Medicare Stars Guide: A Resource for Providers and Clinic Staff

ALAMEDA Alliance FOR HEALTH | Alliance Wellness

Table of Contents

Introduction

Alameda Alliance for Health (Alliance) offers Alameda Alliance Wellness, a Medicare Advantage Health Maintenance Organization (HMO) Dual Eligible Special Needs Plan (D-SNP) designed to serve individuals eligible for both Medicare and Medi-Cal.

This Medicare Stars Guide is a reference designed to support providers and clinic teams in delivering high-quality, coordinated care to our dual-eligible members. It summarizes key components of the Centers for Medicare & Medicaid Services (CMS) 5-Star Quality Rating Program and highlights how provider-level care directly impacts Stars performance.

The guide is organized by Stars-relevant measure areas, including Part C Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures, Part C member experience captured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and the Health Outcomes Survey (HOS), Part D Pharmacy Measures, and preventive care visits (Initial Preventive Physical Exam [IPPE] and Annual Wellness Visit [AWV]). It provides measure definitions, eligibility criteria, coding and documentation guidance, along with evidence-based strategies to close care gaps, improve patient outcomes, and support performance across both clinical quality and member experience measures.

Medicare Star Ratings – Overview

What are Medicare Star Ratings?

Medicare Star Ratings are a quality measurement system developed by the Centers for Medicare & Medicaid Services (CMS) to evaluate the performance of Medicare Advantage (Part C) and Prescription Drug Plans (Part D). Plans are rated annually on a scale from one (1) to five (5) stars, with five (5) stars indicating excellent performance and one (1) star indicating poor performance.

Ratings are based on more than 40 quality measures across key domains:

- Staying Healthy: Preventive screenings, immunizations, and wellness visits
- Managing Chronic Conditions: Diabetes, arthritis, and hypertension care
- Member Experience: Satisfaction with the plan and services
- Customer Service: Responsiveness and support
- Drug Safety and Pricing Accuracy (Part D only)

Data Sources That Drive Star Ratings

Data Source	What It Measures	Provider Relevance
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	Member satisfaction, access to care, and communication.	Reflects patient experience with providers and the health plan.
Healthcare Effectiveness Data and Information Set (HEDIS®)	Clinical outcomes and service delivery (e.g., screenings, chronic care, adherence).	Directly reflects the care provided by clinicians and staff.
Health Outcomes Survey (HOS)	Self-reported health status and changes over time.	Measures perceived quality of care and health improvement.
Operational Data	Customer service, complaint resolution, and plan stability.	Impacts member satisfaction and retention through service quality.
Prescription Drug Event (PDE) Data	Drug-related measures: adherence, safety, and pricing accuracy.	Supports medication management and safe prescribing practices.

Why Star Ratings Matter to Providers and Clinics

Medicare Star Ratings are more than a consumer tool; they are performance drivers for providers and clinics.

Here is why:

- **Quality Performance Drives Incentives**
  Plans that achieve four (4) stars or higher earn bonus payments from CMS, which must be reinvested into member benefits such as dental, vision, and hearing coverage. Providers aligned with these high-performing plans may benefit from increased patient volume, stronger referral networks, and enhanced reimbursement models.

- **Your Care Directly Impacts Ratings**
  Many Star Rating measures are driven by provider performance, including:
  - o Diabetes control and annual eye exams
  - o Medication adherence
  - o Patient-reported health outcomes
  - o Timely cancer screenings

  Consistent, evidence-based care directly improves a plan's rating and its competitiveness in the market.
- **Higher Ratings Impact Enrollment Growth**
  Plans with higher Star Ratings attract more beneficiaries, especially during open enrollment. Providers affiliated with these plans may see increased patient enrollment, stronger retention, and improved satisfaction scores.
- **A Framework for Accountability and Improvement**
  Star Ratings offer a standardized framework for measuring plan quality. Providers can use these metrics to benchmark performance, identify care gaps, and implement targeted quality improvement strategies that align with CMS priorities.

Key Categories for Performance Impact

Performance Category	What It Measures	Provider and Clinic Impact
Delivering Responsive Customer Service	Effectiveness in handling member inquiries and support.	Provide accurate information and timely assistance.
Enhancing Patient Experience	Member satisfaction with the health plan and services.	Deliver compassionate, responsive care and clear communication.
Ensuring Safe and Accurate Medication Use	Accuracy of drug pricing and safety of prescriptions (Part D only).	Prescribe medications safely and ensure patients understand their treatments.
Promoting Preventive Health	Use of flu shots, cancer screenings, and wellness visits.	Ensure patients receive timely screenings, immunizations, and wellness care.
Reducing Complaints and Improving Stability	Frequency of member complaints, plan changes, and performance trends.	Minimize service disruptions and resolve issues quickly.
Supporting Chronic Condition Care	Management of diabetes, arthritis, high blood pressure, and other long-term issues.	Monitor conditions, prescribe appropriate medications, and coordinate care.

Part C – HEDIS® Measures

The Alliance is committed to supporting providers and clinic staff in improving care quality and performance under the Medicare Star Rating Program. A key component of this program includes clinical quality measures derived from the Healthcare Effectiveness Data and Information Set (HEDIS®), which reflect the impact of primary care teams on patient outcomes.

HEDIS® measures are collected using three (3) approved data collection methods:

- **Administrative Method –** Uses claims and pharmacy data to identify eligible members and services received.
- **Hybrid Method –** Combines administrative data with medical record reviews for a sample of members to confirm care not captured through claims.
- **Electronic Clinical Data Systems (ECDS) Method –** Uses structured electronic data from sources such as Electronic Health Records (EHRs), Health Information Exchanges (HIEs), registries, and pharmacy systems. Data must meet the National Committee for Quality Assurance (NCQA) standards.

These methods rely on various data sources, including claims, medical charts, electronic health records, health information exchanges, and supplemental documentation such as lab results or gap closure evidence. All data must meet NCQA technical specifications to be valid for HEDIS® reporting.

This section provides measure-specific guidance, coding tips, and documentation strategies to help clinical teams close care gaps, improve compliance, and enhance performance on HEDIS® measures tied to Medicare Star Ratings.

For more information, please email the Alliance Stars Team at **DeptStarsTeam@alamedaalliance.org**.

1. Breast Cancer Screening (BCS-E)

Data Collection Methodology: ECDS

Measure Description: Members 40-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Measure Population (denominator): Members 42-74 years of age by the end of the measurement period.

Measure Compliance (numerator): One (1) or more mammograms any time on or between October 1st, two (2) years prior to the measurement period and the end of the measurement period.

Please Note: Members 40-74 years of age should screen for breast cancer every two (2) years. However, depending on risk factors, mammograms may need to be done more frequently.

Coding Tips:

Value Set	ICD-10 Codes	Description
History of Bilateral Mastectomy	Z90.13	Acquired absence of bilateral breasts and nipples
Gender Dysphoria	F64.1, F64.2, F64.8, F64.9, or Z87.890	In addition to one of the Gender Dysphoria ICD-10 codes, please include the CPT Code 19318 for Gender Affirming Chest Surgery

Please Note: Mammography codes will be submitted by imaging centers; additional codes are available upon request.

Exclusions:

- Members 66 years of age and older with frailty and an advanced illness diagnosis.
- Members who died at any time during the measurement year.
- Members who had bilateral mastectomy, or both right and left unilateral mastectomies, any time during a member's history through the end of the measurement period.
- Members who received hospice services or palliative care at any time during the measurement year.
- Members with completed gender-affirming chest surgery with a diagnosis of gender dysphoria.

How to Improve Your Stars Performance

- Submit the appropriate ICD-10 diagnosis code that matches member's medical history of a bilateral mastectomy, Z90.13.
- Prepare standing referral for a mammography, assist patient in making appointments and track referral until radiology report is obtained and added to the patient's chart.
- Make every visit count by utilizing monthly gap-in-care reports to identify patients who are due for a mammogram.
- Build preventative care screening alerts in your EHR system.

Appendix – BCS-E Codes

2. Care for Older Adults (COA)

Data Collection Methodology: Administrative and hybrid

Measure Description: The percentage of adults 66 years of age and older who had both of the following during the measurement year:

- Medication Review
- Functional Status Assessment

Measure Population (denominator): Members 66 years and older.

Measure Compliance (numerator):

Sub-measure	Description
Medication Review	At least one (1) medication review by a prescribing practitioner or clinical pharmacist and the presence of a medication list in the medical record or transitional care management services during the measurement year. Medical record: Documentation must come from the same medical record and must include one (1) of 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. • Notation that the person is not taking any medication and the date when it was noted. **Please Note:** An outpatient visit is not required to meet criteria; a medication review performed without the person present meets criteria.

Sub-measure	Description
Functional Status Assessment	At least one (1) functional status assessment during the measurement period, as documented through either administrative data or medical record review. Medical record: Documentation in the medical record of evidence of at least one (1) complete functional status assessment during the measurement year and the date performed. An assessment must include one (1) of the following: • Notation that Activities of Daily Living (ADLs) were assessed or that at least five (5) of the following were assessed: bathing, eating, transferring, using the toilet, walking. • Notation that Instrumental Activities of Daily Living (IADLs) were assessed, or at least four (4) of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medication, handling finances. • Result of assessment using a standardizing assessment tool; including, but 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 & Brody's IADL Scales, Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales. **Please Note:** The Functional Status Assessment indicator does not require a specific setting. Assessments can occur via all telehealth methods, including audio-only telephone visits, e-visits, and virtual check-ins.

