Quality Indicator Physician Medicare HEDIS®, HOS, CAHPS® and Part D Safety Measures Guide for 2017

Note: HEDIS codes can change from year to year. The codes in this document are from the HEDIS 2017 specifications.

Healthcare Effectiveness Data and Information Set (HEDIS)
Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed-care industry. It contains measures that show health plans those areas where a stronger focus could lead to improvements in patient health. HEDIS reporting is mandated by the NCQA for compliance and accreditation. Current ICD-10, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®) manuals should be used at all times.
Measure
Breast cancer screening (BCS) **Weight = 1**
Percentage of women 50 to 74 years old who had a mammogram
Service needed
Mammogram between Oct. 1, 2015, and Dec. 31, 2017
Best practices
• Educate patients about the importance of early detection and encourage testing. • Schedule a mammogram for the patient. • Engage patients to discuss their fears about mammograms and let women know that the test is less uncomfortable and uses less radiation than it did in the past. • Provide female patients with a list of facilities that provide mammograms. • Document month and year of most recent mammogram in the medical record. • Document mastectomy status and year performed in the medical record.
For additional information – BCS
Measure
Colorectal cancer screening (COL) **Weight = 1**
Percentage of patients 50 to 75 years old who have evidence of one of the following screenings: • Fecal occult blood test • Flexible sigmoidoscopy • Colonoscopy • CT colonography • FIT-DNA
Services needed
Fecal occult blood test (FOBT, gFOBT or iFOBT) in the current year
FIT-DNA test during the current measurement year or the **two years** prior to the measurement year
Flexible sigmoidoscopy or CT colonography during the current measurement year or the **four years** prior to the measurement year
Colonoscopy within the **past 10 years** (clear documentation of previous colonoscopy or sigmoidoscopy, including year performed, is required)
Measure Best practices
• Ask patients if they've had a colorectal cancer screening, and update patient history annually. Test and date must be documented in medical record. • Encourage patients who are resistant to having a colonoscopy to do an at-home stool test (either gFOBT or iFOBT). • Order and/or distribute FOBT or FIT kits to patients who need colorectal cancer screening.
For additional information - COL

Measure
Controlling blood pressure (CBP) **Weight = 3**
Percentage of patients 18 to 85 years old diagnosed with hypertension whose blood pressure was adequately controlled during the measurement year based on the following criteria: • Patients 18 to 59 years old whose blood pressure was less than 140/90 mmHg • Patients 60 to 85 years old with a diagnosis of diabetes whose blood pressure was less than 140/90 mmHg • Patients 60 to 85 years old without a diagnosis of diabetes whose blood pressure was less than 150/90 mmHg
Service needed
Documentation in the patient's medical record of: • Hypertension diagnosis **between Jan. 1 and June 30 of the current year** **and** • The most recent adequately controlled blood pressure reading in the current year based on age and diabetes diagnosis. Blood pressure reading must be dated after the diagnosis date for compliance.
Measure best practices
• Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with the patient. • If the blood pressure (BP) is high at the office visit (140/90 or greater), please take it again. HEDIS allows the lowest systolic and lowest diastolic readings in the same day; often, the second reading is lower. • Do not round BP values. If using an automated machine, record exact values. • Review hypertensive medication history and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure, as needed. • If blood pressure is out of target range, have the patient return in three months. • Document blood pressure readings at each visit.
For additional information – CBP
Measure
Diabetes – dilated or retinal eye exam (CDC2-EYE) **Weight = 1**
Percentage of diabetic patients 18 to 75 years old who have received a comprehensive eye exam
Service needed
A comprehensive eye exam during the current year
Measure best practices
• Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with the patient. • Review diabetes services needed at each office visit. • Encourage and/or refer patients to see an eye-care professional for a comprehensive eye exam during the current year. • Document date of most recent diabetic eye exam with results and name of eye-care provider in the medical record. Negative result must be documented to be compliant for two years. • Obtain the record of an eye exam performed in the current measurement year by an ophthalmologist or optometrist. Retain a copy of the exam in the patient's medical record. • Obtain the record of an eye exam performed in the previous measurement year by an ophthalmologist or optometrist. The eye exam must note "no evidence of retinopathy." Retain a copy of the exam in the patient's medical record. • Consider using mobile eye-exam units. Fundus photography captures an image of the retina with a camera that can be operated by health care provider staff after brief training.
For additional information – CDC2-EYE

Measure

Diabetes – HbA1c screening and control (CDC2-HBATEST and CDC2-HBAPOOR)
Test weight = N/A
Poor control weight = 3

Percentage of diabetic patients 18 to 75 years old who have evidence of:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (greater than 9 percent)
- HbA1c control (less than 8 percent)

Service needed

At least one HbA1c test in current year for all eligible patients. Goal is for the most recent HbA1c level in the current year to be less than 9 percent.

