HEDIS® MEASUREMENT YEAR 2020 AT-A-GLANCE GUIDE:
STAR MEASURES

This guide alerts you to important preventive care and services that you can provide to patients to help boost Star Ratings.

WellCare values everything you do to deliver quality healthcare for our members – your patients. This easy-to-use HEDIS® At-A-Glance Guide gives you the tools to meet, document and code HEDIS Measures. Together, we can improve our Star Ratings by ensuring optimum care and service to our members. Please contact your WellCare representative if you need more information or have any questions.

Quality care is a team effort. Thank you for playing a starring role!

*Measurement Year 2020

	Measure	Provider Actions	Sample Codes Used
ASSESSMENT AND SCREENING	**Breast Cancer Screening (BCS)** Women who had one or more mammograms to screen for breast cancer during the measurement year or the two years prior. *Allowable Time Frame: Oct. 1 two years prior to the measurement year through Dec. 31 of measurement year** **STAR Weight: 1** **Ages:** 50-74 years (Women)	• Include documentation of mammogram or exclusions. This measure is to evaluate preventive screening. Do not count biopsies, breast ultrasounds or MRIs as they are not appropriate methods for primary breast cancer screening. • **EXCLUSIONS:** Women who had a bilateral mastectomy or two unilateral mastectomies 14 or more days apart.	**CPT Codes:** 77055-77057, 77061-77063, 77065-77067, G0202, G0204, G0206

*Indicates STAR Measures.

This document is an informational resource designed to assist licensed healthcare practitioners in caring for their patients. Healthcare practitioners should use their professional judgment in using the information provided. HEDIS measures are not a substitute for the care provided by licensed healthcare practitioners and patients are urged to consult with their healthcare practitioner for appropriate treatment. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

www.wellcare.com

NA1PROGDE63312E_0000

	Measure	Provider Actions	Sample Codes Used

ASSESSMENT AND SCREENING	**Colorectal Cancer Screening (COL)**
	Those members who received one or more of the following screenings:
	• Colonoscopy
	  • *Allowable Time Frame: Measurement year or nine years prior**
	• Flexible Sigmoidoscopy
	  • *Allowable Time Frame: Measurement year or four years prior**
	• CT Colonography
	  • *Allowable Time Frame: Measurement year or four years prior**
	• FIT-DNA (Cologuard)
	  • *Allowable Time Frame: Measurement year or the two years prior**
	• Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)
	  • *Allowable Time Frame: Measurement year**
	STAR Weight: 1
	Ages: 50-75 years
		• A note indicating the date the test was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record. If it is not clear, the result or finding must also be present.
		• Digital rectal exams do not count. FOBT tests performed in the office setting or performed on a sample collected via DRE do not count.
		EXCLUSIONS: Those with diagnosis of colorectal cancer or total colectomy.
			Colonoscopy: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
			HCPCS: G0105, G0121
			Flexible Sigmoidoscopy: 45330-45335, 45337-45342, 45345-45347, 45349, 45350
			HCPCS: G0104
			CT Colonography: 74261-74263
			FIT-DNA/Cologuard: 81528
			HCPCS: G0464
			FOBT: 82270, 82274
			HCPCS: G0328

	Care of Older Adults (COA) Those members who had ***each*** of the following during the measurement year: Advance Care Planning *Allowable Time Frame: Measurement year** **No STAR Weight** Medication Review *Allowable Time Frame: Measurement year** **STAR Weight: 1** Functional Status Assessment *Allowable Time Frame: Measurement year** **STAR Weight: Display for 2020** Pain Assessment *Allowable Time Frame: Measurement year** **STAR Weight: 1** **Ages:** 66 years and older	• **Advance care planning** – Evidence must include either the presence of advance care plan (ACP) in the medical record or documentation of advance care planning discussion with the provider and date when it was discussed. Examples of ACP: advance directives, actionable medical orders, living wills and surrogate decision maker. • **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. • **Functional status assessment** – Documentation must include evidence of a complete functional status assessment and the date completed. A functional status assessment limited to an acute or single condition does not meet criteria. • **Pain screening** – Documentation must include an assessment for pain (which may include positive or negative findings) or the result of an assessment using a standardized tool ***and*** the date the assessment was completed. Notations about chest pain do not meet criteria.	**CPT Codes:** **Advance Care Planning** – 99483, 99497 **Medication Review** – 90863, 99605, 99606 **Functional Assessment** – 99483 **Transition of Care 7 Days** – 99496 **Transition of Care 14 Days** – 99495 **CPT II Codes:** **Advance Care Planning** – 1157F (ACP in Medical Record); 1123F, 1124F, 1158F (ACP discus-sion documented) **Medication Review** – 1160F **Medication List** – 1159F **Functional Status Assessment** – 1170F **Pain Screening** 1125F (pain present); 1126F (no pain present) **HCPCS:** **Advance Care Planning** – S0257 **Medication List** – G8427 **Functional Status Assessment** – G0438, G0349