Please Note: Do not include services provided in an acute inpatient setting

Coding Tips:

Value Set	Code		Description
Transitional Care Management Services	CPT	99495	Transitional care management moderate face-to-face 14 day
		99496	Transitional care management high face-to-face 7 day
Functional Status Assessment	CPT	99483	Assessment & care plan patient cognitive impairment
	CPT II	1170F	Functional status assessed
Medication List	CPT II	1159F	Medication list documented in medical record

Value Set	Code		Description
Medication Review	CPT	99483	Assessment & care plan patient cognitive impairment
		99605	Medication therapy management by pharmacist new patient 15 minutes
		99606	Medication therapy management by pharmacist established patient 15 minutes
	CPT II	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as prescriptions, over the counter, herbal therapies, and supplements), documented in the medical record

Please Note: Current Procedural Terminology (CPT) Category (CAT) II codes **are not** reimbursable codes; they are informational codes. The table shows a partial list of value set codes. Additional codes are available upon request.

Exclusions:

- Members who died at any time during the measurement year.
- Members who received hospice services at any time during the measurement year.

3. Colorectal Cancer Screening (COL-E)

Data Collection Methodology: ECDS

Measure Description: Members 45-75 years of age who had appropriate screening for colorectal cancer.

Measure Population (denominator): Members 46-75 years of age by the end of the measurement period.

Measure Compliance (numerator): One (1) or more screenings for colorectal cancer.

Any of the following will meet the criteria:

Screening Method	Screening Frequency
• Fecal Occult Blood Test (gFOBT) • Fecal immunochemical test (FIT)	Yearly
• Multitargeted stool DNA with FIT test (sDNA FIT) Example: Cologuard®	Every 3 years
• Flexible Sigmoidoscopy • CT colonography	Every 5 years
• Colonoscopy	Every 10 years

Coding Tip: Colon cancer screening diagnostic results will be submitted by the lab or specialist completing the test. Additional codes are available upon request.

Exclusions:

- Members 66 years of age and older in an institutional SNP (I-SNP) or living long-term in an institution (LTI).
- Members 66 years of age and older with advanced illness and frailty.
- Members who died at any time during the measurement year.
- Members who received hospice services or palliative care at any time during the measurement year.
- Members who have a history of colorectal cancer and/or total colectomy any time during the member's history through the last day of the measurement period (see exclusion codes).

Exclusion Codes: Colorectal Cancer and Total Colectomy:

Value Set	ICD-10 CM Code	Description
Colorectal Cancer and History of Colorectal Cancer	C18.0	Malignant neoplasm of cecum
	C18.1	Malignant neoplasm of appendix
	C18.2	Malignant neoplasm of ascending colon
	C18.3	Malignant neoplasm of hepatic flexure
	C18.4	Malignant neoplasm of transverse colon
Colorectal Cancer and History of Colorectal Cancer (cont.)	C18.5	Malignant neoplasm of splenic flexure
	C18.6	Malignant neoplasm of descending colon
	C18.7	Malignant neoplasm of sigmoid colon
	C18.8	Malignant neoplasm of overlapping sites of colon
	C18.9	Malignant neoplasm of colon, unspecified
	C19	Malignant neoplasm of rectosigmoid junction
	C20	Malignant neoplasm of rectum
	C21.2	Malignant neoplasm of cloacogenic zone
	C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
	C78.5	Secondary malignant neoplasm of large intestine and rectum
	Z85.038	Personal history of other malignant neoplasm of large intestine
	Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus

Please Note: The table shows a partial list of exclusion value set codes. Additional codes are available upon request.

4. Controlling High Blood Pressure (CBP)

Data Collection Methodology: Administrative and hybrid

Measure Description: Members 18-85 years of age with a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (less than 140/90 mm Hg) during the measurement year.

Measure Population (denominator): Members 18-85 years of age with a diagnosis of hypertension on at least two (2) different dates of service between January 1 of the year prior and June 30 of the measurement year.

Measure Compliance (numerator): The final blood pressure reading of the measurement year is adequately controlled (less than 140/90 mm Hg).

Please Note: The BP reading must occur on or after the date of the second diagnosis of hypertension.

Guidelines for member-reported BP readings documented in the medical record:

- A distinct numeric result for both systolic and diastolic must be documented in the medical record.
- EHR communications with BPs reported must indicate the date taken.
- May obtain BP during telephone visits, e-visits, or virtual check-ins.
- Must indicate the date that BP was taken.
- Patient-reported blood pressures taken with a digital device are acceptable and should be documented in the medical record. The provider does not need to see the digital reading.

Coding Tips: CPT II codes may be used to indicate compliance.

Value Set	CPT II Code	Description
Systolic and Diastolic Result	3074F	Systolic <130
	3075F	Systolic 130-139
	3077F	Systolic ≥140
	3078F	Diastolic <80
	3079F	Diastolic 80-89
	3080F	Diastolic ≥90

Please Note: CPT II codes are not reimbursable codes. They are informational codes that should be submitted in conjunction with a visit code for a visit where a BP reading was taken. The table shows a partial list of value set codes. Additional codes are available upon request.

Not Accepted Readings:

- Readings taken during an acute inpatient setting or an Emergency Department (ED) visit are excluded.
- Readings taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the test or procedure are excluded, except for fasting blood tests.
- Readings reported as a range or threshold are not acceptable.

Exclusions:

- Members 66-80 years of age with advanced illness and frailty, or 81 years of age and older with frailty.
- Members who died during the measurement year.
- Members who had a non-acute inpatient admission during the measurement year.
- Members who had a pregnancy diagnosis during the measurement year.
- Members who had ESRD, dialysis, nephrectomy, or kidney transplant at any time during the member's history.
- Members who received hospice services or palliative care during the measurement year.

How to Improve Your Stars Performance

- Retake the BP if the results are high during an office visit (140/90 mmHg or greater). HEDIS allows use of the lowest systolic/diastolic readings if taken on the same day.
- Take advantage of BP readings taken from remote monitoring devices, as these are now allowed to be used for measure compliance.
- Member reported data are considered services reported by the patient to the health care provider while taking the patient's history and recording in the medical record.
- Member-reported blood pressures are acceptable when performed and documented in the acceptable time frame.
- Documented while obtaining a history (e.g., member reports blood pressure this morning was 127/88).
- Ensure documentation is clear, concise, consistent, complete, and comprehensive.
- Make every visit count by utilizing monthly gap-in-care reports to identify patients who are missing a controlled BP reading in the measurement year.
- Build an alert in your EHR system to prompt clinic staff to retake a patient's BP if reading is elevated.

5. Eye Exam for Patients with Diabetes (EED)

Data Collection Methodology: Administrative

Measure Description: The percentage of diabetic members who received a retinal eye exam.

Measure Population (denominator): Members 18-75 years old with diabetes (type 1 or type 2).

Measure Compliance (numerator): Diabetic members who had one of the following:

- 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 period.

Coding Tip: Codes submitted by an eye care professional.

Exclusions:

- Members 66 years of age and older in an I-SNP or LTI any time during the measurement year.
- Members 66 years of age and older with both frailty (during the measurement year) and advanced illness (during the measurement year or the year prior).
- Members who died at any time during the measurement year.
- Members who received hospice services or palliative services care at any time during the measurement year.
- Members with bilateral absence of eyes or eye enucleation.

How to Improve Your Stars Performance

- A digital eye exam, remote imaging, and fundus photography can count as long as the results are read by an eye care professional (optometrist or ophthalmologist).
- Document date of service eye exam was rendered by an eye care professional and the results (specialty must be noted).
- Prepare standing referral to ophthalmologist, assist patient in making appointment and track referral until specialist report is obtained and added to the patient's chart.
- Member-reported retinal eye exams are acceptable when performed and documented in the acceptable time frame.
- Documented while obtaining a history (e.g., member reports they were examined by optometrist Dr. Vision in 2024 with results negative for retinopathy).
- Make every visit count by utilizing monthly gap-in-care reports to identify patients who are due for a diabetic eye exam.
- Build preventative care screening alerts in your EHR system.

Appendix – EED Codes

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

Data Collection Methodology: Administrative

Measure Description: The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within seven (7) days of the ED visit.

Measure Population (denominator): Members 18 years of age and older with two (2) or more different high-risk chronic conditions that had an ED visit between January 1st and December 24th of the measurement year.

High-risk chronic conditions (diagnosed prior to ED visit during measurement year or year prior):

- Acute myocardial infarction
- Alzheimer's disease and related disorders
- Atrial fibrillation
- Chronic kidney disease
- Chronic obstructive pulmonary disease (COPD), asthma, or unspecified bronchitis
- Depression
- Heart failure
- Stroke and transient ischemic attack

Please Note: Measure is based on ED visits; if a member has more than one (1) ED visit, they could be in the measure more than once.

Measure Compliance (numerator): A follow-up service within seven (7) days on or after the emergency department visit (eight (8) days total).