Measure best practices

- Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with patient.
- Review recommendations for diabetes care at each office visit.
- Order labs prior to patient appointments.
- Bill for service with results, if point-of-care HbA1c tests are completed in-office.
- Ensure documentation in the medical record includes the date when the HbA1c test was performed and the result or finding.
  - Finding must be in the format of a value (example: 7 percent); missing values or results recorded in format other than the above will result in noncompliance for the measure.
- Adjust therapy to improve HbA1c and BP levels. Follow up with patients to monitor changes.
- Order and document follow-up HbA1c testing as appropriate, if result is more than 9 percent.

For additional information – CDC_A1c

Measure

Diabetes – nephropathy (CDC2-NPH)
Weight = 1

Percentage of diabetic patients 18 to 75 years old who received medical attention for nephropathy (nephropathy screening test or evidence of nephropathy)

Services needed

- Documented evidence of a urine test for albumin or protein performed in current measure year and result, such as:
  - 24-hour urine/timed/spot urine for albumin or protein
  - Urine for albumin/creatinine ratio
  - 24-hour urine for total protein
  - Random urine for protein/creatinine ratio

and/or

- Documented evidence of/treatment for nephropathy within the current measurement year:
  - Medical treatment for any of the following (no restriction on provider type)
    - Diabetic nephropathy, end-stage renal disease (ESRD), chronic renal failure (CRF), chronic kidney disease (CKD), dialysis, etc.
    - Renal transplant
  - Angiotensin-converting enzyme (ACE) inhibitor/angiotensin receptor blocker (ARB) therapy

Measure best practices

- Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with the patient.
- Review diabetes services needed at each office visit.
- Order labs prior to patient appointments.
- Send reminders to patients with Type 1 or Type 2 diabetes with information about the required testing and a suggestion to set up an appointment.

For additional information – CDC2-NPH

Measure
Osteoporosis screening and management for women who had a fracture (OMW) **Weight = 1**
Percentage of women 67 to 85 years old who suffered a fracture and had: • Either a bone mineral density (BMD) test within 24 months or a prescription to treat or prevent osteoporosis within 12 months before the fracture **or** • A BMD test or prescription to treat or prevent osteoporosis within 180 days after the fracture Note: Fractures of face, skull, fingers or toes are excluded.
Service needed
• Bone mineral density testing within six months of fracture date or date of discharge if hospitalized for fracture **and/or** • A medication to treat osteoporosis
Measure best practices
• Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with the patient. • Perform bone mineral density testing within six months of fracture date. • Prescribe a medication to treat osteoporosis. (The use of calcium supplements will not meet the criteria for this measure.) • Promote the use of remote/mobile DEXA scans.
For additional information – OMW
Measure
Disease-modifying antirheumatic drug (DMARD) therapy for rheumatoid arthritis (ART) **Weight = 1**
Percentage of patients who were diagnosed with rheumatoid arthritis and were dispensed at least one ambulatory prescription for a DMARD in current year
Services needed
• Assessment of all patients diagnosed with rheumatoid arthritis for DMARD treatment in current year • Referral of all patients not currently treated with a DMARD for rheumatology consultation to confirm diagnosis and assess for DMARD therapy • Completion and return of a rheumatoid arthritis verification form on any patient identified as not having rheumatoid arthritis *or* not currently treated with a DMARD (contraindications to DMARD therapy are not considered as exclusions, per NCQA)
Measure best practices
• Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with the patient. • Confirm rheumatoid arthritis (RA) diagnosis versus osteoarthritis (OA) or joint pain. • Refer patients to network rheumatologists as appropriate for consultation and/or co-management. • Prescribe DMARDs when diagnosing rheumatoid arthritis in patients. • Assess all patients with diagnosis of rheumatoid arthritis for DMARD treatment in current year. • Refer all patients not currently treated with a DMARD for rheumatology consultation to confirm diagnosis and assess for DMARD therapy. • Complete and return a rheumatoid arthritis verification form on any patient identified as not having rheumatoid arthritis or not currently treated with a DMARD.
For additional information – ART

Measure

Adult body mass index (BMI) assessment (ABA)
Weight = 1

Percentage of patients 18 to 74 years old who had an outpatient visit and who had weight and BMI documented during the measurement year or the year prior to the measurement year. The weight and BMI must be from the same data source.