	Measure	Provider Actions	Sample Codes Used
BLOOD PRESSURE	**Controlling High Blood Pressure (CBP)** Those with a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled. <140/<90 or Systolic <140 and Diastolic <90 **STAR Weight: N/A for 2020** **Ages:** 18-85 BP *Allowable Time Frame: Measurement year** Members who had at least two visits on different dates of service and a diagnosis of hypertension on or between January 1 of the prior year to June 30 of the measurement year. Any combination of outpatient visit, telephone visit, online assessment, or telehealth visit meets this criteria.	• The **most recent BP reading during the measurement year** on or after the second diagnosis of hypertension. BP must be the last of the year. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, record the lowest systolic and lowest diastolic BP reading. The systolic and diastolic results do not need to be from the same reading. • If the BP reading is high at the beginning of the visit, retake it at the end of the visit and record the lowest systolic and diastolic reading. • Member reported blood pressure results are acceptable if obtained by a digital device. EXCLUSIONS: • Diagnosis of pregnancy in the measurement year • Non-acute admission in the measurement year • Evidence of ESRD, dialysis, nephrectomy or kidney transplant any time during the member's history through December 31 of the measurement year.	**CPT Codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456 **CPT II:** Systolic: <130: 3074F; 130–139: 3075F; ≥140: 3077F Diastolic: <80: 3078F; 80-89: 3079F; ≥90: 3080F **HCPCS**: G0402, G0438, G0439, G0463, T1015 **Remote BP Monitoring:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474 **Online Assessments:** 98969-98972, 99421-99423, 99444, 99457, G0071 **Telephone Visits:** 98966-98968, 99441-99443

	Measure	Provider Actions	Sample Codes Used
DIABETES	**Comprehensive Diabetes Care (CDC)** Members with diabetes (type 1 and type 2) who had each of the following: HbA1c Controlled *Allowable Time Frame: Measurement year** **STAR Weight: 3** Eye Exam (Retinal or Dilated) *Allowable Time Frame: Measurement year or a negative exam in the prior year** **STAR Weight: 1** Kidney Disease Monitoring *Allowable Time Frame: Measurement year** **STAR Weight: 1** Blood Pressure Controlled *Allowable Time Frame: Measurement year** **No STAR Weight** **Ages:** 18-75 years	Blood and/or urine samples should be sent to lab vendor for analysis. • **HbA1c** - Notation of the most recent HbA1c screening (expanded to include glycohemoglobin, glycated hemoglobin and glycosylated hemoglobin), and result performed in current year. • **Eye Exam (Retinal or Dilated)** - A retinal or dilated eye exam by an optometrist or ophthalmologist in current year. Also a retinal or dilated exam, done in the prior year by an optometrist or ophthalmologist, that was negative for retinopathy meets criteria. If applicable, a notation of bilateral eye enucleation occurring anytime during the members history through Dec. 31 of the measurement year. Kidney Disease Monitoring: • Urine test for protein/albumin/ microalbumin with a date and result. • Notation of a prescribed ACE/ARB therapy. • Documentation of a renal transplant. Blood Pressure Controlled: • Notation of the most recent BP in the medical record. BP can be taken from remote monitor devices that are digitally stored and transmitted directly to provider. EXCLUSIONS: • Members with a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes who do NOT have a diagnosis of diabetes in the measurement year or the year prior.	**HbA1c** **CPT Codes:** 83036, 83037 <7%: 3044F ≥8%-≤9%: 3052F >9%: 3046F **ICD-10-Dx:** Use appropriate code family: E or O **Eye Exam (Retinal) Performed** Diabetic Retinal Screening Negative in prior year: **CPT II:** 3072F **Diabetic Retinal Screening With Eye Care Professional with Retinopathy:** **CPT II Codes:** 2022F, 2024F, 2026F **Diabetic Retinal Screening with Eye Care Professional without Retinopathy:** **CPT II:** 2023F, 2025F, 2033F **Kidney Disease Monitoring** **ICD-10-Dx:** Use appropriate code family: E, I, N, Q, R **CPT Codes:** 81000-81003, 81005, 82042-820 44, 84156 **CPT II Codes:** 3060F, 3061F, 3062F, 3066F, 4010F **Control of Blood Pressure** **CPT II:** **Systolic:** <130: 3074F; 30–139: 3075F; ≥140: 3077F **Diastolic:** <80: 3078F; 80-89: 3079F; ≥90: 3080F **Remote BP Monitoring:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474 **Online Assessments:** 98969-98972, 99421-99423, 99444, 99457, G0071 **Telehealth POS:** 02 **Telephone Visits:** 98966-98968, 99441-99443

