2023 Provider Guidance

Medicare Stars Playbook

AvMed

MEDICARE STARS
Provider Measures

This document provides Medicare Stars measure-specific information for needed services and directions on how to close gaps in the care of your Patients. You should refer to this document to familiarize yourself with current Stars measures and how to close gaps in care.

HOW TO FILL GAPS IN CARE

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
BCS - Breast Cancer Screening: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer during the past two years.	Members who had a bilateral or two unilateral mastectomies. Members receiving palliative care during the measurement year. Members 66 years of age and older enrolled in an Institutional SNP or living long-term in an Institution any time during the measurement year. Members 66 years of age and older with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. **Refer to Appendix for list of advanced illness and frailty codes.** **Note:** Supplemental and medical record data may not be used for frailty and advanced illness exclusions.	Contact members who have not had a mammogram in the last two years and provide a referral for a mammogram. Consider scheduling mammograms before the member's next appointment so that you have results at the appointment. Have the member complete mammography. AvMed contracts with mobile mammography vendor Florida Mobile Mammography. Website: https://www.floridamobilemammography.com/ Phone: 877-318-1349 Email: info@ floridamobilemammography.com	If the member already had a mammogram in the current year or prior year, submit a copy of the medical record with a notation of the date of member's last mammogram and results, if available. If the member had one bilateral or two unilateral mastectomies, submit appropriate diagnosis codes to indicate a history of bilateral or two unilateral mastectomies: • Absence of left breast: Z90.12 • Absence of right breast: Z90.11 • Hx of Bilateral Mastectomy: Z90.13 Alternatively, you may submit medical record with notation of each mastectomy and the date (ex. medical history section noting member had a bilateral mastectomy in 2010). See page 17 for directions on sending medical records to AvMed.
COL - Colorectal Cancer Screening: Percent of plan members aged 45-75 who had appropriate screening for colon cancer. A colorectal cancer screening as defined below: • A colonoscopy every 10 years OR • A flexible sigmoidoscopy every 5 years OR • A CT colonography every 5 years OR • A FIT-DNA test every 3 years ColoGuard is non-par and will require a prior authorization for claims payment OR • A fecal occult blood test (FOBT) every year. (Quest Insure) available without a prior authorization	Members with colorectal cancer, total colectomy. Members 66 years of age and older enrolled in an Institutional SNP or living long-term in an Institution any time during the measurement year. Members 66 years of age and older with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. **Refer to Appendix for list of advanced illness and frailty codes.** **Note:** Supplemental and medical record data may not be used for frailty and advanced illness exclusions	Contact members requiring a colorectal cancer screening and provide a referral for a colorectal cancer screening. If member has not had a screening, consider scheduling member's GI visit while they are on the phone to increase likelihood the member will have a colonoscopy.	If member already had a screening, document the type, date, and result of screening, if available. If member had an FOBT, the medical record should also indicate number of samples taken. Submit medical record with notation of colorectal cancer screening to AvMed. If a member has a history of colorectal cancer or had a total colectomy, submit appropriate diagnosis codes to indicate the member should be excluded from the measure: • Personal Hx of malignant neoplasm of large intestine: Z85.038: • Personal Hx of malignant neoplasm of rectum, rectosigmoid junction, and anus: Z85.048 See page 17 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
HBD - Hemoglobin A1c Control for Patients with Diabetes: Percentage of plan members 18-85 years of age with diabetes (type 1 and 2) who had an A1C lab test during the measurement year. HbA1c Control (<8.0%) HbA1c Poor Control (>9.0%)	Members receiving palliative care during the measurement year. Members 66 years of age and older enrolled in an Institutional SNP or living long-term in an Institution any time during the measurement year. Members 66 years of age and older with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. **Refer to Appendix for list of advanced illness and frailty codes.** **Note:** Supplemental and medical record data may not be used for frailty and advance illness exclusions.	Order at least one HbA1c screening annually and ensure test is completed. Include appropriate CPT codes on claims to indicate member's most recent results and relevant conditions: • HbA1c: 3044F, 3046F, 3051F, 3052F If member does not want to get the test done in-office or at a diagnostic center, you can offer a Quest A1c home kit for them to complete at home, and then mail back. AvMed will normally send kits to non-compliant members during the Fall season. To request a new kit, contact Megan M. Ezeff, from Quest at *Megan.M.Ezeff@QuestDiagnostics.com.* If A1C is out of control (>9%): a. Determine if member has an endocrinologist b. Assist in scheduling an appointment with endocrinologist c. Evaluate for enrollment in Disease Management d. Discuss diet and exercise To refer a Medicare member for Diabetes Disease Management, send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition (Diabetes).	If the member already had a screening, submit a copy of the medical record. Documentation must include a note indicating the date when the HbA1c test was performed and the result or finding. See page 17 for directions on sending medical records to AvMed.
KED Kidney Health Evaluation for Patient with Diabetes: Percentage of plan members 18-85 years of age with diabetes (type 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).	Members receiving palliative care during the measurement year. Members 66 years of age and older enrolled in an Institutional SNP or living long-term in an Institution any time during the measurement year. Members 66 years of age and older with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. **Refer to Appendix for list of advanced illness and frailty codes.** **Note:** Supplemental and medical record data may not be used for frailty and advance illness exclusions.	Order BOTH an eGFR and a uACR at least once annually and ensure the tests are completed. Appropriate codes are billed by the Lab facility. To refer a Medicare Member for Diabetes Disease Management, send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition (Diabetes).	If the member already had a screening, the lab facility will submit claims data. Medical records may not be used for KED at this time or Documentation of medical attention: Chronic renal failure (CRF), chronic kidney disease (CKD), ESRD, Renal insufficiency, Proteinuria, Albuminuria, Renal dysfunction, Acute renal failure (ARF).

