Humana quality measure guide

Your guide to HEDIS, HOS, CAHPS and Patient Safety measures for the Medicare Star Rating Program

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Contents

Click this icon on any page to return here.

Purpose and summary

The Centers for Medicare & Medicaid Services (CMS) created the Star Rating Program to assess the quality of care for Medicare enrollees electing Medicare Advantage (MA) coverage from health plans versus Original Medicare. The program is aligned with CMS' quality strategy goals to optimize health outcomes, improve patients' experience and access to care and maximize efficiency and cost savings.

This guide outlines the Star quality and performance measures that CMS, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA®) use to evaluate the care and services provided to your MA patients. Humana strives to support you in providing quality services and improving the health outcomes of your Humana-covered patients.

The information offered in this guide is from the current Healthcare Effectiveness Data and Information Set (HEDIS®) Volume 2 Technical Specifications for Health Plans and its most current corresponding Value Set Directory, as well as the current CMS Medicare Part C & D Star Ratings Technical Notes available at www.cms.gov. This information is not meant to preclude clinical judgment. Treatment decisions should always be based on the clinical judgment of the physician or other healthcare provider at the time of care.

For each measure, we've provided:

- Measure name and abbreviation
- Weight assigned by CMS that is used when calculating summary or overall Star Ratings
- Definition of the measure, its eligible population and expected quality activity and/or outcome
- Best practices for addressing the measure with patients
- Applicable exclusions that will remove a patient from the eligible population for a measure
- Quality result percentage ranges (i.e., cut points) used to determine each of the measure's rating year Star level
- For HEDIS measures: the service(s) needed and coding guidance to ensure measure compliance
- For Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures: applicable question(s) from the respective survey administered to Medicare Advantage-covered patients
- For Patient Safety measures: the prescription drug activity needed for compliance

You also will find information for display measures within this guide. These measures are not currently part of the Star Rating Program, but in some cases they may be recent Star measures that underwent substantive changes and have been temporarily moved to display. These are often new measures being performance-tested before they are designated as a Star measure. They could also be former Star measures that may be retired in the future.

The information in this guide is subject to change based on CMS regulatory guidance and technical specification changes from NCQA and/or PQA. Measure details can change annually (e.g., service needed for compliance, applicable codes). The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

Letter to providers

Dear valued Humana provider,

We are grateful for the high-quality care you deliver to our Humana-covered patients and are honored to partner with you in the Star Rating Program.

This guide is designed to help care teams understand and succeed in this program, with the primary objective of improving patient outcomes. A major focus of Star Ratings is ensuring patients receive the right care at the right time, including preventive and chronic care services.

This guide provides Star measure details for HEDIS, HOS, CAHPS and Patient Safety, as outlined by CMS. We explain measure specifications, evidence-based best practices and coding guidelines. Additionally, we highlight various Humana resources to help you and your practice share pertinent data and receive action-oriented reporting.

In addition to this guide, we provide the following resources:

- Your Humana representative is happy to partner with you and provide resources to help you identify patients who are in the eligible population for Star and quality measures.
- You can reach out to us with Star-specific questions at AskStars@humana.com.
- You can subscribe to our newsletter and stay in the know with the latest Star news, resources and administrative information at Huma.na/HPNStars.

Again, we are so appreciative of the high-quality care you provide and thank you for partnering in this program.

Sincerely,

Ryan Heyborne, M.D., MBA, FACEP, CPC
National Medical Director, Stars and Risk Adjustment

Keywords to understand this guide

Bonus year (BY)
Bonus year is the year in which CMS pays bonuses for currently enrolled members based on the prior calendar year's rating.

CAHPS
Consumer Assessment of Healthcare Providers and Systems (conducted on behalf of CMS) is a survey that assesses consumers' experiences with the quality of healthcare and plan services, and is focused on MA and prescription drug plans.

CMS
Centers for Medicare & Medicaid Services

Cut points/thresholds
Thresholds are percentage ranges, also referred to as cut points, used to determine the Star level of a measure based on its pass rate.

Exclusions
Exclusions are the CMS-determined criteria that exempt a Medicare Advantage member or an event from being included when determining the pass rate of a measure.

HEDIS
Healthcare Effectiveness Data Information Set is a registered trademark of the National Committee for Quality Assurance (NCQA).

HOS
Health Outcomes Survey is an annually reported outcome survey conducted on behalf of CMS.

IRE
Independent Review Entity, currently Maximus

Measure year (MY)
The period of time when patients are receiving their screenings, filling prescriptions and responding to surveys; information regarding this activity is exchanged with CMS or the IRE.

NCQA
National Committee for Quality Assurance

Patient Safety
This operational category assesses quality and performance of drug plan services; the PQA oversees the Patient Safety category.

PQA
Pharmacy Quality Alliance

Weights
The values assigned to measure types to indicate their impact on the overall or summary Star Rating of a plan.

Click here for more terms in this guide.

Supplemental data

HEDIS measures are designed by the NCQA to improve the standard of care for clinical performance. Health plans, such as Humana, submit HEDIS data to certified auditors who ensure quality data is accurate and compliant. Auditor-verified data is sent to the NCQA to help identify ways to evaluate and improve healthcare quality. The data is also shared with CMS and entities such as state-based health organizations.

Supplemental data is additional data submitted to augment administrative claims data for HEDIS reporting. It supports health plans in achieving accurate and comprehensive reporting, improving quality outcomes and ensuring compliance with HEDIS requirements.

Standard supplemental data
Standard supplemental data files represent standard, structured formats in which data is extracted from automated workflows, adhering to NCQA's guidelines for data validation and traceability. Examples include data from electronic medical records (EMR), state/clinical registries, laboratory feeds, or other provider-generated flat file submissions.

Non-standard supplemental data
Non-standard supplemental data includes information that does not conform to predefined formats or automated workflows. These sources often require manual processing and validation to ensure they meet HEDIS reporting standards. Examples include data from scanned/PDF documents, manual chart abstractions, electronic attestation forms (EAFs) or other patient-level detail reports not available electronically. These files require additional NCQA auditor verification and approval for use in HEDIS reporting.

Why use supplemental data?
For you to have a full and complete picture of the care your patients receive, supplemental data can be used to complement the information coded and submitted via claims and encounters.

- Communicate nonpayable services that might not be coded, such as:
  - Compliance activities that may have occurred prior to the current measurement year (e.g., colorectal cancer screening, breast cancer screening)
  - Activities represented by Current Procedural Terminology (CPT®) II codes that support quality care (e.g., controlling blood pressure, comprehensive diabetes care)
- Reduce the need to manually review charts
- Derive insights from submissions that may improve practice quality activities
- Target open clinical care opportunities

Which method is best for my practice?
Collaborate with your Humana representative to decide which supplemental data option is best for your practice.

HEDIS data collection methods
Coded claims and encounters (administrative data) are the preferred methods of submitting data, and supplemental data is intended to be used as a backup or if those methods need to be corrected. In some specific patient situations, supplemental data can be used to update measure compliance.

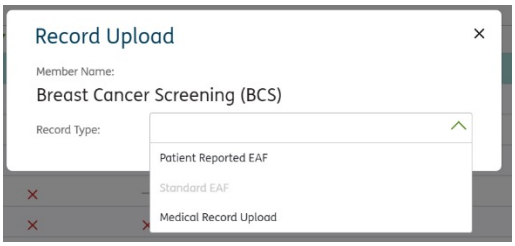
Supplemental data should be used only in the following situations:

- If compliance activities have occurred prior to the current measurement year or with another provider or payer
- Measures that may require several engagements with a patient before compliance is achieved
  - Controlling High Blood Pressure (CBP)
  - Glycemic Status Assessment for Patients With Diabetes (GSD)
- Communication of nonpayable services **that have not been coded previously or are in need of correction**

Tools you can use

Population Insights Compass

Humana's Population Insights Compass is a population health management platform used to share pertinent and timely data with providers, fostering collaboration between payers, providers and patients to improve health and cost outcomes. Based on the type of care opportunity presented, standard and non-standard supplemental data can be submitted through Humana's portal via the Quality/Stars Measure Detail report. This data is processed and reviewed, and a status indicator is shared on whether the care opportunity was closed based on the records submitted.



Icon	Description
+	Indicates the measure is available for attestation
	Indicates documentation has been submitted for the displayed measure
	Indicates documentation is pending validation
✓	Indicates documentation was validated and the measure is now compliant
✗	Indicates documentation did not meet the requirements and the measure remains noncompliant
–	Indicates the displayed measure is not eligible for attestation

For more information on how to use the Electronic Attestation Form (EAF) and medical record upload:

- Medical Record Upload Checklist

Availity

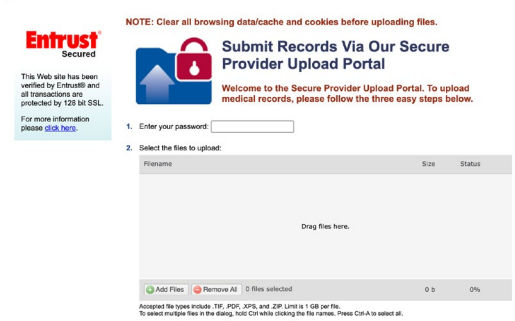
Availity® is a multi-payer digital application that is used to view and respond to health plan requests for clinical data on patients. Within the provider portal called Availity Essentials™, all providers and their clinical teams can access critical patient data in the Clinical Quality Validation (CQV), Risk Condition Validation (RCV) and Primary Care Provider Notification (PCPN) tools at no cost. These tools assist in the sharing of care opportunities and service or condition documentation. Nonstandard supplemental data, in the form of an attestation, and medical records are both submitted through Availity and are processed by Humana in order to close open care opportunities and validate risk conditions. For more information about Availity, go to Availity Essentials.

Submitting records manually

Although Humana has several platforms and tools to leverage for supplemental data, Humana does accept other types of submissions, including:

1. Fax and physical mail
2. Electronic upload via Humana's secure provider upload portal

Learn more about these methods here.



Health Equity Index (HEI)

CMS has finalized a Health Equity Index (HEI) to replace the current reward factor. The HEI summarizes contract performance for patients with specified social risk factors (SRF) across multiple measures into a single score to incentivize plans to focus on equitable healthcare, experiences and outcomes.

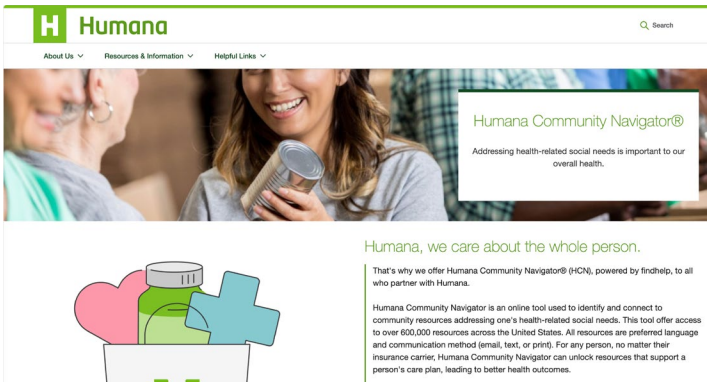
What population is the focus of the HEI?
CMS defines SRF as "factors related to health outcomes that are evident before care is provided, are not consequences of the quality of care, and are not easily modified by healthcare providers."[1,2] The HEI will initially focus on patients with one of the three SRF, and these SRF may be expanded over time.

- Dual-eligible for Medicaid and Medicare (full or partial)
- Disabled
- Low Income Subsidy (LIS)

What is the HEI measuring?
The HEI includes measures that focus on the patient (e.g., HEDIS and Patient Safety measures) but not measures focusing on the plan or provider (e.g., appeals and call center measures).

HEI presentation video

Humana Community Navigator®



Humana also provides resources that can support the care of and conversations with SRF patients.

- There are many standardized, validated health-related social needs (HRSN) screening tools available, such as the Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool, built by CMS. Some electronic health records (EHR) have enhancements that integrate the HRSN screening tool as an assessment.
- HEDIS Social Needs Screening and Intervention flyer
- The Humana Community Navigator allows providers to connect to utility services, food resources, housing support, transportation programs and more.
- For 211 helpline for community information and referrals, dial 211 or visit www.211.org.

1. Social Risk Factors: Definitions and Data, Accounting for Social Risk Factors in Medicare Payment, the National Academies Press, https://nap.nationalacademies.org/read/23635/chapter/4
2. https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files/171041/ASPESESRTCfull.pdf

What are thresholds and cut points?

Star measure thresholds and cut points
CMS defines cut points, also known as thresholds, as measurement ranges that determine Star Ratings. Thresholds are established to determine performance based on the percentage of compliant patients to achieve a certain Star level. Thresholds are established by CMS for each year and are updated to reflect significant changes in industry performance and distribution of scores.

How are thresholds calculated?
Each measure has its own specific thresholds based on compliance rates and informed by CMS requirements. In some cases, health plans may establish their own thresholds for performance tracking and strategic planning throughout the year.

1. HEDIS and Patient Safety measure thresholds reflected in Humana reporting are CMS-established, or in some cases projected based on historic data.
2. The Patient Experience (PE) thresholds represented are created by Humana, driven by Humana's PE survey.
   - Humana's PE survey is influenced by the CAHPS and HOS.
   - The survey questions focus on a different level of experience than CAHPS and HOS and are specific to individual visits rather than specific time frames of care.

More detail around Star-level thresholds is available here.

How are thresholds shown in reporting you receive from Humana?
Similar to the Star Rating Program cycle, thresholds become available on an annual basis and are integrated into Humana's reporting as they become available. It is important to note that in addition to MY there is also mention of BY, which refers to the health plan payment year rather than the provider payment year in the event of an incentive program. Based on the time of year, Humana reporting will show MY performance data and finalized thresholds.

