Quality Indicator Physician Guide for Medicare
HEDIS, HOS, CAHPS and Patient Safety measures

**Note:** The information offered in this guide is from the Healthcare Effectiveness Data and Information Set (HEDIS®) 2020 Volume 2 Technical Specifications for Health Plans and its corresponding Value Set Directory, as well as the Centers for Medicare & Medicaid Services (CMS) Medicare 2020 Part C & D Star Ratings Technical Notes. This information can change from year to year and is not meant to preclude clinical judgment. Treatment decisions should always be based on clinical judgment of the physician or other healthcare provider at the time of care.

### Healthcare Effectiveness Data and Information Set (HEDIS)
Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed-care industry. It contains measures that show health plans the specific areas in which a stronger focus could lead to improvements in patient health. HEDIS reporting is mandated by the NCQA for compliance and accreditation. The HEDIS measures listed here are part of the Medicare Star Rating Program governed by CMS.

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<th>Measure</th>
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| Adult Body Mass Index (BMI) Assessment (ABA) **Weight = 1** | Documented BMI for outpatient visits in the current or prior measurement year | **Physician codes**
  Codes to identify BMI assessment for patients 20 years old and older on the date of service:
  - ICD-10 Diagnosis: Z68.1, Z68.20–39 and Z68.41–45
  Codes to identify BMI percentile for patients younger than 20 years old on the date of service:
  - ICD-10 Diagnosis: Z68.51–Z68.54

| Breast Cancer Screening (BCS) **Weight = 1** | Mammogram between Oct. 1 two years prior to the measurement year and Dec. 31 of the current measurement year (27-month period) | **Radiology codes**
  - CPT: 77061–77063, 77065–77067
  **Note:** Listed below are codes within the HEDIS value set for this measure that are considered obsolete and may be denied for payment processing, if received on claims/encounters submission.
  - CPT: 77055, 77056 and 77057
  - HCPCS: G0202, G0204 and G0206
  **Medical record documentation**
  Patients are excluded if medical record documentation supports history of bilateral mastectomy or history of both a unilateral left and right mastectomy.

**Exclusions**
- Patients in hospice or using hospice services
- Pregnant women
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| Care for Older Adults (COA) | Eligible population: 
• Medicare Advantage patients 66 years old and older who are also enrolled in a Special Needs Plan (SNP) 
  – SNPs are a type of Medicare Advantage plan designed for certain people with Medicare 
  – Some SNPs are for people with certain chronic diseases and conditions, who have both Medicare and Medicaid, or who live in an institution such as a nursing home  
Exclusions 
• Patients in hospice or using hospice services |
| COA – Advance Care Planning (COA–ACP) | **Weight = N/A, not currently a Star or display measure**  
Percentage of COA eligible patients who have had advance care planning during the measurement year such as:  
• Advance directive  
• Living will  
• Power of attorney  
• Healthcare proxy  
• Actionable medical or surrogate decision maker |
| Advance care planning | Documentation of advance care planning in the current measurement year such as:  
• An advance care plan in the medical record  
**OR**  
• Advance care planning discussion with the healthcare provider documented and dated in the medical record  
**OR**  
• Notation that the patient has previously executed an advance care plan that meets criteria |
| Physician codes |  
• CPT: 99483, 99497  
• CPT II: 1123F, 1124F, 1157F, 1158F  
• HCPCS: S0257  
• ICD-10 Diagnosis: Z66 |
| COA – Functional Status Assessment (COA–FSA) | **Weight = 1**  
Percentage of COA eligible patients who had documentation in the medical record of at least one completed functional status assessment in the current measurement year  
**Note:** Functional status assessment limited to an acute or single condition; event or body system does not meet criteria. |
| Functional status assessment |  
• At least one functional status assessment completed in the current measurement year  
• Document the type of assessment and the date it was performed in the medical record  
**Note:** Functional status assessment limited to an acute or single condition; event or body system does not meet criteria. |
| Physician codes |  
• CPT: 99483  
• CPT II: 1170F  
• HCPCS: G0438, G0439 |

**Additional information**  
Notations for a complete functional status assessment may include:  
• Assessment of instrumental activities of daily living (IADL) or activities of daily living (ADL) **OR**  
• Results using a standardized functional status assessment tool **OR**  
• Documentation that three of the four following components were assessed:  
  – Cognitive status  
  – Ambulation status  
  – Sensory ability (hearing, vision and speech are all required)  
  – Other functional independence
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| COA – Medication Review (COA–MDR) | Medication review  
- Documentation of a dated and signed medication review conducted by a healthcare provider with prescribing authority or clinical pharmacist in the current measurement year  
**AND**  
- A medication list present in the same medical record  
**OR**  
- If patient is not taking medication, dated notation should be documented in the chart in the current measurement year | Physician codes  
Medication review  
- CPT: 90863, 99483, 99605, 99606  
- CPT II: 1160F  
Medication list  
- CPT II: 1159F  
- HCPCS: G8427  
Both a medication review and medication list code must be billed with the same date of service for a patient to be compliant.  
Transitional care management services  
- CPT: 99495, 99496  
A transitional care management services code counts for both the medication review and medication list. |
| COA – Pain Screening (COA–PNS) | Pain assessment  
Dated notation in the medical record of one pain assessment or screening performed in an outpatient setting in the current measurement year, which may include:  
- Documentation that the patient was assessed for pain (may include positive or negative findings)  
- Result of assessment using a standardized pain assessment tool | Physician code  
- CPT Category II: 1125F, 1126F |

