To improve quality of care, ICP recommends completing an Annual Wellness Visit (AWV) on all of your Medicare patients annually. The meaningful quality metrics listed below impact your value based payments and most importantly, patient outcomes.

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>Denominator</th>
<th>Numerator</th>
<th>CPT II Codes:</th>
<th>CPT Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam for Patients With Diabetes (EED)</td>
<td>Members 18-75 years of age with type 1 or 2 diabetes who had a retinal eye exam</td>
<td>Retinal or dilated eye exam performed by an ophthalmologist or optometrist in measurement year or year prior to the measurement year, if negative result for retinopathy</td>
<td>*report must be in chart</td>
<td>2022F - DM retinal screening w/evidence of retinopathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2023F – DM retinal screening w/o retinopathy</td>
<td>2023F – DM retinal screening w/o retinopathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3072F - DM retinal screening w/o retinopathy prior year</td>
<td>3072F - DM retinal screening w/o retinopathy prior year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Exclusions:</strong> Steroid-induced diabetes, gestational diabetes, polycystic ovarian syndrome, chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year.</td>
<td><strong>Exclusions:</strong> Steroid-induced diabetes, gestational diabetes, polycystic ovarian syndrome, chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year.</td>
</tr>
</tbody>
</table>

**Best Practice:**
- Make a referral to ophthalmologist for diabetic eye exam annually.
- If patient has an eye exam find out where and retrieve records. The medical record must indicate that a dilated or retinal exam was performed, the date of service, test, result and eye care provider’s name and credentials.
- Submit CPT II code on medical claim at any point throughout the measurement year, if you have a current note from the eye provider addressing the dilated eye exam and retinopathy to close the gap in care.
- Patient reported services are acceptable for a dilated eye exam but must include month/year and confirmation that it was done or interpreted by an eye care professional. For previous year eye exam, it must include negative findings.

<table>
<thead>
<tr>
<th>Hemoglobin A1c Control for Patients with Diabetes (HBD)</th>
<th>Members 18-75 years of age with type 1 or 2 diabetes</th>
<th>Hemoglobin A1c (HbA1c) level with a result <strong>less than or equal to 9.0%</strong> during measurement year <em>(HbA1C poor control greater than 9.0%)</em></th>
<th>CPT II Codes:</th>
<th>CPT Codes: 83036, 83037 For POCT date and result documented in chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>CPT Codes:</strong></td>
<td><strong>CPT II Codes:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3044F - Less than 7%</td>
<td>3044F - Less than 7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3051F - 7.0% - 7.9%</td>
<td>3051F - 7.0% - 7.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3052F - 8.0% - 9.0%</td>
<td>3052F - 8.0% - 9.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3046F - Greater than 9%</td>
<td>3046F - Greater than 9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Exclusions:</strong> Steroid-induced diabetes, gestational diabetes, polycystic ovarian syndrome, chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year.</td>
<td><strong>Exclusions:</strong> Steroid-induced diabetes, gestational diabetes, polycystic ovarian syndrome, chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year.</td>
</tr>
</tbody>
</table>

**Best Practice:**
- HbA1c done every 3 months (every 6 months minimum if well controlled)
- If HbA1c is done at the office (POCT), submit corresponding CPT II code in addition to the CPT code on a claim during the measurement year to inform the payer of result to close the gap in care
- Always list the date of service, results and test together
- Patient reported are acceptable with documentation in the medical record which must include value and date
- Uncontrolled diabetics should have follow up visits at least monthly and engagement with an ICP care manager
### HEDIS Measure

#### Kidney Health Evaluation for Patients With Diabetes (KED) *(WATCH METRIC)*

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation</td>
<td>Estimated glomerular filtration rate (eGFR) <strong>AND</strong> a urine albumin-creatinine ratio (uACR), during the measurement year. Identified in one of two ways:</td>
<td><strong>CPT Codes:</strong> 82043, 82570</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusions:</strong> ESRD, chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year</td>
</tr>
</tbody>
</table>

**Best Practice:**
- This test is only needed once per year. Please order this test with your first A1C test request of the year.
- Collect appropriate testing in a timely manner.

