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 members 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® is a registered trademark of the National Committee for Quality Assurance (NCQA). Devoted Health is an HMO with a Medicare contract. Enrollment in Devoted Health depends on contract renewal.
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
Comprehensive diabetes care (CDC)

**CDC measures**

CDC includes three distinct measures:

- Blood sugar control
- Diabetic retinal exam
- Kidney disease monitorings

These measures apply to patients ages 18 to 75 who have either:

- Diabetes type 1 or type 2
- A prescription for insulin, hypoglycemics, or antihyperglycemics

**Exclusions**

- Patients who receive hospice care in 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
CDC: Blood sugar control

**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 one that counts
- Send your patients to LabCorp or Quest Diagnostics and we’ll get the results automatically

**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%
CDC: Diabetic retinal exam

**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 measurement year).
- Fundus photography in 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 one, contact your Devoted Health representative to see if we can help)

**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**  Seven standard field stereoscopic photos
- **2025F**  Seven standard field stereoscopic photos with no evidence of retinopathy
- **2026F**  Eye imaging validated to match diagnosis from seven standard field stereoscopic photos
- **2033F**  Eye imaging validated to match diagnosis from seven standard field stereoscopic photos and no evidence of retinopathy
- **3072F**  Low risk for retinopathy (no evidence of retinopathy in the prior year)
CDC: Kidney disease monitoring

GOAL Provide medical attention for nephropathy

What counts

- Nephropathy screening or monitoring test (urine protein) in measurement year
- ACE/ARB therapy in measurement year
- Evidence of nephropathy (CKD, ESRD, kidney transplant, nephrologist visit) in measurement year

Tips

Proactively schedule screening or monitoring tests during the measurement year.

CPT II codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>3060F</td>
<td>Positive microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3061F</td>
<td>Negative microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3062F</td>
<td>Positive macroalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3066F</td>
<td>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)</td>
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<tr>
<td>4010F</td>
<td>Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken</td>
</tr>
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</table>
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 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  
98869-98972, 99421-99423, 99444, 99457

HCPCS  
G0071, G2010, G2012, G2061-G2063
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 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 ([www.devoteddollars.com](http://www.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**

<table>
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<td>Colonoscopy [CPT 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398]</td>
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<td>Flexible sigmoidoscopy [CPT 45330-45335, 45337-45342, 45345-45347, 45349-45350]</td>
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<tr>
<td>CT colonography [CPT 74261-74263]</td>
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<tr>
<td>FIT-DNA [CPT 81528]</td>
<td></td>
</tr>
<tr>
<td>FOBT [CPT 82270, 82274]</td>
<td></td>
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<tr>
<td>HCPCS G0328</td>
<td></td>
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</tbody>
</table>
The measure applies to patients ages 18 and older who were discharged from an inpatient facility.

**Exclusions**

Patients who receive hospice care in measurement year

**What counts**

Each patient’s outpatient medical record must have the following documentation:

- Notification of Inpatient Admission on the day of admission or the day after
- Receipt of Discharge Information on the day of discharge or the day after, including:
  - The provider responsible for the patient’s care during the inpatient stay
  - Procedures or treatment provided
  - Diagnoses 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 do not meet criteria)

- Patient Engagement After Inpatient Discharge — such as an office visit, home visit, or telehealth call — within 30 days of discharge*
- Medication Reconciliation by a prescribing practitioner, clinical pharmacist, or registered nurse within 30 days of discharge*
Transitions of care (TRC)
(Continued)

Medication Reconciliation must document review of the patient’s current medications AND discharge medications. The following do not count:

- A statement that current medications were reviewed, but no clear notation they were reconciled with discharge medications
- A list of current medications and a list of discharge medications with no clear notation they were reviewed and reconciled

**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

*30-day window starts the day after discharge*
Statin use for cardiovascular disease (SPC)

**GOAL**
Dispense at least one 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 one 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 one prescription for clomiphene in measurement year or prior year
- End-stage renal disease (ESRD) in measurement year or prior year
- Cirrhosis in 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 — Rhabdomyolysis
  - M79.1 — Myalgia
  - M60.80 M60.9 — Myositis

**What counts**

**High-intensity statin therapy**
- atorvastatin 40-80 mg
- simvastatin 80 mg
- rosvastatin 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
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
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 two 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**

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<th>Online assessment</th>
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<td>G0071, G2010, G2012, G2061-G2063</td>
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</table>
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”
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 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 two 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 ([www.devoteddollars.com](http://www.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
Care for older adults (COA)

**COA Measures**

COA includes three 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) plan.
What counts

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

- At least one 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
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

<table>
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<tr>
<th>CPT II codes</th>
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<td>1170F</td>
<td>99483</td>
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</table>
COA: Pain assessment

Member receives at least one 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