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
EED - Eye Exam for Patients with Diabetes: Percentage of plan members 18 -75 years of age with diabetes (type 1 and 2) who had an eye exam to screen and monitor diabetic retinal disease.	Members receiving palliative care during the measurement year. Members 66 years of age and older enrolled in an Institutional SNP or living long-term in an Institution any time during the measurement year. Members 66 years of age and older with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. **Refer to Appendix for list of advanced illness and frailty codes.** **Note:** Supplemental and medical record data may not be used for frailty and advanced illness exclusions.	Members can receive Retinal/ Dilated eye exam in-office and in-home. For in-office, refer members to an eye care specialist (optometrist or ophthalmologist) for a Retinal/Dilated eye exam annually: • Document name and specialty of member's eye care professional, date of last eye exam and result (+/- DM retinopathy) in medical record • Submit appropriate CPT codes on claims - If member had eye exam during the current year: 2022F - If member had steroscopic photo interpreted by an eye care specialist: 2024F, 2026F - If member's eye exam in the prior year was negative for retinopathy: 3072F - If member had bilateral eye enucleation, document so in medical record If member wants an exam at provider office, iCare does a campaign usually 3rd/ 4th quarter to set up clinics at provider's offices. iCare contacts the members to schedule. If member doesn't belong to provider offering a clinic, offer an in-home visit. Contact iCare: *Rosaria Scalise rscalise@myicarehealth.com*. To discuss setting up a campaign, contact Kimberlyann Wojick, Director of HEDIS Screening Operations, 855-238-4450 ext. 228 HEDIS direct line: 877-991-9998. To refer a Medicare Member for Diabetes Disease Management, send a secure email to *DM@avmed.org*. Please include the Member's name, DOB, AvMed ID number and Condition (Diabetes).	If the member already had a screening, submit a copy of the medical record documenting name and specialty of member's eye care professional, date of last eye exam, and result (+/- DM retinopathy). Prior year negative eye exam will count. See page 17 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
CBP - Controlling High Blood Pressure: Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. **BPD - Blood Pressure Control for Patients with Diabetes:** Percentage of members 18-75 years of age with diabetes (type 1 and 2) whose BP was adequately controlled (<140/90 mm Hg) during the measurement year	Members receiving palliative care during the measurement year. Members 66-80 years of age with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. Members 81 years of age and older with frailty during the measurement year. **Refer to Appendix for list of advanced illness and frailty codes.** **CBP specific exclusions:** Members with evidence of end-stage renal disease (ESRD, dialysis, nephrectomy, kidney transplant, or history of kidney transplant anytime, non-acute inpatient admission or diagnosis of pregnancy in MY2023). **BPD specific exclusions:** Members not diagnosed with diabetes who have had polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes anytime in the MY or the year prior. **Note:** Supplemental and medical record data may not be used for frailty and advanced illness exclusions.	If member has not had a visit this year bring them in for a visit and evaluate BP. Take blood pressure a second time if reading is high due to white coat hypertension. • BP reading must be the latest taken within the measurement year, and on or after the second hypertension diagnosis. • If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. • Ensure coding staff uses HTN diagnosis code appropriately to avoid incorrectly placing member in measure. HTN ICD10 should only be used if HTN has been formally diagnosed. • Include appropriate CPTII codes on claims to indicate member's BP reading on every visit: 3074F (systolic < 130 mmHg) 3075F (systolic = 130-139 mmHg) 3077F (systolic ≥ 140 mmHg) 3078F (diastolic < 80 mmHg) 3079F (diastolic = 80-89 mmHg) 3080F (systolic ≥ 90 mmHg) If the member's most recent BP is ≥ 140/90, bring in the member for a follow-up visit to reassess BP. For members diagnosed with HTN, continue to manage member closely and encourage adherence to hypertension medication until their BP is under control. Members who have a digital home blood pressure monitor can take their blood pressure during a telehealth visit and report it to their provider. To refer a Medicare Member for CAD Disease Management, send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition (CAD).	If a member already had a visit this year, review the BP reading in the chart to make sure it was taken on or after the second hypertension diagnosis and submit a claim with the proper CPTII codes: Systolic: 3074F, 3075F, 3077F Diastolic: 3078F, 3079F, 3080F When reviewing medical records **Do <u>not</u> include:** • BP readings taken during an acute inpatient stay, ER department visit • BP readings taken on the same day of a diagnostic test, or diagnostic or therapeutic procedure that requires a change in diet or medication regimen on or one day before the day of the test or procedure, examples include colonoscopy, dialysis, infusions, chemotherapy, nebulizer treatment with albuterol, etc. **Do include:** • BP readings taken on the same day the member receives a common low-intensity or preventive procedure, examples: Eye exam with dilating agents, injections (allergy, vitamin B-12, insulin, steroid, Toradol, Depo-Provera, testosterone, lidocaine), tuberculosis (TB) test, vaccinations, wart, or mole removal. See page 17 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
SPCR - Statin Therapy for Patients with Cardiovascular Disease (Part C): Percentage of males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.	Members who had a diagnosis for myalgia, myositis, myopathy, or rhabdomyolysis or receiving palliative care any time during the measurement year. Members who had end-stage renal disease (ESRD) diagnosis, dialysis procedure, dispensed at least one prescription for clomiphene, cirrhosis, pregnancy diagnosis, or In vitro fertilization (IVF) any time during the measurement year or the year prior to the measurement year. Members 66 years of age and older enrolled in an Institutional SNP or living long-term in an Institution any time during the measurement year. Members 66 years of age and older with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. **Refer to Appendix for list of advanced illness and frailty codes.** Allergy and statin intolerance are **not** exclusions. **Note:** Supplemental and medical record data may not be used for frailty and advanced illness exclusions.	If the member has not had a visit this year or was not prescribed with a moderate or high intensity statin medication, bring in the member for a visit. To address the gap, the member must fill one of the statins or statin combinations at the pharmacy. **Refer to Appendix for list of acceptable statins medications**. Take the opportunity at every appointment to talk to your members about the importance of taking prescribed medications and address common adherence barriers, such as cost and regimen complexity. To refer a Medicare Member for CAD DM, send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition (CAD). To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll-free: 1-800-772-1213 or TTY 1-800-325-0778 Monday-Friday 7am-7pm.	If the member already had a visit this year, review the chart and assess if member was prescribed a moderate or high intensity statin medication. If they were, follow-up with member to make sure the medication was picked up. Check diagnosis codes in member's chart to see if member should be excluded from this measure. If member meets the exclusion criteria, submit medical record reflecting appropriate exclusion diagnosis and dates to AvMed for review and processing. See page 17 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
TRC- Transition of Care Inpatient Notification: The percent of inpatient discharges (acute or non-acute) for plan members 18 years of age and older with a notification of inpatient admission documented the day of or after the admission. **Note**: This sub-measure is 100 percent Medical Record Review. AvMed will provide additional guidance for medical record submission.	Members enrolled in hospice or using hospice services or members who died any time during the measurement year.	Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after admission. Submit medical record indicating communication between the member's PCP and the hospital staff, or the member's PCP and the member's health plan and include evidence of the date when the documentation was received. (e.g., phone call, fax, email, HIE alert, shared EMR system). You may use the AvMed Hospital Admission Notification fax form to comply. Make sure the form is placed in the member's chart. OR Documentation indicating: • The member's PCP admitted the member to the hospital, ordered tests and treatment anytime during the member's inpatient stay. Include PCP visits where discussion took place regarding an upcoming hospital stay. • Specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. Include PCP notes showing admission documents. Important: When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria.	
TRC- Transition of Care Receipt of Discharge Information: The percent of inpatient discharges (acute or non-acute) for plan members 18 years of age and older with a receipt of discharge information documented the day of or after the discharge. **Note:** This sub-measure is 100 percent Medical Record Review. AvMed will provide additional guidance for medical record submission.	Members enrolled in hospice or using hospice services or members who died any time during the measurement year.	Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge. Submit medical record showing discharge documentation. Information must include all the following: • The name of the care provider responsible for the member's care during the inpatient stay • Procedures or treatments provided during the inpatient stay • Diagnoses at discharge • Test results or documentation of any pending test results • Instructions for member's care post-discharge	