#### Controlling Blood Pressure (CBP)

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members 18-85 years of age who had a diagnosis of HTN and whose BP was adequately controlled</td>
<td>Diagnosis of HTN and whose BP was below 140 /below 90 to close the gap</td>
<td><strong>CPT II Codes:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Systolic</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3074F up to 129</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3075F 130-139</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3077F over 140</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Diastolic</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3078F up to 79</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3079F 80-89</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3080F over 90</td>
</tr>
</tbody>
</table>

**Exclusions:** Chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year. BP's taken in an acute inpatient setting or during an ED visit.

**For example:** If a member’s first BP reading was 160/80 mmHg and the second reading was 120/90 mmHg, (during the same date of service) use the 120 systolic of the second reading and the 80 diastolic of the first reading to show a BP result of 120/80 mmHg

**Best Practice:**
- If the initial BP reading is 140/90 or higher, retake 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
- Patient reported blood pressure during a telehealth visit is accepted as long as an electronic home blood pressure device is used
<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Codes (what to report)</th>
</tr>
</thead>
</table>
| Osteoporosis Management in Women who had a Fracture (OMW) | Female patients ages 67-85 who suffered a fracture* | Bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within 180 days (6 months) after the fracture | Osteoporosis medications:  
Bisphosphonates  
- Alendronate  
- Ibandronate  
- Risedronate  
- Zoledronic acid  
Other agents  
- Adaloparatide  
- Denosumab  
- Raloxifene  
- Romosozumab  
- Teriparatide |
| Exclusions: Chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year. Osteoporosis medication, Bone Mineral Density Tests. |

**Best Practice:**  
- Order a BMD test for all women with a fracture within six months or prescribe medication to prevent osteoporosis. A referral is not sufficient to close the gap.  
  * Members who have had a BMD test within 24 months prior to the fracture will close the gap  
  * Members who were dispensed osteoporosis medication therapy including any long-acting treatment provided during inpatient stay for fracture will close the gap  
- Schedule an appointment to review BMD results and/or medication adherence  
- Ensure accurate coding of fractures  
- Educate member on safety and fall prevention  

*Please discuss with your PTS and provide evidence of this being done*

| Breast Cancer Screening (BCS) | Female patients age 50-74 who had a mammogram to screen for breast cancer | One or more mammograms completed with date and result documented in chart during the following time period: Oct. 1, 2020-Dec. 31, 2022 | Breast Cancer Exclusion Codes:  
Z90.13 History of Bilateral Mastectomy  
Z90.11 Absence of Right Breast  
Z90.12 Absence of Left Breast  
(Unilateral codes only exclude if used together)  
Exclusions: Chronic illness and frailty, members receiving palliative care, in hospice or using hospice services anytime during the measurement year |

**Ultrasound, MRI or Thermography does not meet metric**

**Best Practice:**  
- If documenting a mammogram in a member’s history, please include the month and year. The result is not required.  
- Consider ordering a mammogram every two years for patients beginning at age 50 or sooner when risk factors such as family history exist.  
- Engage patients to discuss their fears about mammograms and let them know that the test is less uncomfortable and uses less radiation than in the past.  

Last updated: 5/24/2022
<table>
<thead>
<tr>
<th><strong>Colorectal Cancer Screening (COL)</strong></th>
<th><strong>Appropriate screening:</strong></th>
<th><strong>Exclusions:</strong> Either of the following any time during the member’s history through December 31st of the measurement year.</th>
</tr>
</thead>
</table>
| Members ages 50-75 who had an appropriate screening for colorectal cancer | • Colonoscopy in measurement year or 9 years prior [2013] | Colorectal Cancer  
ICD-10 CM: C18.0 – C18.9, C19 – C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 |
|  | • Flexible Sigmoidoscopy or Colonography in measurement year or 4 years prior [2018] | Total Colectomy  
ICD-10 CM: Z90.49 |
|  | • Cologuard (fecal immunochemical test FIT- DNA) test in measurement year or 2 years prior [2020] | Other Exclusion:  
• Chronic illness or frailty, members receiving palliative care, hospice or using hospice services anytime during the measurement year |
|  | • FOBT, FIT test in measurement year [2022] | |

Any of the above testing will close the gaps. Please follow clinical guidelines to decide which test is best for your patient.