	Measure	Provider Actions	Sample Codes Used
MUSCULOSKELETAL	**Osteoporosis Management in Women Who Had a Fracture (OMW)** Women who had a fracture and had either a bone mineral density (BMD) test or prescription drug to treat osteoporosis in the 6 months post fracture. *Allowable Time Frame: July 1 year prior to measurement year to June 30 of measurement year** **STAR Weight: 1** **Ages:** 67-85 years	Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria: • A BMD test on the date of fracture or in the 6-month period after fracture • A BMD test during the inpatient stay for the fracture • Osteoporosis therapy on the date of fracture or in the 6-month period after the fracture • A dispensed prescription to treat osteoporosis on the date of fracture or in the 6-month period after the fracture Fractures of finger, toe, face and skull are not included in this measure. For a complete list of medications and NDC codes, **visit www.ncqa.org.**	**Bone Mineral Density Tests** **CPT Codes:** 76977, 77078, 77080, 77081, 77085, 77086 **Osteoporosis Therapy (after fracture) HCPCS:** J0897, J1740, J3110, J3489 **Telehealth POS:** 02 **Telephone Visits:** 98966-98968, 99441-99443 **Telehealth Modifier:** 95, GT
RHEUMATOID	**Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)** Members diagnosed with rheumatoid arthritis (RA) and dispensed at least one ambulatory prescription for a Disease Modifying Anti-Rheumatic Drug (DMARD). *Allowable Time Frame: Measurement year** **STAR Weight: 1** **Ages:** 18 years and older	• As appropriate, refer to network rheumatologists for consultation and/or management. For a complete list of medications and NDC codes, **visit www.ncqa.org**. **EXCLUSIONS:** Diagnosis of HIV or pregnancy during the measurement year.	HCPCS Codes: **DMARDs:** J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310-J9312, Q5103, Q5104, Q5109 **Telephone Visits:** 98966-98968, 99441-99443 **Online Assessments:** 98969-98972, 99421-99423, 99444, 99457, G0071