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
TRC- Transition of Care Patient Engagement After Inpatient Discharge: The percent of inpatient discharges (acute or non-acute) for plan members 18 years of age and older with documentation of member engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.	Members enrolled in hospice or using hospice services or members who died any time during the measurement year.	When provider receives notification of discharge from a hospital, effort should be made to schedule a visit with the patient within 30 days of discharge. The following meet the criteria for member engagement: • In-home or office visit CPT: 99201-05, 99211-15, 99241-45, 99341-45, 99347-50, 99381-87, 99391-97, 99401-04, 99411-12, 99429, 99455-56, 99483. HCPCS: G0402, G0438-39, G0463, T1015 • Telehealth visits CPT: 98966-68, 99441-43 • Transitional care management services CPT: 99495-96 • E-visits or virtual check-ins CPT: 96969-72, 99421-23, 99444, 99457-58. HCPCS: G0071, G2010, G2012, G2061-63, G2250-52 Important: visits on the day of the discharge will not count as compliant.	Documentation in medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria: • An outpatient visit, including office visits and home visits. • A telephone or a real-time interaction (audio & video) telehealth visit. • An e-visit or virtual check-in (telehealth where two-way interaction, which was not real-time, occurred between the member and provider).
TRC- Transition of Care Medication Reconciliation Post- Discharge: The percent of plan members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed.	Members enrolled in hospice or using hospice services or members who died any time during the measurement year.	When provider receives notification of discharge from a hospital, effort should be made to schedule a visit with the patient within 30 days of discharge. If visit within 30 days is not possible, medication reconciliation can be completed telephonically with the member by a nurse and documented in member's chart. Be sure to document medications lists were reconciled using the following codes: • Medication Reconciliation Encounter 99483, 99495, 99496 • Medication Reconciliation Intervention 1111F	Documentation in medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria: • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • Documentation of the member's current medications with a notation that the discharge medications were reviewed. • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
FMC - Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions: The percentage of emergency department (ED) visits for plan members 18 years and older who have 2 or more high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	Members enrolled in hospice or using hospice services or members who died any time during the measurement year. Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care on the date of the ED visit or within 7 days after the ED visit.	Reach out to member as soon as you are notified of their ED visit to schedule a follow-up appointment within 7 days. The following meet criteria for follow-up: • Outpatient or Telephone Visit • Transitional Care Management • Case Management Encounter • Complex Care Management • Behavioral Health Visit (Outpatient or Telehealth) Include: visits that occur on the date of the ED visit will count as compliant.	

