OPTUM®

Closing gaps in quality measures

Including HEDIS®, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Health Outcomes Survey (HOS)

Medicare Advantage, the Affordable Care Act and Medicaid Managed Care

The Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is one of the most widely used standardized set of health care performance measures in the United States. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA), which has expanded the size and scope of HEDIS to include measures for physicians, Preferred Provider Organizations (PPOs) and other organizations. More than 90 percent of America's health plans participate in HEDIS, in which several state laws currently mandate the use of HEDIS measures for various managed care plans. Health plans use HEDIS performance results to evaluate quality of care and service, evaluate provider performance, develop performance improvement initiatives, perform outreach to providers and members, and compare performance with other health plans to measure these important dimensions of care and service. HEDIS consists of 91 measures across 6 domains of care (see official 2020/2021 NCQA listing).

Some HEDIS measures have documentation requirements, others have claims reporting requirements and some require both. In addition to documenting these measure requirements, providers can report some of these measures via Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. Speak with your Optum representative regarding further questions on HEDIS reporting specific to your organization.

CMS Five-Star Quality Rating System

One of the Centers for Medicare & Medicaid Services' (CMS) important goals for the Star Rating system is to improve the quality of care and general health status for Medicare beneficiaries. CMS publishes the Star Ratings each year to: measure the collaborative partnership between health plans and CMS to promote patient-centered, value-based care, assist beneficiaries in finding the best plan for them and determine quality bonus payments. Moreover, the ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals and other providers. Star Ratings are driving improvements stemming from the reporting of health care performance measures (HEDIS data), allowing health plans to effectively and efficiently evaluate their populations and the efficacy of member programs to improve upon their identified service quality scores.

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- HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
- CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
- For additional information about the Medicare Advantage Five-Star Quality Rating System, please visit: go.cms.gov/partcanddstarratings
- For additional information on the Medicare Health Outcomes Survey (HOS), please visit: cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2021: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required."

Codes marked with a ✦ directly after them represent new additions to the FY 2021 ICD-10-CM code classification.

OPTUM®

CMS Five-Star Quality Rating System documentation guidelines

The Healthcare Effectiveness Data and Information Set (HEDIS) and the CMS Five-Star Quality Rating System, or Star Ratings, documentation guidelines are provided to assist you in your ongoing participation in the Optum program offerings. Medical records can be used to support our clients' HEDIS and Star Ratings data collection efforts. This tool may help ensure you have included all the necessary documentation.

Documentation in the medical record should include date/results as defined by specific measure criteria.

Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Breast Cancer Screening (BCS)	Screening is recommended for female patients ages 50–74, who have not had a mammogram in the 27 months prior to December 31 of the current year.	Medical record stating the date that the mammogram was completed or a copy of the diagnostic report. *Documented exclusions: two unilateral mastectomies or bilateral mastectomy.*
Colorectal Cancer Screening (COL)	Screening is recommended for patients ages 50–75, who have not had any of the following: • FOBT in the current calendar year • FIT-DNA test (Cologuard®) during current year or two prior calendar years • CT colonography during current or four prior calendar years • Flexible sigmoidoscopy during current or four prior calendar years • Colonoscopy during current or nine prior calendar years	Medical record stating the screening was completed on a specified date with/without result or radiology/lab report. • Result or finding must also be present, which ensures that the screening was performed and not merely ordered. • Member refusal will **not** make them ineligible for this measure. *Documented exclusions: colorectal cancer or total colectomy.*

Comprehensive Diabetes Care (CDC)	The following is recommended for patients with diabetes (Types 1 and 2), ages 18–75, in the current calendar year:
	• Eye exam: dilated eye exam by an optometrist or an ophthalmologist.
	• HbA1c screening: an HbA1c test or result less than 8%. Star Ratings measure defines HbA1c levels >9.0% as poorly controlled.
	• Nephropathy screening: a nephropathy screening or monitoring test or evidence of nephropathy.
		Medical record stating the exam or screening was completed during the calendar year:
		• Eye exam: screening results by an eye care professional (optometrist/ophthalmologist) or the consultation report during the measurement year, documentation of a negative retinal or dilated exam (negative for retinopathy) in the prior year by an eye care professional.
		• HbA1c screening: documentation of the date and result(s) or copy of lab report.
		• Nephropathy screening:
		  • Microalbumin with date completed with result or copy of lab report
		  • Medical record stating that the patient visited a nephrologist, had a renal transplant, medical attention to CKD stage 4, ESRD, dialysis, etc.
		  • Evidence of treatment or ACE/ARB therapy

Controlling High Blood Pressure (CBP)	Patients with a diagnosis of hypertension whose blood pressure was adequately controlled during the measurement year: • <140/90 for patients 18–85 years of age Patient must have at least two visits on different dates of service with a hypertension diagnosis during the measurement year or the year prior.	Medical record stating hypertension diagnosis and that blood pressure was completed on a specified date with result. • Documentation must be from provider managing condition. • The BP reading must occur on or after the date of the second diagnosis of hypertension. • Diagnosis and BP reading can come from different care providers, providing BP criteria is met in the managing provider's note. *Documented exclusions: patients with ESRD (dialysis) or kidney transplant; a diagnosis of pregnancy during year; or inpatient admission during year.*
Osteoporosis Management in Women Who Had a Fracture (OMW)	For female patients 67–85 years of age, bone mineral density (BMD) testing or a dispensed prescription drug to treat osteoporosis is recommended within 180 days (6 months) of a fracture.	Medical record with result of bone density test or documentation of the prescription that was given to the patient. HEDIS compliance stipulates that the prescription be dispensed. *Documented exclusions: BMD within past 24 months or osteoporosis therapy within past 12 months. Fractures of the finger, toe, face and skull are not included in this measure.*

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CMS Five-Star Quality Rating System documentation guidelines

Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Osteoporosis Screening in Older Women (OSW)	Female patients ages 65–75 years of age who received an osteoporosis screening on or between their 65th birthday and December 31 of the measurement year.	Documentation of acceptable test such as: • Ultrasound bone density measurement (76977) • CT, bone mineral density study (77078) • Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites, axial skeleton (77080) • Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (77081) • Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton, including vertebral fracture assessment (77085)
Care for Older Adults (COA) Applies only to Medicare Special Needs Plans (SNP) & Medicare-Medicaid Plans (MMP)	Recommended during the calendar year for adults 66 years and older. • Advance care planning • Functional status: patient to have at least one functional status assessment • Medication review: annual review of all medications (prescriptions, OTC, herbal/supplemental therapies) • Pain assessment: patient to have at least one pain assessment during the calendar year	• Advance care planning: progress notes documenting the discussion and date when it was discussed or notation that the member previously executed an advance care plan • Functional status: notation that activities of daily living (bathing, dressing, eating, walking, etc.) or instrumental activities of daily living (grocery shopping, driving, meal preparation, laundry, taking medications, etc.) were assessed or documentation of result of assessment using a standardized functional status assessment • Medication review: medication list and evidence of medication review by prescribing practitioner or clinical pharmacist, including date when performed or notation that member is not taking any medication and date when noted • Pain assessment: medical record with documentation of comprehensive pain assessment or result of assessment using standardized pain assessment tool
Advanced Illness and Frailty Exclusion	Quality measures that were designed and intended for a general adult population may not always be appropriate for those with a limited life expectancy or advanced illness and frailty. As such, NCQA is implementing corresponding exclusions across selected HEDIS measures to help focus on the population who are most likely to benefit from preventive health screenings	For additional information, please see the Advanced Illness and Frailty Exclusions tool.
Kidney Health Evaluation for Patients with Diabetes (KED)	The percentage of patients ages 18–75 with diabetes (Types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.	Document date and results of patient's eGFR *and* uACR.
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of patients 40 years of age and older with a new diagnosis of Congestive Obstructive Pulmonary Disease (COPD) or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	An encounter with a diagnosis of COPD and specific spirometry testing completed two years prior through six months after the diagnosis. *Note: The type of encounter (outpatient/inpatient) may alter these requirements. See the NCQA specs for complete information.*

