt (right now)."

Score the chosen face 0, 2, 4, 6, 8 or 10, counting left to right, so "0" = "no pain" and "10" = "very much pain." Do not use words like "happy" or "sad." This scale is intended to measure how someone feels inside, not how their face looks.

Figure 2



Patient name:_____ **Date:** _____

* International Association for the Study of Pain.® Faces Pain Scale - Revised (FPS-R). Reproduced with permission. Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. Faces Pain Scale-Revised: Toward a Common Metric in Pediatric Pain Measurement. PAIN 2001; 93:173-183.

Advanced care planning (ACP)

Description: The percentage of Medicare enrollees 66–80 years of age and older with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.

Population: Members 66 years and older as of December 31 of the measurement year

Requirements for compliance

Evidence of advance care planning as documented through either administrative data or medical record review.

What to report for compliance

Advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end-of-life care. Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record
  - Advance directive (for example, living will, power of attorney, health care proxy)
  - Actionable medical orders (for example, Physician Orders for Life Sustaining Treatment [POLST], Five Wishes)
  - Living will; legal document denoting preferences for life-sustaining treatment and end-of-life care
  - Surrogate decision-maker; a written document designating someone other than the member to make future medical treatment choices
- Documentation of an advance care planning discussion with the provider and the date when it was discussed during measurement year
  - Discussion with a provider or initiation of a discussion by a provider during the measurement year or oral statements, conversations with relatives or friends about life-sustaining treatment and end-of-life care or patient designation of an individual who can make decisions on behalf of the patient
- Notation that a member previously executed an advance care plan

Description	CPT	CPT II	HCPCS	ICD-10-CM
Advance care planning	99483, 99497	1123F, 1124F, 1157F, 1158F	S0257	Z66

Exclusions

Members who use hospice services during the measurement year

Members who die any time during measurement year

Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures

The CAHPS survey assesses consumer responses regarding service, communication, access and quality of care being received from their health providers, including health plan, primary care providers, specialists and others.

The CAHPS survey is administered by CMS-approved vendors annually between February and June; members are randomly chosen to take part in the survey. Participation in the survey is voluntary.

The CAHPS survey is used by health plans, physicians and other health care partners to drive quality improvements, and it also serves as an indicator of member satisfaction and helps drive national quality initiatives through CMS Star Ratings System and the National Committee for Quality Assurance (NCQA).

Six CAHPS measures are included in the annual Medicare Part C Star Ratings:

- Annual flu vaccine
- Getting needed care and seeing specialists
- Getting appointments and care quickly
- Getting needed prescription drugs
- Care coordination
- Medical Assistance With Smoking and Tobacco Use Cessation

CMS Star Rating: Annual flu vaccine

Description: Percent of plan members who received a vaccine (flu shot) prior to flu season.

CAHPS survey question

- Have you had a flu shot since July 1 (of last calendar year)?

Provider action needed to meet measure compliance

Ensure member receives an influenza vaccination prior to flu season.

- Encounter for immunization (Z23)
- Administration of influenza virus vaccine (G0008)
- Administration of pneumococcal vaccine (G0009)

CMS Star Rating Weight

1

CMS Star Rating: Medical assistance with smoking and tobacco use cessation (MSC) - Medicare and Exchange Only

- Do you now smoke cigarettes or use tobacco every day, some days, or not at all?
- In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?
- In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
- In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
- In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?

CMS Star Rating: Getting needed care and seeing specialists

Description: Percent of the best possible score earned by the plan on how easy it is for members to get needed care, including care from specialists.

CMS Star Rating Weight

4

CAHPS survey question

- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last 6 months, how often was it easy to get the care, tests or treatment you needed?

Provider action needed to meet measure compliance

Help members in getting appointments with specialists to receive needed care, tests and/or treatments.

Keep communication open with members to showcase any actions that can help members recognize these efforts.

CMS Star Rating: Getting appointments and care quickly

Description: Percent of the best possible score earned by plan on how quickly members get appointments and care.