**Note:** A review of side effects for a single medication at the time of prescription alone is not sufficient.
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<th>Measure</th>
<th>Service needed</th>
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<tbody>
<tr>
<td><strong>Colorectal Cancer Screening (COL)</strong></td>
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<tr>
<td><strong>Weight = 1</strong></td>
<td></td>
<td>Pathology/laboratory codes</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients 50–75 years old who had an appropriate screening for colorectal cancer</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td></td>
<td>Surgery/hospital codes</td>
</tr>
<tr>
<td>• Patients in hospice or using hospice services</td>
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<tr>
<td>• Patients 66–75 years old who:</td>
<td>Fecal occult blood test Jan. 1 through Dec. 31 of the current measurement year</td>
<td>Flexible sigmoidoscopy Jan. 1 four years prior through Dec. 31 of the current year (five years)</td>
</tr>
<tr>
<td>– Live long-term in an institutional setting</td>
<td>• CPT: 82270, 82274</td>
<td>• CPT: 45330-45335, 45337, 45338, 45340–45342, 45346, 45347, 45349, 45350</td>
</tr>
<tr>
<td>AND/OR</td>
<td>• HCPCS: G0328</td>
<td>• HCPCS: G0104</td>
</tr>
<tr>
<td>– Have frailty and advanced illness</td>
<td>Cologuard test Jan. 1 two years prior through Dec. 31 of the current measurement year (three years)</td>
<td>CT colonography Jan. 1 four years prior through Dec. 31 of the current year (five years)</td>
</tr>
<tr>
<td>• Patients who have had total colectomy or colorectal cancer at any time during the patient’s history through Dec. 31 of the current measurement year</td>
<td>• CPT: 81528</td>
<td>• CPT: 74261–74263</td>
</tr>
<tr>
<td>– Partial colectomy is not an exclusion</td>
<td>• HCPCS: G0464</td>
<td>Colonoscopy Jan. 1 nine years prior through Dec. 31 of the current year (10 years)</td>
</tr>
<tr>
<td></td>
<td>• Pathology/laboratory codes</td>
<td>• CPT: 44388–44393, 44397, 45339, 45345, 45355, 45383, 45387</td>
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<td></td>
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<td>• HCPCS: G0105, G0121</td>
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<td><strong>Note:</strong> The codes below within the HEDIS value set for this measure are considered obsolete and may be denied for payment processing, if received on claims/encounters submission:</td>
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<tr>
<td></td>
<td></td>
<td>• CPT: 44339, 44397, 45339, 45345, 45355, 45383, 45387</td>
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**Note:** Clear documentation of previous colonoscopy, CT colonography or sigmoidoscopy, including year performed, is required.
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<tr>
<th>Measure</th>
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<tr>
<td><strong>Comprehensive Diabetes Care (CDC)</strong></td>
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<tr>
<td>• Patients 18–75 years old with diabetes, type 1 and type 2</td>
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<tr>
<td>• Patients eligible for the CDC measures are identified based on any of the following activity during the current or prior measurement year:</td>
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<tr>
<td>– For an insulin, hypoglycemic or antihyperglycemic medication dispensed on an ambulatory basis OR</td>
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<td>– Claim(s) submitted with a diagnosis of diabetes for:</td>
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<td>• One acute inpatient stay OR</td>
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<tr>
<td>• Two outpatient, observation, emergency department or non-acute inpatient visits</td>
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<tr>
<td>– Can be any combination of visit types that occurred on different dates of service</td>
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<tr>
<td><strong>Exclusions</strong></td>
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<td></td>
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<tr>
<td>• Patients in hospice or using hospice services</td>
<td></td>
<td></td>
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<tr>
<td>• Patients 66–75 years old who:</td>
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<tr>
<td>– Live long-term in an institutional setting or are enrolled in an institutional special needs plan (I-SNP) AND/OR</td>
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<tr>
<td>– Have frailty and advanced illness</td>
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### CDC – Blood Sugar Controlled: Hemoglobin A1c (CDC-HbA1c)

**Weight = 3**

Percentage of eligible diabetic patients who have evidence of HbA1c test with a level of 9% or less

- At least one HbA1c test in current measurement year for all eligible patients with the resulting level reported.
- The most recent HbA1c test in the current measurement year must have a level of 9% or less to be measure compliant

### Physician codes

- CPT II: 3044F (< 7%), 3051F (≥ 7% and < 8%), 3052F (≥ 8% and < 9%), 3046F (> 9%)

### Pathology/laboratory codes

- CPT: 83036, 83037

Note: Listed below are codes within the HEDIS value set for this measure that are considered obsolete and may be denied for payment processing, if received on claims/encounters submission.