Follow-up service timeframe examples:

Compliant

- ED visit on June 10, follow-up service on June 10 (same day)
- ED visit on June 10, follow-up service on June 18 (8th day)

Non-compliant

- ED visit on June 10, follow-up service on June 19th (9th day)

The following meet criteria for follow-up:

- Case management visits
- Community mental health center visit
- Complex Care Management services
- Electroconvulsive therapy
- Intensive outpatient encounter or partial hospitalization
- Outpatient or telehealth behavioral health visit
- Outpatient visit, telephone visit, e-visit, or virtual check-in
- Substance use disorder counseling and surveillance
- Substance use disorder service
- Transitional care management services

Coding Tips:

Value Set	Code		Description
Case Management Encounter	CPT	99366	Team conference with patient by healthcare professionals
	HCPCS	T1016	Case management, each 15 minutes
		T1017	Targeted case management, each 15 minutes
		T2022	Case management, per month
Complex Care Management Services	CPT	99439	Chronic care management for each additional 20 minutes of non-face-to-face
		99490	Chronic care management staff 1st 20 minutes
		99491	Chronic care management provided by a physician 1st 30 minutes
	HCPCS	G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
Outpatient and Telehealth	CPT	98016	Brief communication technology-based service
		99202	Office outpatient new straightforward 15 minutes
		99203	Office outpatient new low 30 minutes
		99204	Office outpatient new moderate 45 minutes
		99205	Office outpatient new high 60 minutes

Value Set	Code		Description
Outpatient and Telehealth (cont.)	CPT	99211	Office outpatient established patient, may not require physician's direct presence
		99212	Office outpatient established patient straightforward 10 minutes
		99213	Office outpatient established patient low 20 minutes
		99214	Office outpatient established patient moderate 30 minutes
		99215	Office outpatient established patient high 40 minutes
		99242	Office outpatient consultation new/established patient straightforward 20 minutes
		99243	Office outpatient consultation new/established patient low 30 minutes
		99244	Office outpatient consultation new/established patient moderate 40 minutes
		99245	Office outpatient consultation new/established patient high 55 minutes
		99341	Home/residence visit new patient straightforward 15 minutes
		99342	Home/residence visit new patient low 30 minutes
		99344	Home/residence visit new patient moderate 60 minutes
		99345	Home/residence visit new patient high 75 minutes
Transitional Care Management Services	CPT	99495	Transitional care management moderate face-to-face 14 days
		99496	Transitional care management high face-to-face 7 days

Please Note: The table shows a partial list of value set codes. Additional codes are available upon request.

Exclusions:

- Members admitted to an acute or nonacute inpatient facility on or within seven (7) days after the ED visit, regardless of the principal diagnosis for admission.
- Members who died at any time during the measurement year.
- Members who received hospice services any time during the measurement year.

7. Glycemic Status Assessment for Patients with Diabetes (GSD)

Data Collection Methodology: Administrative and hybrid

Measure Description: Percentage of diabetic members whose blood sugar was adequately controlled.

Measure Population (denominator): Members 18-75 years old with diabetes (type 1 or type 2).

Measure Compliance (numerator): The last glycemic status assessment of the measurement year result must be ≤9% to show evidence of control.

Documentation of either of the following that includes the result and date performed is acceptable:

- Hemoglobin A1c (HbA1c)
- Glucose Management Indicator (GMI)

For GSD, HEDIS reports both controlled (<8%) and poor control (>9%). Medicare Stars inverts poor control (>9%), capturing members whose average blood sugar is under control (≤9%).

Coding Tips:

Value Set	CPT II Code	Description
HbA1c Level Less Than or Equal To 9.0	3044F	Most recent hemoglobin A1c (HbA1c) level <7.0% (DM)
	3051F	Most recent hemoglobin A1c (HbA1c) level ≥7.0% and <8.0% (DM)
	3052F	Most recent hemoglobin A1c (HbA1c) level ≥8.0% and ≤9.0% (DM)

Please Note: CPT II codes **are not** reimbursable codes; they are informational codes. The table shows a partial list of value set codes. Additional codes are available upon request.

Medical record:

- At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result.
- The person is numerator compliant if the result of the most recent glycemic status assessment during the measurement period is ≤9%.
- When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data's date range used to derive the value. If multiple glycemic status assessments were recorded for a single date, use the lowest result.
- A distinct numeric result is required for numerator compliance.

Exclusions:

- Members 66 and older with advanced illness and frailty.
- Members 66 and older enrolled in an I-SNP or living in LTI during the measurement year.
- Members who died at any time during the measurement year.
- Members who received hospice services or palliative care at any time during the measurement year.

How to Improve Your Stars Performance

- This measure looks at the most recent HbA1c result in the measurement year. If the last result is >9% then the member is not compliant for this measure.
- Ensure documentation in the medical record includes the date when HbA1c was performed, and the result.
- Ensure documentation is clear, concise, consistent, complete, and comprehensive.
- Bill for point-of-care testing if completed in the office. Ensure to include CPT II codes to indicate the HbA1c level.
- Include numeric value; ranges and thresholds do not meet criteria (e.g., <9.0 % is not acceptable).
- This measure requires a lab value. If an HbA1c or glucose management indicator result is missing or it was not completed during the measurement year, the member is numerator compliant for HbA1c Poor Control.
- Make every visit count by utilizing monthly gap-in-care reports to identify patients who are due for labs.
- Build preventative care screening alerts in your EHR system.

8. Kidney Health Evaluation for Patients with Diabetes (KED)

Data Collection Methodology: Administrative

Measure Description: The percentage of diabetic members who received a kidney health evaluation.

Measure Population (denominator): Members 18-85 years old with diabetes (type 1 or type 2).

Measure Compliance (numerator): Diabetic members who received both of the following during the measurement year:

- Serum estimated glomerular filtration rate (eGFR)
- Urine albumin creatinine ratio (uACR) identified by either of the following:
    - o A quantitative urine albumin test and a urine creatinine test from the same urine sample, or
    - o Urine albumin creatinine ratio test (uACR)

Coding Tip: Codes are submitted by the lab company.

Exclusions:

- Members 66-80 years of age with advanced illness and frailty or 81 years of age and older with frailty.
- Members who died at any time during the measurement year.
- Members who use hospice or palliative services at any time during the measurement year.
- Members with ESRD or dialysis at any time during their history.

How to Improve Your Stars Performance

- Ensure that labs are ordered annually, preferably at the beginning of the year to allow time for necessary follow-up and completion.
- Coordinate care with specialists such as an endocrinologist or nephrologist as needed.
- Make every visit count by utilizing monthly gap-in-care reports to identify patients who are due for eGFR and uACR.
- Build preventative care screening alerts in your EHR system.

Appendix – KED Codes

9. Osteoporosis Management in Women Who Had a Fracture (OMW)

Data Collection Methodology: Administrative

Measure Description: The percentage of women who suffered a fracture and received appropriate testing or treatment for osteoporosis.

Measure Population (denominator): Female members ages 67-85 who suffered a fracture from July 1 of the year prior through June 30 of the measurement year.

Measure Compliance (numerator): Female members who received appropriate treatment or testing within six (6) months after the fracture, as defined by having either:

- A bone mineral density (BMD) test on the fracture date or within 180 days after the fracture.
    - o BMD tests during an inpatient stay are acceptable.
- Osteoporosis therapy on the fracture date or within 180 days after the fracture.
- A prescription to treat osteoporosis filled on the fracture date or within 180 days after the fracture. Members must utilize their pharmacy benefit to close the measure.
    - o Long-acting osteoporosis medications used during an inpatient stay are acceptable.

Coding Tips:

Value Set	HCPCS Code	Description
Osteoporosis Medication Therapy	J0897	Injection, denosumab, 1 mg
	J1740	Injection, ibandronate sodium, 1 mg
	J3111	Injection, romosozumab-aqqg, 1 mg
	J3489	Injection, zoledronic acid, 1 mg
	Q5136	Injection, denosumab-bbdz, biosimilar, 1 mg

Please Note: Codes for BMD will be submitted by the imaging company. Additional codes are available upon request.

Osteoporosis Medications:

Category	Prescription
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate • Risedronate • Zoledronic acid
Other agents	• Abaloparatide • Denosumab • Raloxifene • Romosozumab • Teriparatide

Exclusions:

- Members 67-80 years of age with advanced illness and frailty.
- Members 81 years of age or older with frailty.
- Members who died at any time during the measurement year.
- Members who had a bone mineral density test within the 24 months prior to the fracture.
- Members who had a fracture of a finger, toe, face, or skull.
- Members who received hospice services at any time during the measurement year.
- Members who received osteoporosis therapy within the 12 months prior to the fracture.
- Members who received palliative care from July 1st of the prior year through December 31st of the measurement year.

How to Improve Your Stars Performance

- Discuss osteoporosis prevention, including calcium, vitamin D supplements, and weight-bearing exercise.
- When appropriate, provide patients with a BMD prescription, a list of plan-approved BMD testing locations, and where to call for an appointment. Encourage patients to obtain the screening and follow up with them to ensure the test was performed.
- Remind patients to always tell their primary care provider about a fracture, even if they have received treatment for it elsewhere.
- Screen female patients starting at age 65 to reduce the risk of osteoporosis.
- Build preventative care screening alerts in your EHR system.

Appendix – OMW Codes

10. Plan All-Cause Readmissions (PCR)

Data Collection Methodology: Administrative

Measure Description: For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).

Measure Population (denominator): Number of acute inpatient hospital stays during the measurement period.

Measure Compliance (numerator): Number of readmissions for any diagnosis within 30 days of discharge from an acute hospital stay.

