HEDIS® Guide

Devoted HEALTH PLANS

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a powerful tool that evaluates health outcomes and quality of care. It also significantly impacts overall Star Ratings performance.

By using HEDIS measures in our work together, we can achieve 5 stars and make significant improvements in our patients' care. Use this guide to identify key HEDIS measures and how to improve them.

Quick tips to improve HEDIS scores

In addition to focusing on the measures in this guide, here are some other ways you can increase HEDIS scores and Star Ratings.

Communicate early and often

- Reach out to patients you haven't seen during the year
- Use sick visits as an opportunity to capture care needs
- Provide health resources that meet patient literacy and language needs
- Promptly contact patients about test results, and schedule necessary follow-up visits

Proactively schedule preventive care

Schedule these early in the year:

- Annual Wellness Visit
- Breast cancer screening
- Colorectal cancer screening
- Diabetes care
- Hypertension care

HEDIS® Guide

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How to use this guide

Choose your measure

Each section in this guide focuses on a key HEDIS measure. For each measure, we provide the goal, exclusions, what counts toward it, and useful tips. We also provide various billing codes, including CPT II codes.

Why use CPT II codes

CPT II codes are supplemental tracking codes for performance measurement. We include them throughout this guide and strongly encourage you to use them. When you add CPT II codes for preventive care services and test results, it allows us to:

- Get data from you more quickly and efficiently
- See a more complete picture of a patient's health
- Help you address care opportunities tied to HEDIS quality measures
- Improve health outcomes through better targeting of disease management programs
- Eliminate outreach reminders for tests that patients have already received

In short, they're the best way to document that you've provided optimal care to your patients. And they reduce the number of medical records we need to request from you.

Questions? Email us at **starsandriskmgmt@devoted.com**

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Diabetes care

Diabetes care includes 3 individual measures:

- Hemoglobin A1c control
- Eye exams
- Kidney health evaluation

Exclusions

- Patients who receive hospice or palliative care in the measurement year
- Patients ages 66 and older with frailty AND advanced illness in the measurement year
- Patients ages 66 and older who were enrolled in an I-SNP or long-term institution in the measurement year
- Patients with polycystic ovarian syndrome (PCOS), gestational diabetes, or steroid-induced diabetes who didn't have a diabetes diagnosis in the measurement year or the year prior to the measurement year

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HbA1C control for patients with diabetes (HBD)

GOAL: HbA1C level < 9.0%

What counts

- Last HbA1C result of the year

Tips

- Pay close attention to the last HbA1c result of the year — this is the 1 that counts
- Find local lab services in your state's Quick Reference Guide at **devoted.com/providers**

CPT II codes

3044F	HbA1c level less than 7.0%
3051F	HbA1c level greater than or equal to 7.0% and less than 8.0%
3052F	HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%
3046F	HbA1c level greater than 9.0%
3045F	HbA1c level greater than or equal to 7.0% and less than 9.0%

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Eye exam for patients with diabetes (EED)

GOAL: Provide retinal or dilated eye exam.

What counts

- Retinal or dilated eye exam by an ophthalmologist or optometrist in the measurement year (previous year's exam counts if negative for retinopathy)
- Bilateral eye enucleation at any point in patient's history (up to December 31 of the measurement year)
- Fundus photography in the measurement year with review by an optometrist or ophthalmologist (previous year's photography and review count if negative for retinopathy)

Tips

- For help scheduling an appointment, patients can call us at **1-800-338-6833** (TTY 711)
- Consider using a portable retinal camera in your office (if you don't have access to this, contact your Devoted Health representative)

CPT II codes

For all codes below, results must be reviewed by an ophthalmologist or optometrist and documented in patient's record.

2022F	Dilated retinal eye exam
2023F	Dilated retinal eye exam with no evidence of retinopathy
2024F	7 standard field stereoscopic photos
2025F	7 standard field stereoscopic photos with no evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos and no evidence of retinopathy
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

NEW

Kidney health evaluation for patients with diabetes (KED)

GOAL: Evaluate diabetic patients during the measurement year using an estimated glomerular filtration rate (eGFR) and urine albumin-creatinine ratio (uACR).