There are two key milestones for data updates:

1. **April:** MY data flips from the previous year to the current year. The current MY that has been added will not have a threshold available because the newest BY threshold will not be available until October. Only the prior BY threshold can be viewed and may assist in directional planning and performance assessment.
2. **October:** BY thresholds are finalized and integrated into reporting, where applicable. The prior year's thresholds will still be available for historical reference and analysis, understanding that BY payments have not been distributed.

Annual Wellness Visit

Annual Wellness Visits are yearly appointments with a patient's primary care physician. While an Annual Wellness Visit doesn't directly satisfy any Star Rating measures, completing it can contribute to the closing the measures shown below:

HEDIS
Controlling High Blood Pressure (CBP), Glycemic Status Assessment for Patients With Diabetes (GSD), Care for Older Adults – Medication Review (COA–MDR), Care for Older Adults – Functional Status Assessment (COA–FSA), Statin Therapy for Patients With Cardiovascular Disease (SPC)

CAHPS
Annual Flu Vaccine (FLU)

HOS
Monitoring Physical Activity in Older Adults (MPA), Improving or Maintaining Physical Health (IMPH), Improving Bladder Control (IBC), Reducing the Risk of Falling (ROF)

Patient Safety
Medication Adherence for Cholesterol (MAC), Medication Adherence for Diabetes Medications (MAD), Statin Use in Persons with Diabetes (SUPD), Concurrent Use of Opioids and Benzodiazepines (COB)

Types of visits

Annual Wellness Visit
- Unique to Medicare
- Initial Annual Wellness Visit: allowed once per lifetime within first 12 months of Medicare enrollment
  - Establishes medical and family history; list of current providers; list of risk factors and conditions that you recommend or already have interventions underway; written screening schedule for the next five to 10 years
  - Reviews potential risk factors for depression and mood disorders, functional ability and safety, current opioid prescriptions
  - Measures height, weight, BMI, blood pressure and other routine measurements deemed appropriate based on medical and family history
  - Includes Health Risk Assessment (HRA), cognitive function assessment, personalized health advice and appropriate referrals to health education, counseling services or programs; advance care planning at patient's discretion; and screening for potential substance use disorders
- Subsequent Annual Wellness Visit: allowed once per calendar year after initial Annual Wellness Visit
  - Review/update HRA, medical and family history, list of current providers and suppliers, written screening schedule for the next five to 10 years, list of risk factors and conditions that you recommend or already have interventions underway, current opioid prescriptions
  - Measure weight, blood pressure and other routine measurements deemed appropriate based on medical and family history
  - Includes cognitive function assessment; personalized health advice and appropriate referrals to health education, counseling services or programs; advance care planning at patient's discretion; screening for potential substance use disorders[1]
- Humana allows one Annual Wellness Visit per calendar year (January–December)

Initial Preventive Physical Exam (IPPE)
- Known as the Welcome to Medicare preventive visit
- Original Medicare covers IPPE for patients newly enrolled in Medicare Part B
- One-time benefit covered by Humana Medicare Advantage (MA) plans

Annual Preventive Physical Exam
- Humana MA benefit, not covered by Original Medicare
- Humana allows one Annual Preventive Physical Exam per calendar year (January–December)

1. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Annual Wellness Visit

Visit	Code
Initial Preventive Physical Examination (IPPE)	HCPCS code: G0402
Initial Preventive Physical Examination (IPPE) with ECG	HCPCS code: G0402 with G0403, G0404 or G0405
Annual Wellness Visit	HCPCS code: G0438 (initial Annual Wellness Visit), HCPCS code: G0439 (subsequent Annual Wellness Visit)
Annual Preventive Physical Exam	CPT codes: 99381–99387 (new patient), CPT codes: 99391–99397 (established patient)

For additional topics in the "Making It Easier for Physicians and Other Healthcare Providers" series, please visit: **Humana.com/MakingItEasier**

Also accessible on Availity Essentials → Payer Spaces → Humana → Resources → Making It Easier

Additional resources

- Humana's medical and pharmacy coverage policies:
  Humana.com/CoveragePolicies
- Claims payment policies:
  Humana.com/ClaimPaymentPolicies
- Claims processing edits:
  Humana.com/Edits
- Humana's code edit inquiry tools at Availity Essentials
  - Research Procedure Code Edits: Go to Payer Spaces → Humana → Applications → Research Procedure Code Edits
  - Code Edit Simulator: Go to Payer Spaces → Humana → Applications → Code Edit Simulator

Note: Claims submitted with certain modifiers are subject to additional manual review using information on current and historical claims. Actual claim results may differ from simulator results.

- Claim disputes:
  Availity.com
  - Claim Status tool: Go to Claims & Payments → Claim Status → Enter search criteria → Select claim → "Dispute Claim" button

  Humana.com/Publications
  - Provider Manual: Section titled "Provider Claims Dispute Process, Member Grievance/Appeal Process"

Rewards from Go365

View these charts to understand the reward values for certain activities when they've been completed.

Medicare Advantage patients

ACTIVITY	REWARD VALUE
Annual Wellness Visit	$40
Mammogram	$25
Colorectal screening procedure	$25
Diabetic bundle • Kidney urine test • Kidney blood test • Eye exam • Hemoglobin HbA1c test	$40 for completion of all four screenings
GET ACTIVE: EXERCISE AND FITNESS	
Complete a workout tracked via SilverSneakers®, fitness device, online or paper-based tracker (minimum 5,000 steps per day). Other physical activities may include golfing, cycling, swimming, Zumba, yoga, strength training, etc.	
$5 annual maximum *Must report activities within 90 days*	

D-SNP patients

ACTIVITY	REWARD VALUE
Annual Wellness Visit	$25
Mammogram	$30
Colorectal screening procedure	$50
Diabetic bundle • Kidney urine test • Kidney blood test • Eye exam • Hemoglobin HbA1c test	$40 for completion of all four screenings
GET ACTIVE: EXERCISE AND FITNESS	
Complete a workout tracked via SilverSneakers®, fitness device, online or paper-based tracker (minimum 5,000 steps per day). Other physical activities may include golfing, cycling, swimming, Zumba, yoga, strength training, etc.	
$60 annual maximum *For the activities above, get $5 for completing 12 workouts/month* *Must report activities within 90 days*	

Go365 members can redeem their rewards for gift cards to help support daily living needs:

Download the Diabetic Bundle flyer.

These gift cards cannot be used to purchase prescription drugs or medical services covered by Medicare, Medicaid or other federal healthcare programs; alcohol; tobacco; e-cigarettes; or firearms. These cards must not be converted to cash.

What is the Star Rating Program?

The Star Rating Program was created by the Centers for Medicare & Medicaid Services (CMS) to raise the quality of care for MA enrollees and to reduce federal healthcare expenditures. The program holds health plans accountable for the care provided to MA members by physicians, hospitals and other healthcare providers.

Stronger relationships are created among plan administrators, physicians and patients.

Provider benefits
- Improved communications with patients and health plans
- Stronger support for managing chronic conditions
- Greater focus on preventive medicine and early disease detection
- Increased patient safety awareness
- Opportunities to improve patient outcomes
- Additional compensation for value-based relationships that meet Star performance goals

Patient benefits
- Improved relations with physicians
- Greater care coordination
- Greater health plan focus on access to care
- Increased levels of customer service
- Greater focus on preventive services for early detection and healthcare that matches individual needs
- Improved health and lower costs

Humana's goal
Support providers by identifying care opportunities that will improve the health outcomes and care experience of patients.

Provider-facing Humana consultants
- Reporting on health status of eligible patients
- Assistance with claims and error correction

Resources for CMS requirements
- Training
- Provider Measure Guide
- Flyers

Patient outreach to improve engagement and health outcomes
- Telephone campaigns
- Postcards
- Surveys

Assistance with electronic data collection
- Electronic health record (EHR) or electronic medical record (EMR)
- Electronic Attestation Form (EAF)
- Stars Quality Report (SQR)

How is success measured?

Humana
Evaluates member care and awards incentives to providers annually

CMS
Awards plan administrator scores annually based upon a four-year cycle

Documented patient care by the provider influences these categories.

Category	MY25
CAHPS: Consumer Assessment of Healthcare Providers and Systems	21%
HOS: Health Outcomes Survey	11%
HEDIS: Healthcare Effectiveness Data and Information Set	24%
Patient Safety	15%
IRE: Independent Review Entity	5%
CMS: Centers for Medicare & Medicaid Services	12%
Improvement	12%

Plan administrators' scores impact all categories

Healthcare Effectiveness Data and Information Set (HEDIS)

Developed by the NCQA HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans the specific areas in which a stronger focus could lead to improvements in patient health. HEDIS reporting is required by NCQA for compliance and accreditation. HEDIS measures are created for all types of health plans—commercial, Medicaid and Medicare. Listed here are those chosen by CMS to include in the Medicare Star Rating Program as they align with their domains of care for Medicare beneficiaries. The HEDIS measures are targeted specifically to patient activities that will lead to improvements in patient health.

HEDIS (measured January–December)	ABBR	Weight
Preventive screening		
Breast Cancer Screening	BCS-E	1x
Colorectal Cancer Screening	COL-E	1x
Osteoporosis Management In Women Who Had a Fracture	OMW	1x
Care for Older Adults*		
COA – Functional Status Assessment	COA–FSA	1x
COA – Medication Review	COA–MDR	1x
Condition management		
Cardio		
Controlling High Blood Pressure	CBP	3x
Statin Therapy for Patients With Cardiovascular Disease	SPC	1x
Diabetes		
Eye Exam for Patients With Diabetes	EED	1x
Glycemic Status Assessment for Patients With Diabetes	GSD	3x
Kidney Health Evaluation for Patients With Diabetes	KED	1x
Care Coordination		
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions	FMC	1x
Plan All-Cause Readmissions	PCR	3x
Transitions of Care	TRC	1x
Notification of Inpatient Admission	TRC–NIA	**
Receipt of Discharge Information	TRC–RDI	**
Patient Engagement after Inpatient Discharge	TRC–PED	**
Medication Reconciliation Post-Discharge	TRC–MRP	**

* Measures apply only to Special Needs Plans (SNP)
** The TRC score is achieved by averaging four components

Changes to HEDIS measures

Care for Older Adults (COA)
- Functional Status Assessment (FSA) moves from display to active
- Pain Screening (COA–PNS) moves to retired

Colorectal Cancer Screening (COL-E)
Age range has changed to 45–75

Eye Exam for Patients With Diabetes (EED)
- Now administrative-only
- Bilateral eye enucleation is now an exclusion

Medication Reconciliation Post-Discharge (MRP)
MRP retired as a stand-alone measure but is included as a component of the Transitions of Care (TRC) measure

Supplemental data accepted

> Thresholds
Follow this icon in future pages to review measure thresholds.

> Coding
Follow this icon in future pages to review measure coding.

Contents

Humana

> Coding
> Thresholds

Preventive screenings

Breast Cancer Screening (BCS-E)

Breast Cancer Screening (BCS-E) MY25 | Weight = 1

Measurement period
Mammogram(s) performed on or between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year (27-month period). Example of compliance window for MY25: Oct. 1, 2023–Dec. 31, 2025.

Eligible population
Women 52*–74 years of age who had a mammogram to screen for breast cancer (including digital breast tomosynthesis)

Include patients recommended for routine breast cancer screening with any of the following criteria:
- Administrative gender of female at anytime in the patient's history
- Sex assigned at birth of female at anytime in the patient's history
- Sex parameter for clinical use of female during the measurement period

Note: Breast Cancer Screening (BCS-E) is reported via Electronic Clinical Data Systems (ECDS), which is a method of reporting clinical data electronically. Providers do not need to change their documentation or claim/encounter processes.

Service needed for measure compliance
Dated notation in the medical record of:
- Most recent mammogram with date of service (minimum month and year)
- Mastectomy status and date of service (minimum year performed)

All types and methods of mammograms including screening, diagnostic, film, digital, digital tomosynthesis, 2D or 3D views or computer-aided detection (CAD) can be used to satisfy this measure. While magnetic resonance imaging (MRI), ultrasounds or biopsies may be used to help further screen and diagnose breast cancer, they do not count toward this measure.**

Exclusions
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement period
- Patients who had a bilateral mastectomy or both right and left unilateral mastectomies anytime during the patient's history through the end of the measurement period—a single unilateral mastectomy does not count as an exclusion
- Patients who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria anytime during the patient's history through the end of the measurement period
- Patients 66 years of age and older as of Dec. 31 of the MY who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older who have frailty and advanced illness

Measure best practices
- Obtain and review past medical records for new patients, including mammogram history.
- Ensure office processes include key tests and exams into the patient record, and confirm the look-back period is two years.
- When referring/ordering mammograms, ensure office practices have a process for appropriate follow-up and documentation of test. Document date of service (at minimum month and year) of the most recent mammogram in the medical record.
- Document mastectomy status and date of service (minimum year performed) in the medical record. Supplemental data can be used to communicate historical evidence of testing and mastectomies completed.

Supplemental data accepted

** The patient must be 52 years of age in the measure year. However, since the measure has a "look-back" period of two years, the patient may have been 50 years of age at the time of the screening.*

*** Results are not required and, if patient-reported, type and date of screening must be reported in the medical record. Submitted records must include most recent mammogram with date of service (minimum of month and year) or mastectomy status and date of procedure (minimum is year performed).*

> Coding
> Thresholds

Preventive screenings

Colorectal Cancer Screening (COL-E)

Colorectal Cancer Screening (COL-E) MY25 | Weight = 1

Measurement period
January–December

Eligible population
Patients 45–75 years of age must have appropriate screening for colorectal cancer

Note: Colorectal Cancer Screening (COL-E) is reported via Electronic Clinical Data Systems (ECDS), which is a method of reporting clinical data electronically.

Providers do not need to change their documentation or claim/encounter processes.

Service needed for measure compliance
All eligible patients must have a colorectal cancer screening that encompasses the measure year.