The table above provides a summary only. Please refer to the NCQA technical specifications for complete details.

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CMS Five-Star Quality Rating System documentation guidelines

Prescription drug measures	CMS Five-Star Quality Rating requirements	Documentation guidelines
Medication Adherence for Diabetes Medications	Percentage of patients with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	Provider should document prescriptions in patient's medical record. Star Rating is based on pharmacy data. *Medications received at the VA or through discount programs where insurance is not billed are excluded from pharmacy data.*
Medication Adherence for Hypertension (RAS Antagonists)	Percentage of patients with a prescription for blood pressure medication (ACE, ARB or direct renin inhibitor) 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 Cholesterol (Statins)	Percentage of patients with a prescription for cholesterol (a statin drug) medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	
Statin Use in Persons with Diabetes (SUPD)	Percentage of patients 40–75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period.	
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Percentage of males 21–75 years of age and females 40–75 years of age 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 during the measurement year.	

Measures specific to the Affordable Care Act (ACA) and Medicaid population		
Quality measure	CMS Five-Star Quality Rating recommendations	Documentation guidelines
Cervical Cancer Screening (CCS)	Screening is recommended for: • Women 21–64 years of age who had cervical cytology performed during the current calendar year or two years prior. • Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing during the current calendar year or four years prior.	Documentation should include a notation indicating the date and type of screening performed. This quality measure or gap can also be closed via claims as permitted by the health plan.
Chlamydia (CHL)	Screening is recommended for women ages 16–24 who are sexually active and had at least one test for chlamydia during the measurement year.	Documentation should include that a screening test was completed with date. This measure can be closed via claims when the lab test has been billed through the patient's health plan.

OPTUM®

Breast cancer screening

CMS Star Rating Weight

1

Breast cancer screening

Description: Measures the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the prior 27 reported months.

Age: Women 52–74 years of age as of December 31 of the measurement year.

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

1. Medical record stating that screening was completed and/or mammography report.
2. Date screening was completed.
3. Result/mammography report may be submitted in lieu of progress note.
4. Documentation of exclusion, if applicable.

A referral for a mammogram is not sufficient to close the quality gap.

Exclusions

Bilateral mastectomy (CPT codes: 19180, 19200, 19220, 19240, 19303–19307 with modifier RT or LT as applicable or ICD-10-CM: Z90.13 OR Z90.11 + Z90.12) anytime during the member's history through December 31 of the measurement year.

Claims-only exclusions

Members 66 years or older living in I-SNP or long-term institution during the measurement year.

Members 66–80 years or older as of December 31 of measurement year with frailty and advanced illness during measurement year.

Description	CPT	HCPCS
Breast cancer screening	77055–77057, 77061–77063, 77065–77067	G0202, G0204, G0206

- Do not count breast biopsies, ultrasounds or MRIs. *They are not appropriate methods for primary breast cancer screening.*
- Ensure that the mammogram and documentation of mammogram screening date occur within the appropriate time frame, 27 months prior to December 31 of the measurement year.
- Documentation of "*next screening due*" does not meet evidence of completion of breast cancer screening.
- Mastectomy *must be* specified as "*bilateral*" (by one operative session or two operative sessions) to be an acceptable exclusion. Mastectomies can be defined as simple, extended simple, radical or extended radical.

Colorectal cancer screening

CMS Star Rating Weight

1

Colorectal cancer screening

Description: Measures the percentage of members 50–75 years of age who had appropriate screening for colon cancer.

Age: Members 51–75 years of age as of December 31 of the measurement year.

Requirements for compliance

One or more screenings for colorectal cancer. Any of the following meet the criteria:

- Fecal occult blood test (FOBT) during the measurement year. iFOBT (immunological fecal occult blood test) or gFOBT (guaiac fecal occult blood test) are acceptable. Documentation of one or more samples is acceptable.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (Cologuard®) during the measurement year or the two years prior to the measurement year.

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

1. Medical record stating that screening was completed.
2. Date screening was completed.
3. A result is not required if the documentation is clearly part of the *Medical History* section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).
4. Documentation of exclusion, if applicable.

Exclusions

- Colorectal cancer
- Total colectomy

Claims-only exclusions

Members 66 years and older living in I-SNP or long-term institution during the measurement year.

Members 66–80 years of age or older as of December 31 of measurement year with frailty and advanced illness during measurement year or the year prior.

Description	CPT	HCPCS
FOBT (every year)	82270, 82274	G0328
FIT-DNA (every 3 years)	81528	G0464
Flexible sigmoidoscopy (every 5 years)	45330–45335, 45337–45342, 45345–45347, 45349, 45350	G0104
CT colonography (every 5 years)	74261, 74262, 74263	
Colonoscopy (every 10 years)	44388–44397, 44401–44408, 45355, 45378–45393, 45398	G0105, G0121

- Digital rectal exam (DRE) and FOBT tests performed in an office setting or performed on a sample collected via DRE does not count as evidence of colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.
- Ensure that the test occurs within the appropriate time frame. The main reasons that the screening gap does not close from medical record documentation are:
  - The screening date is missing.
  - The screening date is outside of the HEDIS time frame.
- Must be documented as *total colectomy* to count as an exclusion.

OPTUM®

Controlling high blood pressure (CBP)

About HEDIS requirements for high blood pressure

CMS Star Rating Weight

3

Controlling high blood pressure

Description: Measures the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Age: Members 18 to 85 years as of December 31 of the measurement year.

What to report for compliance

This screening can be closed by using the appropriate CPT II code on claims submission or by medical record review.

What you need to include in medical record documentation

1. Date of service
2. BP reading at each visit
3. Documentation and coding of exclusion, if applicable

Exclusions

- Pregnancy (reporting an appropriate pregnancy diagnosis on the claim and in your documentation is necessary, if applicable)
- Members ages 66–80 years of age as of December 31 of the measurement year with advanced illness and frailty. Members must meet the criteria for both advanced illness and frailty. Please see the Optum tool: *Advanced Illness and Frailty* for further details.
- Patients with ESRD (dialysis) or kidney transplant or inpatient admission during the measurement year.