What counts

During the measurement year, patients must receive:

- At least 1 eGFR AND
- At least 1 uACR (can be a quantitative urine albumin test plus a urine creatinine test if conducted within 4 days of each other)

Tips

- Proactively schedule screening or monitoring tests during the measurement year
- Submit codes for each of the required kidney health evaluation tests

Billing codes

Estimated glomerular filtration rate

CPT 80047, 80048, 80050, 80053, 80069, 82565 eGFR

Urine albumin-creatinine ratio

CPT 82043, 82570 uACR

Albumin test

CPT II 3060F - Positive microalbuminuria test result documented and reviewed

3061F - Negative microalbuminuria test result documented and reviewed

3062F - Positive macroalbuminuria test result documented and reviewed

Nephrology treatment

CPT II 3066F - Documentation of treatment for nephropathy (such as patient receiving dialysis; patient being treated for ESRD, CRF, ARF, or renal insufficiency; any visit to a nephrologist)

4010F - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken

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Controlling high blood pressure (CBP)

GOAL: Blood pressure < 140/90

This measure applies to patients ages 18 to 85 with hypertension.

Exclusions

- Patients ages 66 and older who were enrolled in an I-SNP or long-term institution in the measurement year
- Patients ages 66 to 80 with frailty AND advanced illness in the measurement year
- Patients ages 81 and older with frailty as of December 31 of the measurement year
- Patients who receive hospice care in the measurement year

What counts

The most recent blood pressure reading in the measurement year, documented from:

- An outpatient visit
- A telehealth visit
- A non-acute inpatient encounter
- A remote monitoring device that digitally stores results and sends directly to provider
- A patient-reported result (be sure to include date of service)

Tips

- Capture exact readings (don't round up)
- Check cuff size — undersized cuffs may give high readings
- If initial result is high, discuss relaxation strategies and take another reading
- When you have multiple readings to note in the chart, use the lowest systolic and lowest diastolic readings (they don't need to be from the same measurement)
- If the blood pressure reading is out of target, schedule a follow up to take another reading
- Review hypertensive medication history and adherence — consider modifying treatment for uncontrolled blood pressure

Billing codes

Systolic

Be sure to submit a diastolic code, too

CPT II 3074F - systolic less than 130
3075F - systolic 130-139
3077F - systolic greater than 139

Diastolic

Be sure to submit a systolic code, too

CPT II 3078F - diastolic less than 80
3079F - diastolic 80-89
3080F - diastolic greater than 89

Remote blood pressure monitoring

CPT II 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474

Telephone visit

CPT II 98966-98968, 99441-99443

Online assessment

CPT II 98969-98972, 99421-99423, 99444, 99457

HCPCS G0071, G2010, G2012, G2061-G2063

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Colorectal cancer screening (COL)

GOAL: Provide appropriate screening for colorectal cancer.

This measure applies to patients ages 50 to 75.

Exclusions

- Diagnosis of colorectal cancer or total colectomy
- Patients who receive hospice care in the measurement year
- Patients ages 66 and older with frailty AND advanced illness in the measurement year
- Patients ages 66 and older who were enrolled in an I-SNP or long-term institution in the measurement year

What counts

- Colonoscopy in the last 10 years
- Flexible sigmoidoscopy in the past 5 years
- CT colonography (virtual colonoscopy) in the past 5 years
- FIT-DNA (Cologuard®) in past 3 years
- Fecal occult blood test (FOBT) annually — tests performed in an office setting or on a sample collected via DRE are not specific enough and don't count

Tips

- Emphasize importance of colorectal cancer screening and ensure patients are up-to-date with it
- Mention that we offer a Devoted Dollars reward for the screening — learn more at **devoteddollars.com**
- Clearly document past medical and surgical history in patient's medical record, including surgical and diagnostic procedures, dates, and results
- Submit claims and encounter data in a timely manner
- Consider standing orders to allow clinical staff to initiate screenings

Billing codes

Colonoscopy

CPT 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398

Flexible sigmoidoscopy

CPT 45330-45335, 45337-45342, 45345-45347, 45349-45350

HCPCS G0104

CT colonography

CPT 74261-74263

FIT-DNA

CPT 81528

FOBT

CPT 82270, 82274

HCPCS G0328

Devoted HEALTH PLANS

NEW

Transitions of care (TRC)

GOAL: Assess key points of transition.

The measure applies to patients ages 18 and older who were discharged from an inpatient facility.