Service needed

Documented weight and BMI for outpatient visits in current or previous year

Measure best practices

- Use Medicare Stars checklist for reference and place on top of chart as a reminder to discuss with the patient.
- Place proper documentation for BMI in the medical record with all components (i.e., date, weight, height and BMI value or percentile).
  - For patients 20 years old and older on the date of service, documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI value must be from the same data source.
  - For patients younger than 20 years old on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The height, weight and BMI percentile must be from the same data source.
    - For BMI percentile, the following documentation meets criteria:
      - BMI percentile documented as a value (e.g., 85th percentile)
      - BMI percentile plotted on an age-growth chart
- Submit appropriate codes to identify BMI assessment (see ABA clinical overview).
- Place BMI charts near scales in the office as a reminder to discuss with patients.

Note: Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of more than 99 percent or less than 1 percent meets criteria because a distinct BMI percentile is evident (i.e., 100 percent or 0 percent).

For additional information – ABA

Measure

Care for older adults – advanced care planning (COA–ACP)
Weight = N/A

(Medicare special needs plan [SNP] only)
Percentage of adults 66 years old or older who had advance care planning (advance directive, living will, power of attorney, health care proxy, actionable medical decision-maker or surrogate decision-maker) during the measurement year

Service needed

Advance care planning: Documentation of advance care planning in current year
Evidence of advance care planning must include:

- An advance care plan in the medical record or
- Advance care planning discussion with the health care provider documented and dated in the medical record or
- Notation that the patient has previously executed an advance care plan that meets criteria

For additional information – COA

Measure

Care for older adults – medication review (COA–MDR)
Weight = 1

(Medicare special needs plan [SNP] only)
Percentage of adults 66 years old or older who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist along with a medication list or documentation of no medications

Service needed

Medication review

- Documentation of at least one dated medication review conducted by a prescribing practitioner or clinical pharmacist in the current year
- A medication list present in the same medical record. If patient is not taking any medication, dated notation should be documented in the chart in the current year. A review of side effects for a single medication at the time of prescription alone is not sufficient. A medication review and medication list code must be billed for a patient to be compliant.

Measure

Care for older adults – functional status assessment (COA–FSA)
Weight = 1

(Medicare special needs plan [SNP] only)
Percentage of adults 66 years old or older who had documentation in the medical record of at least one complete functional status assessment in current measurement year

Service needed

Functional status

- At least one complete functional status assessment in current measurement year (must include the date it was performed)
- Use of notations for a complete functional status assessment, which may include:
  - Assessment of instrumental activities of daily living (IADL)
  - Assessment of activities of daily living (ADL)
  - Results using a standardized functional assessment tool
  - Documentation of three of the four following components:
    - Cognitive status
    - Ambulation status
    - Sensory ability (hearing, vision and speech are all required)
    - Other functional independence

Measure best practice

- Use the COA assessment form to complete with patients.
  - Assessment can be completed by provider telephonically.

Note: A functional status assessment limited to an acute or single condition, event or body system does not meet criteria for a comprehensive functional status assessment.

Measure

Care for older adults – pain screening (COA–PNS)
Weight = 1

(Medicare special needs plan [SNP] only)
Percentage of adults 66 years old or older who had documentation in the medical record of at least one pain screening assessment for more than one system in current measurement year

Service needed

Pain assessment
Documentation in the medical record of at least one pain assessment or pain management plan in 2017, including the date it was performed. Notations can include a comprehensive pain assessment or results of a screening using a

standardized tool (may include positive or negative findings).

Measure best practices

- Use Medicare Stars checklist for reference and place on top of chart as a reminder to complete with patient.
- Use the COA assessment form to complete with patients.
  - Assessment can be completed telephonically by the health care provider.
- Document in the medical record at least one pain assessment or pain management plan in the current year, including the date it was performed.
- Include notations, such as a comprehensive pain assessment or results of a screening using a standardized tool (may include positive or negative findings).

Measure

Plan all-cause readmissions (PCR)
Weight = 3

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- Percent of patients 18 years old and older discharged from a hospital stay and readmitted to a hospital within 30 days, either for the same condition or for a different reason
- Patients may have been readmitted to the same hospital or a different one
- Rates of readmission are risk-adjusted and account for how sick patients were on the first admission

Service needed

No specific service is needed.

Measure best practices

- Promote health plan services (e.g., transition of care, care coordination, home health, etc.).
- Be aware of the daily discharge census.
- Manage scheduling capacity to be able to see patients who have been discharged from a hospital stay within seven days.
- Conduct a medication reconciliation upon first visit postdischarge.
- Ensure patient has the resources necessary to prevent a readmission (e.g., transportation for follow-up appointments and necessary medications). Connect patient to community resources and/or health plan care management services to help remove barriers to care and/or access to resources.

Measure

Medication reconciliation postdischarge (MRP)
Weight = 1

The percentage of discharges from Jan. 1 to Dec. 1 of the measurement year for patients 18 years old and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days).