CMS Star Rating Weight

4

CAHPS survey question

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Provider action needed to meet measure compliance

Encourage all provider office staff to tend to members' needs as soon as possible and provide timely appointments for visits.

CMS Star Rating: Getting needed prescription drugs

Description: Percent of the best possible score earned by plan on how easy it is for members to get the prescription drugs they need using the plan.

CMS Star Rating Weight

4

CAHPS survey questions

- In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
- In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

Provider action needed to meet measure compliance

Help members coordinate the way they receive their prescription drugs by placing prescriptions with the correct pharmacy, sending appropriate information to the requested pharmacy and having the provider refill prescriptions as needed.

CMS Star Rating: Care coordination

Description: Percent of the best possible score earned by plan on how well the plan coordinates members' care. (This includes whether doctors have the records and information they need about members' care and how quickly members got their test results.)

CMS Star Rating Weight

4

CAHPS survey question

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Provider action needed to meet measure compliance

Care providers should try to keep informed and up to date with care rendered by specialists and other care providers.

Keep medical records, prescriptions and other information up to date by maintaining open discussions with members regarding any updates or changes.

CMS Star Rating: Doctors who communicate well

Description: The how well doctors communicate composite measures members' perception of the quality of communication with their personal doctor in the last 6 to 12 months.

CMS Star Rating Weight

4

CAHPS survey question

- In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did your personal doctor spend enough time with you?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?

For additional information about the CAHPS survey, please refer to: https://www.ma-pdpcahps.org/en/quality-assurance/

About the CAHPS survey

The Centers for Medicare & Medicaid Services (CMS) is committed to measuring and reporting information from the consumer perspective for Medicare Advantage (MA) and Medicare Prescription Drug Plan (PDP) contracts. The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is sponsored by CMS and collects information to fulfill a requirement of Congress under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. The survey provides information to Medicare beneficiaries on the quality of health services provided through MA and Medicare Part D programs.

The survey below is for informational purposes and highlights measures related to Star Ratings. You are not required to complete or distribute this survey. This is not the complete CAHPS survey. The questions below are only a part of the Your Personal Doctor section of the CAHPS survey only.

For the complete survey, please visit:
https://ma-pdpcahps.org/globalassets/ma-pdp/quality-assurance/2024-qapts-v14.0/ma-pdp-cahps-qapts-v14.1-final.pdf

Questions	Measure
Your personal doctor	
A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?	☐ Yes ☐ No
In the last 6 months, how many times did you visit your personal doctor to get care for yourself?	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 to 9 ☐ 10 or more times
In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last 6 months, how often did your personal doctor listen carefully to you?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last 6 months, how often did your personal doctor show respect for what you had to say?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last 6 months, how often did your personal doctor spend enough time with you?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	☐ 0 – Worst personal doctor possible ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 – Best personal doctor possible
In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last 6 months, did your personal doctor order a blood test, x-ray or other test for you?	☐ Yes ☐ No
In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last 6 months, did you take any prescription medicine?	☐ Yes ☐ No
In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?	☐ Yes ☐ No
In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?	☐ Yes, definitely ☐ Yes, somewhat ☐ No

Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is the first patient-reported outcomes measure survey used in the Medicare Advantage (MA) program. The goal of the HOS survey is to gather valid, reliable and clinically meaningful health status data in the MA program for use in quality improvement activities, pay for performance, program oversight, public reporting and improving health.

The National Committee for Quality Assurance (NCQA) is the steward for the HOS measures and an NCQA-certified vendor conducts the HOS survey annually between April and July. The survey is comprised of: 1) a baseline survey and 2) a follow-up survey. The follow-up survey is for beneficiaries who participated in the baseline study two years prior.

A two-year change score is calculated by each member's physical and mental health status movement over the years under the following categories: better, the same or worse than expected and the consideration of risk adjustment factors. Organization-specific results are assigned as percentages of members whose health statuses were better, the same or worse than expected. The survey results also provide a general indication of how well an MA organization manages the physical and mental health of its members.