- Fecal occult blood test (FOBT), guaiac FOBT or immunochemical FOBT (FIT) is compliant for the year it is performed
- Stool DNA (sDNA) with FIT test is compliant for the year it is performed and two years after
- Flexible sigmoidoscopy or computed tomography (CT) colonography is compliant for the year it is performed and four years after
- Colonoscopy is compliant for the year it is performed and nine years after

Note: Clear documentation of previous colonoscopy, CT colonography or sigmoidoscopy, including year performed, is required.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who have had a total colectomy or colorectal cancer anytime during the patient's history through Dec. 31 of the current measurement year
- Patients who were dispensed dementia medications
- Patients who died anytime during the measurement year
- Patients 66 years of age and older as of Dec. 31 of the measurement year who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older who have frailty and advanced illness

Note: Partial colectomy is not an exclusion.

Measure best practices

- Obtain and review new patients' past 10 years of medical records to determine any colon cancer screenings they may have had in that time period.
- Have a process for appropriate follow-up and documentation of a test when ordering/referring patients for colon cancer screenings.
- Document date of service (at minimum month and year) of the most recent colon cancer screening in the medical record.
- Submit supplemental data to communicate historical evidence of testing and colon cancer screenings completed.
- When patients are not willing/able to complete a colon cancer screening, review Humana reporting to determine if the patient received a test kit. Not all patients are eligible, but if they have received one and not yet completed and returned, the provider should encourage that completion.

Supplemental data accepted

> Coding
> Thresholds

Preventive screenings

Osteoporosis Management In Women Who Had a Fracture (OMW)

Osteoporosis Management In Women Who Had a Fracture (OMW) MY25 | Weight = 1

Measurement period
July 1 of prior year to June 30 of the measure year

Eligible population
Women 67–85 years of age who suffered a fracture (not including fractures of face, skull, fingers or toes) between July 1 of the prior year and June 30 of the current measure year.

Service needed for compliance
- A bone mineral density (BMD) test in any setting and/or
- The patient is dispensed osteoporosis medication or therapy, including long-acting osteoporosis therapy provided during inpatient stay for fracture

Service is needed within six months (180 days)
- Of fracture date or
- Discharge date if hospitalized for fracture

Exclusions
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year
- Patients 67–85 years of age living long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 67–80 years of age with both frailty (at least two indications) and advanced illness (at least two different dates of service or dispensed dementia medication)
- Patients 81–85 years of age with frailty only (with at least two indications of frailty)

Patients are also removed from eligibility with evidence of the following:
- BMD test within 24 months prior to the fracture
- Dispensed or active prescription to treat or prevent osteoporosis within the 12 months prior to the fracture
- Osteoporosis therapy within 12 months prior to the fracture

Note: Supplemental data is appropriate for evidence of compliance. However, it cannot be submitted to support an exclusion.

Measure best practices

- Discuss with patient the option to prescribe FDA-approved medications and discuss lifestyle changes to treat or prevent osteoporosis (such as exercise, vitamins, mineral supplements) or for them to complete a BMD test.
- For new patients, obtain medical records and look for evidence of a BMD test 24 months prior to the fracture or evidence of conditions that would exclude a patient from the measure.
- When documenting medication or test, ensure proper documentation of the specifics in the medical record (test date and finding, medication name, dispense date, dosage/strength and administration route) and submit as a claim or supplemental data.

→ **Supplemental data accepted**

> Coding
> Thresholds

Condition management – cardio

Controlling High Blood Pressure (CBP)

Controlling High Blood Pressure (CBP) MY25 | Weight = 3

Measurement period
January–December

Eligible population
Patients 18–85 years of age, with two or more qualifying visits with hypertension diagnosis during the prior year or the first six months of measurement year.

Service needed for measure compliance
BP reading during the current measurement year on or after the second diagnosis of hypertension.

The most recent reading is utilized to determine compliance during the year. For final compliance determination, it will rely on the last reading at a qualified location in the measurement year. Most recent reading in the current measurement year must have a representative systolic BP < 140 mm Hg and a representative diastolic BP < 90 mm Hg to be measure compliant. The adequately controlled result must be documented and reported administratively.

Note: If there are multiple BPs on the same date of service, use the lowest systolic and diastolic BP on that date as the representative BP.

Patient-reported blood pressure readings are accepted.

Exclusions
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year
- Patients with a diagnosis of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant anytime during patient's history
- Patients with a diagnosis of pregnancy anytime during the measurement year
- Patients 66 years of age and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institutional setting
- Patients 81 years of age and older with at least two indications of frailty with different dates of service during the measurement year
- Patients 66–80 years of age as of Dec. 31 of the measurement year with both frailty and advanced illness

Measure best practices

- In-office measurement: Ensure accurate measurement by implementing and maintaining office practices such as:
  - Providing at least five minutes of quiet rest prior to reading
  - Using correct cuff size
  - Re-taking in same visit if systolic BP < 140 mm Hg and/or diastolic BP < 90 mm Hg
- Virtual measurement: Coach patient on best practices, such as sitting up straight with feet on floor; not taking reading over clothing; and avoiding smoking and caffeine prior to reading
- Follow-up: For patients out-of-range (140/90 or greater):
  - Assess for adherence barriers; consider simplified medication options, such as 90/100 day fills, mail order and combination pills
- Review and discuss medication options: Clinical guidelines generally recommend medication adjustments including increasing dosages and/or adding medications
  - Recommend at-home monitoring of blood pressure and provide supporting materials
  - Consider follow-up in approximately a month; offer virtual options where appropriate/convenient

Supplemental data accepted

> Coding
> Thresholds

Condition management – cardio

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Statin Therapy for Patients With Cardiovascular Disease (SPC) MY25 | Weight = 1

Measurement period
January–December

Eligible population
Males 21–75 years of age and females 40–76 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD). Patients will be part of the numerator by event or diagnosis.

Event (during prior year):
- Inpatient discharges with a myocardial infarction (MI)
- Visits in any setting for coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) or any other revascularization procedure

Diagnosis:
- Claims submitted during the current and prior measurement year:
- Only outpatient visits can include telehealth
- With a diagnosis of ischemic vascular disease (IVD)
- In an inpatient or outpatient setting
- At least one acute inpatient discharge
- An outpatient visit, telehealth visit, virtual check-in or acute inpatient encounter

Service needed for compliance
At least one fill for a high- or moderate-intensity statin medication in the measurement year

Exclusions
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year
- Patients with Medicare coverage who are 66–75 years of age and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institutional setting
- Patients 66–75 years of age with both frailty and advanced illness
- Patients with the following diagnoses or services in the current or prior measurement year for:
  - Pregnancy or in vitro fertilization (IVF)
  - Dispensed clomiphene medication
  - End-stage renal disease (ESRD) or dialysis
  - Cirrhosis
- Patients with myalgia or rhabdomyolysis caused by a statin anytime during the patient's history (reaction does not have to occur in the current year but most be documented yearly)

Measure best practices

- Ensure a comprehensive review of new to practice/new to Medicare patients who have been diagnosed with cardiovascular disease to evaluate their current statin therapy.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with cardiovascular disease, especially those who are also receiving care from specialists.
- Ensure there is a process for evaluating current statin therapy and that they are on a medium- to high-dose therapy.
- Document in medical records the statin name, date it was dispensed, dosage/strength and administration route when given to the patient in a clinical setting—this documentation can then be submitted as supplemental data.

> Coding
> Thresholds

Condition management – diabetes

Eye Exam for Patients With Diabetes (EED)

Eye Exam for Patients With Diabetes (EED) MY25 | Weight = 1

Measurement period
January–December

Eligible population
Patients 18–75 years of age with type 1 or type 2 diabetes who meet either of the following criteria during the measurement year or the year prior to the measurement year:
- Two diagnoses of diabetes on different dates of service
- Pharmacy data showing one dispensed insulin or hypoglycemic/antihyperglycemic and at least one diagnosis of diabetes

Service needed for compliance
- Screening or monitoring for diabetic retinal disease via a retinal or dilated eye exam during the current measurement year
- Retinal or dilated eye exam performed in prior year with negative results for diabetic retinopathy

Note: Document the date of most recent diabetic eye exam with results and name the eye care provider in the patient's medical record. If possible, also obtain and retain the most recent eye exam record in the patient's medical record.

Exclusions
- Bilateral eye enucleation anytime during the patient's history through the current measurement year.
  - Two unilateral eye enucleations 14 days apart or
  - A left and right unilateral eye enucleation on the same or different dates of service

Note: Blindness is not an exclusion for diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and do not require an exam.
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients died anytime during the measure year
- Patients who did not have a diagnosis of diabetes during the measure year or the year prior to the measure year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measure year or the year prior
- Patients 66 years of age and older as of Dec. 31 of the measurement year who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older who have frailty and advanced illness

Measure best practices

- Review diabetes services needed at each office visit and refer patients to see an eye care professional for a comprehensive dilated or retinal eye exam during the current year.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with diabetes and those who are new to the practice or Medicare, especially those who are also receiving care from specialists, and submit records that document evidence of completed tests in the measurement year through supplemental data.
- Ensure processes exist when referring patients to eye specialists to follow up with specialist or patient to obtain records and result of exam.
- Submit claims with appropriate CPT Category II codes to indicate result of the exam when performing the exam in the office (via fundus photography) with results interpreted by an appropriate eye care professional, at a reading center with a retinal specialist serving as medical director or a system with artificial intelligence.
- Submit supplemental data when a claim is not submitted that includes the record and result of the exam including place of service, provider and result. (Patients whose exams have negative results showing no evidence of retinopathy will be compliant with this measure for the year in which the screening occurred and the following measurement year.)

→ **Supplemental data accepted**

> Coding
> Thresholds

Condition management – diabetes

Glycemic Status Assessment for Patients With Diabetes (GSD)

Glycemic Status Assessment for Patients With Diabetes (GSD) MY25 | Weight = 3

Measurement period
January–December

Eligible population
Patients 18–75 years of age with type 1 or type 2 diabetes who meet either of the following criteria during the measurement year or the year prior to the measurement year:
- Two diagnoses of diabetes on different dates of service
- Pharmacy data showing one dispensed insulin or hypoglycemic/antihyperglycemic and at least one diagnosis of diabetes

Service needed for compliance
Glycemic status assessment can be either HbA1c test or glucose management indicator (GMI) review from a continuous glucose monitor (CGM).
- HbA1c testing is still required for diagnosed diabetics who do not use a glucose monitor.
- Compliance is achieved by either method if the patient has achieved a glycemic status assessment result equal to or less than 9%.
- For HbA1c and GMI, the last documented/coded reading of the year is the reading of record for compliance. For GMI, a date range is required.

Note: If multiple glycemic status assessments (HbA1c or GMI review) are recorded for a single date, use the lowest result.

Exclusions
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died during the measurement year
- Patients who did not have a diagnosis of diabetes during the measure year or the year prior to the measure year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measure year or the year prior
- Patients 66 years of age and older as of Dec. 31 of the measurement year who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older who have frailty and advanced illness

Measure best practices

- Ensure processes exist to regularly test HbA1c at patient visits during the year.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with diabetes and those who are new to the practice or Medicare, especially those who are also receiving care from specialists, and submit records that document evidence of completed tests in the measurement year through supplemental data.
- Verify provider documentation and coding practices include submitting the appropriate CPT Category II codes or Logical Observation Identifier Names and Codes (LOINC) codes with claims and encounters. Without these codes, the gap will not close.
- Have processes to monitor diabetic patients who are not getting in for regular exams and have them get in-office or in-lab tests completed.
- For patients who are not able/willing to go to an office or lab, verify they have received a test kit from Humana and encourage completion of that test kit.
- Execute processes to monitor patients with greater than 9% HbA1c levels and encourage the appropriate follow-ups and retesting.
- When documenting in a medical record, include the date the HbA1c or GMI test was performed and the results of the test. The medical record must include the date range used to derive the values, and the finding must be in the format of a value (e.g., 7%). Missing values or results recorded in a format other than the above example will not be compliant.

→ **Supplemental data accepted**

> Coding
> Thresholds

Condition management – diabetes

Kidney Health Evaluation for Patients With Diabetes (KED)

Kidney Health Evaluation for Patients With Diabetes (KED) MY25 | Weight = 1

Measurement period
January–December

Eligible population
Patients 18–85 years of age with type 1 or type 2 diabetes who meet either of the following criteria during the measurement year or the year prior to the measurement year:
- Two diagnoses of diabetes on different dates of service
- Pharmacy data showing one dispensed insulin or hypoglycemic/antihyperglycemic and at least one diagnosis of diabetes

Service needed for compliance
Diabetic patients should have a kidney health evaluation in the measurement year. Both an estimated glomerular filtration rate (eGFR) and a urine test are required on same or different dates of service within the measure year.
- The blood test must be an eGFR
- The urine test must measure both the levels of the quantitative albumin and urine creatinine. (A ratio test fulfills both requirements with one sample.) Two samples (no more than four days apart) can be submitted—one with the quantitative albumin and the other with urine creatinine.

Exclusions
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients with ESRD or dialysis anytime during the patient's history on or prior to Dec. 31 of the measure year
- Patients who died anytime during the measure year
- Patients who did not have a diagnosis of diabetes during the measure year or the year prior to the measure year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measure year or the year prior
- Patients 66 years of age and older as of Dec. 31 of the measurement year who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older who have frailty and advanced illness

Measure best practices
- Review diabetes services needed at each office visit.
- Refer patients for both an estimated eGFR and a urine albumin creatinine ratio (uACR) during the measurement year if not able to complete in office.
- Ensure the practice has a process to conduct reviews of patients records when diagnosed with diabetes, and those who are new to the practice or Medicare, especially those who are also receiving care from specialists.
- Submit records that document evidence of completed tests in the measurement year through supplemental data.
- At least once a year, ensure both tests are conducted for this measure regardless of other semi-quantitative methods that might be used.
- Ensure claims and encounters are submitted timely and, if no claim is submitted, provide evidence and results of tests via supplemental data records. Ensure tests meet appropriate time frame for measure compliance.