Service needed

A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record

Measure best practices

- Be aware of patients' inpatient stays.
- Obtain timely discharge summaries.
- Review and reconcile discharge medications against existing outpatient medications.
- See patients in the office as soon as possible after an acute discharge stay.
- Review all discharge summaries, document all medication reconciliations in outpatient medical records (which may be done on the discharge summary filed in the outpatient medical record) and submit code 1111F to the health plan.

Measure
Hospitalization for potentially preventable complications (HPC) **Weight = 1**
For patients 67 years old and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 patients and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions
Service needed
Organizations should work to prevent admissions for complications of chronic and acute ambulatory care sensitive conditions.
Measure best practices
• Ensure appropriate outpatient management of the above conditions. • Coordinate efforts with specialists and other health care providers to prevent complications and subsequent admissions. • Provide prompt follow-up care postdischarge to prevent complications and subsequent readmissions.
Measure
Statin therapy for patients with cardiovascular disease (SPC) **Weight = 1**
Percentage of males 21 to 75 years old and females 40 to 75 years old during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication during the measurement year
Service needed
• Assess cardiovascular disease patients for statin therapy in alignment with the 2013 American College of Cardiology/American Heart Association (ACC/AHA) guidelines. • Use noncompliant patient lists to review medications and evaluate addition of statin therapy to regimen.
What to report
• No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.

Health Outcomes Survey (HOS)

HOS is an annual patient-reported outcome survey, conducted by a contracted Centers for Medicare & Medicaid Services (CMS) vendor for Medicare Advantage plans. 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. Six of the survey areas are included in the CMS Star quality measures.

Measure

Physical activity assessment
Weight = 1

Percentage of plan patients 65 years old or older who 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

Services needed

Complete/document **functional assessment**. Encourage patient to start, increase or maintain physical activity and document communication.

Discuss patient's:

- Level of exercise or physical activity
- Loss of independence/performance
- Activities of daily living
- Level of assistance needed
- Social activities

Advise patient to:

- Determine what level of physical activity is safe and appropriate
- Begin physical activity with short intervals of moderate activity (five to 10 minutes)
- Perform flexibility training, such as stretching and yoga, every day
- Perform strength training, such as carrying laundry or groceries, doing chair exercises or working in the yard, two to three days per week
- Perform cardiorespiratory activities, such as walking, rolling a wheelchair or swimming, three to five days a week for at least 30 minutes

Patient survey questions

- In the past 12 months, did you talk with a doctor or other practitioner about your level of exercise or physical activity?
- In the past 12 months, did a doctor or other practitioner advise you to start, increase or maintain your level of exercise or physical activity?

Measure
Physical health status assessment **Weight = 3**
Percentage of plan patients whose physical health status was better than expected or remained the same
Service needed

• Assess current issues and identify interventions to improve physical health status and document communication.
• Discuss patient's:
  o Loss of independence and/or performance
  o Activities of daily living
  o Level of assistance needed
  o Social activities
• Make efforts to ensure the patient understands services rendered.

Patient survey questions
• During the past four weeks, have you accomplished less than you would like with your work or other regular activities as a result of your physical health? • During the past four weeks, how much of the time has physical health interfered with your social activities?
Measure
Mental health status assessment **Weight = 3**
Percentage of plan patients whose mental health status was better than expected or remained the same
Service needed
• Assess current issues and identify interventions to improve mental health status and document communication. • Make efforts to confirm the patient understands services rendered.
Patient survey questions
• During the past four weeks, have you accomplished less or were you limited with your work or other regular daily activities as a result of your emotional health? • During the past four weeks, have you felt peaceful and calm, had a lot of energy or felt downhearted and blue? • During the past four weeks, how much of the time have emotional problems interfered with your social activities?

Measure
Fall risk and balance assessment **Weight = 1**
Percentage of patients 65 years old or older who in the past 12 months had a fall or had problems with balance or walking, were seen by a practitioner and received fall risk interventions from their current practitioner
Service needed

• Discuss patient balance/fall problem and document prevention interventions.
• Prevention/interventions:
  o Regular exercise and exercise programs (e.g., tai chi) may increase strength and improve balance among older adults.
  o Regular medication reviews by physicians or pharmacists can help reduce side effects and drug interactions.
  o Regular eye exams at least once a year can help maintain eye health.
  o Home assessment and modifications may reduce hazards in the home (e.g., improper lighting) that can lead to falls.
  o Fall prevention programs may be needed to provide and install safety devices to be effective in reducing environmental hazards.
• Make efforts to confirm the patient understands services rendered.

Patient survey questions
• In the past 12 months, have you had a problem with balance or walking? • 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 care provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • Has your doctor or other health care provider done anything to help prevent falls or treat problems with balance or walking?