- Member-reported results are acceptable if BP readings were obtained using a digital device.
- Ensure that the BP was in the appropriate time frame.
- Reasons the measure is not closed from medical record documentation:
  - Screening date is missing.
  - BP reading is 140/90 or greater.

ICD-10-CM code	CPT	CPT II	HCPCS
I10	99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99420, 99429, 99455, 99456, 99483	3074F, 3075F, 3077F, 3078F, 3079F, 3080F	G0402, G0438, G0463, T1015

OPTUM®

Osteoporosis management in women who had a fracture

CMS Star Rating Weight

1

Osteoporosis management in women who had a fracture

Description: Measures the percentage of women ages 67–85 who suffered a fracture and had either a bone mineral density test (BMD) or a prescription for a drug to treat osteoporosis within six months (180 days) after the fracture.

Age: Women 67–85 years of age as of December 31 of the measurement year.

Intake period: Time frame used to capture the first fracture. This is a 12-month window that begins July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

Index episode start date (IESD): Earliest date of service with diagnosis of a fracture during the intake period.

Requirements for compliance

Screening/test required: Appropriate testing or treatment for osteoporosis after the fracture defined by *any of the following criteria*:

- A bone mineral density (BMD) test on the IESD or in the six-month period after the IESD
- A BMD test during the inpatient stay for the fracture (applies only to fractures requiring hospitalization)
- Osteoporosis therapy on the IESD or in the six-month period after the IESD
- Long-acting osteoporosis therapy during inpatient stay (applies only to fractures requiring hospitalization)
- A dispensed prescription to treat osteoporosis on the IESD or in the six-month period after the IESD

What to report for compliance

This screening is typically closed by claims data.

What you need to include in medical record documentation

1. Evidence of completed BMD test (date DXA, ultrasound or CT bone mineral density test was completed)
2. Osteoporosis therapies (prescription must be dispensed by pharmacy)
3. Documentation of exclusion, if applicable

Exclusions

- Members who had a BMD test during the 24 months prior to fracture
- Members with a claim/encounter for osteoporosis therapy during the 12 months prior to the IESD
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the fracture

Claims-only exclusions:

- Members 66 years and older living in I-SNP or long-term institution during the measurement year
- Members 81 years of age and older as of December 31 of the measurement year with frailty during the measurement year
- Members 66–80 years of age or older as of December 31 of measurement year with frailty and advanced illness during measurement year or the year prior

- Fractures of finger, toe, face and skull are not included in this measure.
- If exceptions require use of documentation, include the screening date. Screening date must be within the HEDIS time frame.
- Member must have prescription filled through their Medicare Advantage Part D pharmacy benefit to close gap using claims data.
- A referral is not sufficient to close the gap.

Osteoporosis management in women who had a fracture

Description	CPT	HCPCS
DXA, ultrasound and CT bone mineral density tests	76977, 77078, 77080, 77081, 77085, 77086	G0130
Osteoporosis medications (injectables) and long-acting osteoporosis medications		J0897, J1740, J3110, J3111, J3489

Description	Drug name
Osteoporosis therapies, identified through pharmacy data *Medications received at the VA or through discount programs where insurance is not billed are excluded from pharmacy data.*	• Albandronate • Alendronate • Alendronate cholecalciferol • Denosumab • Ibandronate • Raloxifene • Risedronate • Romosozumab • Teriparatide • Zoledronic acid

Comprehensive diabetes care

The three components of this measure include the following:

- Diabetic eye exam
- Kidney disease monitoring
- Blood sugar controlled

Claims-only exclusions (These exclusions apply for all parts of the CDC measure.)

- Members 66 years and older living in I-SNP or long-term institution during the measurement year
- Members 66–80 years of age or older as of December 31 of measurement year with frailty and advanced illness during measurement year or the year prior

CMS Star Rating Weight

1

Comprehensive diabetes care (CDC): Diabetic eye exam

Description: Measures the percentage of plan members with diabetes who had a retinal or dilated eye exam by an eye care professional during measurement year.

Age: Members ages 18–75 with diabetes (Type 1 or Type 2).

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

At a minimum, documentation in the medical record must include one of the following:

1. A note or letter prepared by an ophthalmologist, optometrist, primary care physician or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional and includes:
    - Date procedure was performed
    - Results of exam
2. A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, you can submit results that were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
3. Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year (CPT II: 3072F), where results indicate retinopathy was not present (e.g., documentation of normal findings).
    - Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.
4. Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.

Description	CPT	CPT II	HCPCS
Eye exam	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114, 67028, 67030, 67031, 67036, 67039–67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213–99215, 99242–99245, 99483	2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F	S0620, S0621, S3000

- To show evidence that a diabetic retinal eye exam was performed, an eye exam from a licensed eye care professional (optometrist or ophthalmologist) must be included in the medical record.
- Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.
- If not specified, verify that the eye exam performed was "retinal" or "dilated."
- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

OPTUM®

Comprehensive diabetes care

CMS Star Rating Weight

1

Comprehensive diabetes care (CDC): Kidney disease monitoring

Description: Measures the percentage of plan members with diabetes who had a nephropathy test during the measurement year or evidence of nephropathy during the year.

Age: Members ages 18–75 with diabetes (Type 1 or Type 2).

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

Nephropathy screening test

- Medical record indicating the date the urine microalbumin was performed
- Result or finding

Any of the following meet criteria for urine microalbumin test: 24-hour urine for microalbumin, timed urine for microalbumin, spot urine for microalbumin, urine for microalbumin/creatinine ratio, 24-hour urine for total protein and/or random urine for protein/creatinine ratio.

Evidence of nephropathy (any of the following):

1. Documentation of a visit to a nephrologist. (*Not a referral to a nephrologist.)*
2. Documentation of a renal transplant.
3. Documentation of medical attention for any of the following (no restriction on provider type): diabetic nephropathy, end stage renal disease, chronic renal failure (CRF), chronic kidney disease (CKD), renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), dialysis, hemodialysis and/or peritoneal dialysis.
4. A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
   - 24-hour urine for albumin or protein, timed urine for albumin or protein, spot urine for albumin or protein, urine for albumin/creatinine ratio, 24-hour urine for total protein, random urine for protein/creatinine ratio.
5. Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitors/ARBs therapy during the measurement year. Any of the following meet criteria: Documentation that a prescription for an ACE inhibitor/ARB was written, filled or taken by the member during the measurement year.

- Ensure that the lab report with microalbumin results is included in the medical record.
- A screening or monitoring test meets criteria, whether result is positive or negative.
- If the patient was referred to a nephrologist for care, include a copy of the progress notes from those visit(s) in the medical record.