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
OMW - Osteoporosis Management: The percent of women 67-85 years of age who suffered a fracture (not including fractures of finger, toe, face, and skull) and had either a bone mineral density test or prescription to treat osteoporosis in the 6 months after the fracture.	Members who had a BMD test during the 24 months prior to the fracture or members who had an osteoporosis therapy or were dispensed a prescription or had an active prescription for a medication to treat osteoporosis during the 12 months prior to the fracture. Members 67-80 years of age with frailty during the measurement year and with an advanced illness during the measurement year or the year prior to the measurement year. Members must meet BOTH frailty and advanced illness criteria to be excluded. Members 81 years of age and older with frailty during the measurement year. Members in hospice or using hospice services or receiving palliative care or members who died during the measurement year. **Refer to Appendix for list of frailty and advance illness codes**.	Have the member complete a bone mineral density test or fill an osteoporosis prescription within 6 months (180 days) of the fracture. Refer to Appendix for approved OMW medications. Best Practice: To help prevent members from being included in this measure incorrectly, review that the fracture codes are being used appropriately. An appropriate way is to verify the fracture through diagnostic imaging. If a fracture code was submitted in error, please submit a corrected claim to fix the misdiagnosis and remove the member from the measure. If member wants in-home bone density, send order to AlliedHealth at concierge@amxdx.com. Make sure you use CPT code 76977 for mobile bone density test.	If member was on osteoporosis medication within the 12 months preceding the fracture, submit medical record to AvMed indicating the date the medication was dispensed, the name of the medication, the quantity, and directions. If member has had a bone density test within the 24 months preceding the fracture, submit medical record indicating date of bone density test to AvMed. See page 17 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
Plan All-Cause Readmissions: Percent of members 18 years of age and older discharged from a hospital stay or outpatient setting who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.	Members in hospice or using hospice services any time during the measurement year.	Prevent readmissions by knowing members, diagnoses, and habits; identifying members' needs and addressing them and ensuring after hours recordings or answering services do not tell members to go to the ED after the office is closed (unless it is a medical emergency). Have receptionists always ask callers if they've been recently discharged from a facility so that the appointments post discharge is made according to recommendations below. 1. See high risk discharge patients within 2 days of discharge to develop a 30-day care plan. 2. See moderate risk discharge patients within 5 days of discharge develop a 30-day care plan. 3. Ensure that all discharged patients know to call your office (including evenings and weekends) with any questions or concerns before going to an emergency room unless it is a medical emergency. 4. Ensure prompt access to your office for visits for those recently discharged patients for the first 30 days. 5. Keep a current running list of recently discharged patients for the office staff to know. 6. Care plan essentials: a. Ensure all medications are filled and being taken as prescribed. Perform a medication reconciliation and code it. b. Ensure weekly contact with high and moderate risk patients at least once a week for the first month. c. Ensure patient understanding of care plan and what to do if something occurs. * These action steps above can be billed for Medicare patients via transitional care management (TCM) codes 99495 and 99496. To refer a Medicare Member for Disease Management (COPD, CAD, CHF, Asthma, Diabetes) send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition. Nurse On Call line: Available to all members 24 hours a day, seven days a week. Members call in to 888-866-5432 to speak with a nurse.	

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
PART D SUPD - Statin Therapy for Patients with Diabetes: To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.	Members enrolled in hospice, or with a diagnosis of any of the following: ESRD; Rhabdomyolysis and Myopathy; Pregnancy, Lactation and Fertility; Liver Disease; Pre-Diabetes; and/or Polycystic Ovary Syndrome. Allergy and statin intolerance are **not** exclusions.	If the member has not had a visit this year or was not prescribed with a statin medication bring in the member for a visit. The member needs to fill a one-time statin medication at the pharmacy to comply. **See Appendix for approved statins**. Take the opportunity at every appointment to talk to your members about the importance of taking prescribed medications and address common adherence barriers, such as cost and regimen complexity. To refer a Medicare Member for Diabetes DM send a secure email to DM@avmed.org Please include the Member's name, DOB, AvMed ID number and Condition (Diabetes). To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll-free: 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm. To address regimen complexity, encourage use of pillbox organizers. Since intolerance is not an exclusion criterion, trialing an alternative statin is encouraged when member reports intolerance.	
PART D Medication Adherence for Diabetes Medications: Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	Members enrolled in hospice or with an ESRD diagnosis. Members with one or more prescriptions for insulin.	Remind members to refill and pick-up their Diabetes Medication. Main reasons behind non-adherence for Diabetes medication are lack of understanding, medication beliefs and cost concerns. Educate your patients on the importance and benefits of taking their medication. To address medical beliefs, think about your patient's perceptions, behaviors, and attitudes when discussing medication. To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll-free: 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm. To refer a Medicare Member for Diabetes Disease Management, send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition (Diabetes).	

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
PART D Medication Adherence for Cholesterol (Statins): Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	Members enrolled in hospice or with an ESRD diagnosis.	Main reasons behind non-adherence for Statins are lack of understanding, forgetfulness, medication beliefs, no refills remaining and discontinued medication. Educate your patients on the importance and benefits of taking their medication. To address forgetfulness, provide medication calendars or schedules that specify the day and time to take medications, comprehensive drug cards or medication charts that have information on the medications the patient is taking, and on when and how these should be taken, unit-of-use packaging such as daily or weekly pill boxes and medication containers with alarms that alert the patient when it's time for their medication. To address medical beliefs, think about your patient's perceptions, behaviors, and attitudes when discussing medication. To refer a Medicare Member for CAD Disease Management, send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition (CAD).	
PART D Medication Adherence for Hypertension (RAS Antagonists): Percent of members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to take the medication.	Members enrolled in hospice or with an ESRD diagnosis. Members with one or more prescriptions for sacubitril/valsartan.	Main reasons behind non-adherence for medication are lack of understanding, medication beliefs and cost concerns. Educate your patients on the importance and benefits of taking their medication. To address medical beliefs, think about your patient's perceptions, behaviors, and attitudes when discussing medication. To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll- free: 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm. Do not provide brand drug samples to members. This may cause gaps in refill history and lower member's adherence percentage below 80%. Member needs to be prescribed a generic since they are zero-dollar cost share and relatively inexpensive to the plan. To refer a Medicare Member for Hypertension DM send a secure email to DM@avmed.org. Please include the Member's name, DOB, AvMed ID number and Condition (Hypertension).	
PART D MTM – Medication Therapy Management Program: Percent of eligible Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period.	Members receiving palliative care or members enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. A member who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates.	Refer the beneficiary to complete CMR by calling AvMed's MTM partner, MedWiseRX at 1-844-866-3735 (TTY 1-800-367-8939). The MTM program will help them manage their drugs. The assessment includes a discussion between the member and a pharmacist about all the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.	

HOW TO FILL GAPS IN CARE (Cont.)

		How to Fill the Gaps	
Quality Measure	Exclusion Criteria	Member Never Received and Qualifies	Member Received or Excluded
HOS Survey Urinary Incontinence: Improving Bladder Control		Ask patients annually if they are experiencing any issues with urinary incontinence. Discuss treatment options including Kegel exercises, medications, or other options.	
HOS Survey Fall Risk: Reducing the Risk of Falling		Ask patients annually if they have balance issues or other medical concerns that could increase risk of falling. Discuss ways to be proactive at preventing falls.	
HOS Survey Physical Activity: Improving or Maintaining Physical Health		Ask patients annually how often they exercise, and which exercises they do. Inform patient about AvMed SilverSneakers® program. Staying physically active can help reduce symptoms of depression, diabetes, and heart disease, and help patients be happier. At SilverSneakers. com, there are on-demand workout videos plus fitness and nutrition tips. Find participating locations at SilverSneakers.com/blog/feel-happier/	

Appendix

Advanced Illness Exclusions

ICD-10 Code	Definition
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0.C25.4, C25.7, C25.9	Malignant neoplasm of pancreas
C71.0-C71.9	Malignant neoplasm of brain
C77.0-C77.5, C77.8, C77.9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00-C78.02	Secondary malignant neoplasm of lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30, C78.39	Secondary malignant neoplasm of unspecified or other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80, C78.89	Secondary malignant neoplasm of unspecified or other digestive organs
C79.00-C79.02	Secondary malignant neoplasm of kidney and renal pelvis
C79.10-C79.11, C79.19	Secondary malignant neoplasm of bladder and other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40, C79.49	Secondary malignant neoplasm of unspecified or other parts of nervous system
C79.51-C79.52	Secondary malignant neoplasm of bone or bone marrow
C79.60-C79.63	Secondary malignant neoplasm of ovary
C79.70-C79.72	Secondary malignant neoplasm of adrenal gland
C79.81-C79.82	Secondary malignant neoplasm of breast or genital organs
C79.89, C79.9	Secondary malignant neoplasm of unspecified or other sites
C91.00, C92.00, C93.00, C93.90, C93.Z0, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse
F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27,F10.97, G31.09, G31.83	Dementia
F04	Amnestic disorder due to known physiological condition
F10.96	Alcohol-induced persisting amnestic disorder
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G31.01	Pick's disease
I09.81, I11.0, I13.0, I13.2, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83,I50.84, I50.89, I50.9	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage 5
I50.1	Left ventricular failure, unspecified
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes, and vapors
J84.10, J84.112, J84.17, J84.170, J84.178	Pulmonary fibrosis