Measure
Urinary incontinence assessment and advice **Weight = 1**
Percentage of plan patients 65 years old or older who reported having a urine leakage problem in the past six months and who received treatment for their current leakage problem
Services needed
• Assess all patients to determine if they are having problems with urinary incontinence. • Discuss urinary problem with patient and document possible treatment options, such as: o Behavioral therapies, such as bladder training and techniques for pelvic muscle rehabilitation (low-intensity behavioral therapies are ideal first-line interventions that are inexpensive, pose a low risk and can be initiated effectively by primary care providers) o Pharmacologic therapies o Surgical therapies (if indicated) • Make efforts to confirm the patient understands services rendered.
Patient survey questions
• Many people experience problems with urinary incontinence, the leakage of urine. In the past six months, have you leaked urine? • How much of a problem, if any, was the urine leakage for you? • Have you talked with your current doctor or other health care provider about your urine leakage problem? • There are many ways to treat urinary incontinence, including bladder training exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problems?

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
CAHPS is an annual patient survey conducted by a contracted CMS vendor for Medicare Advantage plans. The goal of the survey is to assess the experiences of beneficiaries in Medicare Advantage plans. The results of the survey are published in the "Medicare & You" handbook and on the Medicare website: http://www.medicare.gov. Eight areas of the patient survey are included in the Star measures reporting.
Measure
Patient satisfaction with receiving needed care quickly (weight = 1.5) **Patient satisfaction with receiving needed care without delay (weight = 1.5)**
Services needed
• Facilitate referral issuance and assist with the arrangement of specialist appointments, as appropriate. • Ensure limited wait times and the availability of urgent appointments.
Survey questions
• In the last six months, how often was it easy to get appointments with specialists? • In the last six months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan? • In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
Measure
Patient satisfaction with his/her current health care **Weight = 1.5**
Services needed
• Ask questions to gauge the patient's current feeling about the care he/she is receiving. • Discuss options to improve health care. • Discuss options to improve the patient's perception of health care delivery. • Make efforts to confirm the patient understands services rendered.
Survey questions
Using any number from zero to 10, with zero being the worst health care possible and 10 the best health care possible, what number would you use to rate all of your health care in the last six months?

Measure
Influenza vaccination status **Weight = 1**
Percentage of plan patients who reported having received an influenza vaccination between July 2017 and the date when the Medicare CAHPS survey was completed (March through June 2018)
Services needed
• Order influenza vaccine for your office in advance of flu season. • Identify options for purchasing additional vaccines and/or referring patients to alternative administration sites should demand exceed your supply of vaccines. • Encourage all eligible patients to receive an influenza vaccination between September and December each year. • Make efforts to confirm the patient understands services rendered.
Note: Make sure that claim/encounter is submitted and that it includes the appropriate CPT code for the flu shot administration date of service.
Survey question
Did you get a flu shot last year?
Measure
Care coordination **Weight = 1.5**
Six questions posed to the respondent about how well his/her physician kept up with certain aspects of care, including prescription medicines, tests, specialist care and other services.
Factors
• Whether doctor had medical records and other information about the patient's care • Whether there was follow-up with the patient to provide test results • How quickly the patient got the test results • Whether the doctor spoke to the patient about prescription medicines • Whether the patient received help managing care • Whether the personal doctor is informed and up to date about specialist care
Survey questions
• In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? (Responses: 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? (Responses: 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? (Responses: 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? (Responses: never, sometimes, usually, always) • In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists? (Responses: never, sometimes, usually, always, I do not have a personal doctor, I did not visit my personal doctor in the last six months) • 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? (Responses: yes, definitely; yes, somewhat; no)

Part D Patient Safety measures CMS includes several Part D measures in the Star measures reporting, including the following five safety measures.
Measure
Taking diabetes medication as directed **Weight = 3**
Percentage of Medicare Part D beneficiaries 18 years old or older with a prescription for diabetes medication who fill their prescriptions often enough to cover 80 percent or more of the time they are supposed to be taking the medication
Note: In this measure, "diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic, a meglitinide or a sodium glucose co-transporter2 (SGLT2) drug. Plan patients who take insulin are not included.
Services needed
• Assess proactively whether the patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription. • Refer patients to http://humana.com/takemymedicine for adherence tips and tools.
What to report
No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.
Measure
Taking blood pressure medication as directed **Weight = 3**
Percentage of Medicare Part D beneficiaries 18 years old or older with a prescription for a blood pressure medication who fill their prescriptions often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
Note: In this measure, "blood pressure medication" means an angiotensin-converting enzyme (ACE) inhibitor, an angiotensin receptor blocker (ARB) drug or a direct renin-inhibitor (DRI) drug.
Services needed
• Assess proactively whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription. • Refer patients to http://humana.com/takemymedicine for adherence tips and tools.
What to report
No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.