Exclusions:

- Members who died during the hospital stay.
- Members who received hospice services at any time during the measurement year.
- Members with a primary diagnosis of pregnancy on the discharge claim.
- Members with an acute hospitalization where the discharge claim has a diagnosis of:
    - o Chemotherapy maintenance
    - o Principle diagnosis of rehabilitation
    - o Organ transplant
    - o Potentially planned procedure without a principal acute diagnosis

How to Improve Your Stars Performance

- Always track hospital discharges to identify any patients who are a part of the PCP's patient panel.
- Contact patient to schedule a post-discharge follow-up visit with PCP.
- Utilize ADT data from Manifest MedEx.

11. Statin Therapy for Patients with Cardiovascular Disease (SPC-E)

Data Collection Methodology: ECDS

Measure Description: The percentage of members with clinical atherosclerotic cardiovascular disease (ASCVD) who are dispensed and remain adherent to statin therapy.

Measure Population (denominator): Members 21-75 years old during the measurement year and identified as having clinical ASCVD, such as:

- Myocardial infarction (MI)
- Coronary artery bypass graft (CABG)
- Ischemic vascular disease (IVD)
- Percutaneous coronary intervention (PCI)
- Other revascularization procedure

Measure Compliance (numerators): Dispensed Statin (initiation): Members dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

High- and Moderate-Intensity Statin Medications

Category	Prescription
High-intensity	• Amlodipine-atorvastatin 40-80 mg • Atorvastatin 40-80mg • Ezetimibe-simvastatin 80 mg • Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-intensity	• Amlodipine-atorvastatin 10-20 mg • Atorvastatin 10-20 mg • Ezetimibe-simvastatin 20-40 mg • Fluvastatin 40-80 mg • Lovastatin 40 mg • Pitavastatin 1-4 mg • Pravastatin 40-80 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg

Please Note: Members must use their Part D pharmacy benefit to close this measure.

Exclusions:

- Member 66 years of age and older with advanced illness and frailty.
- Members who died at any time during the measurement year.
- Members who had any of the following during the measurement year or the year prior:
    - o Cirrhosis
    - o Pregnancy diagnosis, In vitro fertilization (IVF), or at least one (1) prescription for clomiphene
- Members who had myalgia or rhabdomyolysis caused by a statin at any time during the member's history.
- Members who received hospice services or palliative care at any time during the measurement year.
- Members who were diagnosed with end-stage renal disease or dialysis, Myalgia, myositis, myopathy, or rhabdomyolysis during the measurement year.

How to Improve Your Stars Performance

- Ensure the prescription details (drug name, strength, dose, route, and date) are accurately documented.
- Encourage members to contact you if they think they are experiencing side effects from statin medication.
- Schedule appropriate follow-up to assess if medication is taken as prescribed.
- Build preventative care screening alerts in your EHR system.

12. Transitions of Care (TRC)

Data Collection Methodology: Administrative and hybrid

Measure Description: The percentage of members who received continuity of health care following an inpatient discharge.

Measure Population (denominator): Members 18 years and older with an acute or non-acute inpatient discharge on or between January 1st and December 1st of the measurement year.

Please Note: If members have multiple discharges, they could appear in the measure more than once.

Measure Compliance (numerator): Members who had all four (4) of the following numerators completed and documented in the outpatient medical record:

1. Notification of Inpatient Admission
2. Receipt of Discharge Information
3. Patient Engagement after Inpatient Discharge
4. Medication Reconciliation Post-Discharge

Outpatient Medical Record Requirements:

Numerator	Measurement	Medical Record Criteria
1. Notification of Inpatient Admission	Receipt of notification of inpatient admission and evidence that the information was integrated in the appropriate medical record on the day of admission through two (2) days after admission (three (3) days total). **Please Note:** Can only be met through a medical record review (MRR).	Must include the date of receipt and any of the following criteria: • Communication from inpatient practitioner, hospital staff, or ED regarding admission (phone call, email, or fax). Referral to an ED does not meet the criteria. • Documentation that the PCP or managing specialist admitted the member, or a specialist admitted with PCP or managing specialist notification. • Communication about admission through a health information exchange: an admission, discharge, and transfer alert system (ADT) or a shared electronic medical record (EMR). • Documentation indicating the PCP or managing specialist placed orders for tests and treatments at any time during the member's inpatient stay. • Documentation of a preadmission exam or a planned admission prior to the admit date. The exam must refer to the planned admission (not just pre-op or pre-surgical). • Communication from the member's health plan regarding admission. **Please Note:** Documentation that the member/caregiver notified the PCP or managing specialist of the admission does not count.

Numerator	Measurement	Medical Record Criteria
2. Receipt of Discharge Information	Receipt of discharge information and evidence that the information was integrated in the appropriate medical record on the day of discharge through two (2) days after discharge (three (3) days total). **Please Note:** Can only be met through an MRR.	Must include the date of receipt and all the following criteria: • The practitioner responsible for the member's care during the inpatient stay • Procedures or treatment provided • Diagnoses at discharge • Current medication list • Testing results, documentation of pending tests, or documentation of no tests pending • Instructions for patient care post-discharge **Please Note:** Documenting that the member/caregiver notified the PCP or managing specialist of the discharge does not count.
3. Patient Engagement After Inpatient Discharge	Patient engagement is provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.	Must include the date of engagement with any of the following criteria: • An outpatient visit, including office visits and home visits. • Virtual care visits (asynchronous or synchronous). • Documentation indicating a conversation occurred with the member, regardless of practitioner type. For example, medical assistants (MA), and registered nurses may perform the patient engagement. • Interactions between the member's caregiver and practitioner.
4. Medication Reconciliation Post-Discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 days total). • Must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. Other staff members (e.g., MA or Licensed practical nurse (LPN)) may conduct the medication reconciliation, but it must be signed off by the required practitioner type. • Must be in the outpatient medical record, but an outpatient face-to-face visit is not required.	Must include the date performed AND specific documentation of inpatient hospitalization with any of the following criteria: • Current medication list with a notation that the practitioner reconciled the current and discharge medications. • Current medication list with reference to discharge medications (e.g., no changes in meds post-discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed). • Current medication list and discharge medication list with evidence both lists reviewed on the same date of service. • Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • Discharge summary medication list indicates reconciled with current meds. Must be filed in the outpatient record within 30 days after discharge. • Documentation that no medications were prescribed or ordered upon discharge.

Coding Tips:

Value Set Name	CPT Code	Description
Medication Reconciliation Encounter	99483	Assessment and care plan patient cognitively impaired
	99495	Transitional care management moderate, face-to-face 14 days
	99496	Transitional care management high, face-to-face 7 days
Medication Reconciliation Intervention	1111F CPT II	Discharge medications reconciled with the current medication list in outpatient medical record
Outpatient and Telehealth	98016	Brief communication technology-based service
	99202	Office or other outpatient visit new straightforward 15 minutes
	99203	Office or other outpatient visit new low 30 minutes
	99204	Office or other outpatient visit new moderate 45 minutes
	99205	Office or other outpatient visit new high 60 minutes
	99211	Office or other outpatient established may not require physician or other qualified healthcare professional
	99212	Office or other outpatient established straightforward 10 minutes
	99213	Office or other outpatient established low 20 minutes
	99214	Office or other outpatient established moderate 30 minutes
	99215	Office or other outpatient established high 40 minutes
	99242	Office or other outpatient consultation new/established straightforward 20 minutes
	99243	Office or other outpatient consultation new/established low 30 minutes
	99244	Office or other outpatient consultation new/established moderate 40 minutes
	99245	Office or other outpatient consultation new/ established high 55 minutes
Transitional Care Management Services	99495	Transitional care management moderate face-to-face 14 days
	99496	Transitional care management high face-to-face 7 days

Please Note: The table shows a partial list of value set codes. Additional codes are available upon request.

Exclusions

- Members who died at any time during the measurement year.
- Members who received hospice services at any time during the measurement year.

How to Improve Your Stars Performance

- ADT alerts of inpatient admission should land in the EHR with an auto date/time stamp.
- If the discharge summary is faxed or scanned, document 'date received' and upload into the chart.
- Ensure documentation is clear, concise, consistent, complete, and comprehensive.
- Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Medication reconciliation can be completed without the member present.
- Schedule appointments with members within the first seven (7) days of discharge.
- Remind members of their appointment by making calls or sending texts.
- Make outreach calls and/or send letters to advise members of the need for a visit.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) – Overview

The Centers for Medicare and Medicaid Services (CMS) require the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) to:

- Assess patient satisfaction and experience with healthcare providers and plans.
- Help individuals make informed decisions when choosing providers or health plans.
- Measure how well plans and their contracted entities help members maintain or improve their physical and mental health.
- Provide data for organizations to improve the quality of care.

Please encourage patients to complete these surveys. Results of these surveys drive meaningful changes to improve how individuals engage with providers, receive services, and navigate the health care system, with the goal of enhancing continuity of care for better health outcomes.

For more information, please email the Alliance Medicare Stars team at **DeptStarsTeam@alamedaalliance.org**. Or you can visit **cahps.ahrq.gov** and **hosonline.org**.

CAHPS and HOS Frequently Asked Questions (FAQs)

Question: Why is the Alliance sending out member experience surveys?