Three HOS measures are included in the annual Medicare Part C Star Ratings:

- Fall risk management (FRM)
- Physical activity in older adults (PAO)
- Management of urinary incontinence in older adults (MUI)

CMS Star Rating: Fall Risk Management (FRM)

Description: Percent of plan members 65 and older with a problem falling, walking or balancing who discussed it with their doctor and received a recommendation for how to prevent falls during the year.

HOS survey questions

- A fall is when your body goes to the ground without being pushed.
- In the **past 12 months**, did you talk with your doctor or other health provider about falling or problems with balance or walking?
- Did you fall in the **past 12 months**?
- In the **past 12 months**, have you had a problem with balance or walking?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Such as:
  - Suggest that you use a cane or walker.
  - Suggest that you do an exercise or physical therapy program.
  - Suggest a vision or hearing test.

Compliance needed to meet the intent of the measure

These two components of this measure assess fall risk management:

- Discussing fall risk: The percentage of Medicare members 65 years of age and older who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.
- Managing fall risk: The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.
  - History of falling (Z91.81)
  - Staggering or abnormality of gait (R26.0)
  - Difficulty in walking (R26.2)
  - Unsteadiness on feet (R26.81)
  - Other abnormalities of gait and mobility (R26.89)
  - Unspecified abnormalities of gait and mobility (R26.9)

CMS Star Rating Weight

1

For all Five-Star Quality Ratings listed:

- What to report for compliance: There is nothing for providers to report and members are randomly selected for survey participation.
- Providers should be aware of these questions and develop strategies that help shape a patient's satisfaction and view of health.
- Consider multiple touch points alerting patients to be engaged, considering messaging to patients pre-visit, during and post-visit.
- Encourage patients to engage on these questions via visit summaries or take-home materials.

CMS Star Rating: Physical Activity in Older Adults (PAO)

Description: Percent of plan members 65 and older who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.

CMS Star Rating Weight

1

HOS survey questions

- In the **past 12 months**, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- In the **past 12 months**, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Compliance needed to meet the intent of the measure

- Discussing physical activity: The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity.
- Advising physical activity such as exercise counseling (Z71.82): The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level exercise or physical activity.

CMS Star Rating: Management of Urinary Incontinence in Older Adults (MUI)

Description: Percent of plan members 65 and older with a urine leakage problem in the past 6 months who discussed treatment options with a provider.

CMS Star Rating Weight

1

HOS survey questions

- Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
- There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?

Compliance needed to meet the intent of the measure

The following components of this measure assess the management of urinary incontinence in older adults:

- Discussing Urinary Incontinence: The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past 6 months and who discussed their urinary leakage problem with a health care provider.
- Discussing Treatment of Urinary Incontinence: The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past 6 months and who discussed treatment options for their current urine leakage problem.
- Impact of Urinary Incontinence: The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past 6 months and who reported that urine leakage made them change their daily activities or interfered with their sleep a lot.

Note: A lower rate indicates better performance for this indicator.

About the Health Outcomes Survey

The Medicare Health Outcomes Survey (HOS) is the only patient-reported outcomes measure in Medicare-managed care and therefore remains a critical part of assessing a Medicare Advantage Organization's (MAO) quality. The HOS design is based on a randomly selected sample of individuals from each participating MAO and measures their physical and mental health over a two-year period. The HOS instrument is an assessment of an MAO's ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries. Members were eligible for re-measurement if they had sufficient data to derive physical or mental component scores at baseline.

The survey below is for informational purposes and highlights measures related to Star Ratings. You are not required to complete or distribute this survey. This sample only includes a subset of the questions and is not the complete HOS.