Measure
Taking cholesterol medication as directed **Weight = 3**
Percentage of Medicare Part D beneficiaries 18 years or older with a prescription for a cholesterol medication (statin) who fill their prescriptions often enough to cover 80 percent or more of the time they are supposed to be taking the medication
Services needed
• Assess proactively whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription. • Refer patients to http://humana.com/takemymedicine for adherence tips and tools.
What to report
No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.
Measure
Statin use in persons with diabetes **Weight=1**
Percentage of patients ages 40-75 years dispensed two or more medications for diabetes and who received a statin medication.
Service needed
• Assess diabetic patients for statin therapy in alignment with the 2013 American College of Cardiology/American Heart Association (ACC/AHA) guidelines. • Use noncompliant patient lists to review medications and evaluate addition of statin therapy to regimen.
What to report
No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.
Measure
Percent of medication therapy management (MTM) program enrollees who received a comprehensive medication review (CMR) during the reporting period **Weight = 1**
Percentage of MTM program enrollees who received a CMR
Service needed
• Conduct discussions with MTM-eligible patients, explaining the importance and benefits of completing a comprehensive medication review. • Inform patients they can schedule a CMR by calling RxMentor at **1-855-202-2510**, Monday through Friday, 8 a.m. to 6:30 p.m. Eastern time. • Reference the MTM health program detail report for eligible patients.
What to report
No reporting required from providers.

Display measures

HEDIS display measures
Measure
Follow-up visit after hospital stay for mental illness (within 30 days of discharge)
The percentage of discharges for patients 6 years old or older who were hospitalized for treatment of selected mental health disorders (denominator) and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge (numerator)
Measure
Antidepressant medication management (six months)
The percentage of patients 18 years of age or older with a diagnosis of major depression (denominator) who were newly treated with antidepressant medication and who remained on an antidepressant medication treatment (numerator)
Measure
Continuous beta-blocker treatment
The percentage of patients 18 years of age or older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with an acute myocardial infarction (denominator) and who received persistent beta-blocker treatment for six months after discharge (numerator)
Measure
Appropriate monitoring of patients taking long-term medications
The percentage of patients 18 years old or older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (denominator) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year (numerator)
Measure
Testing to confirm chronic obstructive pulmonary disease
The percentage of patients 40 years old or older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) during the measurement year (denominator) who received appropriate spirometry testing to confirm the diagnosis (numerator)
Measure
Access to primary care doctor visits
The percentage of patients 20 years old or older (denominator) who had an ambulatory or preventive care visit during the measurement year (numerator)
Measure
Pharmacotherapy management of COPD exacerbation – systemic corticosteroid
The percentage of COPD exacerbations for patients 40 years old or older who had an acute inpatient discharge or emergency department encounter on or between Jan. 1 – Nov. 30 of the measurement year and who were dispensed a systemic corticosteroid within 14 days of the event
Measure
Pharmacotherapy management of COPD exacerbation – bronchodilator
The percentage of COPD exacerbations for patients 40 years old or older who had an acute inpatient discharge or emergency department encounter on or between Jan. 1 – Nov. 30 of the measurement year and who were dispensed a bronchodilator within 30 days of the event
Measure
Initiation of alcohol or other drug (AOD) treatment
The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis

Patient safety display measures
Measure
High-risk medications
The percentage of Medicare Part D beneficiaries 65 years old or older who received two or more prescription fills for a drug with a high risk of serious side effects in the elderly
Measure
Drug-to-drug interaction
The percentage of Part D beneficiaries who received a prescription for a target medication during the measurement period and who were dispensed a prescription for a contraindicated medication with or subsequent to the initial prescription
Measure
Diabetes medication dosing
The percentage of Part D beneficiaries who were dispensed a dose higher than the daily recommended dose for the following diabetes treatment therapeutic categories of oral hypoglycemic: biguanide, sulfonylurea, thiazolidinedione or dipeptidyl peptidase (DPP)-IV inhibitor
Measure
Antipsychotic use in persons with dementia
The percentage of individuals 65 years old and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition
Measure
High acetaminophen daily dose
The proportion (out of 1,000) of total days of Medicare Part D acetaminophen (APAP) use that had a daily dose greater than 4g
Measure
Use of opioids from multiple health care providers or at high dosage in persons without cancer
Measure breakouts: 1. Opioid – high dosage (Opioid-HD): The proportion (out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer 2. Opioid – multiple providers (Opioid-MP): The proportion (out of 1,000) of individuals without cancer receiving prescriptions for opioids from four or more prescribers and four or more pharmacies 3. Opioid – high dosage and multiple providers (Opioid-HDMP): The proportion (out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg MED for 90 consecutive days or longer, and who received opioid prescriptions from four or more prescribers and four or more pharmacies