Description	CPT	CPT II	ICD-10-CM
Nephropathy treatment		3066F, 4010F	E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0, N00.1, N00.2, N00.3, N00.4, N00.5, N00.6, N00.7, N00.8, N00.9, N01.0, N01.1, N01.2, N01.3, N01.4, N01.5, N01.6, N01.7, N01.8, N01.9, N02.0, N02.1, N02.2, N02.3, N02.4, N02.5, N02.6, N02.7, N02.8, N02.9, N03.0, N03.1, N03.2, N03.3, N03.4, N03.5, N03.6, N03.7, N03.8, N03.9, N04.0, N04.1, N04.2, N04.3, N04.4, N04.5, N04.6, N04.7, N04.8, N04.9, N05.0, N05.1, N05.2, N05.3, N05.4, N05.5, N05.6, N05.7, N05.8, N05.9, N06.0, N06.1, N06.2, N06.3, N06.4, N06.5, N06.6, N06.7, N06.8, N06.9, N07.0, N07.1, N07.2, N07.3, N07.4, N07.5, N07.6, N07.7, N07.8, N07.9, N08, N14.0, N14.1, N14.2, N14.3, N14.4, N17.0, N17.1, N17.2, N17.8, N17.9, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0, Q60.1, Q60.2, Q60.3, Q60.4, Q60.5, Q60.6, Q61.00, Q61.01, Q61.02, Q61.11, Q61.19, Q61.2, Q61.3, Q61.4, Q61.5, Q61.8, Q61.9, R80.0, R80.1, R80.2, R80.3, R80.8, R80.9, Z99.2
Urine protein test	81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156	3060F, 3061F, 3062F	

OPTUM®

Comprehensive diabetes care

CMS Star Rating Weight

3

Comprehensive diabetes care (CDC): Blood sugar controlled

Description: Measures the percentage of plan members who had an HbA1c test during the year and demonstrate good control.

Age: Members ages 18–75 with diabetes (Type 1 or Type 2).

Requirements for compliance
Hemoglobin A1c screening test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

HbA1c control is based on the last test value of the year.

What to report for compliance
This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation
- HbA1c test performed during the measurement year
- Date the HbA1c test was performed
- Result

HEDIS specifies that HbA1c control for this population is <8.0%. The member is compliant if the result for the most recent HbA1c level during the measurement year is <8.0%. The Five-Star Quality Rating defines poor control for this measure as >9.0%. *Missing test result (HbA1c value) is considered not compliant for HbA1c control for HEDIS and Five-Star Quality Ratings.*

Description	CPT	CPT II
HbA1c test	83036, 83037	
HbA1c level less than 7.0%		3044F
HbA1c level 7.0–7.9%		3051F
HbA1c level 8.0–9.0%		3052F
HbA1c level greater than 9.0%		3046F

- Always document the most recent HbA1c test results in the progress note.
- NCQA only recognizes the last HbA1c result of the measurement year.
- Only the HbA1c test will close this measure.
- Ensure that the name of the test performed specifically includes "A1c" and that this label translates from lab results to the electronic medical record and/or to printed medical record.
- If using CPT category II codes to report the result, a copy of the lab results must be included in the medical record.

Care for Older Adults (COA)

COA measures are only reported for Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) members. The four components of this measure include the following:

- Medication review
- Pain assessment
- Functional status assessment
- Advanced care planning

- A review of side effects for a single medication at the time of prescription alone *is not* sufficient.
- An outpatient visit is not required to meet criteria.

CMS Star Rating Weight

1

Medication review

Description: The percentage of Medicare Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) enrollees 66 years and older who received at least one medication review in the measurement year.

Age: 66 years and older as of December 31 of the measurement year.

Requirements for compliance

Both of the following on the same date of service during the measurement year:

- At least one medication review conducted by a prescribing practitioner or clinical pharmacist
- The presence of a medication list in the medical record or notation that no medications were prescribed and the date of service was noted

What to report for compliance

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, as documented through either administrative data or medical record review.

Medication list

A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).

Medical record

Documentation must come from the same medical record and must include the following:

- A medication list in the medical record *and* evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed, *or*
- Notation that the member is not taking any medication and the date when it was noted

Description	CPT	CPT II	HCPCS
Medication review	90863, 99483, 99605, 99606	1160F	
Medication list		1159F	G8427

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Care for Older Adults (COA)

CMS Star Rating Weight

1

Functional status assessment

Description: The percentage of Medicare Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) enrollees 66 years and older who had a functional assessment in the measurement year.

Age: 66 years and older as of December 31 of the measurement year.

Medical record
Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.

What to report for compliance (includes evidence in medical record, other actions provider needs to take)
To comply, the following must be included:

- Evidence of functional assessment and date of service
- Date of service

Notations for a complete functional status assessment must include one of the following:

- Notation that activities of daily living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (that is, getting in and out of chairs), using toilet, walking
- Notation that instrumental activities of daily living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®
  - Assessment of Living Skills and Resources (ALSAR)
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
  - Bayer ADL (B-ADL) Scale
  - Barthel Index
  - Edmonton Frail Scale
  - Extended ADL (EADL) Scale
  - Groningen Frailty Index
  - Independent Living Scale (ILS)
  - Katz Index of Independence in ADL
  - Kenny Self-Care Evaluation
  - Klein-Bell ADL Scale
  - Kohlman Evaluation of Living Skills (KELS)
  - Lawton and Brody's IADL scales
  - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

- A functional status assessment limited to an acute or single condition, event or body system (for example, lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

Description	CPT	CPT II	HCPCS
Functional status	99843	1170F	G0438, G0439

OPTUM®

Care for Older Adults (COA)

Activities of daily living (ADL)

Please circle the appropriate response for each activity, based on what the member actually does rather than what he/she could do.

For the functional assessment, at least five of the following must be assessed: toilet use, bathing, eating, dressing, mobility (walking) and/or transferring.

Activity	Independent	Needs some assistance	Requires assistance
Bladder	Continent (>7 days)	Occasional accidents (within 24 hours)	Incontinent; needs assistance with catheterization; needs assistance with ostomy care
Bowels	Continent	Occasional accidents (within one week)	Incontinent; needs assistance with bowel routine; needs assistance with ostomy care
Toilet use	Independent (on and off, dressing, wiping)	Needs help with some tasks	Dependent on assistance
Bathing	Independent	Needs help with some tasks (transfer, drying)	Dependent on assistance
Eating	Independent (using proper utensils to bring food to the mouth as well as chewing and swallowing)	Needs minimal assistance but can do most tasks unaided	Dependent on assistance
Dressing	Independent (buttons, zippers, laces)	Needs help but can do some tasks unaided	Dependent
Mobility	Independent	Walks with cane or needs minor assistance (verbal or one person)	Immobile, wheelchair/scooter-bound
Transferring	Independently transfers to and from sitting position	Needs minor assistance (verbal or one person)	No sitting balance or requires help of more than one person
Stairs	Independent both up and down stairs	Needs help (verbal, physical, bolstering aid)	Unable

- **Based on the above, determine if the patient is a candidate for supervised care. ☐ YES ☐ NO**
- **Based on first three questions, determine if patient needs counseling for urinary and/or bowel incontinence. ☐ YES ☐ NO**
- **Based on the last three questions, determine if patient requires fall prevention counseling. ☐ YES ☐ NO**

1. Faces Pain Scale - Revised (FPS-R). www.iasp-pain.org/FPSR. Copyright ©2001, International Association for the Study of Pain.® Reproduced with permission. Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. Faces Pain Scale-Revised: Toward a Common Metric in Pediatric Pain Measurement. PAIN 2001; 93:173-183. With the instructions and translations as found on the website www.iasp-pain.org/FPSR.