- CPT: 3045F

A copy of all lab results should be kept in the patient’s medical record. Only the most recent result is counted for the measure and a patient’s clinical opportunity may reopen if the test has a noncompliant or missing result.
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<tr>
<th>Measure</th>
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<tbody>
<tr>
<td>CDC – Eye Exam (CDC-EYE)</td>
<td><strong>Weight = 1</strong>&lt;br&gt;Percentage of eligible diabetic patients who have received a screening or monitoring for diabetic retinal disease</td>
<td>• A retinal or dilated eye exam by an eye care professional (ophthalmologist or optometrist) during the current measurement year&lt;br&gt;• A negative retinal or dilated eye exam (negative for diabetic retinopathy) by an eye care professional (ophthalmologist or optometrist) in the prior or current measurement year&lt;br&gt;• Bilateral eye enucleation any time during the patient’s history or the current measurement year&lt;br&gt;Note: Obtain the record of an eye exam performed in the current year by an ophthalmologist or optometrist and retain in the patient’s medical record.</td>
</tr>
<tr>
<td>CDC – Kidney Disease Monitoring: Nephropathy (CDC-Neph)</td>
<td><strong>Weight = 1</strong>&lt;br&gt;Percentage of eligible diabetic patients who received a nephropathy screening or monitoring test, or have evidence of nephropathy in the current measurement year</td>
<td>• Nephropathy screening or monitoring test for albumin or protein&lt;br&gt;• Angiotensin converting enzyme inhibitor or angiotensin receptor blocker (ACE/ARB) therapy or dispensed medication&lt;br&gt;• A visit with a nephrologist&lt;br&gt;• Evidence of or treatment for kidney disease or kidney transplant</td>
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<tr>
<td>Controlling Blood Pressure (CBP)</td>
<td>• The most recent adequately controlled blood pressure reading in the current measurement year</td>
<td>Note: Document the actual blood pressure reading. To pass administratively, the most recent adequately controlled blood pressure reading of the year must be documented and reported. If there are multiple BPs on the same date of service, record the lowest systolic and diastolic BP on that date as the representative BP.</td>
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<tr>
<td>Weight = Display (MY18 &amp; MY19)</td>
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<tr>
<td></td>
<td>• The most recent adequately controlled blood pressure reading in the current measurement year</td>
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<td></td>
<td>• The most recent adequately controlled blood pressure reading in the current measurement year</td>
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<td></td>
<td>Note: The BP reading must occur on or after the second diagnosis of hypertension.</td>
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<tr>
<td>Exclusions</td>
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<td></td>
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<td></td>
<td>• Patients in hospice or using hospice services</td>
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<tr>
<td></td>
<td>• Patients 66–85 years old in long-term or institutional setting</td>
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<td></td>
<td>• Patients 66–80 years old with frailty and advanced illness</td>
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<td></td>
<td>• Patients 81–85 years old with frailty</td>
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<td></td>
<td>Percentage of hypertensive patients 18–85 years old whose blood pressure (BP) was adequately controlled (&lt; 140/90 mm Hg) during the current measurement year</td>
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<tr>
<td></td>
<td>Patients become eligible for this measure once they have had two outpatient visits with a diagnosis of hypertension (ICD-10: I10). The visits can occur during the current or prior measurement year but must have two different dates of service and any combination of visit type applies.</td>
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<td></td>
<td>Note: These results do not meet Star measure control levels and will not fully address care opportunities. However, these codes should be used to verify that the test was performed and for monitoring/reporting of results.</td>
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</table>

**Physician codes**
- CPT II codes:
  - Systolic: 3074F, 3075F, 3077F*
  - Diastolic: 3078F, 3079F, 3080F*

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**Note:**
- The BP reading must occur on or after the second diagnosis of hypertension.
- Patients become eligible for this measure once they have had two outpatient visits with a diagnosis of hypertension (ICD-10: I10). The visits can occur during the current or prior measurement year but must have two different dates of service and any combination of visit type applies.
- These results do not meet Star measure control levels and will not fully address care opportunities. However, these codes should be used to verify that the test was performed and for monitoring/reporting of results.
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| Medication Reconciliation Post-Discharge (MRP) | Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the patient’s date of discharge through 30 days after discharge (31 total days) | Physician codes  
• CPT: 99483, 99495, 99496  
• CPT II: 1111F  
Notations for a complete medication reconciliation may include:  
• Current medications with a notation that a clinician reconciled the current and discharge medications  
• Current medications with a notation that references the discharge medications  
• Patient’s current medications with a notation that the discharge medications were reviewed  
• Current medication list, a discharge medication list and a notation that both lists were reviewed on the same date of service  
• Current medication list with documentation that patient was seen for post-discharge follow-up with medications reviewed or reconciled after hospitalization/discharge  
• Documentation in discharge summary that discharge medications were reconciled with most recent medication list in outpatient record; must include evidence that the discharge summary was filed in outpatient record within 30 days after discharge  
• Notation that no medications were prescribed or ordered upon discharge |
| Weight = 1                                   | Percentage of discharges from Jan. 1–Dec. 1 of the current measurement year for patients 18 years old and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days) |  
Exclusions  
• Patients in hospice or using hospice services  
Additional considerations:  
• Medication name is required; while dose and frequency are not required their inclusion is highly recommended  
• The reconciled medication list should be communicated to the discharged patient by a clinician  
• Medication reconciliation may be done via home visit or telephonically |
### Osteoporosis Management in Women Who Had a Fracture (OMW)

**Weight = 1**

Percentage of females 67–85 years old who suffered a fracture* and who had either a bone mineral density (BMD) test or prescription to treat or prevent osteoporosis in the six months after the fracture

* Fractures of face, skull, fingers or toes are excluded

**Exclusions**
- Patients in hospice or using hospice services
- Patients 67–85 years old living long-term in an institutional setting
- Patients 67–80 years old with frailty and advanced illness
- Patients 81–85 years old with frailty