Exclusions

- Patients who receive hospice care in the measurement year

What counts

Each patient's outpatient medical record must have all 4 of the following documentation:

- Notification of Inpatient Admission: receipt of notification when inpatient is admitted on the day of admission plus the following 2 days (3 days total)
- Receipt of Discharge Information: receipt of inpatient's discharge information on the day of discharge plus the following 2 days (3 days total). Must include the following if applicable:
  - The provider responsible for the patient's care during the inpatient stay
  - Procedures or treatment provided
  - Diagnosis at discharge
  - Current medication list
  - Test results (or documentation of pending tests or no tests pending)
  - Patient care instructions for the PCP or ongoing care provider (patient discharge instructions to follow-up with their PCP don't meet criteria)
- Patient Engagement after Inpatient Discharge: patient engagement (office visits, home visits, telehealth visits) within 30 days of discharge
- Medication Reconciliation Post-Discharge: medication reconciliation on the date of discharge through 30 days post-discharge (31 days total)

Billing codes

Transition of care

CPT II 1111F - Discharge medications reconciled with the current medication list in outpatient medical record

99483 - Care planning for patients with cognitive impairment

99495 - Transitional care management, moderate complexity, within 14 days post-discharge

99495 - Transitional care management, high complexity, within 7 days post-discharge

Telephone visit

CPT II 98966-98968, 99441-99443

Online assessment

CPT II 98969-98972, 99421-99423, 99444, 99457

HCPCS G0071, G2010, G2012, G2061-G2063

Devoted HEALTH PLANS

NEW

Transitions of care (TRC)

(Continued)

Tips

- Include copies of Devoted Health's notifications in the patient's medical record
- Clearly document reconciliation of discharge medications with current medications
- Clearly document if no medications were prescribed or ordered upon discharge
- See or speak with patients within 30 days of discharge

Devoted HEALTH PLANS

Statin use for cardiovascular disease (SPC)

GOAL: Dispense at least 1 high or moderate-intensity statin during the measurement year to patients with clinical atherosclerotic cardiovascular disease (ASCVD).

This measure applies to males ages 21 to 75 and females ages 40 to 75 in the measurement year who had one of the events or diagnoses below.

Any of the following events in the year prior to the measurement year:

- Myocardial infarction (acute or non-acute inpatient stay)
- Coronary artery bypass graft (any setting)
- Percutaneous coronary intervention (any setting)
- Other revascularization (any setting)

At least 1 ischemic vascular disease (IVD) diagnosis in both the measurement year AND the prior year in the following settings:

- Outpatient visit, telephone visit, or online assessment
- Acute inpatient discharge encounter or acute inpatient discharge

Exclusions

- Filled at least 1 prescription for clomiphene in the measurement year or prior year
- End-stage renal disease (ESRD) in the measurement year or prior year
- Cirrhosis in the measurement year or prior year
- Patients ages 66 and older who were enrolled in an I-SNP or long-term institution in the measurement year
- Patients ages 66 and older with frailty AND advanced illness in the measurement year
- Myalgia, myositis, or rhabdomyolysis during the measurement year, identified through:
  - G72.0 — Drug-induced myopathy
  - G72.2 — Myopathy due to other toxic agents
  - G72.9 — Myopathy, unspecified
  - M62.82 — Rhabodomyolysis
  - M79.1 — Myalgia
  - M60.80 M60.9 — Myositis

What counts

High–intensity statin therapy

- atorvastatin 40-80 mg
- simvastatin 80 mg
- rosuvastatin 20-40 mg
- amlodipine and atorvastatin 40-80 mg
- ezetimibe and simvastatin 80 mg

Moderate-intensity statin therapy

- atorvastatin 10-20 mg
- simvastatin 20-40 mg
- lovastatin 40 mg
- rosuvastatin 5-10 mg
- pravastatin 40-80 mg
- amlodipine and atorvastatin 10-20 mg
- ezetimibe and simvastatin 20-40 mg
- fluvastatin 40 – 80 mg
- pitavastatin 2-4 mg

Devoted HEALTH PLANS

Statin use for cardiovascular disease (SPC)

(Continued)

Tips

- Evaluate statin therapy at every encounter with patients who have cardiovascular disease
- For patients beginning statin therapy, discuss common side effects and advise them to call your practice before discontinuing
- Prescribe a 100-day supply to support adherence
- Reminder: this measure is separate from the Part D measure Statin Use In Patients with Diabetes (SUPD). This SPC measure is for patients who required moderate or high-intensity statin therapy, and includes a different exclusion list.