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Care for Older Adults (COA)

CMS Star Rating Weight

1

Pain assessment

Description: The percentage of Medicare Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) enrollees 66 years and older who were screened for pain in the measurement year.

Age: 66 years and older as of December 31 of the measurement year.

Medical record
Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

What to report for compliance
Notations for a pain assessment must include one of the following:

- Documentation that the patient 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)
  - Face, Legs, Activity, Cry, Consolability (FLACC) scale
  - Verbal descriptor scales (5–7 word scales, present pain inventory)
  - Pain thermometer
  - Pictorial pain scales (faces pain scale, Wong-Baker FACES® Pain Rating Scale)
  - Visual analogue scale
  - Brief pain inventory
  - Chronic pain grade
  - PROMIS Pain Intensity scale
  - Pain Assessment in Advanced Dementia (PAINAD) scale

- Notation of a pain management or treatment plan alone does not meet criteria.
- Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.

Description	CPT II
Pain present	1125F
Pain not present	1126F

1. Faces Pain Scale - Revised (FPS-R). www.iasp-pain.org/FPSR. Copyright ©2001, International Association for the Study of Pain.® Reproduced with permission. Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. Faces Pain Scale-Revised: Toward a Common Metric in Pediatric Pain Measurement. PAIN 2001; 93:173-183. With the instructions and translations as found on the website www.iasp-pain.org/FPSR.

Comprehensive pain screening[1]

1. Does the patient complain of any pain symptoms? ☐ YES ☐ NO
   If yes, circle the appropriate face in FIGURE 1 below. If the score is 2 or higher, then document the following:
2. How long has the patient had the pain? _____
3. Describe the characteristics of the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Other: _____
4. The type of pain: ☐ Intermittent ☐ Variable (constant with intense breakthrough pain) ☐ Constant at a stable intensity
5. The location of the pain (indicate on FIGURE 2 below):

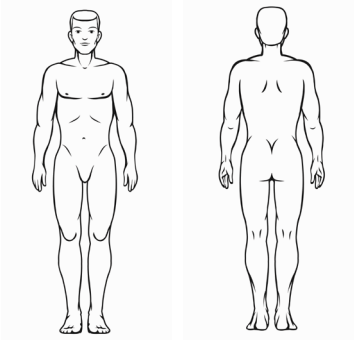
Document, code and provide a treatment plan for the pain and its management.

FIGURE 1: Faces Pain Scale-Revised (FPS-R)*

"These faces show how much something can hurt. This face (point to face on far left) shows no pain. The faces show more and more pain (point to each from left to right) up to this one (point to face on far right) — it shows very much pain. Point to the face that shows how much you hurt (right now)."

Score the chosen face 0, 2, 4, 6, 8 or 10, counting left to right, so "0" = "no pain" and "10" = "very much pain." Do not use words like "happy" or "sad." This scale is intended to measure how someone feels inside, not how their face looks.

FIGURE 2



Patient name: _____ **Date:** _____

Care for Older Adults (COA)

Advanced care

Description: The percentage of Medicare Special Needs Plans (SNP) and Medicare-Medicaid Plan (MMP) enrollees 66 years and older with evidence of advance care planning during the measurement year.

Age: 66 years and older as of December 31 of the measurement year.

Requirements for compliance
Evidence of advance care planning as documented through either administrative data or medical record review.

What to report for compliance
Advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end-of-life care. Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record
  - Advance directive (for example, living will, power of attorney, health care proxy)
  - Actionable medical orders (for example, Physician Orders for Life Sustaining Treatment [POLST], Five Wishes)
  - Living will; legal document denoting preferences for life-sustaining treatment and end-of-life care
  - Surrogate decision-maker; a written document designating someone other than the member to make future medical treatment choices
- Documentation of an advance care planning discussion with the provider and the date when it was discussed during measurement year
  - Discussion with a provider or initiation of a discussion by a provider during the measurement year or oral statements, conversations with relatives or friends about life-sustaining treatment and end-of-life care or patient designation of an individual who can make decisions on behalf of the patient
- Notation that a member previously executed an advance care plan

Description	CPT	CPT II	HCPCS	ICD-10-CM
Advance care planning	99483, 99497	1123F, 1124F, 1157F, 1158F	S0257	Z66

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Health Outcomes Survey (HOS)

About Health Outcomes Survey (HOS) measures

The Medicare Health Outcomes Survey (HOS) is the first patient-reported outcomes measure survey used in the Medicare Advantage (MA) program. The goal of the HOS survey is to gather valid, reliable and clinically meaningful health status data in the MA program for use in quality improvement activities, pay for performance, program oversight, public reporting and improving health.

The National Committee for Quality Assurance (NCQA) is the steward for the HOS measures and an NCQA-certified vendor conducts the HOS survey annually between April and July. The survey is comprised of: 1) a baseline survey and 2) a follow-up survey. The follow-up survey is for beneficiaries who participated in the baseline study two years prior.

A two-year change score is calculated by each member's physical and mental health status movement over the years under the following categories: better, the same or worse than expected and the consideration of risk adjustment factors. Organization-specific results are assigned as percentages of members whose health statuses were better, the same or worse than expected. The survey results also provide a general indication of how well an MA organization manages the physical and mental health of its members.

Five HOS measures (two functional health measures and three HEDIS Effectiveness of Care measures) are included in the annual Medicare Part C Star Ratings:

- Reducing the risk of falling
- Improving or maintaining physical health
- Improving or maintaining mental health
- Monitoring physical activity
- Improving bladder control

CMS Star Rating Weight

1

CMS Star Rating: Reducing the risk of falling

Description: Percent of plan members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.

HOS survey questions

- A fall is when your body goes to the ground without being pushed.
- In the past 12 months, did your doctor or other health provider talk with you 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? Such as: Suggest 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 test.

Compliance needed to meet the intent of the measure

The percentage of Medicare Advantage members 65 years or older who had a fall or had problems with balance or walking in the past 12 months who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.

These two components of this measure assess fall risk management:

– Discussing fall risk

– Managing fall risk

- History of falling (Z91.81)
- Staggering or abnormality of gait (R26.0)
- Difficulty in walking (R26.2)
- Unsteadiness on feet (R26.81)
- Other abnormalities of gait and mobility (R26.89)
- Unspecified abnormalities of gait and mobility (R26.9)

OPTUM®

Health Outcomes Survey (HOS)

CMS Star Rating Weight

1

CMS Star Rating: Monitoring physical activity

Description: Percent of plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.

HOS survey questions

- In the past 12 months, did you talk with a doctor or other health provider about your level of exercise of physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- In the past 12 months, did a doctor or other health care 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.

Compliance needed to meet the intent of the measure

The percentage of sampled Medicare Advantage members 65 years of age or older (denominator) 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 (numerator).

The two components of this measure assess promoting physical activity in older adults:

– Discussing physical activity

– Advising physical activity such as exercise counseling (Z71.82)

CMS Star Rating Weight

3

CMS Star Rating: Improving or maintaining physical health

Description: Percent of all plan members whose physical health was the same or better than expected after two years.

HOS survey questions

- In general, would you say your health is excellent, very good, good, fair or poor?
- 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? Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf: limited a lot, limited a little, not limited at all.
- 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? Climbing several flights of stairs: limited a lot, limited a little, not limited at all.
- 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? Accomplished less than you would like: none of the time, a little of the time, some of the time, most of the time, all of the time.
- 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? Were limited in the kind of work or other activities: none of the time, a little of the time, some of the time, most of the time, all of the time.
- During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? Not at all, a little bit, moderately, quite a bit, extremely.

Compliance needed to meet the intent of the measure

The percentage of sampled Medicare Advantage enrollees whose physical health statuses were the same or better than expected.

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Health Outcomes Survey (HOS)

CMS Star Rating Weight

3

CMS Star Rating: Improving or maintaining mental health

Description: Percent of all plan members whose mental health was the same or better than expected after two years.

HOS survey questions

- 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: none of the time, a little of the time, some of the time, most of the time, all of the time.
- 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)? Didn't do work or other activities as carefully as usual: none of the time, a little of the time, some of the time, most of the time, all of the time.
- How much of the time during the past four weeks have you felt calm and peaceful? None of the time, a little of the time, some of the time, most of the time, all of the time.
- How much of the time during the past four weeks did you have a lot of energy? None of the time, a little of the time, some of the time, most of the time, all of the time.
- How much of the time during the past four weeks have you felt downhearted and blue? None of the time, a little of the time, some of the time, most of the time, all of the time.
- 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.)? None of the time, a little of the time, some of the time, most of the time, all of the time.

Compliance needed to meet the intent of the measure

The percentage of sampled Medicare Advantage enrollees whose mental health statuses were the same or better than expected.

Health Outcomes Survey (HOS)

CMS Star Rating Weight

1

CMS Star Rating: Improving bladder control

Description: Percent of plan members with a urine leakage problem in the past six months who discussed treatment options with providers.

HOS survey questions

- Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced 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 health care provider about any of these approaches?

Compliance needed to meet the intent of the measure

The percentage of Medicare Advantage members 65 years or older reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider.

For all Five-Star Quality Ratings listed:

What to report for compliance: There is nothing for providers to report and members are randomly selected for survey participation.

- Providers should be aware of these questions and develop strategies that help shape a patient's satisfaction and view of health.
- Consider multiple touch points alerting patients to be engaged, considering messaging to patients pre-visit, during and post-visit.
- Encourage patients to engage on these questions via visit summaries or take-home materials.

For additional information on the Medicare Health Outcomes Survey (HOS), please refer to: cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/

OPTUM®

Health Outcomes Survey (HOS)

About the Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is the only patient-reported outcomes measure in Medicare-managed care and therefore remains a critical part of assessing a Medicare Advantage Organization's (MAO) quality. The HOS design is based on a randomly selected sample of individuals from each participating MAO and measures their physical and mental health over a two-year period. The HOS instrument is an assessment of an MAO's ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries. Members were eligible for re-measurement if they had sufficient data to derive physical or mental component scores at baseline.

The survey below is for informational purposes and highlights measures related to Star Ratings. *You are not required to complete or distribute this survey. This sample only includes a subset of the questions and is not the complete Health Outcomes Survey (HOS).*

For the complete survey, please visit: http://www.hosonline.org/en/survey-instrument/

Questions	Measure
MONITORING PHYSICAL ACTIVITY	
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.	☐ Yes ☐ No ☐ I had no visits in the past 12 months
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.	☐ Yes ☐ No
REDUCE RISK OF FALLING	
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?	☐ Yes ☐ No ☐ I had no visits in the past 12 months
Did you fall in the past 12 months?	☐ Yes ☐ No
In the past 12 months, have you had a problem with balance or walking?	☐ Yes ☐ No
Has your doctor or other health provider done anything to help prevent falls or treat problems with balancing 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 test.	☐ Yes ☐ No ☐ I had no visits in the past 12 months
IMPROVING AND MAINTAINING PHYSICAL HEALTH	
In general, would you say your health is:	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
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?	
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all
Climbing **several** flights of stairs.	☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all
During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**	
Accomplished less than you would like **as a result of your physical health?**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time

OPTUM®

Health Outcomes Survey (HOS)

The survey below is for informational purposes and highlights measures related to Star Ratings. *You are not required to complete or distribute this survey. This sample only includes a subset of the questions and is not the complete Health Outcomes Survey (HOS).*

For the complete survey, please visit: http://www.hosonline.org/en/survey-instrument/

Questions	Measure
IMPROVING AND MAINTAINING PHYSICAL HEALTH	
Were you limited in the **kind** of work or other activities **as a result of your physical health?**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time
During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?	☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
IMPROVING AND MAINTAINING MENTAL HEALTH	
During the **past 4 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?**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time
Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems?**	☐ No, none of the time ☐ Yes, a little of the time ☐ Yes, some of the time ☐ Yes, most of the time ☐ Yes, all of the time
How much of the time during the past 4 weeks:	
Have you felt calm and peaceful?	☐ All of the time ☐ Most of the time ☐ A good bit of the time ☐ Some of the time ☐ A little of the time ☐ None of the time
Did you have a lot of energy?	☐ All of the time ☐ Most of the time ☐ A good bit of the time ☐ Some of the time ☐ A little of the time ☐ None of the time
Have you felt downhearted and blue?	☐ All of the time ☐ Most of the time ☐ A good bit of the time ☐ Some of the time ☐ A little of the time ☐ None of the time
During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?	☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Source: *Medicare Health Outcomes Survey*. National Committee for Quality Assurance (NCQA). Health Services Advisory Group. Centers for Medicare & Medicaid Services., n.d. Web. 2015. http://www.hosonline.org/en/survey-instrument/.

OPTUM®

CAHPS® survey

About Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures

The CAHPS survey assesses consumer responses regarding service, communication, access and quality of care being received from their health providers, including health plan, primary care providers, specialists and others. The CAHPS survey is administered by CMS-approved vendors annually between February and June; members are randomly chosen to take part in the survey. Participation in the survey is voluntary.

The CAHPS survey is used by health plans, physicians and other health care partners to drive quality improvements, and it also serves as an indicator of member satisfaction and helps drive national quality initiatives through CMS Star Ratings System and the National Committee for Quality Assurance (NCQA).

CMS Star Rating Weight

1

CMS Star Rating: Annual flu vaccine

Description: Percent of plan members who received a vaccine (flu shot) prior to flu season.

CAHPS survey question

- Have you had a flu shot since July 1 (of last calendar year)?

Provider action needed to meet measure compliance

Ensure member receives an influenza vaccination prior to flu season.

- Encounter for immunization (Z23)
- Administration of influenza virus vaccine (G0008)
- Administration of pneumococcal vaccine (G0009)

CMS Star Rating Weight

1.5

CMS Star Rating: Getting needed care

Description: Percent of the best possible score earned by the plan on how easy it is for members to get needed care, including care from specialists.

CAHPS survey question

- In the last six months, how often was it easy to get appointments with specialists?
- In the last six months, how often was it easy to get the care, tests or treatment you needed through your health plan?

Provider action needed to meet measure compliance

Help members in getting appointments with specialists to receive needed care, tests and/or treatments.

Keep communication open with members to showcase any actions that can help members recognize these efforts.

CMS Star Rating Weight

1.5

CMS Star Rating: Getting appointments and care quickly

Description: Percent of the best possible score earned by plan on how quickly members get appointments and care.

CAHPS survey question

- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed it?
- In the last six months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed it?
- In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?

Provider action needed to meet measure compliance

Encourage all provider office staff to tend to members' needs as soon as possible and provide timely appointments for visits.

CAHPS® survey

CMS Star Rating Weight

1.5

CMS Star Rating: Customer service

Description: Percent of the best possible score earned by how easy it is for members to get information and help from the plan when needed.

CAHPS survey question

- In the last six months, how often did your health plan's customer service give you the information or help you needed?
- In the last six months, how often did your health plan's customer service treat you with courtesy and respect?
- In the last six months, how often were the forms for your health plan easy to fill out?

Provider action needed to meet measure compliance

Encourage all staff to provide the best quality of service, by fostering a courteous, friendly and positive atmosphere at provider's office.

CMS Star Rating Weight

1.5

CMS Star Rating: Rating of health care quality

Description: Percent of the best possible score earned by plan from members who rated the quality of the health care they received.

CAHPS survey question

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?

Provider action needed to meet measure compliance

Provide members with timely answers to medical questions received in person or via phone.

If applicable, ensure members are aware of 24-hour hotlines to help answer any medical questions on weekends or after hours.

CMS Star Rating Weight

1.5

CMS Star Rating: Rating of health plan and drug plan

Description: Percent of the best possible score earned by plan from members who rated the health plan and/or prescription drug plan. *These are two separate measures, each measure with a separate weight of 1.5 and separate questions on the actual CAHPS survey.*

CAHPS survey question

- Using any number from 0 to 10, where 0 is the worst health or prescription drug plan possible and 10 is the best health or prescription drug plan possible, what number would you use to rate your health or prescription drug plan?

Provider action needed to meet measure compliance

Keep open lines of communication with members and help educate members on any coordinated efforts that may need to take place between member, provider and health plan in order to receive specific prescription drugs, care, tests and/or treatments.

Such coordinated efforts may require administrative procedures such as form filing and submissions.

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CMS Star Rating Weight

1.5

CMS Star Rating: Care coordination

Description: Percent of the best possible score earned by plan on how well the plan coordinates members' care. (This includes whether doctors have the records and information they need about members' care and how quickly members got their test results.)

CAHPS survey question

- 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?
- 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?
- 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?
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- 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?
- In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

Provider action needed to meet measure compliance

Care providers should try to keep informed and up to date with care rendered by specialists and other care providers.

Keep medical records, prescriptions and other information up to date by maintaining open discussions with members regarding any updates or changes.

CMS Star Rating Weight

1.5

CMS Star Rating: Getting needed prescription drugs

Description: Percent of the best possible score earned by plan on how easy it is for members to get the prescription drugs they need using the plan.

CAHPS survey question

- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

Provider action needed to meet measure compliance

Help members coordinate the way they receive their prescription drugs by placing prescriptions with the correct pharmacy, sending appropriate information to the requested pharmacy and having the provider refill prescriptions as needed.

For additional information about the CAHPS survey, please refer to: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/index

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About the CAHPS survey

The Centers for Medicare & Medicaid Services (CMS) is committed to measuring and reporting information from the consumer perspective for Medicare Advantage (MA) and Medicare Prescription Drug Plan (PDP) contracts. The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is sponsored by CMS and collects information to fulfill a requirement of Congress under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. The survey provides information to Medicare beneficiaries on the quality of health services provided through MA and Medicare Part D programs.

The survey below is for informational purposes and highlights measures related to Star Ratings. *You are not required to complete or distribute this survey. This is not the complete CAHPS survey. The questions below are only a part of the* Your Personal Doctor *section of the CAHPS survey only.*

For the complete survey, please visit: http://www.ma-pdpcahps.org/en/survey-instruments/

Questions	Measure
YOUR PERSONAL DOCTOR	
A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?	☐ Yes ☐ No
In the last six months, how many times did you visit your personal doctor to get care for yourself?	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 to 9 ☐ 10 or more
In the last six months, how often did your personal doctor explain things in a way that was easy to understand?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last six months, how often did your personal doctor listen carefully to you?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last six months, how often did your personal doctor show respect for what you had to say?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last six months, how often did your personal doctor spend enough time with you?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	☐ 0 — Worst personal doctor possible ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 — Best personal doctor possible
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?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last six months, did your personal doctor order a blood test, X-ray or other test for you?	☐ Yes ☐ No
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?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
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?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
In the last six months, did you take any prescription medicine?	☐ Yes ☐ No
In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?	☐ Never ☐ Sometimes ☐ Usually ☐ Always
Doctors may use computers or handheld devices during an office visit to do things like look up your information or order prescription medicines. In the last six months, did your personal doctor use a computer or handheld device during any of your visits?	☐ Yes ☐ No
During your visits in the last six months, was your personal doctor's use of a computer or handheld device helpful to you?	☐ Yes, a lot ☐ Yes, a little ☐ No, not at all

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During your visits in the last six months, did your personal doctor's use of a computer or handheld device make it harder or easier for you to talk to him or her?	☐ Harder ☐ Not harder or easier ☐ Easier
In the last six months, did you get care from more than one kind of health care provider or use more than one kind of health care service?	☐ Yes ☐ No
In the last six months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?	☐ Yes ☐ No
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?	☐ Yes, definitely ☐ Yes, somewhat ☐ No
Visit notes sum up what was talked about on a visit to a doctor's office. Visit notes may be available on paper, on a website or by email. In the last six months, did anyone in your personal doctor's office offer you visit notes?	☐ Yes ☐ No