Answer: The Alliance is federally required to have CAHPS and HOS administered to a random sample of Alameda Alliance Wellness members. Survey responses account for a significant portion of our plan's Medicare Star Rating. Alliance Group Care and Medi-Cal members may also receive a member experience survey during the year. However, their responses do not contribute to the plan's Medicare Star rating.

Question: Why do health care providers need to know about CAHPS and HOS?

Answer: Care teams play a key role in patient experience. An individual's experience influences the provider-patient relationship, adherence to treatment plans, and retention within the health system.

Question: What if my practice administers our own patient experience survey?

Answer: This is great! However, we do ask that you delay from administering your surveys influenced by CAHPS when our official survey is administered, which is annually, from March through June.

Question: How can members complete the CAHPS and HOS survey?

Answer: Surveys may be completed over the phone or mailed. From March through June of each year, a random sample of Alameda Alliance Wellness members will receive the CAHPS survey. From July through November of each year, a random sample of Alameda Alliance Wellness members will receive the HOS. We highly encourage practices to inform their patients that they may receive these surveys and should complete them.

Question: Will the Alliance talk to members about CAHPS and HOS?

Answer: Members are informed that they may receive member experience surveys in the Welcome Kit and on our website. Between late February and June, we are prohibited from asking members questions that can influence their official survey responses.

How to Improve Your Stars Performance

- Hold appointment slots for sick visits and urgent needs. Inform patients of telehealth options, weekend appointments, alternative locations, and/or affiliated urgent care sites. The 24/7 Advice Nurse Line is **1.888.433.1876**.
- Confirm the patient's care team, including specialists, and review current medications during every encounter.
- Include functional, cognitive, and balance/gait assessments in standard screening questionnaires, especially during annual wellness visits.
- Explain lab orders and referrals, their purpose, and when follow-up may be needed.
- Proactively schedule follow-up appointments during check-out.

CAHPS Survey Questions

Annual Flu Vaccine

- Have you had a flu shot in the past year?

Getting Needed Care

- In the last six (6) months, how often was it easy to get the care you needed?

Getting Appointments and Care Quickly

- In the last six (6) months, how often did you get care as soon as you needed?
- In the last six (6) months, how often did you get an appointment for a routine visit when you needed it?

Rating of Health Care Quality

- From zero (0) to ten (10), with ten being best, in the last six (6) months, how would you rate the health care you have received?

Care Coordination

- In the last six (6) months, when you had a visit with your primary care provider, how often were they informed about your care and current treatments?
- In the last six (6) months, when you had a visit with your primary care provider, how often were they informed about your specialists?
- In the last six (6) months, when you had a visit with your primary care provider and they ordered a test for you, how often did someone from the office update you on your results?
- In the last six (6) months, did your primary care provider's office help manage the different healthcare providers you see or services you need?

HOS Survey Questions

Monitoring Physical Activity

- In the past 12 months, did your primary care provider or another health care provider recommend you exercise or take part in a physical activity?

Reduce the Risk of Falling

- In the past 12 months, did your primary care provider or another health care provider talk with you about falling or about your balance?
- Has your primary care provider or another health care provider recommended anything to help prevent falls or improve your balance? This may include:
    - o Cane or walker
    - o Exercise or physical therapy
    - o Vision or hearing test

Improving Bladder Control

- Have you ever talked with a health care provider about urinary incontinence?

Improving/Maintaining Physical Health

- During the past four (4) weeks, have you had any of these issues with your work or other regular activities because of your physical health?
    - o Did not accomplish as much as you would like.
    - o Were restricted in the type of work or other activities you were able to complete.
- During the past four (4) weeks, how much did pain interfere with your work inside and outside of your home?

Improving/Maintaining Mental Health

- During the past four (4) weeks, have you had any of these issues with your work or other regular activities because of any emotional problems?
    - o Did not accomplish as much as you would like.
    - o Did not do your work or other activities as carefully as usual.
- How much of the time during the past four (4) weeks:
    - o Did you feel calm and peaceful?
    - o Did you have a lot of energy?
    - o Did you feel downhearted or blue?

1. Concurrent Use of Opioids and Benzodiazepines (COB)

Measure Description: These measures evaluate whether Medicare members are on both prescription opioids and benzodiazepines. While there are instances where concurrent use is appropriate, it is considered a serious safety concern. The COB measures define concurrent use of overlapping days' supply for opioid and benzodiazepines of at least 30 cumulative days during the measurement period.

Measure Compliance (numerator): Members from the eligible population who have at least two (2) prescription claims of a benzodiazepine with unique dates of service and concurrent use of opioids and benzodiazepines during the measurement period.

Please Note: A lower rate indicates better performance.

Measure Population (denominator): Members 18 years of age and older with concurrent use of two (2) or more prescription opioids and benzodiazepine, and at least a 15 cumulative day supply of opioids during the measurement period.

Exclusions: The following members are excluded from the denominator if at any time during the measurement period:

- Cancer diagnosis
- Hospice
- Palliative care
- Sickle cell disease

Clinical Evidence:

- Concurrent use of opioids and benzodiazepines may increase the risk of respiratory depression. This is especially true for overlapping prescriptions from multiple clinicians who aren't coordinating care.
- The American Geriatrics Society Beers Criteria recommends against the use of all benzodiazepines in older adults, as they can cause an increased risk of falls, cognitive impairment, and delirium.

How to Improve Your Stars Performance

- Clinicians should closely monitor patients who are unable to taper and who continue high-dose or high-risk regimens (e.g., opioids prescribed with benzodiazepines).
- Long-term use of benzodiazepines could increase the risk of cognitive impairment, delirium, falls, fractures, and motor vehicle crashes, especially in older adults.
- Discuss benefits, risks, and safer non-opioid alternatives with patients.
- Patients who have been assessed with risk factors for overdose should be prescribed naloxone.
- Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are the first line for the preferred initial therapy option, as they are effective and well-tolerated.
- The selection of Cognitive Behavioral Therapy (CBT) vs medication is dependent on the patient and shared decision-making with providers. A combination of CBT and medication yields a superior response rate.
- Benzodiazepines are used for patients who are refractory to prior antidepressants.
- Patients who have been on benzodiazepines for four (4) to six (6) weeks should be considered for tapering.

2. Medication Adherence (MA)

Measure Description: The percentage of plan members who have a medication prescription for diabetes, hypertension, or cholesterol and who fill their prescription often enough to cover 80% or more of the time they are taking the medication.

Medication Adherence has three (3) measures:

- Medication adherence for diabetes medications,
- Medication adherence for hypertension (RAS antagonists), and
- Medication adherence for cholesterol (statins).

Measure Compliance (numerator): Members from the eligible population who maintained a proportion of days covered (PDC) of ≥80% to their prescribed medications within the therapeutic class during the measurement year.

Measure Population (denominator): Medicare Part D beneficiaries, 18 years of age and older with at least two (2) medication fills for diabetes, hypertension, or cholesterol, on unique dates of service during the measurement year.

Exclusions: The following members are excluded from the denominator if at any time during the measurement period:

- In hospice
- ESRD diagnosis or dialysis coverage dates
- One (1) or more prescriptions for insulin (for diabetes measure only)
- One (1) or more prescriptions for sacubitril/valsartan (for hypertension measure only)

Overview of the Three (3) Adherence Measures

Measure	Description	Importance	Medication Class Included
Medication Adherence for Diabetes Medications	Evaluates the percentage of Medicare members who filled prescriptions for diabetes medications (e.g., metformin, SGLT2 inhibitors, etc.) and maintained at least 80% (measured by PDC) adherence during the measurement year.	Consistent use of diabetes medications is associated with improved glycemic control and a lower risk of complications.	Biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)- 4 Inhibitors, GIP/GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Part D – Pharmacy Measures

Measure	Description	Importance	Medication Class Included
Medication Adherence for Hypertension (RAS Antagonists)	Assesses the percentage of members taking medication in the renin-angiotensin system (RAS) antagonist class (e.g., ACE inhibitors, ARBs) who maintained a PDC of ≥80% during the measurement year	Adherence to antihypertensives helps reduce the risk of stroke, heart attack, and kidney disease in patients with high blood pressure.	Angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications.
Medication Adherence for Cholesterol (Statins)	Measure the percentage of members prescribed statins who achieved ≥80% PDC during the measurement year.	Statins are essential in managing cardiovascular risk, particularly in patients with diabetes or atherosclerotic cardiovascular disease.	Statins

What is Proportion of Days Covered (PDC)?

PDC is the percentage of days a member had their medication available over the course of a year. A PDC of 80% or greater is considered adherent.

PDC accounts for:

- Overlapping fills
- Switching between drugs in the same therapeutic class
- Total days supplied (PDC is a day-level adherence measure – not just a count of how many times a member filled their medication)

How to Improve Your Stars Performance

- Prescribe 90-day supplies whenever clinically appropriate to reduce refill gaps.
- Align refill dates for patients on multiple chronic medications.
- Encourage mail-order pharmacy for reliable, timely delivery.
- Simplify regimens (e.g., once-daily dosing) to reduce complexity.
- Assess barriers at each visit (cost, side effects, transportation, forgetfulness).
- Pill boxes or blister/bubble packs for easier organization.
- Pharmacy or mobile reminder alerts for timely doses.
- Use automatic refill programs to prevent missed fills.
- Review and address side effects promptly.
- Screen for and address Social Determinants of Health (SDOH) barriers.

3. Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)

Measure Description: This measure evaluates Medicare beneficiaries who are 65 years of age or older with concurrent use of two (2) or more unique anticholinergic (ACH) medications during the measurement year.

Measure Compliance (numerator): Members from the eligible population who have at least two (2) or more distinct ACH medications, with an overlap of 30 or more days. A lower rate indicates better performance.

Measure Population (denominator): Members 65 years or older, with at least two (2) claims for the same anticholinergic medication during the measurement year.

Exclusions: The following members are excluded from the denominator if at any time during the measurement period:

- Hospice

Medications Included in the Measure

Drug Class	Drug name	Recommended Alternatives (over-the-counter not covered)
Antidepressants	Amitriptyline, Clomipramine, Doxepin (>6 mg/day), Nortriptyline, Paroxetine	• Escitalopram, sertraline • Duloxetine, Desvenlafaxine, Venlafaxine
Antihistamines	Diphenhydramine(oral), Doxylamine, Hydroxyzine, Meclizine	• Second-generation antihistamines (e.g., levocetirizine, loratadine, cetirizine) • Intranasal normal saline • Intranasal steroid
Antimuscarinics	Oxybutynin, Darifenacin, Trospium	• Mirabegron • Vibegron
Anti-nausea	Prochlorperazine, Promethazine, Scopolamine	• Ondansetron, palonosetron
Antiparkinsonian agents	Amantadine, Benztropine, Trihexyphenidyl	• Carbidopa/Levodopa • Pramipexole, Ropinirole • Selegiline, Rasagiline • Entacapone
Antipsychotics	Chlorpromazine, Clozapine, Olanzapine	Avoid antipsychotics for behavioral problems of dementia or delirium unless behavioral interventions have failed.
Skeletal Muscle Agents	Carisoprodol, Cyclobenzaprine, Methocarbamol	• Baclofen (eGFR >60) • Ibuprofen, Naproxen (short term) • Acetaminophen

Please Note: This is not an all-inclusive list.

How to Improve Your Stars Performance

- Review indication and duration for each anticholinergic medication and discontinue medications where potential harm outweighs the benefit. Discuss benefits, risks, and safer alternatives with patients.
- Keep in mind over-the-counter drugs such as Diphenhydramine (Benadryl) during your medication reconciliation.
- When conducting a medication reconciliation, look for any prescribing cascade.
    - For example: If a prescriber prescribes Donepezil and your patient experiences incontinence, prescribers may prescribe Oxybutynin to help counter the incontinence without realizing that this is a side effect of Donepezil. Another example is prescribing antiparkinsonian drugs to counter the side effects of an antipsychotic.
- Educate patients on the risk of side effects using multiple anticholinergic medications.

4. Statin Use in Persons with Diabetes (SUPD)

Measure Description: This measure evaluates the percentage of Medicare members with diabetes who received a statin medication filled during the measurement year to reduce their risk of developing heart disease.

Measure Compliance (numerator): Members from the eligible population who received a statin medication fill during the measurement year.

Measure Population (denominator): Medicare Part D beneficiaries, 40-75 years old, with at least two (2) diabetes medication fills on unique dates of service during the measurement year, and the first prescription fill date for a diabetes medication occurs at least 90 days prior to the end of the measurement year.

Exclusions: The following members are excluded from the denominator if at any time during the measurement period:

- Cirrhosis
- ESRD diagnosis or dialysis coverage dates
- Hospice Enrollment
- Polycystic Ovary Syndrome
- Pre-Diabetes
- Pregnancy, Lactation, and Fertility
- Rhabdomyolysis and Myopathy

High-Intensity and Moderate-Intensity Statin

High intensity statin (lowers LDL by >50%)	Moderate-intensity statin therapy (lower LDL by 30-49%)
Atorvastatin 40-80 mg	Atorvastatin 10-20 mg
Rosuvastatin 20-40 mg	Rosuvastatin 5-10 mg
Amlodipine-Atorvastatin 40-80 mg	Simvastatin 20-40 mg
Ezetimibe-Simvastatin 80 mg	Pravastatin 40-80 mg
Simvastatin 80 mg	Lovastatin 40 mg
	Fluvastatin XL 80 mg
	Pitavastatin 1-4 mg
	Amlodipine-Atorvastatin 10-20 mg
	Ezetimibe-Simvastatin 20-40 mg

How to Improve Your Stars Performance

- Hydrophilic statins such as Pravastatin and Rosuvastatin are less likely to cause myopathy.
- For patients with diabetes and Atherosclerotic Cardiovascular Disease (ASCVD), high-intensity statin therapy is recommended.
- The addition of Ezetimibe or a PCSK9 inhibitor is recommended if the goal is not achieved on maximum tolerated statins or intolerant to statins. These drugs may require prior authorization.
- Bempedoic acid is a novel LDL-lowering agent that avoids direct muscle effects; it may require prior authorization.
- A two (2)-week washout period is recommended for statin-associated muscle side effects.

Initial Preventive Physical Exam and Annual Wellness Visit (IPPE/AWV)

Methodology: Medicare

Measure Description: Members enrolled in Alameda Alliance Wellness who had one (1) IPPE or AWV in the measurement year.

Measure Population (denominator): Members who are enrolled in Alameda Alliance Wellness.

Measure Compliance (numerator): Members in the denominator who receive an IPPE or AWV within the measurement year.

Visit Components:

Component	IPPE	AWV
Eligibility/ Frequency	Once per lifetime, within the first 12 months of Medicare Part B enrollment.	Annually
Purpose	Health promotion, disease prevention, and detection to help members stay well.	Develop/update a personalized prevention plan and perform a Health Risk Assessment.
Health History	Review of medical and social history and family history.	Review/update medical, family, and social history.
Health Risk Assessment	Initial Health Risk Assessment is completed.	Health Risk Assessment is administered/updated
Physical Exam	Includes a physical exam: • Blood pressure • BMI • Height • Visual acuity screening • Weight	Routine measurements taken, but generally no hands-on physical exam: • Blood pressure • BMI • Height • Weight
Cognitive Assessment	Review of potential risk factors for depression and other mood disorders.	Detection of possible cognitive impairment is mandatory.
Functional/Safety Assessment	Review of functional ability and level of safety: • Fall risk • Hearing impairment • Home safety	Assessment of functional ability and level of safety.
Medication Review	Review of current medications and supplements	Review/update of current prescriptions, supplements, and list of providers/suppliers.

Preventive Care Visits – Initial Preventive Physical Exam and Annual Wellness Visit (IPPE/AWV)

Component	IPPE	AWV
Preventive Plan/ Education	Education, counseling, and referrals for preventive services.	Development/update of a personalized prevention plan and a screening schedule for appropriate services.
Advance Care Planning	Optional	Optional

Coding Tips:

HCPCS Code	Description
G0402	Initial Preventive Physical Examination (IPPE) or "Welcome to Medicare Visit." Medicare pays for one (1) IPPE per lifetime within the first 12 months a patient has Medicare Part B coverage.
G0438	Initial Annual Wellness Visit
G0439	Subsequent Annual Wellness Visit. Billed each subsequent year after the initial visit.
G0468	An IPPE or AWV completed by a Federally Qualified Health Center (FQHC).

How to Improve Your IPPE/AWV Rates

- Perform AWVs early in the year, preferably within the first six (6) months.
- Encourage patients to arrive 15 minutes prior to their scheduled appointment to complete the health risk assessment if not completed prior to check-in.
- Develop a template in your EMR that captures all necessary components of an IPPE and AWV.
- Ensure all active conditions are properly documented in the medical record and coded on the claim.
- Schedule follow-ups and next year's AWV during check-out.
- Make every visit count by utilizing monthly gap-in-care reports to identify patients who are due for an AWV.

Appendix – Reference Guide for Providers

Measure Type	Measure	Description	Documentation
HEDIS®	**Controlling High Blood Pressure (CBP)**	Members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	Use the appropriate CPT II codes to document the lowest systolic and diastolic readings from the visit: • **Systolic <130:** 3074F • **Systolic 130-139:** 3075F • **Systolic ≥140:** 3077F • **Diastolic <80:** 3078F • **Diastolic 80-89:** 3079F • **Diastolic ≥90:** 3080F
HEDIS®	**Statin Therapy for Patients with Cardiovascular Disease (SPC-E) – Received Statin Therapy**	Members 21-75 years of age during the measurement period who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: • Received Statin Therapy. Members who were dispensed at least one (1) high-intensity or moderate-intensity statin medication during the measurement period.	• Ensure the prescription details (drug name, strength, dose, route, and date) are accurately documented. • Document any side effects a member experiences when taking a statin.
HEDIS®	**Glycemic Status Assessment for Patients with Diabetes (GSD)**	Members 18-75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was controlled (≤9%) on the latest reading in the measurement year.	• Document the HbA1c or GMI test in the measurement year, along with the result. Goal is <8.0%. • Repeat labs indicating poor control (>9.0%) later in the measurement year. • When the service is completed off-site, obtain the record and results to ensure the medical record is complete.