Appendix

Advanced Illness Exclusions

ICD-10 Code	Definition
J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
N18.6	End stage renal disease
G35	Multiple Sclerosis

Frailty Exclusions

CPT Code	Definition
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care

HCPCS Codes	Definition
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147-E0149	Walker
E0163, E0165, E0167-71	Commode chair
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-E0297, E0301-E0304	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-E0472	Respiratory assist device
E0561, E0562	Humidifier used with positive airway pressure device
E1130, E1140, E1150, E1160, E1161, E1170-E1172, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-E1298	Wheelchair
G0162, G0299, G0300, G0493, G0494	Skilled RN services related to home health/ hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124,T1000-T1005,T1019-T1022,T1030,T1031	Nursing, respite care, and personal care services
ICD10 Codes	**Definition**
L89.00-L89.96	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified state
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.0	Ataxic gait
R26.1	Paralytic gait
R26.2	Difficulty in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R41.81	Age-related cognitive decline
R53.1	Weakness
R53.81	Other malaise
R53.83	Other fatigue

HOW TO FILL GAPS IN CARE (Cont.)

Frailty Exclusions

ICD10 Codes	Definition
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA–W01.198S, W06.XXXA– W10.9XXS, W18.00XA–W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator [ventilator] status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

Relevant Mediations by Measure

Osteoporosis Therapies (OMW)

Description	Prescription	J-codes
Bisphosphonates	Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid	J1740, J3489
Other Agents	Abaloparatide, Denosumab, Raloxifene, Romosozumab, Teriparatide	J0897, J3110, J3111

Statins

High-Intensity Statins	Moderate-Intensity Statins
Atorvastatin 40-80 mg	Atorvastatin 10-20 mg
Amlodipine-atorvastatin 40-80 mg	Amlodipine-atorvastatin 10-20 mg
Rosuvastatin 20-40 mg	Rosuvastatin 5-10 mg
Simvastatin 80 mg	Simvastatin 20-40 mg
Ezetimibe-simvastatin 80 mg	Ezetimibe-simvastatin 20-40 mg
	Pravastatin 40-80 mg
	Lovastatin 40 mg
	Fluvastatin 40-80 mg
	Pitavastatin 2–4 mg

CARE OPPORTUNITY REPORT PROVIDER RESPONSE FORM

HEDIS measures are used to gauge the quality of care health plan members are receiving. The AvMed Care Opportunity Report provides you pertinent information regarding your patient's compliance status for selected measure.

Having proper coding practices is the best way to close member gaps in your Care Opportunity Report and reduces the need for medical record reviews.

You may have relevant information regarding a member that you are unable to submit via a claim. When this is the case, you can close the gap by submitting the medical record indicating the member has already received the relevant service within the correct time frame, or has a condition that excludes them from the measure.

All medical records should show the member's name, date of birth and date of service.

Fax all medical records, along with this completed cover page, to AvMed Corporate Quality Improvement at 1-800-331-3843. Use additional pages if necessary.

Records may also be uploaded to AvMed's secure portal at https://transfer.AvMed.org.
The Username is Hedis 2019, and the Password is _____, then select the files to be uploaded.
Note: The sftp password changes every 80 days. If you have issues logging into the sftp, please contact Dinah.Torres@avmed.org.

Member Name:	**Member ID:**
Provider Name:	**Provider ID:**
List measure(s) for which medical record is being submitted (ex. "Breast Cancer Screening" or "BCS"):	Describe information being submitted (ex. "Member had bilateral mastectomy in 2010"):
Clinician Signature:	Date
Clinician Credentials:	

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