#### What to report (sample of codes)

- Perform bone mineral density testing within 180 days of fracture date
- Prescribe a medication to treat or prevent osteoporosis within 180 days (six months) after the fracture

Patients are removed from the eligible population if they have had any one of the following:
- BMD test within 24 months before the fracture
- Osteoporosis therapy or prescription to treat or prevent osteoporosis within 12 months before the fracture

**Physician codes**
- Osteoporosis therapy – medication injections
- HCPCS: J0897, J1740, J3110, J3489

**Radiology codes**
- Bone mineral density test
- CPT: 76977, 77078, 77080, 77081, 77085, 77086
- ICD-10 Procedure: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1

**Note:** The codes within the HEDIS value set for this measure listed below are considered obsolete and may be denied for payment processing, if received on claims/encounters submission:
- CPT: 77082

**Osteoporosis medications**

Listed below are the NCQA-approved medications to treat osteoporosis for which processed pharmacy claims will address your patients’ open OMW opportunities:

**Bisphosphonates**
- Alendronate (Fosamax®)
- Zoledronic acid (Reclast®)
- Risedronate (Actonel®)

**Other agents**
- Denosumab (Prolia®)
- Teriparatide (Forteo®) (TYMLOS®)
- Raloxifene (Evista®)
- Abaloparatide
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<td>Plan All-Cause Readmissions (PCR)</td>
<td>No particular service is needed. However, practices can identify patients who have been discharged from acute facilities using daily discharge reporting. Outreaches to these patients to schedule follow-up care and medication reconciliation could reduce the risk of readmission.</td>
<td>No reporting is needed from healthcare providers.</td>
</tr>
<tr>
<td>Weight = Display (MY19 &amp; MY20) 1 (MY21)</td>
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<tr>
<td>Percentage of patients 18 years old and older who have had an acute inpatient or observation stay and experience an unplanned* readmission to a hospital within 30 days, either for the same condition or for a different reason.</td>
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<tr>
<td>* Planned admissions for chemotherapy, rehabilitation, transplant, etc., are not included as readmissions. Rehabilitation exclusions are limited to fitting and adjustment of prosthesis and other medical devices, such as infusion pumps, neuropacemakers, etc.</td>
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<td></td>
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<tr>
<td><strong>Exclusions</strong></td>
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<tr>
<td>• Pregnant women</td>
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<tr>
<td>• Patients in hospice</td>
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<tr>
<td>• Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1 of the current measurement year</td>
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<td>• For stays that included a direct transfer, exclude original admission’s discharge date. Only the last discharge should be considered.</td>
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</table>
| **Rheumatoid Arthritis Management: Disease-Modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis (ART)** | • Confirm RA diagnosis versus osteoarthritis (OA) or joint pain  
• Assess for DMARD therapy, if necessary  
• Refer patients diagnosed with RA to a network rheumatologist as warranted  
• Coordinate care and DMARD therapy with rheumatologists as appropriate  
• For medications given to the patient in a clinical setting, document in the medical record the DMARD medication name, the date that it was dispensed and its dosage/strength and administration route. This documentation can then be submitted as supplemental data. | **Physician codes**  
**DMARD therapy – medication injections**  
• HCPCS: J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515–J7518, J9250, J9260, J9310, Q5103, Q5104, Q5109  
**Note:** Listed below are codes within the HEDIS value set for this measure that are considered obsolete and may be denied for payment processing, if received on claims/encounters submission:  
• HCPCS: Q5102  
**DMARD medications**  
Listed below are the NCQA-approved DMARD medications for which processed pharmacy claims will address your patients’ open ART opportunities:  

<table>
<thead>
<tr>
<th>Type of medication</th>
<th>Medication name</th>
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<tbody>
<tr>
<td>5-aminosalicylates</td>
<td>Sulfasalazine</td>
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<tr>
<td>Alkylating agents</td>
<td>Cyclophosphamide</td>
</tr>
<tr>
<td>Aminoquinolines</td>
<td>Hydroxychloroquine</td>
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<tr>
<td>Anti-rheumatics</td>
<td>Auranofin</td>
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<td></td>
<td>Leflunomide</td>
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<td></td>
<td>Methotrexate</td>
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<td></td>
<td>Penicillamine</td>
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<td>Immunomodulators</td>
<td>Abatacept</td>
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<td></td>
<td>Adalimumab</td>
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<td></td>
<td>Anakinra</td>
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<td></td>
<td>Certolizumab pegol</td>
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<td>Etanercept</td>
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<td>Golimumab</td>
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<td>Infliximab</td>
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<td>Rituximab</td>
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<td>Tocilizumab</td>
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<td>Sarilumab</td>
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<td>Immunosuppressive agents</td>
<td>Azathioprine</td>
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<td></td>
<td>Cyclosporine</td>
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<td></td>
<td>Mycophenolate</td>
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<td>Janus kinase (JAK) inhibitor</td>
<td>Tofacitinib</td>
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<tr>
<td>Tetracyclines</td>
<td>Baricitinib</td>
</tr>
<tr>
<td></td>
<td>Minocycline</td>
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</tbody>
</table>

**Weight = 1**

Percentage of patients 18 years old or older who were diagnosed with rheumatoid arthritis (RA) and who were dispensed at least one ambulatory prescription for a DMARD in the current measurement year