Measure Type	Measure	Description	Documentation
HEDIS®	**Eye Exam for Patients with Diabetes (EED)**	Members 18-75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.	• Document the date of service eye exam was rendered by an eye care professional, and the results (specialty must be noted) • Member-reported retinal eye exams are acceptable when performed and documented in the acceptable time frame. Member-reported retinal eye exams are acceptable when performed and documented in the acceptable time frame. • Documented while obtaining a history (e.g., member reports they were examined by optometrist Dr. Vision in 2024 with results negative for retinopathy).
HEDIS®	**Kidney Health Evaluation for Patients with Diabetes (KED)**	Members 18-85 years of age with diabetes (type 1 or type 2) who received the following kidney health evaluation during the measurement year: • An estimated glomerular filtration rate (eGFR) and • A urine albumin-creatinine ratio (uACR)	Based on claims data.
HEDIS®	**Breast Cancer Screening (BCS-E)**	Women 40-74 years of age who had a mammogram between October 1, two (2) years prior to the measurement period, and December 31 of the measurement period.	Based on claims data.

Measure Type	Measure	Description	Documentation
HEDIS®	**Colorectal Cancer Screening (COL-E)**	Members 45-75 years of age who had appropriate screening for colorectal cancer. Qualifying screenings include: • Fecal Occult Blood Test (gFOBT) • Fecal immunochemical test (FIT) • Multitargeted stool DNA with FIT test (sDNA FIT) (e.g., Cologuard®) • Flexible Sigmoidoscopy • CT colonography • Colonoscopy	• When the screening is completed off-site, obtain the record and results and document in the member's chart to ensure the medical record is complete. • Document if the member has had a total colectomy at any time during the member's history.
HEDIS®	**Care for Older Adults (COA) – Functional Status Assessment (FSA)**	Members 66 years of age and older who had an FSA during the measurement year, using a standardized tool.	• ADLs were assessed or that at least five (5) of the following were assessed: bathing, dressing, eating, transferring, using the toilet, and walking. • Notation that Instrumental Activities of Daily Living (IADLs) were assessed, or at least four (4) of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medication, handling finances. • Result of assessment using a standardized assessment tool

Measure Type	Measure	Description	Documentation
HEDIS®	**Care for Older Adults (COA) – Medication Review**	Members 66 years of age and older with a medication review completed during the measurement year.	• Evidence of a 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. • A medication list, signed and dated during the measurement year by the appropriate practitioner type (RNs, LPNs, MAs, or CMAs are not acceptable). • If the member is not taking any medication, document in the medical record with the date.
HEDIS®	**Transitions of Care (TRC) – Patient Engagement After Inpatient Discharge**	Members 18 years of age and older who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.	Based on claims data.
HEDIS®	**Transitions of Care (TRC) – Medication Reconciliation Post-Discharge**	Members 18 years of age and older who had documentation of medication reconciliation on the date of discharge through 30 days after discharge.	• Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • Medication reconciliation can be completed without the member present.
HEDIS®	**Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)**	Members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within seven (7) days of the ED visit.	Based on claims data.

Measure Type	Measure	Description	Documentation
HEDIS®	**Osteoporosis Management in Women Who Had a Fracture (OMW)**	Women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the 180 days (six (6) months) after the fracture.	Based on claims data.
HEDIS®	**Plan All-Cause Readmissions (PCR)**	Members 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).	Based on claims data.
Preventive Care Visits	**Initial Preventive Physical Exam (IPPE) or an Annual Wellness Visit (AWV)**	Members enrolled in Alameda Alliance Wellness who have had one (1) IPPE or AWV in the measurement year.	Based on claims data.

Measure Type	Measure	Description	Documentation
HEDIS®	**Controlling High Blood Pressure (CBP)**	Members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.	**CPT II:** • **Systolic <130:** 3074F • **Systolic 130-139:** 3075F • **Systolic ≥140:** 3077F • **Diastolic <80:** 3078F • **Diastolic 80-89:** 3079F • **Diastolic ≥90:** 3080F
HEDIS®	**Statin Therapy for Patients with Cardiovascular Disease (SPC-E) – Received Statin Therapy**	Members 21-75 years of age during the measurement period who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: • Received Statin Therapy. Members who were dispensed at least one (1) high-intensity or moderate-intensity statin medication during the measurement period.	**Myalgia** **ICD-10-CM:** M79.10-M79.12, M79.18 **Myositis** **ICD-10-CM:** M60.80, M60.811,M60.812, M60.21, M60.22, M60.29, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89 **Myopathy** **ICD-10-CM:** G72.0, G72.2, G72.9 **Rhabdomyolysis** **ICD-10-CM:** M62.82 **Cirrhosis** **ICD-10-CM:** K70.30, K71.7, K74.3-K74.60, K74.69, P78.81 **End-stage renal disease** **ICD-10-CM:** K74.69, P78.81 **Dialysis** **HCPCS:** S9339, G0257 **CPT:** 90935, 90937, 90945, 90947, 90997, 90999

Appendix – Reference Guide for Billing Staff

Measure Type	Measure	Description	Documentation
HEDIS®	**Glycemic Status Assessment for Patients with Diabetes (GSD)**	Members 18-75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was controlled (≤9%) on the latest reading in the measurement year.	**HbA1c level <7.0%:** **CPT II:** 3044F **HbA1c level ≥7.0% and <8.0%:** **CPT II:** 3051F **HbA1c level ≥8.0% and ≤9.0%:** **CPT II:** 3052F
HEDIS®	**Eye Exam for Patients with Diabetes (EED)**	Members 18-75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.	Codes submitted by an eye care professional.
HEDIS®	**Kidney Health Evaluation for Patients with Diabetes (KED)**	Members 18-85 years of age with diabetes (type 1 or type 2) who received the following kidney health evaluation during the measurement year: • An estimated glomerular filtration rate (eGFR) and • A urine albumin-creatinine ratio (uACR).	Codes submitted by the laboratory.
HEDIS®	**Breast Cancer Screening (BCS-E)**	Women 40-74 years of age who were recommended for routine breast cancer screening and completed a mammogram.	Codes submitted by the imaging center. **Unilateral Mastectomy** **CPT:** 19180, 19220, 19240, 19303-19307 **Gender Dysphoria** **CPT:** 19318
HEDIS®	**Colorectal Cancer Screening (COL-E)**	Members 45-75 years of age who had appropriate screening for colorectal cancer, which includes: • Fecal Occult Blood Test (gFOBT) • Fecal immunochemical test (FIT) • Multitargeted stool DNA with FIT test (sDNA FIT) (e.g., Cologuard®) • Flexible Sigmoidoscopy • CT colonography • Colonoscopy	Codes submitted by a specialist or laboratory.

Measure Type	Measure	Description	Documentation
HEDIS®	**Care for Older Adults (COA) – Functional Status Assessment**	Members 66 years of age and older who had a functional status assessment during the measurement year using a standardized tool, including but not limited to the following: • Assessment of Living Skills and Resources (ALSAR) • Barthel ADL Index Physical Self-Maintenance (ADLS) Scale© • Barthel Index© • Bayer ADL (B-ADL) Scale • 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 & Brody's IADL scales© • Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales© • SF-36®	**FSA** **CPT:** 99483 **CPT II:** 1170F **Care Management** **CPT:** 99496
HEDIS®	**Care for Older Adults (COA) – Medication Review**	Members 66 years of age and older with a medication review completed during the measurement year.	**Medication List** **CPT II:** 1159F **Medication Review** **CPT:** 99483, 99605, 99606 **CPT II:** 1160F

Measure Type	Measure	Description	Documentation
HEDIS®	**Transitions of Care (TRC) – Patient Engagement After Inpatient Discharge**	Members 18 years of age and older who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.	**Outpatient and Telehealth** **CPT:** 98016, 99202-99205, 99211-99215, 99242-99245, 99341, 99342, 99344, 99345 **Transitional Care Management** **CPT:** 99495, 99496
HEDIS®	**Transitions of Care (TRC) – Medication Reconciliation Post Discharge**	Members 18 years of age and older who had documentation of medication reconciliation on the date of discharge through 30 days after discharge.	**Medication Reconciliation Encounter** **CPT:** 99483, 99495, 99496 **Medication Reconciliation Intervention** **CPT:** 99605, 99606
HEDIS®	**Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)**	Members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within seven (7) days of the ED visit.	**Outpatient and Telehealth** **CPT:** 98016, 99202-99205, 99211-99215, 99242-99245, 99341-99345 **Transitional Care Management Services** **CPT:** 99495, 99496 **Case Management Encounter** **CPT:** 99366 **HCPCS:** T1016, T1017, T2022 **Complex Care Management Services** **CPT:** 99439, 99490, 99491 **HCPS:** G0506
HEDIS®	**Osteoporosis Management in Women Who Had a Fracture (OMW)**	Women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the 180 days (six (6) months) after the fracture.	**Bone Mineral Density Tests** **CPT:** 77080, 77081, 77085, 77086 **ICD-10-PCS:** BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **Osteoporosis Medication Therapy** **HCPS:** J0897, J1740, J3111, J3489, Q5136

Measure Type	Measure	Description	Documentation
HEDIS®	**Plan All-Cause Readmissions (PCR)**	Members 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).	Codes submitted by the facility.
Preventive Care Visits	**Initial Preventive Physical Exam (IPPE) or an Annual Wellness Visit (AWV)**	Members enrolled in Alameda Alliance Wellness who have had one (1) IPPE or AWV in the measurement year.	IPPW/AWV Code for FQHCs: **HCPCS:** G0468