	Measure	Provider Actions	Sample Codes Used
MEDICATION MANAGEMENT	**Transition of Care (TRC)** The percentage of discharges for members who had each of the following. *Notification of Inpatient Admission.* **No Star Weight** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). *Receipt of Discharge Information.* **No Star Weight** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). *Patient Engagement After Inpatient Discharge.* **No Star Weight** Documentation of patient engagement provided within 30 days after discharge. *Medication Reconciliation Post-Discharge.* **STAR Weight: 1** Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). *Allowable Time Frame: Jan. 1 – Dec. 1 of measurement year** **Ages:** 18 years of age and older	Notification of Inpatient Admission • Date of notification must be evident the provider responsible for the member's care was notified Receipt of Discharge Information • Date of notification must be evident • Notification must include: – The practitioner responsible for the member's care during the inpatient stay – Procedures or treatment provided – Diagnoses at discharge – Current medication list – Testing results or documentation of pending tests, or no tests pending – Instructions for patient care post-discharge Patient Engagement After Inpatient Discharge • Any of the following meet criteria: – An outpatient visit, including office visits and home visits – A telephone visit – A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication – An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider) Medication Reconciliation Post-Discharge • Documentation of a current Medication List AND any of the following on or within 30 days of discharge: – Documentation of the current medications with evidence the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review – Discharge and current medications were reviewed and reconciled – Current medications were reviewed with reference to discharge medication status (e.g., no changes) – No medication changes or additions were prescribed upon discharge	**Notification of Inpatient Admission:** No applicable codes **Receipt of Discharge Notification:** No applicable codes **Patient Engagement After Inpatient Discharge:** **CPT Codes:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387 **HCPCS:** G0402, G0438, G0439, G0463, T1015 **Medication Reconciliation Post-Discharge** **CPT Codes:** 99382, 99495, 99496 **CPT II Code:** 1111F **Online Assessments:** 98969-98972, 99421-99423, 99444, 99457, G0071 **Telephone Visits:** 98966-98968, 99441-99443

	Measure	Provider Actions	Sample Codes Used
CARDIOVASCULAR DISEASE	**Statin Therapy for Patients with Cardiovascular Disease (SPC)** Members identified as having atherosclerotic cardiovascular disease (ASCVD) and have met the following criteria: • **Received Statin Therapy** Members who were dispensed at least one high- or moderate-intensity statin medication during the measurement year. • **Statin Adherence 80%** Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period. *Allowable Time Frame: Measurement year** **Ages:** Males 21–75 & Females 40–75 *STAR Weight: 1	• Select lowest tier medication on formulary that will treat the patient – Visit **www.wellcare.com** to utilize our formulary search tool. • Consider prescribing the medication electronically to the patient's pharmacy of choice. • Make it easier for the patient to adhere to treatment by suggesting a 90-day supply, home delivery or auto-refills – especially for patients stable on therapy. • Assess health literacy to determine need for additional support in medication management. • Educate the member on the role the medication plays in their disease process and what to do if they experience a side effect. • Focus on chronic disease self-management for the patient – For CM Referrals, please contact **1-866-635-7045** – Connect patient to community resources – For Community Connections Help Line, please contact **1-866-775-2192**	During the measurement year, patients were dispensed high- or moderate-intensity statin medications: Please refer to HEDIS MY 2020 Final NDC Lists. (Released 11/1/2020) Table SPC-B: High and Moderate-Intensity Statin Medications at **http://www.ncqa.org/hedis-quality-measurement**. **MI – ICD-10:** I21.01, I21.02, I21.09, I21.11, 121.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0-I23.8, I25.2 **CABG** – 33510-33514, 33516-33519, 33521-33523, 33533-33536 **PCI – CPT:** 92920, 992924, 992928, 992933, 92937, 92941, 92943 **Outpatient – CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483 **IVD – Use appropriate code family:** I **Acute Inpatient** – 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 **ESRD** – N18.5, N18.6, Z99.2 **Telehealth Modifier:** 95, GT **Telehealth POS:** 02 **Telephone Visits:** 98966-98968, 99441-99443 **Online Assessments:** 98969-98972, 99421-99444, 99457, G0071