For the complete survey, please visit: hosonline.org/en/survey-instrument/

Questions	Measure
Monitoring physical activity	
In the **past 12 months**, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.	☐ Yes ☐ No ☐ I had no visits in the past 12 months
In the **past 12 months**, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.	☐ Yes ☐ No
Reduce risk of falling	
A fall is when your body goes to the ground without being pushed. In the **past 12 months**, did you talk with your doctor or other health provider about falling or problems with balance or walking?	☐ Yes ☐ No ☐ I had no visits in the past 12 months
Did you fall in the **past 12 months**?	☐ Yes ☐ No
In the **past 12 months**, have you had a problem with balance or walking?	☐ Yes ☐ No
Has your doctor or other health provider done anything to help prevent falls or treat problems with balancing or walking? Some things they might do include: • Suggest that you use a cane or walker. • Suggest that you do an exercise or physical therapy program. • Suggest a vision or hearing test.	☐ Yes ☐ No ☐ I had no visits in the past 12 months
Improving and maintaining physical health (Display measure only)	
In general, would you say your health is:	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
The following items are about activities you might do during a typical day. Does **your health <u>now</u> limit you** in these activities? If so, how much?	
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all
Climbing **several** flights of stairs.	☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

Questions	Measure
During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?	
Accomplished less than you would like **as a result of your physical health**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time
Were you limited in the kind of work or other activities **as a result of your physical health**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time
Improving and maintaining mental health (Display measure only)	
During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?	
Accomplished less than you would like as a **result of any emotional problems**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time
Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time
How much of the time during the past 4 weeks:	
Have you felt calm and peaceful?	☐ All of the time ☐ Most of the time ☐ A good bit of the time ☐ Some of the time ☐ A little of the time ☐ None of the time
Did you have a lot of energy?	☐ All of the time ☐ Most of the time ☐ A good bit of the time ☐ Some of the time ☐ A little of the time ☐ None of the time
Have you felt downhearted and blue?	☐ All of the time ☐ Most of the time ☐ A good bit of the time ☐ Some of the time ☐ A little of the time ☐ None of the time
During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?	☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

National Committee for Quality Assurance. Medicare Health Outcomes Survey. Health Services Advisory Group. Centers for Medicare & Medicaid Services., n.d. Web. 2015.

Transitional care management services and medication reconciliation

Transitional care management (TCM) services are used for new or established patients whose medical and/or psychosocial problems require moderate or high-complexity medical decision-making during transitions in care. TCM services can include care from: an inpatient acute, psychiatric or long-term care hospital; skilled nursing facility; inpatient rehab facility; hospital outpatient observation or partial hospitalization at a community mental health center; to patient's community setting (home, domiciliary, nursing home or assisted living facility). The ultimate goal of TCM is to avoid gaps between facility and post-discharge to improve quality of patient care and decrease readmissions.

Transitional care management parameters[1,2]

When the service period begins: On the day of discharge and continues for the following 29 days. TCM services cannot be billed within a postoperative global surgery period by the provider of the surgery services.

- Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Who can report TCM services: Only one qualified physician or nonphysician practitioner may report TCM services per beneficiary per 30-day period following a discharge, which includes a combination of one face-to-face visit and several non face-to-face services.

- Face-to-face services can only be done by a qualified health care professional and/or licensed clinical staff who can provide some non-face-to-face services (under the direct supervision of a physician or other qualified clinician, subject to your state's supervision laws, scope of practice and applicable "incident to" rules and regulations), which may include:
  - Identify available community and health resources
  - Communicate with agencies or other community services the patient uses
  - Communication (with patient, guardian or caregiver, surrogate decision makers, and/or other professionals) with regards to aspects of care
  - Educate the patient and/or caregiver to support self-management, independent living, and activities of daily living
  - Assess and support treatment adherence and medication management
  - Assist the patient and family in accessing needed care and services

99495 — Transitional care management services with all following required elements:

- Communication (face-to-face, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Medical decision-making of at least moderate complexity during the service period.
- Face-to-face visit, within 14 calendar days of discharge.

99496 — Transitional care management services with all following required elements:

- Communication (face-to- face, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Medical decision-making of high complexity during the service period.
- Face-to-face visit, within 7 calendar days of discharge.
- Note: If medical decision making is of high complexity but patient is not seen within 7 days of discharge, report 99495.