CAHPS Display Measures

CAHPS
Measure
Doctors who communicate well
This case-mix adjusted composite measure is used to assess how well doctors communicate. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
CAHPS survey questions (question numbers vary depending on survey type):
• In the last six months, how often did your personal doctor explain things in a way that was easy to understand? • In the last six months, how often did your personal doctor listen carefully to you? • In the last six months, how often did your personal doctor show respect for what you had to say? • In the last six months, how often did your personal doctor spend enough time with you?
Measure
Pneumonia vaccine
The percentage of sampled Medicare enrollees (denominator) who reported ever having received a pneumococcal vaccine (numerator)
CAHPS survey question (question number varies depending on survey type):
Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from a flu shot. It also is called the pneumococcal vaccine.
Measure
Reminders for appointments
The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about appointments (numerator)
CAHPS survey question (question number varies depending on survey type):
In the last six months, did anyone from a doctor's office or your health plan contact you to remind you to make appointments for tests or treatment?
Measure
Reminders for immunizations
The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about getting immunizations (numerator)
CAHPS survey question (question number varies depending on survey type):
In the last six months, did anyone from a doctor's office or your health plan contact you to remind you to get a flu shot or other immunization?
Measure
Reminders for screening tests
The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about getting a screening test (numerator)
CAHPS survey question (question number varies depending on survey type):
In the last six months, did anyone from a doctor's office or your health plan contact you to remind you about screening tests such as breast cancer or colorectal cancer screening?
Measure
Computer used during office visits
The percentage of sampled Medicare enrollees (denominator) who reported their doctor used a computer or handheld device during an office visit (numerator)
CAHPS survey question (question number varies depending on survey type):
Doctors may use computers or handheld devices during an office visit to do things like look up your information or order prescription medicines. In the last six months, did your personal doctor use a computer or handheld

device during any of your visits?
Measure
Computer use by doctor helpful
This case-mix adjusted measure is used to assess how helpful providers' computer use is. The CAHPS score is the percentage of sampled Medicare enrollees (denominator) who reported that their doctor's use of a computer or handheld device was helpful "a lot" or "a little."
CAHPS survey question (question number varies depending on survey type):
During your visits in the last six months, was your personal doctor's use of a computer or handheld device helpful to you?
Measure
Computer use made talking with doctor easier
This case-mix adjusted measure is used to assess whether providers' computer use made talking harder or easier. The CAHPS score is the percentage of sampled Medicare enrollees (denominator) who reported that their doctor's use of a computer or handheld device made talking to them easier.
CAHPS survey question (question number varies depending on survey type):
During your visits in the last six months, did your personal doctor's use of a computer or handheld device make it harder or easier for you to talk to him or her?
Measure
Getting information from drug plan
This case-mix adjusted composite measure is used to assess how easy it is for patients to get information from the plan about prescription drug coverage and cost. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
CAHPS survey question (question number varies depending on survey type):
• In the last six months, how often did your health plan's customer service staff give you the information or help you needed about prescription drugs? • In the last six months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? • In the last six months, how often did your health plan give you all the information you needed about which prescription medicines were covered? • In the last six months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?
Measure
Reminders to fill prescriptions
The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about filling or refilling a prescription (numerator)
CAHPS survey question (question number varies depending on survey type):
In the last six months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription?
Measure
Reminders to take medications
The percentage of sampled Medicare enrollees (denominator) who reported that they were reminded about taking medications as directed (numerator)
CAHPS survey question (question number varies depending on survey type):
In the last six months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you were taking medications as directed?

CMS Star-rating thresholds

(Thresholds are subject to change.)

HEDIS measures	2 stars	3 stars	4 stars	5 stars
Breast cancer screening	43	63	69	76
Colorectal cancer screening	55	62	71	81
Body mass index (BMI)	45	63	87	96
Special needs plan (SNP)	33.5	54.1	74.2	92.9
Care for older adults (COA) – medication review	30	57	75	87
COA – functional status assessment	36	56	74	86
COA – pain assessment	37	59	75	88
Osteoporosis management in women	21	34	51	70
Diabetes care – eye exam	46	61	73	81
Diabetes care – kidney disease monitoring	92	94	96	98
Diabetes care – blood sugar controlled	49	62	76	84
Controlling blood pressure	38	56	64	75
Rheumatoid arthritis	54	72	76	82
All-cause readmissions	15	12	10	8

Breast Cancer Screening (BCS)

For the commercial, Medicaid and Medicare lines of business

This measure evaluates the percentage of women 50 to 74 years old who had a mammogram to screen for breast cancer. The table below outlines Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), Revenue and ICD-10-CM procedure codes that indicate a breast cancer screening has taken place.