Transitional care management services and medication reconciliation

Transitional care management (TCM) services are used for new or established patients whose medical and/or psychosocial problems require moderate or high-complexity medical decision-making during transitions in care. TCM services can include care from: an inpatient acute, psychiatric or long-term care hospital; skilled nursing facility; inpatient rehab facility; hospital outpatient observation or partial hospitalization at a community mental health center; to patient's community setting (home, domiciliary, rest home or assisted living). The ultimate goal of TCM is to avoid gaps between facility and post-discharge to improve quality of patient care and decrease readmissions.[1,2]

Transitional care management parameters [1,2,3,4]

- When the service period begins: On the day of discharge and continues for the following 29 days. TCM services cannot be billed within a postoperative global surgery period by the provider of the surgery services.
- Who can report TCM services: Only one qualified physician or nonphysician practitioner may report TCM services per beneficiary per 30-day period following a discharge, which includes a combination of one face-to-face visit and several non-face-to-face services.
  - **Face-to-face services** can only be done by a qualified health care professional and/or licensed clinical staff who can provide some non-face-to-face services (under the direct supervision of a physician or other qualified clinician, subject to your state's supervision laws), which may include:
    - Identify available community and health resources
    - Communicate with agencies or other community services the patient uses.
    - Educate the patient and/or caregiver to support self-management and activities of daily living
    - Assess and support treatment adherence and medication management
    - Assist the patient and family in accessing needed care and services
  - **Non-face-to-face services** can be done by a provider or other qualified clinician and may include:
    - Management of any services noted for the staff
    - Obtain, review, complete discharge information for discharge summary, continuation of care documents, etc.
    - Review follow-up needs on pending tests and/or treatment
    - Interact with other clinicians who will assume or reassume care for the patient's specific problems or conditions
    - Educate patient, family, guardian and/or caregivers
    - Establish or reestablish referrals and arrange for community resources for specialized care
    - Assist in scheduling follow-up with other providers and health services
- Medication reconciliation: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days). Only the documentation in the outpatient medical record meets the intent of the measure, but an outpatient visit is not required. Documentation must include evidence of medication reconciliation and the date when it was performed. Any (one) of the following meets the criteria:
  - **Documentation of current medications** with notation that the provider reconciled current and discharge medications with references of discharge medications (for example, no medication changes since discharge, same medications at discharge, discontinue all discharge medications). Include a notation that the discharge medications were reviewed.
  - **Document a current and discharge medication list** and notate that both lists were reviewed on the same date of service. Include evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review, and indicate the provider was aware of the member's hospitalization or discharge. The discharge summary must reveal that the discharge medications were reconciled with the most recent medication listed in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). Notate that "no" medications were prescribed or ordered upon discharge, if applicable.

Medication reconciliation and management must occur no later than the date of the face-to-face visit.

1111F- Discharge medications reconciled with the current medication list (outpatient medical record).

- This is a nonreimbursable CPT II code necessary to meet HEDIS requirements and diminishes the need for additional chart pulls.
- Diagnosis codes, including chronic conditions associated with the patient's current status, should be used to indicate the reason(s) for the services being provided.

99495- Transitional care management services with all following required elements:

- Communication (face to face, telephone, electronic) with the patient and/or caregiver within two business days of discharge.
- Medical decision-making of at least moderate complexity during the service period.
- Face-to-face visit, within 14 calendar days of discharge.

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Transitional care management services and medication reconciliation

- Discharge from TCM services: The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services and bill TCM services. The required face-to-face visit may not take place on the same day you report discharge day management services.

    - **Patient readmission** within the 30 days – billing can be completed for the face-to-face service only. Another 30 days is started after discharge and the process can begin again for the transitional care management to be billed. Otherwise, the full 30 days of the first admission can include the second admission if no one else has billed for it within that same time frame. If the patient dies before the 30 days have elapsed, only face-to-face service, if provided, can be billed. If other services are provided for the patient above and beyond those of the transitional care, they are billed separately.

Medication reconciliation post-discharge (ages 18 and older)

Document reconciliation with the most recent medication list in the outpatient medical record within 30 days of discharge.

Description	CPT	CPT II
Transitional care management	99483, 99495, 99496	
Medication reconciliation		1111F
Note: Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.		

(continued from previous page)

99496- Transitional care management services with all following required elements:

- Communication (face to face, telephone, electronic) with the patient and/or caregiver within two business days of discharge.
- Medical decision-making of high complexity during the service period.
- Face-to-face visit, within seven calendar days of discharge.

Note: When you report CPT codes 99495 and 99496 for Medicare payment, do not report the following codes during the TCM service period:

- Care plan oversight services — home health or hospice supervision: HCPCS codes G0181 and G0182.
- End-stage renal disease services: CPT codes 90951–90970.
- Chronic care management (CCM) services (CCM and TCM service periods cannot overlap).
- Prolonged E/M services without direct patient contact (CPT codes 99358 and 99359).
- Other services excluded by CPT reporting rules.

The following references were used to create this document:

1. Transitional Care Management Services. Centers for Medicare & Medicaid Services. cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf. Published January 2019. Accessed January 22, 2021.
2. Frequently Asked Questions About Billing the Medicare Physician Fee Schedule for Transitional Care Management Services. Centers for Medicare & Medicaid Services. cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf. Published March 17, 2016. Accessed January 22, 2021.
3. "HEDIS Measures." National Committee for Quality Assurance. ncqa.org/hedis/measures. Accessed January 22, 2021.
4. American Medical Association. Current Procedural Terminology Professional. 2021. Chicago , IL: AMA; 2020.

How can we help you?

Our goal is to help health care professionals facilitate and support accurate, complete and specific documentation and coding with an emphasis on early detection and ongoing assessment of chronic conditions. Through targeted outreach and education, we help our clients and their providers:

- Deliver a more comprehensive evaluation for their patients
- Identify patients who may be at risk for chronic conditions
- Improve patient care to enhance longevity and quality of life
- Comply with Centers for Medicare & Medicaid Services (CMS) and Health and Human Services (HHS) risk adjustment requirements

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For the Affordable Care Act (ACA): The Department of Health & Human Services Hierarchical Condition Category (HHS-HCC) model applies in the health exchange risk adjustment program under the Affordable Care Act. This model differs significantly from the CMS-HCC model, which applies in the Medicare Advantage risk adjustment program. For more information, please visit: cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Premium%20Stabilization%20Programs. HHS also issues an annual notice of benefit and payment parameters which may contain additional guidance on risk adjustment coding and other related issues under the Affordable Care Act.

For Medicaid Managed Care, risk adjustment standards, if any are applicable, are established by each state Medicaid agency and such standards often vary from state to state.

This guidance is to be used for easy reference; however, the current ICD-10-CM code classification and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. This presentation supplies general information regarding HEDIS and the Five-Star Quality Rating System, but NCQA administers HEDIS and CMS administers the Five-Star Quality Rating System and you should consult the NCQA and CMS websites for further information. Lastly, on April 6, 2020, the Centers for Medicare & Medicaid Services (CMS) announced that 2020 dates of service for the 2021 payment year model are based on the Centers for Medicare & Medicaid Services Announcement: cms.gov/files/document/2021-announcement.pdf.