- Non-face-to-face services can be done by a provider or other qualified clinician and may include:
  - Nursing
  - Obtain, review, complete discharge information for discharge summary, continuation of care documents, etc.
  - Review follow-up needs on pending tests and/or treatment
  - Interact with other clinicians who will assume or reassume care for the patient's specific problems or conditions
  - Educate patient, family, guardian and/or caregivers
  - Establish or reestablish referrals and arrange for community resources for specialized care
  - Assist in scheduling follow-up with other providers and health services

Medication reconciliation: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, registered nurse, or physicians assistant as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days). Only the documentation in the outpatient medical record meets the intent of the measure, but an outpatient visit is not required. Documentation must include evidence of medication reconciliation and the date when it was performed. Any (one) of the following meets the criteria:

- Documentation of current medications with notation that the provider reconciled current and discharge medications with references of discharge medications (for example, no medication changes since discharge, same medications at discharge, discontinue all discharge medications). Include a notation that the discharge medications were reviewed.
- Document a current and discharge medication list and notate that both lists were reviewed on the same date of service. Include evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review, and indicate the provider was aware of the member's hospitalization or discharge. The discharge summary must reveal that the discharge medications were reconciled with the most recent medication listed in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). Notate that "no" medications were prescribed or ordered upon discharge, if applicable.

Discharge from TCM services: The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services and bill TCM services. The required face-to-face visit may not take place on the same day you report discharge day management services.

- Patient readmission within the 30 days – billing can be completed for the face-to-face service only with the appropriate E/M code. Another 30 days is started after discharge and the process can begin again for the transitional care management to be billed. Otherwise, the full 30 days of the first admission can include the second admission if no one else has billed for it within that same time frame. If the patient dies before the 30 days have elapsed, only face-to-face service, if provided, can be billed. If other services are provided for the patient above and beyond those of the transitional care, they are billed separately.

Medication reconciliation and management must occur no later than the date of the face-to-face visit.

1111F – Discharge medications reconciled with the current medication list (outpatient medical record).

- This is a nonreimbursable CPT II code necessary to meet HEDIS requirements and diminishes the need for additional chart pulls.
- Diagnosis codes, including chronic conditions associated with the patient's current status, should be used to indicate the reason(s) for the services being provided.
- Note: Code 1111F can be reported with a code for Transitional Care Management (99495, 99496).

Medication reconciliation post-discharge (ages 18 and older)

Document reconciliation with the most recent medication list in the outpatient medical record within 30 days of discharge.

Description	CPT	CPT II
Transitional care management	99483, 99495, 99496	
Medication reconciliation		1111F
Note: Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, registered nurse, or physicians assistant.		

1. Centers for Medicare & Medicaid Services. Transitional Care Management Services. Published May 2023. Accessed December 5, 2023.
2. National Committee for Quality Assurance. HEDIS Measures. Accessed December 5, 2023.

How can we help you?

Our goal is to help health care professionals facilitate and support accurate, complete and specific documentation and coding with an emphasis on early detection and ongoing assessment of chronic conditions.

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The Department of Health & Human Services Hierarchical Condition Category (HHS-HCC) model applies to the health exchange risk adjustment program under the Affordable Care Act. This model differs significantly from the CMS-HCC model, which applies to the Medicare Advantage risk adjustment program. For more information, please visit: cms.gov/marketplace/health-plans-issuers/premium-stabilization-programs.

For Medicaid Managed Care, risk adjustment standards, if any are applicable, are established by each state Medicaid agency and such standards often vary from state to state. For more information, please visit: medicaid.gov/medicaid/managed-care/index.html.

This tool is to be used for easy reference; however, the current ICD-10-CM code classification and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment plan and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 1, 2024, the Centers for Medicare & Medicaid Services (CMS) announced that 2024 dates of service for the 2025 payment year model are based on the Centers for Medicare & Medicaid Services Announcement. Announcement of Calendar Year (CY) 2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (cms.gov).