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Osteoporosis management in women (OMW)

GOAL: Perform a BMD test or dispense a prescription for a drug to treat osteoporosis within 180 days of the fracture. For a fracture diagnosed in the hospital, the 180 days is calculated based on the discharge date. If a patient transfers to a different hospital or other inpatient facility, the 180 days is based on the discharge date of the last admission.

This measure applies to women ages 67 to 85 who had a fracture between July 1 the prior year and June 30 of the current year. Finger, toe, face, and skull fractures are not included in this measure. Work on this measure will begin in July 2020 and count toward our 2023 Star Rating.

Exclusions

- Patients who had a bone mineral density (BMD) test any time in the 2 years prior to the fracture
- Patients treated for osteoporosis any time in the year prior to the fracture
- Patients ages 67 and older who were enrolled in an I-SNP or long-term institution in the measurement year
- Patients ages 67-80 with frailty AND advanced illness in the measurement year
- Patients ages 81 and older with frailty in the measurement year

What counts

- Bone mineral density test
- Osteoporosis therapies
  - Bisphosphonates: Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid
  - Other Agents: Abaloparatide, Denosumab, Raloxifene, Teriparatide

Billing codes

BMD test

CPT 76977, 77078, 77080-77082, 77085, 77086

Telephone visit

CPT 98966-98968, 99441-99443

Online assessment

CPT 98969-98972, 99421-99423, 99444, 99457

HCPCS G0071, G2010, G2012, G2061-G2063

Devoted HEALTH PLANS

Osteoporosis management in women (OMW)

(Continued)

Tips

General

- Consider bone density screenings for all women within age range
- Educate patients about fall prevention and safety
- If there is no evidence of an active fracture, submit a corrected claim to remove the patient from OMW measure

Coding

- Code appropriately to differentiate between active fractures and aftercare treatment (active fracture treatment is not usually provided in a primary care setting)
- 7th character A is for active treatment of the fracture (X-ray, ED, surgery, etc.)
- 7th character D is for after the patient has completed active treatment for the fracture (routine care in healing or recovery phase)
- For patients with a history of osteoporosis fractures, use status code Z87.310 “Personal history of (healed) osteoporosis fracture”

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Breast cancer screening (BCS)

GOAL: Provide a mammogram to screen for breast cancer between October 1 two years prior to the measurement year through December 31 of the measurement year.

This measure applies to women ages 52-74. Breast cancer screenings provided in 2021 will count toward our 2024 Star Rating.

Exclusions

- Women who had a bilateral mastectomy or 2 unilateral mastectomies any time during the patient's history
- Patients ages 66 and older who were enrolled in an I-SNP or long-term institution in the measurement year
- Patients ages 66 and older with frailty AND advanced illness in the measurement year

What counts

Only screening, diagnostic, film, digital, and digital breast tomosynthesis mammograms count. MRIs, ultrasounds, and biopsies don't count, even if indicated for diagnostic purposes or evaluating higher risk patients.

Tips

- Emphasize importance of breast cancer screening and ensure patients are up to date with annual mammogram
- Mention that we offer a Devoted Dollars reward for the screening — learn more at **devoteddollars.com**
- Document the specific date and result of the screening in the medical record
- Document medical and surgical history, including dates, in the medical record
- Use correct diagnosis and procedure codes
- Submit claims and encounter data in a timely manner

Billing codes

CPT codes

77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067

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Care for older adults (COA)

COA Measures

COA includes 3 distinct measures:

- Medication review
- Functional status assessment
- Pain assessment

These measures apply only to patients ages 66 and older who have a Dual Special Needs (D-SNP) or Chronic Special Needs (C-SNP) plan.

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COA: Medication review

GOAL: Patient receives a comprehensive medication review by a doctor or pharmacist.

What counts

Services provided in acute patient settings don't count toward this measure. Only the following do:

- At least 1 medication review documented with a medication list in the medical record
- Transitional care management services

Tips

- Integrate a high-risk medication review into every encounter with elderly patients
- Review patient history during each visit to capture falls and chronic conditions
- If the patient experiences undesirable side effects, replace harmful drug classes with medically appropriate alternatives

Billing codes

Medication review

CPT 0863, 99605, 99606

CPT II 1160F

Medication list

CPT II 1159F

HCPCS G8427

Transitional care management services

CPT 99495, 99496

Devoted HEALTH PLANS

NEW

COA: Functional status assessment

GOAL: Patient receives at least 1 functional status assessment in the measurement year.

What counts

- Functional status assessments performed during an office visit, telephone visit, e-visit, or virtual check-in all count. Services provided in acute inpatient settings don't count toward the measure.

Tips

- Integrate a functional status assessment into well visits
- Document any functional status assessments you complete (IADLs, ADLs, etc.)

Billing codes

CPT II codes

1170F

CPT codes

99483

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COA: Pain assessment

GOAL: Patient receives at least 1 pain assessment in the measurement year.

What counts

- Pain assessments performed during an office visit, telephone visit, e-visit, or virtual check-in all count. Services provided in acute inpatient settings don't count toward the measure.

Tips

- Document the date of any pain assessment you complete (PROMIS, FLACC, etc.)
- During a pain assessment, document any notes critical to continuing care

CPT II codes
1125F, 1126F

Devoted HEALTH PLANS

NEW

Follow-up after ER visit for patients with multiple high-risk chronic conditions

GOAL: Follow up within 7 days of Emergency Room visit.

This measure applies to all patients ages 18 and older with any of the following high-risk chronic conditions who visited the Emergency Room:

- COPD and asthma
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

Exclusions

- Patients who received hospice care at any time in the measurement year
- Emergency Room visits that resulted in an inpatient stay or were followed by an inpatient care setting admission within 7 days

What counts

- A follow-up service within 7 days of the Emergency Room visit (8 days total, including visits that occur on the date of the Emergency Room visit), including:
  - Outpatient
  - Telephone, e-visit or virtual check-in, and telehealth
  - Transitional care management services, complex care management services
  - Case management
  - Outpatient or telehealth behavioral health
  - Intensive outpatient encourage or partial hospitalization
  - Community mental health center
  - Electroconvulsive therapy
  - Observation
  - Substance use disorder service

Billing codes

In addition to an outpatient visit or behavioral health visit code, the following are compliant codes for a follow-up visit within 7 days.

Transitional care management

CPT	99495, 99496

Case management visit/encounter

CPT	99366
HCPCS	T1016, T1017, T2022, T2023

Complex case management services

CPT	99487, 99489, 99490, 99419
HCPCS	G0506

Devoted HEALTH PLANS

NEW

Follow-up after ER visit for patients with multiple high-risk chronic conditions

(Continued)

Tips

- Schedule Emergency Room follow-up visit within 3–5 days of discharge. Consider developing a daily process to schedule patients who have been discharged from the Emergency Room or an inpatient setting.
- Encourage patients to have regular PCP visits to monitor and manage chronic disease conditions
- Encourage patients to call PCP's office or after-hours line when condition changes (weight gain, medication changes, high/low blood sugar readings)
- Submit claims in a timely manner and include the appropriate codes for diagnosis, health conditions, and the services provided

Devoted HEALTH PLANS

NEW

Plan all cause readmissions (PCR)

GOAL: Follow up within 7 days post-discharge to prevent readmissions.

This measure applies to all patients age 18 and older with acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and a predicted probability of an acute readmission.

Exclusions

- Patients in hospice
- Non-acute inpatient stays
- Hospital stays in which:
  - The Index Admission Date is the same as the Index Discharge Date
  - The patient died during the stay
  - Female patients who are diagnosed as pregnant when discharged
  - Patients who are diagnosed with a condition relating to the perinatal period
- Planned admissions for:
  - Chemotherapy
  - Rehabilitation
  - Organ transplant
  - A potentially planned procedure without a principal acute diagnosis

Note: patients with 4 or more hospital stays are considered outliers and reported outside of the measure.

What counts

- A low count of index hospital stays: Acute inpatient or observation stays with a discharge on or between January 1 and December 1 of the measurement year. Includes acute discharges from any type of facility (including behavioral healthcare).

Tip

- If a patient hasn't scheduled a follow-up appointment post-discharge, reach out and schedule an appointment within 7 days of discharge or sooner as needed
- Keep open appointments so patients who are discharged from the hospital can be seen within 7 days of their discharge
- Consider implementing a post-discharge process to track, monitor and follow-up with patients