Supplemental data accepted

> Coding
> Thresholds

Care for Older Adults – Functional Status Assessment (COA–FSA)

Care for Older Adults – Functional Status Assessment (COA–FSA) MY25 | Weight = 1

Measurement period
January–December

Eligible population
Percentage of COA-eligible patients 66 years of age or older by end of the measurement year who had documentation in the medical record of at least one completed functional status assessment in the current measurement year. COA measures apply to Special Needs Plan (SNP) patients only.

Service needed for compliance
A complete functional assessment must include one of the following:
- Notation that activities of daily living (ADL) were assessed or at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet and walking
- Notation that instrumental activities of daily living (IADL) were assessed or at least four of the following were assessed: grocery shopping, driving, using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications or handling finances
- Notation and results of a completed standardized function status assessment tool (examples but not limited to Bayer-ADL Scale, Barthel Index, Edmonton Frail Scale, Extended ADL Scale, Independent Living Scale, Katz Index of Independence in ADL and Klein-Bell ADL Scale)

Examples of FSAs that do not meet criteria:
- A functional status assessment limited to an acute or single condition, event or body system (e.g. lower back, leg)
- A functional status assessment performed in an acute inpatient setting

Note: Functional status assessment limited to an acute or single condition, event or body system does not meet criteria. There is no test score or result that needs to be submitted for measure closure, just notification that the assessment was completed. Assessments can occur via all telehealth methods including audio-only telephone visit, e-visit and virtual check-in.

Exclusions
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year

Measure best practices
- Perform a comprehensive functional status assessment with older patients as a part of annual wellness or physical exam. These can be conducted via all telehealth methods including audio-only telephone visit, e-visit and virtual check-in.
- Complete the COA assessment form annually with eligible patients. Completed forms can then be submitted as supplemental data.

Supplemental data accepted

> Coding
> Thresholds

Care for Older Adults – Medication Review (COA–MDR)

Care for Older Adults – Medication Review (COA–MDR) MY25 | Weight = 1

Measurement period
January–December

Eligible population
Percentage of COA-eligible patients 66 years of age or older by end of the measurement year whose doctor or clinical pharmacist reviewed all the patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies.

Service needed for compliance
Both of these services need to occur for compliance:

1. Documentation of a dated and signed medication review conducted by a healthcare provider with prescribing authority or clinical pharmacist in the current measurement year
2. A medication list present in the same medical record with a dated notation or transitional care management services during the measurement year. If the patient is not taking medication, dated notation of this should be documented in the chart in the current measurement year

There is no result that needs to be submitted for gap closure, just notification that the medication review occurred and is documented.

Note: Medication reviews can be completed via all telehealth methods, including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. An outpatient visit or patient's presence is not required.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year

Measure best practices

- Ensure clinician review and reconciliation of medications. Documentation of review must include date of review and medication list codes from the same date of service for compliance.
- Complete reviews by either in-person visit or via telehealth methods, including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. Neither an outpatient visit nor patient presence are required.
- Complete COA assessment form annually with eligible patients. Completed form can be submitted via supplemental data.
- Follow necessary steps to close gap for an initial qualifying event, even if there is a second qualifying event in the same measurement year.

Supplemental data accepted

> Coding
> Thresholds

Care coordination

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) MY25 | Weight = 1

Measurement period
Jan. 1–Dec. 24*

Applicable data collection method
Administrative only

Eligible population
Patients 18 years of age and older with multiple high-risk chronic conditions who visit an emergency department (ED). The high-risk chronic conditions in scope include chronic respiratory conditions (chronic obstructive pulmonary disease, asthma and emphysema), Alzheimer's disease and related disorders, stroke and transient ischemic attack, chronic kidney disease, depression, heart failure, acute myocardial infarction and atrial fibrillation.

Service needed for compliance
Patients must have a follow-up visit or service within seven days of the ED visit (eight days total) via:

- An outpatient, telephone or telehealth visit, including those for behavioral health (BH) services in a clinic, at home or at a community mental health center
- An intensive outpatient encounter or partial hospitalization stay, including observation visits
- Transitional care management services
- A case management visit
- Complex care management services
- Monitored electroconvulsive therapy in an outpatient, ambulatory surgical, community mental health or partial hospitalization setting
- An e-visit or virtual check-in
- A substance use disorder service
- A domiciliary or rest home visit

Exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year
- Any ED visit that results in an inpatient admission on the day of, or within seven days following, the ED visit
- ED visits occurring within the same eight-day period (if a patient has more than one ED visit in an eight-day period, include only the first eligible ED visit).

Measure best practices

- Implement processes with hospitals to facilitate sharing of ED disposition information.
- Work with hospitals to obtain access to electronic health records.
- Obtain census information from EDs/facilities whenever possible.
- Educate and encourage patients to notify their primary care physician (PCP), following an ED visit for additional guidance.
- Allow scheduling flexibility to accommodate a follow-up visit within seven days of the ED visit, including telehealth visits. Telephonic check-ins can be utilized if unable to obtain an appointment within seven days.
- Ensure via claim or documentation in the patient record there was appropriate follow-up with the patient via in-office or telehealth appointment.

Supplemental data accepted

Note: FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed.

* Odd ending date to allow for seven-day follow up period

> Thresholds

Care coordination

Plan All-Cause Readmissions (PCR)

Plan All-Cause Readmissions (PCR) MY25 | Weight = 3

Measurement period
Jan. 1–Dec. 1

Eligible population
Patients 18 years of age and older who have had an acute inpatient or observation stay. Patients require follow up to prevent an unplanned readmission of any type (inpatient or observation stay) within 30 days of discharge.

Service needed for compliance
The needed action is to avoid readmission within 30 days. The goal is that practices should follow the identified protocols of the TRC measures. Practices can identify patients who have been discharged from acute facilities using daily discharge reporting. Reach out to these patients to schedule follow-up care, and medication reconciliation, which could reduce the risk of readmission.

Exclusions
- Stays with discharge dates of Dec. 2–31
- Pregnancy-related admission
- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died during stay
- Patients with four or more hospital stays (acute inpatient and observation) between Jan. 1 and Dec. 1
- For stays that included a direct transfer, excluding original admission's discharge date. Only the last discharge should be considered.

Note: Planned admissions for chemotherapy, rehabilitation, transplant, etc., are not included as readmissions. Rehabilitation exclusions are limited to fitting and adjustment of prosthesis and other medical devices, such as infusion pumps, neuropacemakers, etc.

Measure best practices
- Have processes to review daily discharge census.
- Have processes to accommodate scheduling appointments as close to the point of discharge as possible, ideally within seven days. If a patient cannot be seen within seven days, checking in with patient by telephone is highly encouraged.
- Have processes to conduct medication reconciliation during first post-discharge visit with patient.
- Recommend appropriate health plan or community resources to patients to assist with any barriers to accessing resources necessary to prevent a readmission (i.e., ability to get the medications prescribed at discharge, transportation for follow-up appointments, family or community support, food services or in-home services).

> Coding
> Thresholds

Care coordination

Transitions of Care (TRC)

Transitions of Care (TRC) MY25 | Weight = 1 (with four component measures)

Overview

The Transitions of Care (TRC) measure assesses instances of admission and discharge information delivered to a patient's physician, as well as evaluating patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year for patients 18 years of age and older.

The TRC measure organizes patient care and follow-up activities after a hospital admission and discharge. There are four components that contribute to the TRC score, and each requires engagement from the PCP within a certain period of time, as listed below.

- Notification of Inpatient Admission (TRC–NIA)
- Receipt of Discharge Information (TRC–RDI)
- Patient Engagement After Inpatient Discharge (TRC–PED)
- Medication Reconciliation Post-Discharge (TRC–MRP)

For all the components, take note if the patient is readmitted or transferred directly to an inpatient care setting within 30 days of discharge. In this event, use the first admission's admit date and the discharge date of the last discharge.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year
- Discharges occurring after Dec. 1 of the measurement year

Measure best practices

- Have processes in place with hospitals to facilitate sharing of admission and discharge information.
- Be aware of patients' inpatient stays and obtain timely discharge summaries.
- Review discharge summaries to ensure that the minimum required information is included.
- Have processes to accommodate scheduling appointments as close to the point of discharge as possible, ideally within seven days. If a patient cannot be seen within seven days, checking in with patients by telephone is highly encouraged.
- Ensure all notifications of admits or discharges are appropriately documented in patient charts and follow-up actions are conducted.

> Coding
> Thresholds

Care coordination

Transitions of Care (TRC)

Notification of Inpatient Admission (TRC–NIA) MY25

Measurement period
January–December

Applicable data collection method
Medical record review only

Action needed for compliance
- PCP practice must document, in the patient's outpatient medical record, receipt of notification of inpatient admission on the day of admission or within the two following days (three days total).
- Evidence must include the date the documentation was received.

Service required
Documentation in the patient's outpatient medical record of the admission communications:
- Between inpatient providers or staff and the PCP or ongoing care provider
- Between the ED and the PCP
- From a health information exchange or an automated admission, discharge and transfer (ADT) alert system
- Through a shared EHR system (received date is not required but must have been accessible to the PCP on the day of admission or within the two following days)
- From the patient's health plan

There are no procedure codes that can be submitted via claims to address TRC–NIA. Information is collected via health plan medical record review only.
- If an observation stay turns into an inpatient admission, the admit notification must be documented as being received on the admit date of the observation stay or within the two following days.
- For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable and:
  - Must clearly apply to the admission event and include a time frame for the planned inpatient admission
  - Is not limited to the admit date or the two following days

There may be other indications in the outpatient medical record about the admission if:
- The PCP admitted the patient or ordered tests and treatments anytime during the patient's inpatient stay
- A specialist admitted the patient and notified the PCP
- There is documentation that the PCP performed a preadmission exam for—or received communication about—a planned inpatient admission

Receipt of Discharge Information (TRC–RDI) MY25

Measurement period
January–December

Applicable data collection method
Medical record review only

Action needed for compliance
- PCP practice must document discharge receipt information on the day of discharge or within the two following days (three days total).

Service required
Documentation must include:
- Name and credentials of the physician or practitioner responsible for the patient'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 to the PCP or ongoing care provider for patient care

If using a shared EHR system, evidence that the information was filed in the EHR and accessible to the patient's PCP on the day of discharge or within the two following days meets criteria—and "received date" isn't required.

> Coding
> Thresholds

Care coordination

Transitions of Care (TRC)

Patient Engagement After Inpatient Discharge (TRC–PED) MY25

Measurement period
January–December

Applicable data collection methods
Administrative and hybrid

Eligible population
Patients 18 years of age and older who were discharged from an inpatient facility

Service required
- Engagement must take place within 30 days of discharge.
- Engagement that takes place on the day of discharge is not measure compliant.
- Follow up with patients as soon as possible following an acute stay discharge to prevent readmission and ensure understanding of post-discharge instructions.
- Medication reconciliation can be performed on the day of discharge. If that has not happened, be sure to do so at the follow-up event.

Note: If a patient is unable to communicate, their PCP can interact with their caregiver for any reason, including setting up an appointment.

The engagement can take place via any of the following ways:
- Outpatient visits, including office or home visits
- A telephone visit
- Synchronous telehealth visit where real-time interaction occurred between the patient and their PCP with audio and video communication
- Asynchronous or e-visits/virtual check-ins that are not real time

Medication Reconciliation Post-Discharge (TRC–MRP) MY25

Measurement period
January–December

Applicable data collection methods
Administrative and hybrid

Eligible population
Patients 18 years of age and older who were discharged from an inpatient facility

Service required
- Medications must be reconciled by an approved provider on the date of discharge up to 30 days after discharge (31 days total). However, follow up with patients as soon as possible after discharge to avoid duplication or dangerous reactions.
- Medication reconciliation must be conducted by an approved provider, e.g., prescribing practitioner, clinical pharmacist or registered nurse.
- Documentation must reference both the current medication and the discharge medication in order to meet HEDIS measure criteria
- Licensed practical nurses (LPNs) and other nonlicensed staff can perform the medication reconciliation, but it must be co-signed anytime in the measurement year by an approved provider.
- When patients are directly transferred to another facility, perform reconciliation for final discharge.

Different codes will be required depending upon when the MRP is conducted. Refer to most recent coding information

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is an annual patient survey conducted for MA plans by a contracted CMS vendor. The goal of the survey is to assess the experiences of beneficiaries in MA plans, and the results of the survey are published in the "Medicare & You" handbook and on the Medicare website: www.medicare.gov. Nine areas of the patient survey are included in the Star measures reporting. The first six measures below directly correlate to patient experience with their physicians and other healthcare providers, the remaining three correlate to a patient's experience with their MA plan. CMS excludes enrollees who are under age 18, known to be deceased, known to reside in institutional settings or reside outside of the U.S. Additionally, CMS sample procedures do not allow for the selection of more than one enrollee per household.

CAHPS (measured February–June of following year)	ABBR	Weight
Annual Flu Vaccine	FLU	1x
Care Coordination	CC	2x
Getting Needed Care	GNC	2x
Getting Appointments and Care Quickly	GAQC	2x
Getting Needed Prescription Drugs	GNRx	2x
Rating of Health Care Quality	RHCQ	2x
Customer Service	CS	2x
Rating of Health Plan	RHP	2x
Rating of Drug Plan	RDP	2x

Why surveys matter

Surveys provide insight into how our members/your patients are experiencing aspects of their care. To learn more about surveys your patients may receive, please watch the video to the right.

Click above to learn more about PE surveys.

Contents

Annual Flu Vaccine (FLU)

Annual Flu Vaccine (FLU) MY25 | Weight = 1

Overview
Percentage of sampled Medicare enrollees who received an influenza vaccination

Patient survey question
- Have you had a flu shot since July 1 (prior year)?