Patients become eligible for this measure once they have had two visits during the current measurement year from Jan. 1 to Nov. 30 with different dates of service during which a diagnosis of RA and/or one of the following conditions was identified via ICD-10 diagnosis coding:

- Rheumatoid heart disease with RA
- RA with involvement of other organs and systems
- Rheumatoid lung disease with RA
- Rheumatoid bursitis
- Rheumatoid vasculitis with RA
- Rheumatoid nodule
- Rheumatoid myopathy with RA
- Felty’s syndrome
- Rheumatoid polyneuropathy with RA
- Adult-onset Still’s disease

**Exclusions**

- Patients in hospice or using hospice services
- Patients 66 years old and older
- Living long-term in an institutional setting
- Patients 66–80 years old with frailty and advanced illness
- Patients 81 years old and older with frailty
- Patients diagnosed with human immunodeficiency virus (HIV)
- Pregnant women
### Measure: Statin Therapy for Patients With Cardiovascular Disease (SPC)

**Weight = 1**

Percentage of males 21–75 years old and females 40–75 years old during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication in the current measurement year.

**Exclusions**
- Patients in hospice or using hospice services
- Patients 66–75 years old who:
  - Live long-term in an institutional setting **AND/OR**
  - Have frailty and advanced illness
- Patients with the following diagnoses or services in the current or prior measurement year for:
  - Pregnancy
  - In-vitro fertilization (IVF)
  - Cirrhosis
  - Dispensed clomiphene medication
  - End-stage renal disease (ESRD)
- Patients with myalgia, myositis, myopathy or rhabdomyolysis during the current measurement year

**What to report**
- At least one dispensing event for a high- or moderate-intensity statin medication in the measurement year
- Use lists of SPC eligible patients to review medications and evaluate addition of statin therapy to existing regimen in alignment with the 2018 American College of Cardiology and American Heart Association (ACC/AHA) guidelines

**Statin medications**

Listed below are the NCQA-approved statin medications for which processed pharmacy claims will address your patients’ open SPC opportunities:

- **Moderate-intensity statin therapy**
  - Atorvastatin 10–20 mg
  - Simvastatin 20–40 mg
  - Pravastatin 40–80 mg
  - Fluvastatin 40 mg bid

- **High-intensity statin therapy**
  - Atorvastatin 40–80 mg
  - Rosuvastatin 20–40 mg
  - Simvastatin 80 mg*

*Although simvastatin 80 mg was evaluated in randomized controlled trials (RCTs), initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the Food and Drug Administration due to the increased risk of myopathy, including rhabdomyolysis.

**Event** – any of the following during the prior measurement year:
- Inpatient discharges with a myocardial infarction (MI)
- Visits in any setting for coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or any other revascularization procedure

**Diagnosis** – during the current or prior measurement year:
- At least one acute inpatient or outpatient visit with a diagnosis of ischemic vascular disease (IVD)
# Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

## Health Outcomes Survey (HOS)
HOS is an annual patient-reported outcome survey conducted for Medicare Advantage plans by a vendor contracted by the Centers for Medicare & Medicaid Services (CMS). The goal of the survey is to gather valid and reliable health status data for use in quality improvement activities, public reporting, Medicare Advantage organization accountability and improving health outcomes. The survey contains questions regarding physical and mental health, chronic medical conditions, functional status (e.g., activities of daily living), clinical measures and other health status indicators. Five of the survey areas are included in the CMS Star Rating Program.

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<thead>
<tr>
<th>Measure</th>
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</table>
| **Improving Bladder Control Management of Urinary Incontinence in Older Adults (MUI)**  
Weight $= 1$  
Percentage of surveyed patients 65 years old and older who reported having a urine leakage problem in the past six months and who received treatment for their current leakage problem  
Exclusions  
• Patients in hospice | • Discuss bladder control issues and symptoms with your older patients  
• Ask patients to keep a daily diary tracking when they urinate and when they experience urine leakage  
• Assist patients with determining the right bladder control product for their size, lifestyle and severity of condition  
• Determine if exercise or other treatment options, such as medications or surgery, may help  
• If surgery is needed, refer patient to a specialist to follow through on the care plan | • Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?  
• During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?  
• Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?  
• There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other healthcare provider about any of these approaches? |
| **Improving or Maintaining Mental Health**  
Weight $= 3$  
Percentage of surveyed patients 65 years old and older whose mental health status was better than expected or remained the same  
No member/patient exclusions exist for this measure | • Discuss mental/emotional health and explain to patients that this is a part of their well-being and is as important as their physical health  
• Listen to patients’ stories and suggest activities or recommend medication, if necessary  
• Administer PHQ-2 and PHQ-9 Mental Health Assessments | • During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?  
– Accomplished less than you would like as a result of any emotional problems  
– Didn’t do work or other activities as carefully as usual as a result of any emotional problems  
• How much of the time during the past four weeks:  
– Have you felt calm and peaceful?  
– Did you have a lot of energy?  
– Have you felt downhearted and blue?  
• During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? |
## Quality Indicator Physician Guide for Medicare

### HEDIS, HOS, CAHPS and Patient Safety measures

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<tr>
<td><strong>Improving or Maintaining Physical Health</strong>&lt;br&gt;Weight = 3</td>
<td>• Assess the overall physical health of your patients annually&lt;br&gt;• Ensure patients understand the personalized health advice you provide based on their risk factors&lt;br&gt;• Develop a plan for preventive screenings and services that will help patients manage their chronic conditions&lt;br&gt;• Determine an exercise or physical therapy program that is appropriate for patients’ needs and abilities&lt;br&gt;• Perform a pain assessment to determine if a pain management or treatment plan is needed</td>
<td>• The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?&lt;br&gt;  – Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf&lt;br&gt;  – Climbing several flights of stairs&lt;br&gt;• During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?&lt;br&gt;  – Accomplished less than you would like as a result of your physical health?&lt;br&gt;  – Were limited in the kind of work or other activities as result of your physical health?&lt;br&gt;• During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?</td>
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</table>

No member/patient exclusions exist for this measure.