	Measure	Provider Actions	Sample Codes Used
PHARMACY (PART D)	**Statin Use in Persons with Diabetes (SUPD)** Percentage of patients with at least 2 diabetes medications dispensed, and who also received a statin medication fill during the year. *Allowable Time Frame: Measurement year** Ages: 40–75 *STAR Weight: 3	• Select lowest tier medication on formulary that will treat the patient – Visit **www.wellcare.com** to utilize our formulary search tool. • Consider prescribing the medication electronically to the patient's pharmacy of choice. • Make it easier for the patient to adhere to treatment by prescribing a 90-day supply, home delivery or auto-refills – especially for patients stable on therapy. • Assess health literacy to determine need for additional support in medication management. • Educate the member on the role the medication plays in their disease process and what to do if they experience a side effect. • Focus on chronic disease self-management for the patient. – For CM Referrals, please contact **1-866-635-7045.** • Connect patient to community resources – For Community Connections Help Line, please contact **1-866-775-2192.** *For Providers engaged in RxEffect:* RxEffect FAQ **Log on to the RxEffect Portal at https://www.rxante.com/ and click on the RxEffect Resources Tab to reference the RxEffect FAQ document.** *For Providers not yet engaged in RxEffect:* RxEffect Overview **https://www.rxante.com/ and click on Client Portal** *Why should you use RxEffect?* • Providers may not always have insight into how compliant their patients are with their medications once they leave the office. • RxEffect can be insightful for providers to see whether or not their patients are filling their prescriptions. • If patients are not taking their medications as prescribed, this could lead to short-term and long-term complications such as strokes and heart attacks. • Use of RxEffect can help practices perform better on quality measures and drive Star Ratings. • RxEffect can help improve the member experience (CAHPS®) by providing real time data to the prescriber, allowing for timely, meaningful discussions on medication management.	Intentionally left blank

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

	Measure	Provider Actions	Sample Codes Used
PHARMACY (PART D)	**Medication adherence for: Diabetes, Hypertension (RAS antagonists), Cholesterol (statins)** Plan members who adhere to their prescribed drug therapy. Adherence is defined as the proportion of days covered (PDC) of 80% or more during the measurement period. *Allowable Time Frame: Measurement year* Diabetes Meds **STAR Weight: 3** HTN Meds (RAS antagonists) **STAR Weight: 3** Cholesterol Meds (statin) **STAR Weight: 3** **Ages:** 18 years and older	• **Diabetes Meds:** Diabetes medications include: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT) inhibitors • **HTN Meds:** Blood pressure medications include angiotensin converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), and direct renin inhibitors. These are examples and not an all inclusive list. 1. ACE inhibitors: lisinopril and benazepril 2. ARB: losartan and valsartan 3. Direct renin inhibitors: aliskiren • **Cholesterol Meds:** Common generic statins: simvastatin, rosuvastatin and atorvastatin. Diabetes Meds/HTN Meds/Cholesterol Meds » Engage your patient in a discussion about adherence and identify their barriers such as cost, side effects and forgetting to take medication. » Select lowest tier medication on formulary that will treat the patient. Visit **www.wellcare.com** to utilize our formulary search tool. » Consider prescribing the medication electronically to the patient's pharmacy of choice » Make it easier for the patient to adhere to treatment by prescribing a 90-day supply, mail order or auto-refills – especially for patients stable on therapy » Assess health literacy to determine need for additional support in medication management » Educate the member on the role the medication plays in their disease process and what to do if they experience a side effect » Focus on chronic disease self-management for the patient – For CM Referrals, please contact **1-866-635-7045** • Connect patient to community resources: For Community Connections Help Line, please contact **1-866-775-2192**	Intentionally left blank

	Measure	Provider Actions	Sample Codes Used
PHARMACY (PART D) CONTINUED		*For Providers engaged in RxEffect:* RxEffect FAQ **Log on to the RxEffect Portal at https://www.rxante.com/ and click on the RxEffect Resources Tab to reference the RxEffect FAQ document.** *For Providers not yet engaged in RxEffect:* RX Effect Overview **https://www.rxante.com/ and click on Client Portal** *Why should you use RxEffect?* • Providers may not always have insight into how compliant their patients are with their medications once they leave the office. • RxEffect can be insightful for providers to see whether or not their patients are filling their prescriptions. • If patients are not taking their medications as prescribed, this could lead to short-term and long-term complications such as strokes and heart attacks. • Use of RxEffect can help practices perform better on quality measures and drive Star Ratings. • RxEffect can help improve the member experience (CAHPS®) by providing real time data to the prescriber, allowing for timely, meaningful discussions on medication management.	

Quality care is a team effort.

Thank you for playing a starring role!

©WellCare 2020