Measure best practices
- Talk to patients about getting vaccinated during regularly scheduled visits during flu season.
- Consider having office staff reach out to your patients who are at a higher risk of experiencing flu complications with a reminder to be vaccinated.
- Encourage patients to take advantage of vaccination opportunities at convenient locations, such as their local pharmacies.
- During their next office visit, confirm patients were vaccinated.

Care Coordination (CC)

Care Coordination (CC) MY25 | Weight = 2

Overview
Assesses how well patient care is coordinated, including whether or not doctors had the records and information they needed about patients' care and how quickly patients got their test results

Patient survey questions

- In the last six months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
  Answer choices: Yes, definitely; Yes, somewhat; No
- In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?
  Answer choices: Never; Sometimes; Usually; Always

Note: There are four HEDIS Star measures that are also referred to as Care Coordination measures. See Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC), Medication Reconciliation Post-Discharge (MRP), Plan All-Cause Readmissions (PCR) and Transitions of Care (TRC).

Measure best practices

- When sending out pre-appointment reminders, encourage patients to bring a list of all their current medications and supplements to their appointment.
- Have patients confirm their up-to-date medications and supplements at each appointment in their pre-appointment paperwork.
- Discuss medications in detail with patients to ensure they understand doctor instructions and any potential interactions, and inquire if patients are experiencing any side effects from medications and if they are struggling to pay for their medications.
- Include detailed medication instructions for patients in the after-visit summary, and consider using plain language when writing instructions.
- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/services where available. If specialist follow-up care cannot be scheduled when your patient is in your office, give him/her the names and phone numbers of specialists.
- Contact patients with the results of any screenings as soon as they are available, and schedule any necessary follow-up care.

Getting Appointments and Care Quickly (GACQ)

Getting Appointments and Care Quickly (GACQ) MY25 | Weight = 2

Overview
Assesses how quickly the patients were able to get appointments and care

Patient survey question
- In the last six months, when you needed care right away, how often did you get care as soon as you needed?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often did you get an appointment for a checkup or routine care as soon as you needed?
  Answer choices: Never; Sometimes; Usually; Always

Measure best practices

- When possible, leave scheduling gaps for urgent appointments and have processes in place to help patients receive care from other providers (such as urgent care or other colleagues within your practice) when necessary.
- Leverage telehealth resources where appropriate.
- Utilize online appointment scheduling as an alternative to having patients call in to the office for scheduling.
- Consider implementing extended or flex office hours on certain days.
- If applicable, have office staff schedule any follow-up appointments for patients at the end of their current appointments.

Getting Needed Care (GNC)

Getting Needed Care (GNC) MY25 | Weight = 2

Overview
Assesses how easy it was for patients to get needed care and see specialists

Patient survey questions
- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often was it easy to get the care, tests or treatment you needed?
  Answer choices: Never; Sometimes; Usually; Always

Measure best practices
- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/services where available.
- If office staff is assisting with scheduling specialist appointments, consider using specialist reminder cards to give to the patients as part of the after-visit summary. If specialist follow-up care cannot be scheduled when your patient is in your office, provide the names and phone numbers to call for an appointment.
- Utilize interoperability or data-sharing functionality within your EHR to assist with real-time prior authorization.

Getting Needed Prescription Drugs (GNRx)

Getting Needed Prescription Drugs (GNRx) MY25 | Weight = 2

Overview
Assesses how easy it is for patients to get the medicines prescribed by their doctor

Patient survey questions

- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
  Answer choices: Never; Sometimes; Usually; Always
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
  Answer choices: Never; Sometimes; Usually; Always; I did not use my prescription drug plan to fill a prescription at my local pharmacy in the last six months
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?
  Answer choices: Never; Sometimes; Usually; Always; I did not use my prescription drug plan to fill a prescription by mail in the last six months; I am not sure if my drug plan offers prescriptions by mail

Measure best practices

- Some medications require prior authorizations in order to be covered. Utilize interoperability or data-sharing functionality within your EHR to assist with formulary visibility and real-time prior authorization. You can also check the current preauthorization and notification list(s) at Humana.com/PAL to determine if a medication requires preauthorization before it can be dispensed or administered.
- Recommend patients switch to 90-day supplies from their community pharmacy or via a mail-order pharmacy.

Rating of Health Care Quality (RHCQ)

Rating of Health Care Quality (RHCQ) MY25 | Weight = 2

Overview
Patient's rating of health plan

Patient survey question

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

Measure best practices

- Ensure office staff understands the importance of providing a welcoming atmosphere for patients.
- Monitor patient experience surveys for improvement opportunities, and keep tabs of online reviews and have a plan to act and follow-up on poor experiences.
- Ask questions to gauge the patient's current experience and perception of the care they are receiving from your practice, specialists and other healthcare providers.
- Consider the teach-back method when giving patients instructions, as studies cite that 50% of patients leave appointments without fully understanding the provider's instructions.*

* Bodenheimer T. Teach-Back: A Simple Technique to Enhance Patients' Understanding. FPM. 2018 Jul/Aug;25(4):20-22. PMID: 29989780.

The following CAHPS measures are related to a patient's experience with their MA plan. These measures are not provider-impacted.

Rating of Drug Plan (RDP)

Rating of Drug Plan (RDP) MY25 | Weight = 2

Overview
Patient's rating of drug plan

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

Customer Service (CS)

Customer Service (CS) MY25 | Weight = 2

Overview
Measures patient's satisfaction with specific customer service components of their health plan

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

Rating of the Health Plan (RHP)

Rating of the Health Plan (RHP) MY25 | Weight = 2

Overview
Patient's rating of health plan

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

Health Outcomes Survey (HOS)

HOS is an annual patient-reported outcome survey conducted for MA plans by a vendor contracted by the CMS. The goal of the survey is to gather valid and reliable health status data for use in quality improvement activities, public reporting, Medicare Advantage organization accountability and improving health outcomes. The survey contains questions regarding physical and mental health, chronic medical conditions, functional status (e.g., activities of daily living), clinical measures and other health status indicators. The survey is distributed annually between July and November.

Changes to HOS measures

- **Improving or Maintaining Physical Health** now weighted 3x
- **Improving or Maintaining Mental Health** now weighted 3x

HOS (measured August–November)	ABBR	Weight
Improving Bladder Control	IBC	1x
Improving or Maintaining Mental Health	IMMH	3x
Improving or Maintaining Physical Health	IMPH	3x
Monitoring Physical Activity in Older Adults	MPH	1x
Reducing the Risk of Falling	ROF	1x

Why surveys matter

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Contents

Improving Bladder Control (IBC)

Improving Bladder Control (IBC) MY25 | Weight = 1

Overview

Percentage of surveyed patients 65 years of age and older who reported having any urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider

Patient survey questions

- Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
  Answers: Yes; No
- During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
  Answers: A lot; Somewhat; Not at all
- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?
  Answers: Yes; No
- There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other healthcare provider about any of these approaches?
  Answers: Yes; No

Exclusion

- Patients in hospice

Measure best practices

- Discuss bladder control issues and symptoms with your older patients, including during telehealth visits, and consider ways to destigmatize the topic.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- Determine if exercise or other treatment options such as medications, bladder control products or surgery may help.
- If recommending specific bladder exercises, write down clear instructions along with informational pamphlets demonstrating the exercises.

Monitoring Physical Activity in Older Adults (MPA)

Monitoring Physical Activity in Older Adults (MPA) MY25 | Weight = 1

Overview

Percentage of sampled Medicare patients 65 years of age and older who have had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level of exercise or physical activity

Patient survey questions

- In the past 12 months, did you talk with a doctor or other healthcare provider about your level of exercise or physical activity? For example, a doctor or other healthcare provider may ask if you exercise regularly or take part in physical exercise.
  Answers: Yes; No
- In the past 12 months, did a doctor or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other healthcare provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.
  Answers: Yes; No

Exclusions

- Patients in hospice
- Patients responding, "I had no visits in the past 12 months"

Measure best practices

- Determine if it is appropriate for your patients to start, maintain or increase the level of physical activity based on their overall health and have relevant discussions with the patient.
- Include any recommended activity with frequency and duration in the patient after-visit summary and ensure they have a physical copy of the goals/plan for maintaining or increasing activity.
- Share handouts or items patients can keep or have in their homes to help them remember the conversation for the survey.

Improving or Maintaining Physical Health (IMPH)

Improving or Maintaining Physical Health (IMPH) MY25 | Weight = 3

Overview
Percentage of sampled Medicare patients 65 years of age and older whose physical health status was the same or better than expected after two years

Patient survey questions

- In general, would you say your health is:
  Answers: Excellent; Very good; Good; Fair; Poor
- The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
  - Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
  - Climbing several flights of stairs?

  Answers: Yes, limited a lot; Yes, limited a little; No, not limited at all
- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
  - Accomplished less than you would like as a result of your physical health?
  - Were limited in the kind of work or other activities as a result of your physical health?

  Answers: No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; Yes, all of the time
- During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
  Answers: Not at all; A little bit; Moderately; Quite a bit; Extremely
- Compared to one year ago, how would you rate your physical health in general now?
  Answers: Much better; Slightly better; About the same; Slightly worse; Much worse

Measure best practices

- Develop a plan for preventive screenings and services for patients.
- Determine an exercise or physical therapy program that is appropriate for patients' needs and abilities.
- Perform a pain assessment to determine if a pain management or treatment plan is needed.
- If recommending specific exercises, write down clear instructions and any goals specific to the patient, and include informational pamphlets demonstrating the exercises.

Improving or Maintaining Mental Health (IMMH)

Improving or Maintaining Mental Health (IMMH) MY25 | Weight = 3

Overview
Percentage of sampled Medicare enrollees 65 years of age and older whose mental health status was the same or better than expected after two years

Patient survey questions

- During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
  - Accomplished less than you would like as a result of any emotional problems
  - Didn't do work or other activities as carefully as usual as a result of any emotional problems?
    Answers: No, none of the time; Yes, a little of the time; Yes, some of the time; Yes, most of the time; Yes, all of the time
- How much of the time during the past four weeks:
  - Have you felt calm and peaceful?
  - Did you have a lot of energy?
  - Have you felt downhearted and blue?
    Answers: All of the time; Most of the time; A good bit of the time; Some of the time; A little of the time; None of the time
- During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
  Answers: All of the time; Most of the time; A good bit of the time; Some of the time; A little of the time; None of the time
- Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed, or irritable) in general now?
  Answers: Much better; Slightly better; About the same; Slightly worse; Much worse

Measure best practices

- Administer PHQ-2 and PHQ-9 Mental Health Assessments.
- Check in with patient's mental/emotional health at each visit, asking about stress, loneliness or any big life changes that have occurred and may be causing uneasiness.
- Provide written materials regarding mental well-being and identify local resources.
- Connect patients to resources that may be able to assist (e.g., Humana Community Navigator).

Reducing the Risk of Falling (ROF)

Reducing the Risk of Falling (ROF) MY25 | Weight = 1

Overview

Percentage of Medicare patients 65 years of age and older who have had a fall or had problems with balance or walking, were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner

Patient survey questions

- A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?
  Answers: Yes; No
- Did you fall in the past 12 months?
  Answers: Yes; No
- In the past 12 months, have you had a problem with balance or walking?
  Answers: Yes; No
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
  - Suggest that you use a cane or walker
  - Suggest that you do an exercise or physical therapy program
  - Suggest a vision or hearing test (Yes; No)

Exclusions

- Patients in hospice
- Patients responding, "I had no visits in the past 12 months"

Measure best practices

- Take advantage of, and share, the Centers for Disease Control and Prevention's (CDC) "Stopping Elderly Accidents, Deaths and Injuries" (STEADI) online training and materials.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- If recommending exercises specific to fall risk, write down clear instructions and give the patient informational pamphlets demonstrating the exercises.
- Assess patients' risk factors and share information and resources that might assist in reducing the risk of falls in their homes and daily lives.

Humana Patient Experience (PE) Survey*

The Humana Patient Experience Survey is a voice-automated telephone call to Humana members following an in-person visit with their healthcare provider. The survey questions are similar to the content of the CAHPS survey and HOS administered by the CMS to MA members. The CMS CAHPS/HOS surveys for health plans are measured at the contract level and individual response data is not available as it relates to provider performance. Because of this, Humana's PE Survey questions are informed by the CMS surveys but are phrased, organized and implemented differently to provide more focus on measures that can be impacted by providers. The overall purpose of the Humana Patient Experience Survey is to help providers gain insights into how they can partner with Humana on strategies to improve the overall experience of patients.

Humana PE Survey (measured January–December)	ABBR	Weight
Coordination of Care	CC	5.5x**
Getting Needed Care	GNC	5.5x**
Getting Care Quickly	GCQ	5.5x**
Patient Discussion		4.5x**
Monitoring Physical Activity	MPA	1x**
Improving or Maintaining Mental Health	IMMH	1.5x**
Reducing the Risk of Falls	ROF	1x**
Improving Bladder Control	IBC	1x**

* Not included as part of CMS Star Ratings, applicable for provider performance

** Humana-established weights, not CMS-established

Note: Humana's Patient Experience Survey is influenced by CAHPS and HOS, but the questions are specific to CAHPS and HOS measures that Humana has deemed provider-impacted.

In addition, the questions in the Humana Patient Experience Survey measure a different aspect of experience than CAHPS and HOS. CAHPS and HOS ask respondents to evaluate the totality of their care received over specific timeframes, whereas the Humana Patient Experience Survey asks respondents to evaluate one particular visit.

Because Humana's Patient Experience Survey focuses on specific measures from CAHPS and HOS as well as a different aspect of experience, the specific weighting of the Humana Patient Experience Survey does not match the weighting CMS uses for CAHPS and HOS.