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<tr>
<td><strong>Monitoring Physical Activity Physical Activity in Older Adults (PAO)</strong>&lt;br&gt;Weight = 1</td>
<td>• Explain to patients that an exercise regimen could increase their quality of life and longevity&lt;br&gt;• Determine if it is appropriate for your patients to start, maintain or increase the level of physical activity, based on their overall health&lt;br&gt;• Include any recommended activity with frequency and duration in the patient after-visit summary; use physical activity prescription pads to “prescribe” the exercise regimen</td>
<td>• In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.&lt;br&gt;• In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.</td>
</tr>
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</table>

Percentage of surveyed patients 65 years old and older who had a doctor’s visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity

**Exclusions**
- Patients in hospice
- Patients responding “I had no visits in the past 12 months”
<table>
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<tr>
<th>Measure</th>
<th>Best practices</th>
<th>Survey questions</th>
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</table>
| **Reducing the Risk of Falling**  
**Fall Risk Management (FRM)**  
**Weight = 1**  
Percentage of patients 65 years old and older who in the past 12 months had a fall or had problems with balance or walking, were seen by a practitioner and received fall-risk interventions from their current practitioner  
**Exclusions**  
- Patients in hospice | • Take advantage of the Centers for Disease Control and Prevention’s (CDC) Stopping Elderly Accidents, Deaths & Injuries (STEADI) online training and materials  
- Discuss with patients if they have fallen, are afraid of falling or feel unsteady  
- Talk with your patients about the factors that can lead to a higher risk of falls  
- Determine interventions for your patients for factors present that can be impacted  
- Share information with your patients on how to make their homes safer  
- Recommend that they wear shoes that provide extra security | • A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?  
• Did you fall in the past 12 months?  
• In the past 12 months, have you had a problem with balance or walking?  
• Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:  
  - Suggest that you use a cane or walker  
  - Check your blood pressure lying or standing  
  - Suggest that you do an exercise or physical therapy program  
  - Suggest a vision or hearing testing |
**Quality Indicator Physician Guide for Medicare
HEDIS, HOS, CAHPS and Patient Safety measures**

**Consumer Assessment of Healthcare Providers and Systems (CAHPS)**
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an annual patient survey conducted for Medicare Advantage plans by a contracted CMS vendor. The goal of the survey is to assess the experiences of beneficiaries in Medicare Advantage plans. The results of the survey are published in the “Medicare & You” handbook and on the Medicare website: http://www.medicare.gov. Nine areas of the patient survey are included in the Star measures reporting. The six areas below directly correlate to patient experience with his or her physicians and other healthcare providers.

<table>
<thead>
<tr>
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</thead>
</table>
| Annual Flu Vaccine     | • Stress the importance of flu vaccination for all patients in your practice, as it can increase the herd immunity effect  
                       | • Talk to patients about getting the flu shot when they are in for their regularly scheduled appointment during flu season  
                       | • Reach out to your patients who are at a higher risk of experiencing flu complications with a reminder to be vaccinated. High-risk patients include:  
                       | • Ensure any practice staff scheduling appointments is aware of community resources for flu vaccines  
                       | • Encourage patients to take advantage of vaccination opportunities at convenient locations, such as their local pharmacies  
                       | • During their next office visit, confirm patients were vaccinated                                                        |
| Weight = 1             | • Have you had a flu shot since July 1 (prior year)?                                                                                       |

**No member/patient exclusions exist for this measure.**
Quality Indicator Physician Guide for Medicare
HEDIS, HOS, CAHPS and Patient Safety measures