1. Eye Exam for Patients with Diabetes (EED)

Value Set	Code		Description
Retinal Eye Exams	CPT	92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
		92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
		92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
		92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
		92018	Complete ophthalmological examination and evaluation performed under general anesthesia
		92019	Limited ophthalmological examination and evaluation under general anesthesia
		92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
		92201	Extended Ophthalmoscopy with retinal drawing and scleral depression for the peripheral retina, with interpretation and report, performed unilaterally or bilaterally
		92202	Extended ophthalmoscopy with drawing of the optic nerve or macula, along with an interpretation and report, for conditions like glaucoma or macular pathology
		92230	Fluorescein angioscopy with interpretation and report
		92235	Fluorescein angiography includes multi-frame imaging
		92250	Fundus photography with interpretation and report
		99203	Office outpatient new low 30 minutes
		99204	Office outpatient new moderate 45 minutes
		99205	Office outpatient new high 60 minutes
		99213	Office outpatient established low 20 minutes
		99214	Office outpatient established moderate 30 minutes

Appendix – Additional Value Set Codes

Value Set	Code		Description
Retinal Eye Exams (cont.)	CPT	99215	Office outpatient established high 40 minutes
		99242	Office outpatient consultation new or established straightforward 20 minutes
		99243	Office outpatient consultation new or established low 30 minutes
		99244	Office outpatient consultation new or established moderate 40 minutes
		99245	Office outpatient consultation new or established high 55 minutes
Retinal Imaging	CPT	92137	Computerized ophthalmic diagnostic imaging of the posterior segment (retina) including OCT angiography (OCT-A)
		92227	Imaging of retina for detection or monitoring of disease clinical staff
		92228	Imaging of retina for detection or monitoring of disease physician/ QHP
Eye Exam With Evidence of Retinopathy	CPT-CAT-II	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
		2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
		2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)
Eye Exam Without Evidence of Retinopathy	CPT-CAT-II	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
		2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
		2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)

EDD Measure Details

2. Kidney Health Evaluation for Patients with Diabetes (KED)

Value Set	Code		Description
Estimated Glomerular Filtration Rate Lab Test	CPT	80047	Metabolic panel ionized calcium
		80048	Metabolic panel total calcium
		80053	Comprehensive metabolic panel
		80069	Renal function panel
		82565	Assay of creatinine
	LOINC	102097-3	Glomerular filtration rate/1.73 sq m. predicted [volume rate/area] in serum, plasma, or blood by creatinine, cystatin c and urea-based formula (ckid)
		50044-7	Glomerular filtration rate/1.73 sq m. predicted among females [volume rate/area] in serum, plasma or blood by creatinine-based formula (mdrd)
		50210-4	Glomerular filtration rate/1.73 sq m. predicted [volume rate/area] in serum, plasma or blood by cystatin c-based formula
Quantitative Urine Albumin Lab Test	CPT	82043	Urine albumin quantitative
	LOINC	100158-5	Microalbumin [mass/volume] in urine collected for an unspecified duration
		14957-5	Microalbumin [mass/volume] in urine
		1754-1	Albumin [mass/volume] in urine
Urine Albumin Creatinine Ratio Lab Test	LOINC	13705-9	Albumin/creatinine [mass ratio] in 24-hour urine
		14958-3	Microalbumin/creatinine [mass ratio] in 24-hour urine
		14959-1	Microalbumin/creatinine [mass ratio] in urine
Urine Creatinine Lab Test	CPT	82570	Assay of urine creatinine
	LOINC	20624-3	Creatinine [mass/volume] in 24-hour urine
		2161-8	Creatinine [mass/volume] in urine
		39982-4	Creatinine [mass/volume] in urine – baseline

Please Note: LOINC codes **are not** covered and displayed for informational purposes. The codes are typically submitted by the laboratory company. The table shows a partial list of value set codes. Additional codes are available upon request.

KED Measure Details

3. Breast Cancer Screening (BCS-E)

Value Set	CPT Code	Description
Mammography	77061	Breast tomosynthesis unilateral
	77062	Breast tomosynthesis bilateral
	77063	Breast tomosynthesis bilateral
	77065	Diagnostic mammography including computer-aided detection (CAD) when performed unilateral
	77066	Diagnostic mammography incl including computer-aided detection (CAD) when performed bilateral
	77067	Screening mammography bilateral including computer-aided detection (CAD) when performed
Unilateral Mastectomy	19180	Simple, complete mastectomy
	19220	Radical mastectomy
	19240	Modified radical mastectomy
	19303	Mastectomy simple complete
	19304	Mastectomy, subcutaneous
	19305	Mastectomy radical
	19306	Mastectomy radical urban type
	19307	Mastectomy modified radical
Gender Dysphoria	19318	Breast reduction

Please Note: Mammography CPT codes are submitted by the imaging company. The table shows a partial list of value set codes. Additional codes are available upon request.

BCS-E Measure Details

4. Colorectal Cancer Screening (COL-E)

Value Set	CPT Code	Description
sDNA FIT Lab Test*	81528	Oncology colorectal screening
FOBT Lab Test*	82270	Occult blood feces
	82274	Assay test for blood fecal
Flexible Sigmoidoscopy**	45330	Diagnostic sigmoidoscopy
	45331	Sigmoidoscopy and biopsy
	45332	Sigmoidoscopy w/foreign body removal
	45333	Sigmoidoscopy & polypectomy
	45334	Sigmoidoscopy for bleeding
	45335	Sigmoidoscopy w/submucosal injection
	45337	Sigmoidoscopy & decompress
	45338	Sigmoidoscopy w/tumor remove
	45340	Sigmoidoscopy w/transendoscopic balloon dilation
	45341	Sigmoidoscopy w/ultrasound
	45342	Sigmoidoscopy w/ultrasound guide biopsy
	45346	Sigmoidoscopy w/ablation
	45347	Sigmoidoscopy w/stent placement
	45349	Sigmoidoscopy w/resection
	45350	Sigmoidoscopy w/band ligation
CT Colonography**	74261	CT colonography diagnostic
	74262	CT colonography diagnostic w/dye
	74263	CT colonography screening
Colonoscopy**	44388	Colonoscopy through stoma separate procedure
	44389	Colonoscopy with biopsy
	44390	Colonoscopy for foreign body
	44391	Colonoscopy for bleeding

Value Set	CPT Code	Description
Colonoscopy (cont.)**	44392	Colonoscopy & polypectomy
	44394	Colonoscopy w/snare
	44401	Colonoscopy with ablation
	44402	Colonoscopy w/stent placement
	44403	Colonoscopy w/resection
	44404	Colonoscopy w/injection
	44405	Colonoscopy w/dilation
	44406	Colonoscopy w/ultrasound
	44407	Colonoscopy w/needle aspiration biopsy
	44408	Colonoscopy w/decompression
	45378	Diagnostic colonoscopy
	45379	Colonoscopy w/foreign body removal
	45380	Colonoscopy and biopsy
	45381	Colonoscopy submucous injection
	45382	Colonoscopy w/control bleed
	45384	Colonoscopy w/lesion removal
	45385	Colonoscopy w/lesion removal
	45386	Colonoscopy w/balloon dilation
	45388	Colonoscopy w/ablation
	45389	Colonoscopy w/stent placement
	45390	Colonoscopy w/resection
	45391	Colonoscopy w/endoscope ultrasound
	45392	Colonoscopy w/endoscopic fine needle aspiration/biopsy
	45393	Colonoscopy w/decompression
	45398	Colonoscopy w/band ligation

Appendix – Additional Value Set Codes

Value Set	CPT Code	Description
Total Colectomy	44150	Total abdominal colectomy without a proctectomy, with an ileostomy or ileoproctostomy
	44151	Total colectomy (abdominal, without proctectomy) with Continent Ileostomy
	44155	Total abdominal colectomy with proctectomy with ileostomy
	44156	Total abdominal colectomy with proctectomy (removal of the colon and rectum) and the creation of an ileostomy
	44157	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy
	44158	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J)
	44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy
	44211	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop
	44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy

*Codes submitted by the lab company.

**Codes submitted when the diagnostic test is completed.

Please Note: The table shows a partial list of value set codes. Additional codes are available upon request.

COL-E Measure Details

5. Osteoporosis Management in Women Who Had a Fracture

Value Set	Code		Description
Bone Mineral Density Tests	CPT	77080	DXA bone density axial
		77081	DXA bone density appendicular
		77085	DXA bone density axial, including vertebral fracture
		77086	Vertebral fracture assessment via DXA
	ICD-10-PCS	BQ00ZZ1	Plain radiography of right hip, densitometry
		BQ01ZZ1	Plain radiography of left hip, densitometry
		BQ03ZZ1	Plain radiography of right femur, densitometry
		BQ04ZZ1	Plain radiography of left femur, densitometry
		BR00ZZ1	Plain radiography of cervical spine, densitometry
		BR07ZZ1	Plain radiography of thoracic spine, densitometry
		BR09ZZ1	Plain radiography of lumbar spine, densitometry
		BR0GZZ1	Plain radiography of whole spine, densitometry
Osteoporosis Medication Therapy	HCPCS	J0897	Injection, denosumab, 1 mg
		J1740	Injection, ibandronate sodium, 1 mg
		J3111	Injection, romosozumab-aqqg, 1 mg
		J3489	Injection, zoledronic acid, 1 mg
		Q5136	Injection, denosumab-bbdz, biosimilar, 1 mg

OMW Measure Details