If interested in learning more about Humana's Patient Experience survey, please register for one of our live-session webinars with the following link:
https://humana.zoom.us/webinar/register/WN_yN_nm09OQZGaizTA1y7tjw

Contents

Coordination of Care (CC)

Humana PE Survey Weight = 5.5

Overview
Assesses how well patient care is coordinated, including whether or not doctors had conversations about a patient's medicines as well as how informed personal doctors are about any specialist care their patients received

Humana PE survey questions

- Did your personal doctor talk about all the prescription medicines you were taking?
  Answers: Yes; No; Doesn't apply
- Did your personal doctor seem informed and up to date about the care you got from specialists?
  Answers: Yes; No; Doesn't apply

Measure best practices

- When sending out pre-appointment reminders, encourage patients to bring a list of all their current medications and supplements to their appointment.
- Have patients confirm their up-to-date medications and supplements at each appointment in their pre-appointment paperwork.
- Discuss medications in detail with patients to ensure they understand doctor instructions and any potential interactions, and inquire if patients are experiencing any side effects from medications and if they are struggling to pay for their medications.
- Include detailed medication instructions for patients in the after-visit summary, and consider using plain language when writing instructions.
- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/services where available. If specialist follow-up care cannot be scheduled when your patient is in your office, give him/her the names and phone numbers of specialists.
- Contact patients with the results of any screenings as soon as they are available, and schedule any necessary follow-up care.

Getting Needed Care (GNC)

Humana PE Survey Weight = 5.5

Overview
Assesses how easy it was for patients to get a referral to see a specialist from their personal doctor (if necessary)

Humana PE Survey questions

- Did you have any trouble getting a referral from your personal doctor to see a specialist?
  Answers: Yes; No; Doesn't Apply

The following questions are asked to gauge Humana members' experience with their health plan and prescription drug plan. These questions are not included in a provider's Patient Experience Rating (PER) received from Humana.

- Did you have trouble with your prescription drug plan covering any medication your doctor prescribed?
  Answers: Yes; No; Doesn't Apply
- Did you have problems getting approval through your health plan for any tests, care or treatment your doctor said you needed?
  Answers: Yes; No; Doesn't Apply

Measure best practices

- Ensure office staff has processes in place to assist with specialist referrals. Leverage referral center/services where available.
- If office staff is assisting with scheduling specialist appointments, consider using specialist reminder cards to give to the patients as part of the after-visit summary. If specialist follow-up care cannot be scheduled when your patient is in your office, give him/her the names and phone numbers to call for an appointment.
- Utilize interoperability or data-sharing functionality within your EHR to assist with real-time prior authorization.

Getting Care Quickly (GCQ)

Humana PE Survey Weight = 5.5

Overview
Assesses how quickly the patients were able to get appointments and care

Humana PE Survey questions
- Did you experience any difficulty scheduling your appointment?
  Answers: Yes; No; Doesn't apply
- How long after your scheduled appointment time did you wait in the waiting room and exam room to see the person you came to see?
  Answers: 0-15 minutes; 15-30 minutes; 30-60 minutes; 60 or more minutes

Measure best practices

- If possible, schedule a patient's follow-up visit before the patient leaves their appointment.
- Utilize online appointment scheduling as an alternative to having patients call in to the office for scheduling.
- Consider adding extended or flex office hours on certain days to accommodate patients with difficulties being seen during normal business hours.
- Try to take patients back to the exam room within 15 minutes of their scheduled appointment time even if they aren't seeing the physician right away.

Monitoring Physical Activity (MPA)

Patient Discussion • Humana PE Survey Weight = 1

Overview
Patients are asked if they received advice from their doctor to start, increase or maintain their level of exercise or physical activity

Humana PE Survey question
- Did your doctor or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity?
  Answers: Yes; No

Measure best practices
- Determine if it is appropriate for your patients to start, maintain or increase their level of physical activity based on their overall health, and have relevant discussions with the patient.
- Include any recommended activity with frequency and duration in the patient after-visit summary and ensure they have a physical copy of the goals/plan for maintaining or increasing activity.
- Share handouts or items patients can keep or have in their homes to help them remember the conversation for the survey.

Improving or Maintaining Mental Health (IMMH)

Patient Discussion • Humana PE Survey Weight = 1.5

Overview

Patients are asked if they've talked to their doctors about how to manage their mental health. Patients are asked an introductory question that allows them to identify if they've had any recent mental health struggles. If they answer "yes," they will be asked the Humana PE Survey question. If they answer "no," it will skip the question.

Humana PE Survey question

- Has your doctor or other healthcare provider talked to you about how to manage your mental or emotional health?
  Answers: Yes; No

Measure best practices

- Administer PHQ-2 and PHQ-9 Mental Health Assessments.
- Check in with patients' mental/emotional health at each visit, asking about stress, loneliness or any big life changes that have occurred and may be causing uneasiness.
- Provide written materials regarding mental well-being and identify local resources.
- Connect patients to resources that may be able to assist (e.g., Humana Community Navigator).

Improving Bladder Control (IBC)

Patient Discussion • Humana PE Survey Weight = 1

Overview
Patients are asked about conversations with their provider about urine leakage. If patients answer that this is not an applicable topic for them, the second question will be skipped.

Humana PE survey questions

- Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?
  Answers: Yes; No; Not applicable
- Has your doctor, nurse or other healthcare provider talked to you about ways to control or manage leaking urine, including bladder training exercises, medication and surgery?
  Answers: Yes; No

Measure best practices

- Discuss bladder control issues and symptoms with your older patients, including during telehealth visits, and consider ways to destigmatize the topic.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- Determine if exercise or other treatment options such as medications, bladder control products or surgery may help.
- If recommending specific bladder exercises, write down clear instructions along with informational pamphlets demonstrating the exercises.

Reducing the Risk of Falls (ROF)

Patient Discussion • Humana PE Survey Weight = 1

Overview

Patients are asked about conversations with their provider about fall risk. They are asked an initial gatekeeper question about balance, and the two questions below are skipped if the member answers "No."

Humana PE survey questions

- Did your doctor or other healthcare provider talk to you about falling or problems with balance or walking?
  Answers: Yes; No; Doesn't apply
- Did your doctor or other health provider suggest any treatment, such as using a cane or walker, having your blood pressure checked or having regular vision or hearing tests?
  Answers: Yes; No

Measure best practices

- Take advantage of, and share, the CDC's "Stopping Elderly Accidents, Deaths and Injuries" (STEADI) online training and materials.
- Consider having questions on this topic in questionnaires, as these allow the patient to note potential issues that can be brought up to the doctor to discuss.
- If recommending exercises specific to fall risk, write down clear instructions along with informational pamphlets demonstrating the exercises.
- Assess patients' risk factors and share information and resources that might assist in reducing the risk of falls in their homes and daily lives.

Patient Safety

Patient Safety includes measures to assess prescription drug plan (Part D) quality and performance in the Star Rating Program. The Patient Safety measures monitor Part D services to ensure the safety of Medicare Advantage enrollees. These measures are developed and endorsed by the PQA. They apply to both Medicare Advantage prescription drug (MAPD) plan and prescription drug-only plans (PDP). When a prescription is filled under a Medicare Part D plan, a prescription drug event (PDE) is submitted to CMS by Medicare Advantage organizations, such as Humana. Only PDE information is used by CMS to evaluate these measures; therefore, no quality reporting is required by physicians.

Patient Safety (measured January–December)	ABBR	Weight
Medication Adherence		
Cholesterol (statins)	MAC	3x
Diabetes Medication	MAD	3x
Hypertension (ACE/ARB)	MAH	3x
Statin Use in Persons with Diabetes	SUPD	1x
Concurrent Use of Opioids and Benzodiazepines	COB	1x
Use of Multiple Anticholinergic (ACH) Medications in Older Adults	POLY-ACH	1x
Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults	POLY-CNS	Display

Changes to Patient Safety

- **Use of Multiple Anticholinergic Medications in Older Adults** moves from display to now weighted 1x
- **Concurrent Use of Opioids and Benzodiazepines** moves from display to now weighted 1x

Contents

Medication Adherence (MA)

CMS uses a metric called proportion of days covered, or PDC, to determine medication adherence. PDC is determined by dividing the days of medication coverage—which is determined based on the claims billed to the insurance plan—by the number of days in the period being measured. The specific number of days included in the measurement period, or calendar year, is determined based on the start date of the medication.

If a patient's PDC is greater than or equal to 80%, the patient is deemed adherent. A rate lower than 80% is considered nonadherent. The PDC threshold of 80% is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit based on clinical evidence.*

Measure best practices

- Conduct open discussions with patients to identify and resolve patient-specific adherence barriers.
- Reinforce patients' understanding of the role of diabetes, cholesterol and hypertension medications in their therapy and the expected duration of the therapy.
- Ask if transportation to the pharmacy is an issue. Retail 90-day fills may offer less frequent trips to the pharmacy or eliminate them altogether in the case of mail delivery.
- Encourage adherence by providing a 90-day prescription for maintenance drugs.
- Provide an updated prescription to the pharmacy if the patient's medication dose has changed since the original prescription.
- Refer patients to Humana.com/TakeMyMedicine for adherence tips and tools.

Brain health

Association of medication adherence quality measures Measures for diabetes, hypertension and hyperlipidemia compliance thresholds have continued to increase year over year.** Humana performance in these measures has been declining compared to previous years. Humana Healthcare Research (HHR) conducted a retrospective claims-based study involving nearly 100,000 older adults living with all three of these conditions to examine the relationship with medication nonadherence. The data looked at calendar years 2018, 2019 and 2020, which was equal to nine total measures (three measures over three years).

Members who missed one medication adherence measure, compared to those who didn't miss any, had a:

- **23% increased risk** of cognitive decline
- **27% increased risk** of Alzheimer's disease
- **33% increased risk** of dementia

Patients who missed two to three medication adherence quality measures had:

- **Almost twice the increased risk** for developing Alzheimer's disease
- **58% increased risk** of dementia

Patients who missed four or more adherence measures had:

- **The greatest odds** of cognitive decline with double the risk of dementia
- **148% increased risk** of Alzheimer's disease

Not achieving compliance for MA measures for these conditions was associated with increased risk of cognitive decline disorders.

* www.cms.gov
** PubMed

Medication Adherence (MA)

Medication Adherence for Cholesterol (Statins) (MAC) MY25 | Weight = 3

Measurement period
January–December

Overview
Proportion of days covered: Statins (PDC–STA/MAC)

Percentage of patients 18 years of age and older with Part D benefits with at least two cholesterol medication (a statin drug) prescription fills on unique service dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication

Exclusions
- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis

Medication Adherence for Diabetes Medications (MAD) MY25 | Weight = 3

Measurement period
January–December

Overview
Proportion of days covered: Diabetes all-class rate (PDC–DR/MAD)

Percentage of patients 18 years of age and older with Part D benefits with at least two diabetes medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
- Drug therapy across these classes of diabetes medications are included in this measure: biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)-IV inhibitors, incretin mimetics, meglitinides and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Exclusions
- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis
- Patients who had filled a prescription for insulin after measure eligibility

Medication Adherence for Hypertension (ACE/ARB) (MAH) MY25 | Weight = 3

Measurement period
January–December

Overview
Proportion of days covered: renin angiotensin system antagonists (PDC–RASA/MAH)

Percentage of patients 18 years of age and older with Part D benefits with at least two high blood pressure medication prescription fills on unique dates who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication
- Blood pressure medication therapy programs for these renin angiotensin system (RAS) antagonists are included in this measure: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB) or direct renin inhibitor medications.

Exclusions
- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis
- Prescription(s) filled for Entresto® (sacubitril/valsartan) after measure eligibility

Concurrent Use of Opioids and Benzodiazepines (COB)

Concurrent Use of Opioids and Benzodiazepines (COB) MY25 | Weight = 1

Measurement period
Jan. 1–Dec. 31 of the measurement year

Eligible population
Patients 18 years of age and older:
- Enrolled in a Part D plan
- Having had two or more fills for opioids on different dates of service (claims can be for same or different opioids)
- And with 15 or more cumulative days' supply during measurement year
  - With no more than one gap in enrollment of up to 31 days during the measurement year
  - The earliest date of service can be no more than 30 days from the last day of the measurement year (Jan. 1–Dec. 2)

Only paid, irreversible prescription claims are included in the data set to calculate the measure.

Service required
- CMS wants to ensure patients are not taking opioids and benzodiazepines together with overlapping days' supply for 30 or more cumulative days during the measurement period.
- A patient moves into the numerator if there are two or more claims of any benzodiazepine on different dates of service and concurrent use of opioids and benzodiazepines for 30 or more cumulative days.
- The patient does not enter the numerator if:
  - The number of fills for each drug is less than two, or
  - The number of overlapping days' supply is less than 30 cumulative days

Exclusions
- Patients with cancer, sickle cell disease or palliative care during the measure year if there is at least one claim in the primary diagnosis or other diagnosis fields during the measure year
- Patients in hospice or using hospice services
- Hospice patients are identified in the enrollment database if there is at least one hospice claim, encounter or medical record during the measure year

Measure best practices

- Review patient medications regularly, especially those that utilize specialists and receive care through other facilities such as hospitals and urgent care clinics.
- Utilize standard criteria, such as the Beers Criteria, to identify medications that should not be taken together.
- Monitor the use of high-risk medications in patients and work with them to discontinue any that are inappropriate or should not be taken with other prescribed medications.
- Ensure patient records include clear documentation and that patients have a strong understanding of the direction given to them on discontinuing medications.
- Work with the patient's pharmacy to ensure no additional refills are available on discontinued medications.

Statin Use in Persons with Diabetes (SUPD)

Statin Use in Persons with Diabetes (SUPD) MY25 | Weight = 1

Measurement period
Calendar year

Eligible population
Patients 40–75 years of age with diabetes who were:
- Dispensed at least two diabetic prescription fills on unique dates during the measurement year
- Dispensed a statin medication fill during the measurement year

Service required
- At least one fill for a statin medication of any intensity in the measurement year

Exclusions
- Patients in hospice or using hospice services
- Patients with end-stage renal disease (ESRD) or dialysis
- Patients with rhabdomyolysis or myopathy
- Patients who are pregnant or lactating or undergoing therapy for fertility (clomiphene)
- Patients with cirrhosis
- Patients with prediabetes
- Patients with polycystic ovary syndrome (PCOS)

Measure best practices
- Ensure a comprehensive review of new to practice/new to Medicare patients who have been diagnosed with diabetes to evaluate their current statin therapy.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with diabetes, especially those who are also receiving care from specialists to ensure there is a process for evaluating current statin therapy and ensuring they are on a medium- to high-dose therapy.