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<tr>
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<tbody>
<tr>
<td>Care Coordination</td>
<td>• Within patients’ medical records, document services rendered with date of service and results&lt;br&gt;• During visits, use family history, medical record information and any reporting available to you to provide personalized health advice based on each patient’s risk factors&lt;br&gt;• Contact patients with the results of any screenings as soon as they are available and schedule any necessary follow-up care&lt;br&gt;• Talk to patients about the specialists providing care to them and document the names of the patient’s interdisciplinary care team members, as well as the results of any services rendered by other healthcare providers&lt;br&gt;• Schedule specialist follow-ups on behalf of your patients before they leave your office&lt;br&gt;• If specialist follow-up care cannot be scheduled when your patient is in your office, give them the names and phone numbers to call specialists&lt;br&gt;• Request patients follow up within one month of specialist visits to discuss the results&lt;br&gt;• Advise your patients to bring to their next appointment all prescription medicines they are taking so you can evaluate whether changes are needed&lt;br&gt;• Review all of your patient’s medications, including prescription medicines, over-the-counter medications and herbal or supplemental therapies&lt;br&gt;• Complete and provide a medication action plan and/or personal medication list to educate and help patients organize medication-related information</td>
<td>• In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?&lt;br&gt;• In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor’s office follow up to give you those results?&lt;br&gt;• In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?&lt;br&gt;• In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?&lt;br&gt;• In the last six months, did you get the help you needed from your personal doctor’s office to manage your care among these different providers and services?&lt;br&gt;• In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?</td>
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</table>
## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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<thead>
<tr>
<th>Measure</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Getting Appointments and Care Quickly</strong></td>
<td>• Schedule patients’ follow-up visits before they leave their current appointment</td>
<td>• In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?</td>
</tr>
<tr>
<td>Weight = 2</td>
<td>• Reach out periodically to patients who have not been in for their annual visits to make sure they do not wait until the end of the year to schedule them</td>
<td>• In the last six months, not counting the times when you needed care right away, how often did you get an appointment for your healthcare at a doctor’s office or clinic as soon as you thought you needed?</td>
</tr>
<tr>
<td>Assesses how quickly the patients were able to get appointments and care</td>
<td>• Advise patients to schedule appointments outside of your practice’s busiest hours</td>
<td>• In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?</td>
</tr>
<tr>
<td>No member/patient exclusions exist for this measure</td>
<td>• Try to take patients back to the exam room within 15 minutes of their scheduled appointment time even if they aren’t seeing the physician right away</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If possible, avoid overscheduling patients to prevent appointments from backing up</td>
<td></td>
</tr>
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</table>

| **Getting Needed Care**                      | • Schedule specialist follow-ups on behalf of your patients before they leave your office            | • In the last six months, how often was it easy to get appointments with specialists? |
| Weight = 2                                   | • If specialist follow-up care cannot be scheduled when your patients are in your office, give them the names and phone numbers to call specialists | • In the last six months, how often was it easy to get the care, tests or treatment you needed through your health plan? |
| Assesses how easy it was for patients to get needed care and see specialists | • Use specialist appointment reminder tear-off pads so patients remember that your office assisted in scheduling the follow-up appointment |                                                                                 |
| No member/patient exclusions exist for this measure | • Check the current preauthorization and notification list(s) at Humana.com/PAL to determine if the service requires preauthorization before being administered |                                                                                 |
|                                              | • If a service requires preauthorization, obtain approval from Humana before performing or ordering it |                                                                                 |

| **Getting Needed Prescription Drugs (GNRx)** | • Consult the Humana formulary prior to prescribing a new medication to a patient                    | • In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed? |
| Weight = 2                                   | • Check the current preauthorization and notification list(s) at Humana.com/PAL to determine if a medication requires preauthorization before it can be dispensed or administered | • In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy? |
| Assesses how easy it is for patients to get the medicines their doctor prescribed | • Prior to prescribing higher-cost brand medication, consider a generic or lower cost brand alternative drug or therapeutic equivalent, if available and clinically appropriate | • In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail? |
| No member/patient exclusions exist for this measure | • Recommend switching to 90-day supplies from their community pharmacy or via a mail-order pharmacy |                                                                                 |
### Consumer Assessment of Healthcare Providers and Systems (CAHPS)

<table>
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<tr>
<th>Measure</th>
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<tr>
<td>Rating of Health Care Quality</td>
<td>• Ask questions to gauge the patient’s current experience and perception of the care he or she is receiving from your practice, specialists and other healthcare providers</td>
<td>• Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last six months?</td>
</tr>
<tr>
<td>Weight = 2</td>
<td>• Based on feedback, discuss options to improve his or her healthcare</td>
<td></td>
</tr>
<tr>
<td>Assesses patients’ view of the quality of the healthcare they received</td>
<td>• Provide insights on patients’ perception of the healthcare they are receiving</td>
<td></td>
</tr>
</tbody>
</table>
| No member/patient exclusions exist for this measure. | • Make efforts to confirm patients understand:  
  – Their care plan  
  – Services performed or ordered  
  – How to manage their chronic conditions  
  – When and how to best take their medications |                                                                                 |
Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

**Patient Safety**
CMS includes measures to assess prescription drug plan (Part D) quality and performance in the Star Rating Program. The five Patient Safety measures below monitor Part D services to ensure the safety of Medicare Advantage enrollees. These measures are developed and endorsed by the Pharmacy Quality Alliance (PQA). They apply to both Medicare Advantage plans with prescription drug coverage (MAPD) and prescription drug-only plans (PDP). When a prescription is filled under a Medicare Part D plan, a prescription drug event (PDE) is submitted to CMS by MA organizations such as Humana. Only PDE information is used by CMS to evaluate these measures; therefore, no reporting is required by physicians.

**Medication adherence**
CMS uses a metric called proportion of days covered, or PDC, to determine medication adherence. PDC is determined by dividing the days of medication coverage—which is determined based on the claims billed to the insurance plan—by the number of days in the period being measured. The specific number of days included in the measurement period, or calendar year, is determined based on the start date of the medication.

If a patient’s PDC is greater than or equal to 80%, the patient is deemed adherent. A rate lower than 80% is considered nonadherent. The PDC threshold of 80% is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit based on clinical evidence.

