2020 ICP Focused Medicare Advantage Quality Metrics Tip Sheet

For our Medicare/Medicare Advantage patient population, ICP will be keenly focused on the AWV and the quality metrics listed below

HEDIS Measure	Denominator	Numerator	Codes
Comprehensive Diabetes Care: Eye Exam	Members 18-75 years of age with type 1 or 2 diabetes	Dilated retinal eye exam performed by an ophthalmologist or optometrist in measurement year or year prior if negative result for retinopathy	**CPT II Codes:** *report must be in chart 2022F - Diabetic retinal screening w/ eye care prof. 3072F – Diabetic retinal screening negative *Exclusions: Steroid induced diabetes*
Best Practice: Make a referral to ophthalmologist for diabetic eye exam annually. *Submit CPT II code on medical claim at any point throughout the measurement year if showing as a gap in care and you have a current note from the eye provider addressing the dilated eye exam and retinopathy			
Comprehensive Diabetes Care: Blood Sugar Controlled	Members 18-75 years of age with type 1 or 2 diabetes	A1c test with a result **less than or equal to 9.0%** during measurement year (Poor control >9%)	**CPT Codes:** *date and result documented in chart 83036, 83037 **CPT II Codes:** 3044F - Less than 7% 3045F - Between 7%-9% 3046F - Greater than 9% *Exclusions: Steroid induced diabetes*
Best Practice: HbA1c done every 3 months (every 6 months minimum if well controlled) *If HbA1c is done at the office, or is listed as a gap in care, submit corresponding CPT II code on a claim during the measurement year to inform the payer of result **Uncontrolled diabetics should have follow up visits at least monthly and engagement with an ICP care manager			
Comprehensive Diabetes Care: Kidney Disease Monitoring	Members 18-75 years of age with type 1 or 2 diabetes	Medical attention to nephropathy met by 1 of the following: • Urine Protein (U/A) • Microalbumin • ACE/ARB medication • Annual visit to nephrologist	**CPT Codes:** *date and result documented in chart 81000, 81001, 81002, 82043, 82044, 84156 **CPT II Codes:** 3060F - Positive microalbuminuria 3061F - Negative microalbuminuria *Exclusions: Steroid induced diabetes*
Best Practice: Micro-albumin done annually during each measurement year. *Submit corresponding CPT II code on any claim during the measurement year if the test has been done and is showing up as a gap on your gap in care list. A urinalysis done in the office will close the gap as well.			

Last revised 01/15/2020

Measure	Population	Description	Codes / Notes
Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	Members 18 years of age or older diagnosed with RA	Dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD)	*Exclusions: HIV diagnosis*
Best Practice: Refer patient to rheumatologist. *Ensure members with RA have at least two primary care or rheumatologist visits per year, and are prescribed at least one ambulatory Rx for a DMARD.			
Controlling Blood Pressure	Members 18-85 years of age who had a diagnosis of HTN and whose BP was adequately controlled	diagnosis of HTN and whose BP was adequately controlled (<140/90) or (150/90) for members 60-85 with a diagnosis of diabetes	**CPT II Codes:** Systolic: 3074F - <130; 3075F – 130-139; 3077F – >140 Diastolic: 3078F – <80; 3079F – 80-89; 3080F - >90
Best Practice: If the initial reading is 140/90 or higher, perform a second blood pressure reading at the end of the visit. *Submit corresponding CPT II codes (systolic/diastolic) on claim to inform the payer of the BP result. Ensure staff competency on proper technique when obtaining a blood pressure reading.			
Medication Reconciliation Post-Discharge	All members	• Review all acute and non-acute inpatient stays • Reconcile discharge medication and outpatient medications within 30 days of discharge • Reconciliation must be done by a prescribing practitioner, registered nurse or clinical pharmacist	**CPT II Code: 1111F** Indicates a medication reconciliation was performed *TOC CPT Code: 99495 – moderate complexity, seen within 14 days of discharge *TOC CPT Code - 99496 – high complexity, seen within 7 days of discharge *make sure to note the reconciliation in the medical record, referencing the outpatient med list and discussion of the discharge medications
Best Practice: Ensure all patients receive, preferably within 7 calendar days but not more than 30 days from discharge, comprehensive outpatient PCP follow-up care, including medication reconciliation. *Submit CPT II code 1111F on the TOC claim to inform payer the medication reconciliation was performed, and is appropriately documented in the medical record (reviewed and reconciled current and discharge medications).			

Last revised 01/15/2020

Colorectal Cancer Screening	Members ages 50-75 who had an appropriate screening for colon cancer	Appropriate screening: • **Colonoscopy** *In measurement year or 9 years prior • **Flexible Sigmoidoscopy** or **Colonography** * In measurement year or 4 years prior • **FIT-DNA test** (Cologuard) *In measurement year or 2 years prior • **FOBT/FIT test** *In measurement year	**Exclusions:** Any time in patients history through Dec. 31st of measurement year Colorectal Cancer **ICD-10 CM:** C18.0 – C18.9, C19 – C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 Total Colectomy **ICD-10 CM:** Z90.49
Best Practice: Any of the above testing will close the gap. Please follow clinical guidelines for which test is best for your patient. Consider FIT test annually unless the colonoscopy was within 12 months. *FOBT done in office during a digital rectal exam (DRE) does NOT qualify as a colorectal cancer screening.			