Polypharmacy

Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH)

Use of Multiple Anticholinergic Medications in Older Adults (POLY–ACH)
MY25 | Weight = 1

Measurement period
Jan. 1–Dec. 31 of the measurement year

Eligible population
Patients 65 years of age and older who are enrolled in a Part D plan and have had two or more fills of same ACH medication on different dates of service, with no more than one gap in enrollment of up to 31 days during the measurement year*

Service required
CMS wants to ensure patients are not taking two or more unique ACH medications and have an overlapping days' supply for 30 or more cumulative days during the measurement period.

The patient does not enter the numerator if the number of fills for each unique ACH drug is less than two or the number of overlapping days' supply is less than 30 cumulative days.

Exclusions
- Patients in hospice care during the measurement period
- Hospice patients are identified in the enrollment database if there is at least one hospice claim, encounter or medical record during the measure year

Measure best practices
- Review all patients' medication lists at every visit and specifically review patient medical records when they are taking a medication that falls on the POLY–ACH measure drug list. Ensure there are not other medications that should not be taken with the POLY medication. If there is a conflict, work with the patient to ensure one medication is discontinued.
- Before prescribing a new medication, check to see if it falls on the POLY–ACH measure drug list and review all patient-reported medications and what is notated in the patient charts.
- Minimize negative outcomes when POLY–ACH medications cannot be avoided by utilizing the lowest dose and frequency.
- Ensure medications have limits to supply and/or duration.
- Document risks in the patient's chart and discuss. Ensure the patient has written documentation of the concern and the potential harmful effects.
- Review medications at each visit for polypharmacy and consider removal or replacement with a clinical alternative.

* The earliest service date can be no more than 30 days from the last day of the measurement year (Jan. 1–Dec. 2).

Polypharmacy

Use of Multiple Central Nervous System-Active Medications in Older Adults (POLY–CNS)

Use of Multiple Central Nervous System-Active Medications in Older Adults (POLY–CNS) MY25 | Weight = Display

Measurement period
Jan. 1–Dec. 31 of the measurement year

Eligible population
Patients 65 years of age and older:

- Enrolled in a Part D plan
- Having had two or more fills of the same CNS medication on different dates of service
  - With no more than one gap in enrollment of up to 31 days during the measurement year
  - The earliest date of service can be no more than 30 days from the last day of the measurement year (Jan. 1–Dec. 2)

Service required
CMS wants to ensure patients are not taking three or more unique CNS medications that have overlapping days' supply for 30 or more cumulative days during the measurement period.

The patient does not enter the numerator if the number of fills for each unique CNS drug is less than three or the number of overlapping days' supply is less than 30 cumulative days.

Exclusions

- Patients with a seizure disorder diagnosis during the measurement period
- Hospice patients in care during the measurement period are excluded if they are identified in the hospice enrollment database or if there is at least one hospice claim, encounter or medical record during the measure year.

Measure best practices

- Review all patients' medication lists at every visit and specifically review patient medical records when they are taking a medication that falls on the POLY–CNS measure drug list. Ensure there are not other medications that should not be taken with the POLY medication. If there is a conflict, work with the patient to ensure one medication is discontinued.
- Before prescribing a new medication, check to see if it falls on the POLY–CNS measure drug list and review all patient-reported medications and what is notated in the patient charts.
- Minimize negative outcomes when POLY medications cannot be avoided by utilizing the lowest dose and frequency.
- Ensure medications have limits to supply and/or duration.
- Document risks in chart and discuss with the patient. Ensure the patient has written documentation of the concern and the potential harmful effects.
- Review medications each visit for polypharmacy and consider removal or replacement with a clinical alternative. Avoid unless safer drug alternatives and nonpharmacological strategies have been ineffective.
- Consider reducing use of other CNS-active medications.
- Consider tapering to avoid symptom recurrence and discontinuation syndromes.

Additional operational categories*

Improvement measures how a plan's performance has improved from one year to the next. Improvement measures, unlike other Star measures, are not based on a data set of their own. Rather, improvements are determined by comparing the current year performance of eligible Star measures against the prior year. Eligible measures will be rated only if there is enough data to determine significant improvement or a decline of 50% or greater.

Improvement	ABBR	Weight
Part C Improvement	HPQI	5x
Part D Improvement	DPQI	5x

The Independent Review Entity (IRE) is an independent entity (currently Maximus) contracted by CMS to review Medicare health and drug plans' response to appeals and denials. These measures review the timeliness of responses on appeals as well as whether the IRE agrees with the carrier decision to deny claims.

IRE	ABBR	Weight
Timely Decisions About Appeals	PTD	2x
Reviewing Appeals Decisions	RAD	2x

Operational categories are tied to specific information that is used by CMS to measure quality or performance. For example, prescription claims data is used to determine drug safety.

CMS	ABBR	Weight
Medicare Plan Finder Accuracy	MPF	1x
Call Center-Foreign Language Interpreter and TTY/TDD Part C	FLIC	2x
Call Center-Foreign Language Interpreter and TTY/TDD Part D	FLID	2x
Complaints about the Health/Drug Plan	CHPC/CHPD	2x
Comprehensive Medication Review	CMR	Display
Special Needs Care Management	SNP	1x
Members Choosing to Leave the Plan	MLPC/MLPD	2x

* Measures are a part of the MA plan Star Rating but not influenced by providers.

Contents

Glossary

Baseline survey
For the Health Outcomes Survey (HOS), the baseline survey is the first of two surveys performed to assess the patient's perception of their own health. The same population, or cohort, of patients will receive a follow-up survey two years later.

Bonus year (BY)
Bonus year is the year in which CMS pays bonuses for currently enrolled patients based on the prior calendar year's rating.

CAHPS
CAHPS® is the Consumer Assessment of Healthcare Providers and Systems. It is conducted on behalf of CMS. CAHPS is a survey that assesses consumers' experiences with the quality of healthcare and plan services and is focused on Medicare Advantage and prescription drug plans.

CMS
The Centers for Medicare & Medicaid Services.

Composite measures
Composite measures are only applicable to the CAHPS survey. The pass rate for these measures is determined by the responses to multiple questions. The rate for each question is calculated and those rates are averaged into a combined, or composite, score for the measure.

CPT
Current Procedural Terminology (CPT®) codes are developed by the American Medical Association (AMA). CPT Category I codes are used to communicate a procedure or service administered to a patient. CPT Category II codes are supplemental codes used for quality performance measurement.

Cut points
Cut points—also known as thresholds—are established to determine performance based on the percentage of patients that must be in compliance to achieve a certain Star Rating. Thresholds are established by CMS for each year and are updated to reflect significant changes in industry performance and distribution of scores.

Denominator
Denominator includes the eligible population or events being assessed via a measure.

Discussion measures
Discussion measures apply to the HOS and assess how well physicians are doing in initiating discussion of certain health topics and addressing them with their patients.

Display measures
Display measures do not currently impact a Medicare Advantage plan's Star Rating. In some cases, these are former Star measures that have been transitioned to display. However, most of them are new measures being tested before they are designated as a Star measure, or they are on display for informational purposes only. If they become a Star measure, they would then be assigned one of the Star measure types (outcome or intermediate outcome).

Exclusions
Exclusions are the CMS-determined criteria that exempt a Medicare Advantage patient or an event from being included when determining pass rate of a measure.

Follow-up survey
For HOS, the follow-up survey is the second of two surveys performed to assess the patient's perception of their own health. Patients who completed a baseline survey two years prior and remained on the same MA contract will receive the follow-up survey.

HCPCS
HCPCS is the Healthcare Common Procedure Coding System used by CMS and maintained by the AMA.

HEDIS
Healthcare Effectiveness Data and Information Set is a registered trademark of the National Committee for Quality Assurance (NCQA). It is a set of standardized performance measures designed to help compare the performance of health plans on an "apples-to-apples" basis. The details of its measures can change annually. It is governed by NCQA. HEDIS measure performance is used to determine clinical quality performance.

HOS
Health Outcomes Survey is an annually reported outcome survey conducted on behalf of CMS. It assesses the ability of a Medicare Advantage organization (MAO) to maintain or improve its patients' physical and mental health, as well as ascertain if physicians are having meaningful discussions with patients on certain health topics.

ICD-10-CM
ICD-10-CM is the International Classification of Diseases, Tenth Revision, Clinical Modification developed by the World Health Organization and provided by CMS and the National Center for Health Statistics (NCHS).

Improvement measures
Improvement measures, unlike other Star measures, are not based on a data set of their own, but rather are determined by comparing the current year performance of eligible Star measures against the prior year. Eligible measures will be rated only if there is enough data to determine significant improvement or decline of ≥ 50%. There are two measures—one for Part C and one for Part D. These measures both have a weight of five.

Improvement survey measures
Improvement survey measures apply to the HOS and are used to assess whether a patient's self-reported physical and/or mental health has improved or declined between the two survey periods: baseline and follow-up.

IRE
IRE is an Independent Review Entity. Currently CMS' IRE is Maximus.

MAO
Medicare Advantage organization

MAPD
Medicare Advantage prescription drug plan

Measure year (MY)
Measure year or measurement year is the period of time when patients are receiving their screenings, filling prescriptions and responding to surveys. Information regarding this activity is being exchanged with CMS or the IRE.

Metric
Metric is the methodology used to assess a particular measure as it pertains to Medicare Advantage members.

Numerator
Numerator includes the patients or events for a specific test, screening or survey that are used to determine measure compliance or pass rates.

Operational categories
Operational categories are tied to specific information that is used by CMS to measure quality or performance. For example, prescription claims data is used to determine drug safety.

Outcome measures
Outcome measures reflect improvements in a patient's health and are central to assessing quality of care. These measures are all triple-weighted. Improving or Maintaining Physical Health and Improving or Maintaining Mental Health are both outcome measures.

Overall rating
The overall rating of a plan is calculated using the weighted average Star Ratings of the included measures. It is not an aggregate of the summary rating. This is the rating that will be visible on Medicare Plan Finder when patients are choosing their plan.

Part C
Part C measures evaluate the health or medical portion of an MAPD plan and make up the Part C summary rating.

Part D
Part D relates to prescription drug plan services. Part D measures are used when assessing both prescription drug plan (PDP) and Medicare Advantage prescription drug (MAPD) plans. These measures make up the Part D summary rating for these plans. In the case of a PDP, these measures make up both the Part D summary rating and the overall rating of the plan.

Pass rate
Pass rate is the resulting percentage of a measure when assessed and is also referred to as a compliance rate. For most measures, a higher rate indicates better performance. However, there are inverse measures, such as Plan All-Cause Readmissions, for which a lower rate indicates better performance.

Patient Safety
Patient Safety is the operational category used to assess quality and performance of drug plan services. The Pharmacy Quality Alliance (PQA) oversees the Patient Safety category.

PDP
Prescription drug plan

PQA
Pharmacy Quality Alliance

Process measures
Most Star measures are process measures. These measures must have a process in place to gather information—primarily from healthcare providers—that will be reported to CMS to demonstrate services are being provided to improve, maintain or monitor the health of Medicare Advantage patients. Process measures are single-weighted.

Quality bonus
Quality bonuses are earned on plans rated four stars or higher and are invested back into Medicare Advantage plans to provide more benefits and services to members.

Rating year
Rating year is the plan year (Jan. 1–Dec. 31) for which a Star Rating is in effect. MAOs learn their plans' Star Ratings in October of the prior year, just before AEP, which is the Annual Election Period (AEP) for MA patients.

Reporting year
Reporting year is when data from all plan administrators is being submitted to and collected by CMS.

Thresholds
Thresholds—also known as cut points—are established to determine performance based on the percentage of patients that must be in compliance to achieve a certain star level. Thresholds are established by CMS for each year and are updated to reflect significant changes in industry performance and distribution of scores.

Measure thresholds

CMS defines cut points, also known as thresholds, as measurement ranges that determine Star Ratings. Thresholds are established to determine performance based on the percentage of compliant patients to achieve a certain Star level. Thresholds are established by CMS for each year and are updated to reflect significant changes in industry performance and distribution of scores.

HEDIS	**BY24**		**BY25**		**BY26**	
Measure	**4 star**	**5 star**	**4 star**	**5 star**	**4 star**	**5 star**
Breast Cancer Screening (BCS-E)	70%	77%	71%	79%	75%	82%
Care for Older Adults – Functional Status Assessment (COA–FSA)	N/A	N/A	N/A	N/A	N/A	N/A
Care for Older Adults – Medication Review (COA–MDR)	82%	93%	87%	98%	92%	98%
Care for Older Adults – Pain Assessment (COA–PNS)	85%	94%	90%	96%	92%	96%
Colorectal Cancer Screening (COL-E)	71%	79%	71%	80%	75%	83%
Eye Exam for Patients With Diabetes (EED)	71%	79%	73%	81%	77%	83%
Kidney Health Evaluation for Patients With Diabetes (KED)	N/A	N/A	N/A	N/A	N/A	N/A
Glycemic Status Assessment for Patients With Diabetes (GSD)	75%	83%	80%	87%	84%	90%
Controlling High Blood Pressure (CBP)*	73%	80%	74%	82%	80%	85%
Osteoporosis Management in Women Who Had a Fracture (OMW)	55%	73%	50%	68%	52%	71%
Plan All-Cause Readmissions (PCR)†	N/A	N/A	10%	8%	10%	8%
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)‡	N/A	N/A	60%	68%	60%	69%
Statin Therapy for Patients With Cardiovascular Disease (SPC)	85%	89%	86%	90%	88%	92%
Transitions of Care – Medication Reconciliation Post-Discharge (TRC–MRP)	69%	82%	68%	82%	73%	87%
Transitions of Care – Composite (TRC)	N/A	N/A	64%	78%	63%	77%
Patient Safety: Medicare Advantage prescription drug (MAPD) plan values						
Medication Adherence for Diabetes Medications (MAD)	88%	92%	88%	90%	87%	91%
Medication Adherence for Hypertension (MAH)	89%	91%	89%	91%	90%	92%
Medication Adherence for Cholesterol (MAC)	88%	92%	88%	91%	89%	93%
Statin Use in Persons with Diabetes (SUPD)	86%	90%	88%	92%	89%	93%

* CBP was on display MY20/BY23 and returned to the Star Rating Program starting with MY21/BY24.
† PCR was on display starting with MY19/BY22 and returned to the Star Rating Program in MY22/BY25. For PCR, lower percentages reflect better performance.
‡ FMC is new for MY22/BY25.

CMS: Medicare Advantage prescription drug (MAPD) plan values	BY24		BY25		BY26	
MTM Program Completion Rate for Comprehensive Medication Review (CMR)	82%	89%	85%	92%	89%	93%
CAHPS: Due to CMS Interim Final Rule 1744, BY22 cut points did not change						
Annual Flu Vaccine (FLU)	75%	79%	74%	78%	71%	76%
Care Coordination (CC)	86%	87%	86%	87%	87%	88%
Customer Service (CS)	91%	92%	90%	92%	91%	92%
Getting Appointments and Care Quickly (GACQ)	78%	80%	78%	80%	84%	86%
Getting Needed Care (GNC)	82%	84%	81%	83%	82%	83%
Getting Needed Prescription Drugs (GNRx)	91%	92%	90%	91%	90%	91%
Rating of Drug Plan (RDP)	87%	88%	87%	89%	87%	89%
Rating of Health Care Quality (RHCQ)	87%	88%	87%	88%	87%	88%
Rating of Health Plan (RHP)	88%	89%	88%	89%	88%	89%
HOS: Health Outcomes Survey						
Improving/Maintaining Physical Health (IMPH)	N/A	N/A	N/A	N/A	N/A	N/A
Improving/Maintaining Mental Health (IMMH)	N/A	N/A	N/A	N/A	N/A	N/A
Monitoring Physical Activity (MPA)	53%	57%	53%	58%	52%	60%
Improving Bladder Control (IBC)	48%	53%	47%	51%	48%	52%
Reducing the Risk of Falling (ROF)	60%	69%	60%	70%	63%	73%

Source of measure pass rates and weights: "Medicare 2024 Part C & D Star Ratings Technical Notes"

Coding

BCS-E coding

Return to BCS-E page

Code	Code type	Definition
77061–77063	CPT	Breast, mammography
77065	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	CPT	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	CPT	Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed

CBP coding

Return to CBP page

Code	Code type	Definition
3074F	CPT II	Systolic: blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD)
3075F	CPT II	Systolic: blood pressure 130–139 mm Hg (DM)
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
3078F	CPT II	Diastolic: blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
3079F	CPT II	Diastolic: blood pressure 80–89 mm Hg (HTN, CKD, CAD) (DM)
3080F	CPT II	Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)
99457	CPT	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

COL-E coding

Return to COL-E page

Code	Code type	Definition
82270, 82274	CPT	**Pathology/laboratory codes:** Fecal occult blood test between Jan. 1 and Dec. 31 of the current year
G0328	HCPCS	**Pathology/laboratory codes:** Fecal occult blood test between Jan. 1 and Dec. 31 of the current year
81528	CPT	Cologuard (FIT-DNA) test between Jan. 1 two years prior and Dec. 31 of the current year
45330–45335, 45337, 45338, 45340–45342, 45346, 45347, 45349, 45350	HCPCS	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year
G0104	CPT	**Surgery/hospital codes:** Flexible sigmoidoscopy between Jan. 1 four years prior and Dec. 31 of the current year

COL-E coding

Return to COL-E page

74261–74263	CPT	CT colonography between Jan. 1 four years prior and Dec. 31 of the current year
44388, 44391–44394, 44397, 44401–44408, 45355–45393, 45398	CPT	Colonoscopy between Jan. 1 nine years ago and Dec. 31 of the current year
G0105, G0121	HCPCS	Colonoscopy between Jan. 1 nine years ago and Dec. 31 of the current year
708699002	SNOMED	Colorectal cancer detected by DNA-based stool screening (finding)
841000119107	SNOMED	History of flexible sigmoidoscopy (situation)
851000119109	SNOMED	History of colonoscopy (situation)
119771000119101	SNOMED	History of total colectomy (situation)

EED coding

Return to EED page

Code type	Code
Most common CPT codes for diabetic retinal screening	
CPT	92002, 92004, 92012, 92014, 92134, 92225, 92228, 92230, 92250, 92260
Other CPT codes for diabetic retinal screening	
CPT	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92018, 92019, 92201, 92202, 92229, 92235, 92240, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
CPT code for automated eye exam	
CPT	92229
Without evidence of retinopathy**	
CPT II	2023F, 2025F, 2033F, 3072F
With evidence of retinopathy	
CPT II	2022F, 2024F, 2026F
HCPCS	S0620, S0621, S3000
ICD-10-CM to report diabetes mellitus without complications	
ICD-10-CM	E10.9, E11.9, E13

** When negative retinopathy results are reported for a patient, he or she will be compliant for the measurement year in which the testing occurred through the end of the following measurement year.

GSD coding

Return to GSD page

Code	Code type	Definition
3044F, 3046F*, 3051F, 3052F	CPT II	Physician codes. **Note:** These codes count for both the HbA1c test and HbA1c level
83036, 83037	CPT	Pathology/laboratory codes. **Note:** Pathology/laboratory codes count for the HbA1c test measure. They must include the result value to count for the HbA1c poor control measure.
97506-0	LOINC	Glucose management indicator

** Code indicates results that do not meet Star measure control levels and will not fully address care opportunities. However, this code should be used to verify that the test was performed and for monitoring/reporting of results.*

KED coding

Return to KED page

Blood test	AND	Urine test (must include both quantitative albumin and urine creatinine)		
		Option 1	Option 2	
Estimated glomerular filtration rate lab test (eGFR)		Urine albumin-creatinine ratio (uACR)	Quantitative urine albumin lab test	Urine creatinine lab test
CPT: 80047, 80048, 80050*, 80053, 80069, 82565		LOINC: 13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7	CPT code 82043	CPT code 82570
			If submitting two urine tests: • One must be quantitative urine albumin lab test • The other must be urine creatinine lab test • The two test dates must be within the measurement year and the test dates must be within four days of each other	

** 80050 is a general health panel; providers must share the components of the panel for Humana to pay.*

COA Coding

Return to COA page

Code	Code type	Definition
COA – Functional Status Assessment (FSA)		
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on care-giving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
1170F	CPT II	Functional status assessed
G0438	HCPCS	Annual Wellness Visit, includes a personalized prevention plan of service (PPS), initial visit
G0439	HCPCS	Annual Wellness Visit, includes a personalized prevention plan of service (PPS), subsequent visit

COA coding

Return to COA page

COA – Medication Review (MDR)		
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on care-giving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99495	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit within 14 calendar days of discharge
99496	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge
99605	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, new patient
99606	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, established patient
1159F	CPT II	Medication list documented in medical record
1160F	CPT II	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
G8427	HCPCS	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

OMW coding

Return to OMW page

Code	Code type	Definition
76977	CPT	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
77078	CPT	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77080	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77085	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment
77086	CPT	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
BP48ZZ1	ICD-10-PCS	Ultrasonography of right shoulder, densitometry
BP49ZZ1	ICD-10-PCS	Ultrasonography of left shoulder, densitometry
BP4GZZ1	ICD-10-PCS	Ultrasonography of right elbow, densitometry
BP4HZZ1	ICD-10-PCS	Ultrasonography of left elbow, densitometry
BP4LZZ1	ICD-10-PCS	Ultrasonography of right wrist, densitometry
BP4MZZ1	ICD-10-PCS	Ultrasonography of left wrist, densitometry
BP4NZZ1	ICD-10-PCS	Ultrasonography of right hand, densitometry
BP4PZZ1	ICD-10-PCS	Ultrasonography of left hand, densitometry
BQ00ZZ1	ICD-10-PCS	Plain radiography of right hip, densitometry
BQ01ZZ1	ICD-10-PCS	Plain radiography of left hip, densitometry
BQ03ZZ1	ICD-10-PCS	Plain radiography of right femur, densitometry
BQ04ZZ1	ICD-10-PCS	Plain radiography of left femur, densitometry
BR00ZZ1	ICD-10-PCS	Plain radiography of cervical spine, densitometry
BR07ZZ1	ICD-10-PCS	Plain radiography of thoracic spine, densitometry
BR09ZZ1	ICD-10-PCS	Plain radiography of lumbar spine, densitometry
BR0GZZ1	ICD-10-PCS	Plain radiography of whole spine, densitometry

SPC coding – ICD-10-CM

Return to SPC page

Code	Definition
G72.0	Drug-induced myopathy
G72.2	Myopathy due to other toxic agents
G72.9	Myopathy, unspecified
M60.80	Other myositis, unspecified site
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.819	Other myositis, unspecified shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.829	Other myositis, unspecified upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.839	Other myositis, unspecified forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.849	Other myositis, unspecified hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.859	Other myositis, unspecified thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.869	Other myositis, unspecified lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.879	Other myositis, unspecified ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M62.82	Rhabdomyolysis
M79.1	Myalgia
M79.10	Myalgia, unspecified site
M79.11	Myalgia of mastication muscle
M79.12	Myalgia of auxiliary muscles, head and neck
M79.18	Myalgia, other site

FMC coding

Return to FMC page

Code type	Code
Outpatient visits	
CPT/CPT II	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
HCPCS	G0402, G0438, G0439, G0463, T1015
SNOMED	185463005, 185464004, 185465003, 281036007, 30346009, 3391000175108, 37894004, 439740005, 444971000124105, 77406008, 84251009
UBREV	0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983
Telephone visits	
CPT/CPT II	98966, 98967, 98968, 99441, 99442, 99443
SNOMED	185317003, 314849005, 386472008, 386473003, 401267002
Transitional care management	
CPT	99495, 99496
Case management services encounter	
CPT	99366
HCPCS	T1016, T1017, T2022, T2023
Complex care management services	
CPT	T1016, T1017, T2022, T2023
HCPCS	G0506
Outpatient or telehealth behavioral health visit	
CPT	98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99492, 99493, 99494, 99510
HCPCS	G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015
UBREV	0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0919, 0982, 0983
SNOMED	185465003, 281036007, 3391000175108, 391223001, 391224007, 391225008, 391233009, 391237005, 391239008, 391242002, 391257009, 391260002, 391261003, 439740005, 444971000124105, 77406008, 84251009
Intensive outpatient visit or partial hospitalization–with POS code 52 (Psychiatric Facility–Partial Hospitalization) or POS code 53 (Community Mental Health Center visit)	
CPT/CPT II	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

FMC coding

Return to FMC page

Code type	Code
Intensive outpatient visit or partial hospitalization	
CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
HCPCS	G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485
UBREV	0905, 0907, 0912, 0913
SNOMED	305345009, 305346005, 305347001, 391038005, 391042008, 391043003, 391046006, 391047002, 391048007, 391054008, 391055009, 391056005, 391133003, 391150001, 391151002, 391152009, 391153004, 391170007, 391185001, 391186000, 391187009, 391188004, 391191004, 391192006, 391194007, 391195008, 391207001, 391208006, 391209003, 391210008, 391211007, 391228005, 391229002, 391232004, 391252003, 391254002, 391255001, 391256000, 7133001
Electroconvulsive therapy with POS code 24 (Ambulatory Surgical Center); POS code 52 (Psychiatric Facility–Partial Hospitalization); POS code 53 (Community Mental Health Center visit)	
CPT	90870
ICD-10-PCS	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
SNOMED	1010696002, 1010697006, 10470002, 11075005, 231079005, 231080008, 23835007, 284468008, 313019002, 313020008
Telehealth visit with POS 02 (Telehealth Provided Other than in Patient's Home) or POS 10 (Telehealth Provided in Patient's Home)	
CPT	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255
Substance use disorder service or substance abuse counseling and surveillance	
CPT	99408, 99409
HCPCS	G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012
UBREV	0906, 0944, 0945
SNOMED	182969009, 20093000, 23915005, 266707007, 310653000, 370776007, 70854007, 384742004, 385989002, 386449006, 386450006, 386451005, 414054004, 414056002, 414283008, 414501008, 415662004, 424589009, 428211000124100, 445628007, 445662007, 450760003, 56876005, 61480009, 64297001, 67516001, 704182008, 707166002, 710081004, 711008001, 713106006, 713107002, 713127001, 713700008, 720174008, 720175009, 720176005, 720177001, 763104007, 763233002, 763302001, 772813001, 774090004, 774091000, 792901003, 792902005, 827094004, 865964007, 87106005

TRC–PED coding

Return to TRC page

Code	Definition
98966, 98967, 98968, 99441, 99442, 99443, 99483	Telehealth visit (audio only)
99495, 99496	Transitional care management service
98969, 98970, 98971, 98972	Online assessments

Links

- Humana's Quality Resources webpage:
  https://provider.humana.com/working-with-us/quality-resources
- CMS Part C and D Star Ratings:
  https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data
- www.availity.com
- www.submitrecords.com/Humana
- For Humana's Patient Experience Survey, please register for one of our live-session webinars with the following link:
  https://humana.zoom.us/webinar/register/WN_yN_nm09OQZGaizTA1y7tjw
- Humana's medical and pharmacy coverage policies:
  Humana.com/CoveragePolicies
- Humana's claims payment policies:
  Humana.com/ClaimPaymentPolicies
- Humana's claims processing edits:
  Humana.com/Edits


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