**Best Practice:**

- Consider FIT test annually unless the colonoscopy was within 12months
- FOBT done in office during a digital rectal exam (DRE) does NOT qualify as a colorectal cancer screening
- **The US Preventative Services Task Force (USPSTF) recommends screening in adults for colorectal cancer starting at 45 years of age**

Please note member refusal will NOT make them ineligible for this measure:

- Please recommend a flexible sigmoidoscopy, FIT-DNA test, FOBT or FIT test if a member refuses or can’t tolerate a colonoscopy.
- If testing of the patient’s sample has unfavorable results, further diagnostic testing such as a colonoscopy is recommended.

**Documentation:**

- Clearly document the administered screenings, including date of service, abbreviations are not accepted (COL 2015; BEST= Colonoscopy 2015).
- Exclusions: document total colectomy or colorectal cancer in patient’s medical record and use appropriate coding to reflect.
- If a patient reports completing a colonoscopy, please ensure you obtain a copy of the report for your records.
- Always include a date of service [year only and result of screening is acceptable] when documenting a colonoscopy, flexible sigmoidoscopy, FIT-DNA test, CT colonography or FOBT.
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.
<table>
<thead>
<tr>
<th>Medication Adherence Tips and Pharmacy Measures</th>
<th>Quality Measures for CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy measures are closed by pharmacy claims (patient fills Rx regularly to be adherent)</td>
<td><strong>Medication Adherence for Diabetes Medications:</strong> Patients with diabetes should adhere to their diabetes medications ≥80% of the time. Patients with at least two fills of a diabetes medication (except insulin) during the current calendar year will be captured in the measure.</td>
</tr>
<tr>
<td>• Recommend automatic refills to support adherence (discuss mail order or delivery options with patient)</td>
<td><strong>Exclusions:</strong> Patients taking insulin, Hospice, ESRD</td>
</tr>
<tr>
<td>• Write for 90 day supply to improve adherence and reduce copay</td>
<td><strong>Medication Adherence for Hypertension (RAS antagonists):</strong> Patients taking a RAS antagonist (ACEi, ARB, aliskiren) should adhere to their medication ≥80% of the time. Patients with at least two fills of a RAS antagonist during the current calendar year will be captured in the measure.</td>
</tr>
<tr>
<td>• Remind patients to always ask for medication to be processed through insurance benefit</td>
<td><strong>Exclusions:</strong> Patients taking sacubitril/valsartan (Entresto), Hospice, ESRD</td>
</tr>
<tr>
<td>• Outreach patient to identify any barriers to adherence such as: SDOH-Lack of funds? A problem with side effects? or other barrier(s) to filling prescription as prescribed</td>
<td><strong>Medication Adherence for Cholesterol (Statins):</strong> Patients taking a statin should adhere to their medication ≥80% of the time. Patients with at least two fills of a statin during the current calendar year will be captured in the measure.</td>
</tr>
<tr>
<td>• Check Dispense Hx (Surescripts) for Rx refill dates based on claims data</td>
<td><strong>Exclusions:</strong> Hospice, ESRD</td>
</tr>
<tr>
<td>• Check Proportion of Days Covered (PDC) thermometer for DM, HTN, and statin meds</td>
<td><strong>Statin Use in Persons with Diabetes (SUPD):</strong> Patients 40-75 y/o with diabetes should receive a statin. This is based on the ADA and ACC guidelines recommending a moderate to high intensity statin for patients 40-75 y/o with diabetes regardless of LDL to lower the risk of developing heart disease.</td>
</tr>
<tr>
<td><strong>Best Practice:</strong></td>
<td><strong>Exclusions:</strong> Hospice, ESRD, rhabdomyolysis or myopathy, pregnancy/lactation/fertility, liver disease, pre-diabetes, PCOS</td>
</tr>
<tr>
<td>• If instructing patient to take less than prescribed amount, ensure SIG reflects correct day supply</td>
<td>• Example: SIG is “every other day” or “take ½ tablet daily” if that’s how you are instructing patient to take it</td>
</tr>
<tr>
<td>• ½ tablet = 45 tablet for a 90 day supply</td>
<td></td>
</tr>
</tbody>
</table>
## Care for Older Adults (COA)