**Best practices for medication adherence measures**
- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers
- Reinforce patients’ understanding of the role of diabetes, cholesterol and hypertension medications in their therapy and the expected duration of the therapy
- Ask if transportation to the pharmacy is an issue; retail 90-day fills may offer less-frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery
- Encourage adherence by providing a 90-day prescription for maintenance drugs
- Provide an updated prescription to the pharmacy if the patient’s medication dose has changed since the original prescription
- Refer patients to Humana.com/TakeMyMedicine for adherence tips and tools

<table>
<thead>
<tr>
<th>Medication adherence measure</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **Medication Adherence for Cholesterol (Statins)**  
Proportion of Days Covered: Statins (PDC-STA)  
Weight = 3  
Percentage of patients with Part D benefits with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication |   |
| **Medication Adherence for Diabetes Medications**  
Proportion of Days Covered: Diabetes All-Class Rate (PDC-DR)  
Weight = 3  
Percentage of patients with Part D benefits with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication |   |

Drug therapy across these classes of diabetes medications are included in this measure: biguanides, sulfonylureas, thiazolidinediones, Dipeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors

- Patients in hospice
- Patients with end-stage renal disease (ESRD)
- Prescriptions filled for insulin
# Quality Indicator Physician Guide for Medicare HEDIS, HOS, CAHPS and Patient Safety measures

## Patient Safety

### Medication adherence measure

**Medication Adherence for Hypertension (RAS Antagonists)**  
**Proportion of Days Covered: Renin Angiotensin System Antagonists (PDC-RASA)**  
**Weight = 3**

Percentage of patients with Part D benefits with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Blood pressure medication therapy programs for these renin angiotensin system (RAS) antagonists are included in this measure: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.

### Exclusions

- Patients in hospice
- Patients with end-stage renal disease (ESRD)
- Prescriptions filled for Entresto® (sacubitril/valsartan)

### Measure

**Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)**  
**Weight = 1**

Percentage of Part D patients eligible for and enrolled in the MTM program for at least 60 days who received a comprehensive medication review (CMR) during the measurement year.

MTM eligibility criteria:

- Have three of the following five chronic diseases:  
  - Diabetes mellitus  
  - Congestive heart failure  
  - Dyslipidemia  
  - Rheumatoid arthritis  
  - Asthma  
- Minimum of eight Part D medications  
- Anticipated Part D drug cost of more than $4,255 per year

Eligibility is determined by looking back at the most recent three months’ calculation.

### Exclusions

- Patients in hospice

### Activity needed

- An interactive, person-to-person or telehealth medication review and consultation of all medications completed by a pharmacist or qualified healthcare professional during the measurement year  
- The review should include all of your patients’ medication such as prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies  
- Following the CMR, the patient should receive a written summary of the discussion, including an action plan that recommends what the patient can do to better understand and use his or her medications

### Best practices

- Reference health plan reports for MTM-eligible patients  
- Conduct discussions with MTM-eligible patients, explaining the importance and benefits of completing a CMR  
- Complete and provide a written summary of the CMR discussion to patients. The summary should:  
  - Remind patient of what occurred during the CMR  
  - How to contact the MTM program  
  - Include a plan to assist in resolving current drug therapy issues  
  - Help achieve treatment goals with specific action items  
  - Have a reconciled list of all medications in use at the time of the CMR

- Inform patients with Humana coverage that they can schedule a CMR by calling Humana Pharmacy at 1-855-202-2510, Monday – Friday, 8 a.m. – 7 p.m., Eastern t.
### Quality Indicator Physician Guide for Medicare

**HEDIS, HOS, CAHPS and Patient Safety measures**

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<th>Measure</th>
<th>Activity needed</th>
<th>Best practices</th>
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</thead>
</table>
| **Statin Use in Persons With Diabetes (SUPD)** | • At least one fill for a statin medication of any intensity in the measurement year  
• Use lists of SPC eligible patients to review medications and evaluate addition of statin therapy to existing regimen in alignment with the 2018 American College of Cardiology and American Heart Association (ACC/AHA) guidelines | • Be sure to share with patients that statin therapy can reduce their risk of heart attack and stroke  
• For patients beginning statin therapy, discuss common side effects such as muscle weakness and advise them to contact your practice to discuss options before discontinuing  
• To minimize potential side effects, select the appropriate dose based on patient’s health factors and any drug-to-drug interactions with current medications |

**Weight = 1**

Percentage of patients with Part D benefits who are 40–75 years old who received at least two diabetic medication fills during the measurement year and were dispensed a statin medication fill during the measurement year.

**Exclusions**
- Patients in hospice
- Patients with end-stage renal disease (ESRD)

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**HEDIS®** is a set of standardized performance measures designed to help purchasers and consumers compare the performance of health plans on an “apples-to-apples” basis.

**HEDIS®** is a registered trademark of the National Committee for Quality Assurance (NCQA).

**HOS** is the Health Outcomes Survey, an annual-reported outcome survey conducted on behalf of CMS. **CAHPS®** is the Consumer Assessment of Healthcare Providers and Systems conducted on behalf of CMS.

**CPT®** Current Procedural Terminology and Current Procedural Terminology Category II (CPT II) codes are developed by the American Medical Association. CPT codes are used to communicate services and procedures rendered to patients. CPT II codes are supplemental tracking codes used for quality performance measurement.

**HCPCS** is the Healthcare Common Procedure Coding System used by CMS and maintained by the American Medical Association (AMA).

**ICD-10** is the International Classification of Diseases, 10th Revision, Clinical Modification developed by the World Health Organization and provided by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS).