brand new day
HEALTHCARE YOU CAN FEEL GOOD ABOUT

HEDIS Stars Measures Reference Guide for 2020-2021

Brand New Day requires all contracted providers and groups to adhere to the current NCQA HEDIS guidelines for preventive care screenings & CMS best practices for managing chronic disease. Below is an outline of primary STAR & HEDIS measures to meet criteria and specific ICD-10, CPT coding.

Breast Cancer Screening (BCS)

The percentage of women age 50–74 who had a mammogram to screen for breast cancer within the measurement year.

Measure Compliance:	Exclusions:
CPT: 77055–77057, 77061–77063, 77065 –77067 **HCPCS:** G0202, G0204, G0206 Preventive care screening to detect breast cancer in women. All types and methods of mammograms qualify.	• Hx bilateral mastectomy or unilateral mastectomy **ICD-10:** Z90.13 or Z90.11 Right, Z90.12 Left **IDC-10 PCS:** 0HTV0ZZ, 0HTU0ZZ, 0HTT0ZZ **CPT:** 19180, 19200, 19220, 19240, 19303 - 19307 • Age 66 or older with advanced illness and frailty • Hospice

Colorectal Cancer Screening (COL)

The percentage of members age 50–75 who had screening for colorectal cancer.

Measure Compliance:		
Colonoscopy during measurement years or the 9 years prior to the measurement year	**CPT:** 44388- 44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **HCPCS:** G0105, G0121	
FOBT (g-FOBT or FIT) during measurement year	**CPT:** 82270, 82274	**HCPCS:** G0328
FIT-DNA (Cologuard®) during measurement year or the two years prior to measurement year	**CPT:** 81528	**HCPCS:** G0464
Flexible Sigmoidoscopy during measurement year or the four years prior to measurement year	**CPT:** 45330– 45335, 45337–45342, 45345-45347, 45349, 45350	**HCPCS:** G0104
CT colonography during the measurement year or the four years prior to measurement year	**CPT:** 74261, 74262, 74263	

Exclusions:
- Colorectal cancer:
  - **ICD-10:** Z85.038 (Personal hx of other malignant neoplasm of large intestine)
  - **ICD-10:** Z85.048 (Personal hx of other malignant neoplasm of rectum, rectosigmoid junction, and anus)
  - **ICD-10:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5,
  - **ICD-9:** 153.0-154.1, 197.5, V10.05, V10.06
  - **HCPCS:** G0213-G0215, G0231
- Total colectomy:
  - **CPT:** 44150 – 44153, 44155 – 44158, 44210 – 44212
  - **ICD-10:** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ
  - **ICD-9:** 45.81, 45.82, 45.83
- Age 66 or older with advanced illness and frailty Hospice

Comprehensive Diabetes Care (CDC)

Diabetic Control: Member identified by two outpatient visits with a diabetes diagnosis, or one acute inpatient encounter with a diabetes diagnosis; or pharmacy claims for insulin or oral anti-diabetic agents during the measurement year or the year prior to the measurement year.

Exclusions:
- Gestational diabetes or steroid-induced diabetes during measurement year or the year prior to measurement year
- Age 66 or older with advanced illness and frailty

HgbA1c Good Control

The percentage of members age 18-75 with diabetes whose most recent HbA1c test during the measurement year ≤ 9%.

Measure Compliance: The most recent HgbA1c value ≤ 9%. Medical record must include a note with date when HbA1c test was done with a distinct numeric result.

HbA1c Test Coding: **CPT:** 83036, 83037 **CPT II:** 3044F, 3046F, 3051F, 3052F

Dilated or Retinal Eye Exam

The percentage of members age 18-75 with diabetes who had screening or monitoring for diabetic retinal disease.

Measure Compliance: Screening or monitoring for diabetic retinal disease, including diabetics who have had a retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year, **or** had a negative retinal or dilated eye exam(negative for retinopathy) by an optometrist or ophthalmologist in the year prior to the measurement year.

Documentation in the medical record must include one of the following:
- A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was done and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results.
- Documentation of a negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year; results indicating retinopathy was not present.
- Documentation anytime in the member's history of evidence that the member had bilateral eye enucleation or acquired absence of both eyes.

Dilated Retinal Screening: **CPT:** 67028-67113, 67121-67221, 67227-67228, 92002-92014, 92018, 92019, 92134, 92225-92240, 92250-92260 **HCPCS:** S0620, S0621, S3000
CPT II (with evidence of retinopathy)**:** 2022F, 2024F, 2026F **CPT II** (without evidence of retinopathy)**:** 2023F; 2025F; 2033F

Dilated Retinal Screening – Negative in prior year: **CPT II:** 3072F

Unilateral Eye Enucleation: **CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
ICD-10: (Left) 08B10ZX, 08B10ZZ, 08B13ZX, 08B13ZZ, 08B1XZX, 08B1XZZ **(Right)** 08B00ZX, 08B00ZZ, 08B03ZX, O8B03ZZ, 08B0XZX, 08B0XZZ

Nephropathy Screening

The percentage of members age 18-75 with diabetes who had nephropathy screening or monitoring test during the measurement year or evidence of nephropathy during the measurement year.

Measure Compliance:

Any of the following meets criteria for a nephropathy screening or monitoring test or evidence of nephropathy:
- A ***urine*** test for albumin (micro albumin) or protein during the measurement year; documentation must include a note indicating the date the urine test was done and the result or finding. One of the following will meet criteria: 24-hour urine for albumin or protein; time urine for albumin or protein; spot urine (urine dipstick or urine test strip) for albumin or protein; urine for albumin/creatinine ratio; 24-hour urine for total protein; random urine for protein/creatinine ratio
- Documentation of a visit to a nephrologist
- Documentation of a renal transplant
- Documentation of medical attention for nephropathy includes any of the following documented in the measurement year: Nephropathy, end-stage renal disease (ESRD), chronic renal failure, stage 4 chronic kidney disease, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure, dialysis, nephrectomy kidney transplant
- Documentation includes a note that member received a prescription for an ACE inhibitor/ARB or has taken an ACE inhibitor/ARB in the measurement year

Urine Protein Test: **CPT:** 81000-81005, 82042-82044, 84156 **CPT II:** 3060F, 3061F, 3062F

Nephropathy Treatment: **CPT II:** 3066F, 4010F
ICD-10: E08.21-E08.29, E09.21-E09.29, E10.21-E10.29, E11.21-E11.29, E13.21-E13.29, I12.0-I15.1, N00.0-N08, N14.0-N14.4, N17.0-N19, N25.0-N26.9, Q60.0-Q61.9, R80.0-R80.9

Stage 4 Chronic Kidney Disease: **ICD-10:** N18.4 **ESRD:** N18.5, N18.6, Z99.2 **Nephrectomy**: **CPT:** 50340, 50370 **ICD-10**: 0TB00ZX, 0TB00ZZ, 0TB03ZX, 0TB03ZZ, 0TB04ZX, 0TB04ZZ, 0TB07ZX, 0TB07ZZ, 0TB08ZX, 0TB08ZZ, 0TB10ZX, 0TB10ZZ, 0TB13ZX, 0TB13ZZ, 0TB14ZX, 0TB14ZZ, 0TB17ZX, 0TB17ZZ, 0TB18ZX, 0TB18ZZ

Dialysis: **CPT**: 90935, 90937, 90945, 90947, 90997, 90999, 99512 **HCPCS**: G0257, S9339 **ICD-10:** 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

Rheumatoid Arthritis (ART)

The percentage of members age 18 and older as of December 31of the measurement year, who were diagnosed rheumatoid arthritis and dispensed prescription for a disease-modifying anti-rheumatic drug.

Identifying Event	Measure Compliance	Exclusions:
Two dates of service on or between January 1 and November 30 of measurement year. *OP visit with any diagnosis of RA *Non-acute IP any diagnosis of RA *Telephone visit assessment with a RA diagnosis **Rheumatoid Arthritis** ICD-10: M05.00-M06.39 M06.80-M06.9	**Measure Compliance:** Dispensed at least one ambulatory prescription for DMARD. This measure requires proof that the member received the medication, which can be through a prescription claim or documentation indicating dispensing or infusion administration date. Prescribing intent in medical record will not meet the requirement for this measure. • Qualifying the diagnosis can be completed with a CCPA lab or Rheumatologist consult report **DMARD** • HCPCS: J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, J9311, J9312, Q5102, Q5103, Q5014, Q5109 • Rx claims information for the following medications: sulfasalazine, cyclophosphamide, hydroxychloroquine, auranofin, leflunomide, penicillamine, methotrexate, abatacept, adalimumab, anakinra, certolizumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, sarilumab, tocilizumab, azathioprine, cyclosporine, mycophenolate, tofacitinib, minocycline, baricitinib	• HIV anytime during the member's history through December 31 of measurement year • Pregnancy any time during measurement year • Age 66 or older with advanced illness and frailty

Osteoporosis Management in Women with a Fracture (OMW)

The percentage of women age 67-85 who suffered a fracture and who had either a bone mineral density scan or a prescription for a drug to treat osteoporosis in the six months after the fracture.

Identifying Event	Measure Compliance:	Exclusions:
Woman, age 67-85 years, who suffered a fracture	Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following: • BMD test or osteoporosis therapy in any setting within 180-days (6 months) after the fracture **Bone Mineral Density Test** CPT: 76977, 77078, 77080, 77081, 77082, 77085, 77086 ICD-9: 88.98 ICD-10 PCS: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **Osteoporosis Medication** HCPCS: J0897, J1740, J3110, J3489 Rx Claims information for osteoporosis therapy: • Bisphosphonates: alendronate, alendronate-cholecalciferol, risedronate, zoledronic acid, ibandronate • Other agents: abaloparatide, denosumab,raloxifene, teriparatide	• Had BMD test within the 24 months prior to the fracture • Received osteoporosis therapy during the 12 months prior to the fracture • Received a dispensed Rx or had an active Rx to treat osteoporosis during the 365 days prior to the fracture • Age 67-80 with advanced illness and frailty

Flu Shot

The percentage of sampled Medicare members who received an influenza vaccination in the measurement year.

Health Plan CAHPS question: Have you had a flu shot during the flu season? Survey period is a sample from March through early June, each year.

Statin Therapy for members with cardiovascular disease (SPC)

The percentage of males age 21-75 and females age 40-75 during the measurement year, who were identified as having with Cardiovascular Disease atherosclerotic cardiovascular disease (ASCVD) and were, dispensed at least one high- or moderate–intensity statin medication during the measurement year.

Measure Compliance: Dispensed at least one high or moderate intensity statin medication during the measurement year.

Intensity	Prescription (Formulary Tier applies to generic formulation)	
High-intensity statin therapy	atorvastatin 40-80 mg amlodipine–atorvastatin 40-80 mg	simvastatin 80 mg rosuvastatin 20-40 mg ezetimibe–simvastatin 10-80 mg
Moderate-intensity statin therapy	atorvastatin 10-20 mg lovastatin 40 mg amlodipine–atorvastatin 10-20 mg ezetimibe–simvastatin 20-40 mg fluvastatin XL 80 mg fluvastatin 40 mg	simvastatin 20-40 mg rosuvastatin 5-10 mg pravastatin 40-80 mg pitavastatin 2-4 mg

Exclusions:

- Myalgia, myositis, or rhabdomyolysis during the measurement year
- **ICD-10:** G72.0, G72.2, G72.9, M60.8-M60.9, M62.82, M79.1-M79.18
- ESRD during measurement year or the year prior
- Cirrhosis during measurement year or the year prior
- Pregnancy, IVF or dispensed at last one Rx for clomiphene during the measurement year or the year prior
- Age 66 or older with advanced illness and frailty

Statin Therapy for Persons

The percentage of members age 40-75 who were dispensed at least two diabetes medication (oral hypoglycemic or insulin)

Numerator Compliance: At least one statin prescription (any intensity) dispensed in the measurement year

Statin Medications		
lovastatin	atorvastatin	simvastatin
pravastatin	rosuvastatin	
pitavastatin	fluvastatin	
Statin CombinationProducts		
atorvastatin and amlodipine	ezetimibe and simvastatin	

Exclusions:

- ESRD

Medication Adherence: Part D Pharmacy Quality Alliance measure

Eligible Population: The number of members who were dispensed two or more diabetes prescriptions, who received statin medication for the measurement year.

Adherence is calculated and benchmarked solely on pharmacy claims.

Exclusions:

- Members with ESRD, identified using ICD-10 codes and/or by the Rx HCC for dialysis status

Supplemental data use is not permitted for Part D measures.

Transitions of Care (TRC)

The percentage of discharges an inpatient facility stays between January 1 and December 1 of the measurement year for members age 18 and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

All documentation must come from the same outpatient medical record

Notification of Inpatient Admission

Documentation of receipt of notification of inpatient admission within 72 hours of admission

Measure Compliance: Documentation in the outpatient medical record must include evidence of receipt of notification (time/date stamped) of inpatient admission on the day of admission or the following day.

Examples: Communication between the emergency department (ED), inpatient providers or staff and the member's primary care physician (PCP) or ongoing care provider (e.g., phone call, email, fax).

Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via ADT alert system; or a shared electronic medical record.

Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.

Indication that the PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay. Indication that the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam.

Receipt of Discharge Information

Documentation of receipt of discharge information within 72 hours of discharge

Measure Compliance: Evidence of the date when the documentation was received. Information must include practitioner responsible for member's care during the inpatient stay; procedure or treatment provided; diagnosis at discharge; current medication list; testing results or documentation of pending test or no test pending; instructions for patient care.

Examples: Discharge information may be included in a discharge summary or summary of care record or be in structured fields in an electronic health record.

Patient Engagement After Inpatient Discharge

Documentation of patient engagement (e.g., office visit, visit to the home, or telehealth) provided within 30 days after discharge. Does not count on date of discharge

Measure Compliance: Documentation in the outpatient record must include evidence of patient engagement within 30 days after discharge. Day of discharge does not count. Any of the following meet criteria: Outpatient visit (including office and home visits); telephone visit; or synchronous telehealth visit.

***If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria

CPT: Outpatient visits: 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483; Telephone visit: 98966-98968, 99441-99443; Transition of care management: 99496, 99495

HCPCS: G0402, G0438, G0439, G0463, T1015 **Rev Codes:** 0510-0517, 0519-0523, 0526-0529, 0982, 0983

Care for Older Adult

Eligible Population: Medicare Special Needs Plan members, 66 years and older as of December 31 of the measurement year.

Exclusions: Hospice

Medication Review

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.

Measure Compliance: Either of the following will meet the measure's criteria:

1) Medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist with the date it was performed (must be in the same medical record)
2) Notation that the member is not taking any medication and the date when it was noted

Medication Review: **CPT:** 90863, 99483, 99605, 99606 **CPT II:** 1160F **Medication List:** **CPT II:** 1159F **HCPCS:** G8427
Transitional Care Management Services during the measurement year: **CPT:** 99495, 99496

Functional Assessment

A functional status assessment during the measurement year, as documented through either administrative claim data or medical record review.

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

- Result of assessment using a standardized functional status assessment tool, not limited to: SF-36®, ALSAR, ADLS, B-ADL, Barthel Index, EADL, ILS, Katz6 Index of Independence in ADL, Kenny Self-Care Evaluation, Klein-Bell ADL Scale, KELS, Lawton & Brody's IADL, PROMIS, Staying Healthy Assessment tool, 602A form

Functional Status Assessment: **CPT:** 99483 **CPT II:** 1170F **HCPCS:** G0438, G0439

Pain Assessment

At least one pain assessment during the measurement year; documented through either administrative claims data or medical record review.

Measure Compliance: Documentation in the medical record must include evidence of a pain assessment and the date it was performed. Notations for a pain assessment must include one of the following:

- Documentation that the member was assessed for pain (which may include positive or negative findings for pain)
- Result of assessment using a standardized pain assessment tool, not limited to numeric rating scales (verbal or written), FLACC, verbal descriptor scales, pain thermometer, pictorial pain scales, visual analogue scale, brief pain inventory, chronic pain grade, PROMIS pain intensity scale, PAINAD

Pain Assessment: **CPT II:** 1125F, 1126F

Advance Care Planning

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

Measure Compliance: Documentation in the medical record of advance care planning. Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record during the measurement year
- Documentation of an advance care planning discussion with the provider and the date it was discussed. The discussion must be noted during the measurement year.
- Notation that the member previously executed an advance care plan. The notation must be dated during the measurement year.

Examples: Advance directive, actionable medical orders, living will, surrogate decision-maker
HCPCS: S0257 **ICD-10:** Z66 **Assessment:** **CPT:** 99483, 99497 **CPT II:** 1123F, 1124F, 1157F, 1158F

Plan All-Cause Readmission

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

Plan all cause readmission assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.

** Inpatient 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 inpatient stays.

A lower rate indicates better performance.

Exclusions:

- Exclude an inpatient hospital stay if:
  - The principal diagnosis of pregnancy or a condition originating in the perinatal period is documented on the discharge claim
  - The member died during the stay
- Any first hospital stay if it is for:
  - Principal diagnosis of maintenance chemotherapy or rehabilitation
  - Organ transplant
  - Certain potentially planned procedures without a principal acute diagnosis

Controlling High Blood Pressure

The percentage of members age 18- 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.

Identifying Event:
Two or more visits on different dates of service up to 6/30 of the measurement year with a diagnosis of HTN during the measurement year or the year prior.

Any of the following code combinations meet criteria:

- Outpatient visit with a diagnosis of hypertension
- A telephone visit with a diagnosis of hypertension
- An online assessment with a diagnosis of hypertension

Measure Compliance:
Adequate control:
For BP to be identified as controlled, the systolic and diastolic BP must be lower than 140/90 mm HG.

The representative BP is the most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple blood pressures are recorded during an eligible visit, the lowest systolic and lowest diastolic BP reading will count toward the measure.

If you recheck a blood pressure during a visit due to an original elevated reading, please be sure to record the reading in the medical record!

BP readings from acute inpatient stay, ED visit, day of major diagnostic or surgical procedures, or member-reported **do not** count toward meeting the measure. It must be entered into a progress note.

BP readings can be captured through codes reported on claims or through medical record review.

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

Exclusions:

- ESRD
- Kidney transplant
- Pregnancy during measurement year
- Age 66 or older with advanced illness and frailty

Frailty Frailty coded once during the measurement year.
Home visit for mechanical care (99504); Home visit for stoma care and maintenance including colostomy and cystostomy (99505) Cane (E0100, E0105); Walker (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149); Commode chair (E0163, E0165, E0167, E0168, E0169, E0170, E0171) Hospital bed (E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-E0297, E301-E0304); Oxygen (E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-E0444) Rocking bed (E0462); Home ventilator (E0465, E0466); Respiratory assist device (E0470-E0472); Humidifier used with positive airway pressure device (E0561-E0562) Wheelchair (E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298) Skilled RN services related to home health/hospice setting (G0162, G0299, G0300, G0493, G0494, S9123, S9124, T1000 – T1005, T1019 – T1022, T1030, T1031) Physician management of member home care, hospice (S0271) Comprehensive management (S0311) Pressure ulcer (L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90) Muscle wasting and atrophy, not elsewhere classified, unspecified site (M62.50); Muscle weakness (generalized) (M62.81); Sarcopenia (M62.84) Ataxic gait (R26.0); Paralytic gait (R26.1); Difficulty in walking, not elsewhere classified (R26.2); Other abnormalities of gait & mobility (R26.89); Unspecified abnormalities of gait & mobility (R26.9) Age-related cognitive decline (R41.81); Weakness (R53.1); Other malaise (R53.81); Other fatigue (R53.83); Age-related physical debility (R54) Adult failure to thrive (R62.7); Abnormal weight loss (R63.4); Underweight (R63.6); Cachexia (R64) Fall (W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS,W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S,W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS,W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS) Unspecified place in other specified residential institution as the place of occurrence of the external cause (Y92.199) Problems related to living in residential institution (Z59.3); Limitation of activities due to disability (Z73.6); Bed confinement status (Z74.01); Other reduced mobility (Z74.09) Need for assistance with personal care (Z74.1); Need for assistance at home and no other household member able to render care (Z74.2); Need for continuous supervision (Z74.3); Other problems related to care provider dependency (Z74.8); [Z74.9] Problem related to care provider dependency, unspecified (Z74.9) History of falling (Z91.81); Dependence on respirator [ventilator] status (Z99.11); Dependence on wheelchair (Z99.3); Dependence on supplemental oxygen (Z99.81) Dependence on other enabling machines and devices (Z99.89)