The percentage of Medicare adults 66 years and older and who are enrolled in a Special Needs Plan (SNP) who had each of the following during the measurement year:

- Functional status assessment
- Medication review
- Pain assessment

### COA: Functional Status Assessment

**Functional status assessment:** To address this care opportunity, a member’s functional status must be assessed with one of the following during the measurement year:

- Activities of Daily Living (ADL)/ Instrumental Activities of Daily Living (IADL)
- Standardized functional status assessment tool and results
- Body systems assessment that includes three of these four components: ambulation status, cognitive status, functional independence or sensory ability
- A notation showing the assessment was done must be included in a member’s medical record for completion

**Claim coding:**

1170F (Functional status)

### COA: Medication Review

**Medication review:** To address this care opportunity:

- At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.
- A member’s list of medications must be documented in their medical record during the measurement year.

**Claim coding:**

1159F (Med list)
1160F (Med Review)

### COA: Pain Assessment

**Pain assessment:** To address this care opportunity, a member must have a comprehensive pain assessment or pain management plan done at least one time during the measurement year.

**Claim coding:**

1125F (Pain Present)
1126F (Pain absent)

### Exclusions:

Members in hospice or using hospice services anytime during the measurement year

### Best Practice:

- Use an annual wellness visit as an opportunity to address and document Care for Older Adults (COA) measures
- Use CPT II codes to capture completed services codes
- Incorporate a standardized template to capture these measures for members 66 years and older, if on EMR
- Always clearly document the date of the functional status assessment
- Both the Medication review and Medication list CPT II codes must be submitted together for the same date of service
- Documentation in the medical record must include evidence of a pain assessment and the date when it was performed
- COA assessments conducted in an acute inpatient setting will not meet compliance
# Care Coordination Measures

**TRC:** Transitions of Care measure evaluates patient engagement within 30 days after an acute or non-acute discharge from inpatient facility.
- Notification of Inpatient Admission (TRC-NIA)
- Receipt of Discharge Information (TRC-RDI)
- Patient Engagement after Inpatient Discharge (TRC-PED)
- Medication Reconciliation Post-Discharge (TRC-MRP)

**PCR:** Plan All-Cause Readmissions

**FMC:** Follow-Up after Emergency Department Visit for People with Multiple High-Risk *Chronic Conditions*

<table>
<thead>
<tr>
<th>Transitions of Care-Medication Reconciliation Post-Discharge (TRC)</th>
<th>The percentage of discharges (Jan 1 to Dec 1) for members 18 years of age and older who had each of the following. Four rates are reported:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Notification of Inpatient Admission.</strong> Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).</td>
<td>Medical record should include a medication reconciliation by a qualified health care professional post-discharge in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.</td>
</tr>
<tr>
<td>2. <strong>Receipt of Discharge Information.</strong> Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).</td>
<td>- The medication list may include medication names only or may include medications names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies</td>
</tr>
<tr>
<td>3. <strong>Patient Engagement After Inpatient Discharge.</strong> Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.</td>
<td>- Physician assistant added as an appropriate provider type to perform a medication reconciliation for the Medication Reconciliation Post-Discharge</td>
</tr>
<tr>
<td>4. <strong>Medication Reconciliation Post-Discharge.</strong> Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).</td>
<td>- <strong>Documentation</strong> of “post-op/surgery follow-up” without a reference to “hospitalization,” “admission” or “inpatient stay” does not meet criteria for Medication Reconciliation Post-Discharge</td>
</tr>
</tbody>
</table>

**Exclusion:** Members in hospice or using hospice services anytime during the measurement year.

**Note:** If the member is unable to communicate with the provider, interaction between the member’s caregiver and the provider meets criteria.
### Plan All-Cause Readmissions (PCR)

For patients 18 years of age and older, the number of acute inpatient and observations stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

- Identify and document all acute inpatient and observation stay discharges on or between January 3 and December 31 of the measurement year.
- Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

**This measure includes acute discharges from any type of facility (including behavioral healthcare facilities).**

**Exclusions:** Members in hospice or using hospice services anytime during the measurement year, pregnancy, members who died during hospital stay. Planned admissions for chemotherapy, organ transplant, principle diagnosis of rehabilitation, potentially planned procedure without principal acute diagnosis.

### Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

The percentage of emergency department (ED) visits for members 18 years of age and older with multiple high-risk chronic conditions who had a follow-up service within 8 days (including the discharge date)

- **ED visit occurring on or between January 1 and December 24 of the measurement year 2022**
- **Within the two years prior to the ED visit, looking for diagnosis of two or more chronic conditions.**

Document if the member had multiple high-risk chronic conditions (e.g. COPD, Alzheimer’s, CKD, depression, CHF, AMI, atrial fibrillation, stroke, etc.) who had a follow-up service within 7 days after the ED visit (8 total days) and identify all ED visits between January 1 and December 24 of the measurement year.

**The following meet criteria for follow-up:**
- Outpatient visit
- Telephone or telehealth visit
- An e-visit or virtual check-in
- Transitional care management services
- Care management visits
- Outpatient or telehealth behavioral health visit
- An intensive outpatient encounter or partial hospitalization
- A community mental health center visit, etc.

**Exclusion:** Members in hospice or using hospice services anytime during the measurement year. ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within 7 days after ED visit, regardless of the principal diagnosis for admission.

### *List of Chronic Conditions*

- Acute myocardial infarction
- Alzheimer’s and related disorders
- Atrial fibrillation
- Asthma, COPD
- Chronic kidney disorders
- Depression
- Heart Failure
- Stroke and transient ischemic attack

### Best Practice

- Remind patients what to do and who to call outside of regular office hours
- Identify all acute and non-acute inpatient stays
- Identify the discharge date for the stay
- Identify the admission date for the stay
- Member engagement provided within 30 days after discharge
- Documentation of “post-op/surgery follow-up” should have a reference to “hospitalization,” “admission” or “inpatient stay” in your notes
- Provide education to patients if ED visit was not needed and schedule office visits for follow-up on chronic conditions
- Care Teams need a workflow to schedule post-ED follow-up within 7 days on all patients with at least two of the listed chronic conditions seen in ED
- Outreach patients to schedule follow-up care and medication reconciliation to reduce the risk of readmission
- 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)
- Engage with your ICP Care Manager on Transitions of Care (includes Med Rec Post-discharge) & Follow-Up After ED for People w/ Multiple High-Risk Chronic Conditions

Last updated: 5/24/2022
# Health Outcomes Survey (HOS) Measures

HOS measures patients’ perception of health outcomes

## Management of Urinary Incontinence in Older Adults:
- Measures the number of patients who reported having urine leakage in the past six months and discussed their urinary leakage with a healthcare provider, discussed treatment options or reported that urine leakage made them change their daily activities or interfered with their sleep

## Questions to ask:
- In the past six months, have you experienced leaking of urine?
- How often and when do the leakage problem occur?
- Does urinary incontinence affect your daily life (social withdrawals, depression or loss of sleep)

## Physical Activity in Older Adults:
- Measures the number of eligible patients who spoke with a doctor or other health provider about their level of exercise or physical activity or received advice to start, increase or maintain their level of exercise or physical activity.

## Questions to ask:
- What’s your daily activity level?
- What activities do you enjoy?
- Do you feel better when you are active?

## Fall Risk Management:
- Measures the number of patients seen by a doctor in the past 12 months who discussed falls or problems with balance or walking and those who received a recommendation for how to prevent falls or treat problems with balance or walking.

## Questions to ask:
- Have you had a fall in the past year?
- What were the circumstances?
- Have you felt dizzy or had problems with balance or walking in the past year?

## Best Practice:
- Incorporate questions about urinary incontinence, falls risk and physical activity in AWV template
- Provide opportunity for asking these questions of the patient prior to an examination
- Develop a process for assuring that each patient receives an After Visit Summary (AVS) before the end of the visit
- Document your discussions surrounding urinary incontinence (UI), treatment of UI, Falls Risk and Management for reducing risk of falling and physical activity.