Code	Code Type	Definition
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
G0202	HCPCS	Screening mammography, producing direct digital image, bilateral, all views
G0204	HCPCS	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	HCPCS	Diagnostic mammography, producing direct digital image, unilateral, all views
0401	Revenue	Diagnostic mammography
0403	Revenue	Screening mammography
87.36	Procedure	Xerography of breast
87.37	Procedure	Other mammography

CPT codes are the Current Procedural Terminology codes developed by the American Medical Association.
HCPCS is the Healthcare Common Procedure Coding System used by the Centers for Medicare & Medicaid Services.
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ICD-10-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, developed by the World Health Organization.
Revenue codes were developed by the National Uniform Billing Committee for use on the UB-04 claim form.

Colorectal Cancer Screening (COL)

For the commercial, Medicaid and Medicare lines of business

This measure evaluates the percentage of patients 50 to 75 years old who had appropriate screening for colorectal cancer through the performance of a fecal occult blood test (FOBT), flexible sigmoidoscopy or colonoscopy. Below are the Current Procedural Terminology (CPT®), Current Procedural Terminology Category II (CPT II), Healthcare Common Procedure Coding System (HCPCS), Logical Observation Identifiers Names and Codes (LOINC®) and ICD-10-CM procedure codes that indicate these services have been performed.

Fecal occult blood test (FOBT)

Code	Code type	Definition
82270	CPT	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, one determination
82274	CPT	Blood, occult, by fecal hemoglobin, qualitative, one to three simultaneous determinations
G0328	HCPCS	Colorectal cancer screening, fecal occult blood test, immunoassay, one to three simultaneous determinations
2335-8	LOINC	Hemoglobin gastrointestinal (presence) in stool
12503-9	LOINC	Hemoglobin gastrointestinal (presence) in stool – fourth specimen
12504-7	LOINC	Hemoglobin gastrointestinal (presence) in stool – fifth specimen
14563-1	LOINC	Hemoglobin gastrointestinal presence in stool – first specimen
14564-9	LOINC	Hemoglobin gastrointestinal (presence in stool – second specimen
14565-6	LOINC	Hemoglobin gastrointestinal (presence) in stool – third specimen
27396-1	LOINC	Hemoglobin gastrointestinal (mass/mass) in stool
27401-9	LOINC	Hemoglobin gastrointestinal (presence) in stool – sixth specimen
27925-7	LOINC	Hemoglobin gastrointestinal (presence) in stool – seventh specimen
27926-5	LOINC	Hemoglobin gastrointestinal (presence) in stool – eighth specimen
29771-3	LOINC	Hemoglobin gastrointestinal (presence) in stool by immunologic method
56490-6	LOINC	Hemoglobin gastrointestinal (presence) in stool by immunologic method – second specimen
56491-4	LOINC	Hemoglobin gastrointestinal (presence) in stool by immunologic method – third specimen
57905-2	LOINC	Hemoglobin gastrointestinal (presence) in stool by immunologic method – first specimen
58453-2	LOINC	Hemoglobin gastrointestinal (mass/mass) in stool by rapid immunoassay

Flexible sigmoidoscopy

Code	Code type	Definition
45330	CPT	Sigmoidoscopy, flexible, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45331	CPT	Sigmoidoscopy, flexible, with biopsy, single or multiple
45332	CPT	Sigmoidoscopy, flexible, with removal of foreign body
45333	CPT	Sigmoidoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45334	CPT	Sigmoidoscopy, flexible, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45335	CPT	Sigmoidoscopy, flexible, with directed submucosal injection(s), any substance
45337	CPT	Sigmoidoscopy, flexible, with decompression of volvulus, any method
45338	CPT	Sigmoidoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45339	CPT	Sigmoidoscopy, flexible, with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy, forceps, bipolar cautery or snare technique
45340	CPT	Sigmoidoscopy, flexible, with dilation by balloon, one or more strictures
45341	CPT	Sigmoidoscopy, flexible, with endoscopic ultrasound examination
45342	CPT	Sigmoidoscopy, flexible, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45345	CPT	Sigmoidoscopy, flexible, with transendoscopic stent placement (includes predilation)
G0104	HCPCS	Colorectal cancer screening, flexible sigmoidoscopy
45.24	Procedure	Flexible sigmoidoscopy

Colonoscopy

Code	Code type	Definition
44388	CPT	Colonoscopy through stoma, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44389	CPT	Colonoscopy through stoma, with biopsy, single or multiple
44390	CPT	Colonoscopy through stoma, with removal of foreign body
44391	CPT	Colonoscopy through stoma, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
44392	CPT	Colonoscopy through stoma, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
44393	CPT	Colonoscopy through stoma, with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44394	CPT	Colonoscopy through stoma, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
44397	CPT	Colonoscopy through stoma, with transendoscopic stent placement (includes predilation)

45355	CPT	Colonoscopy, rigid or flexible, transabdominal via colostomy, single or multiple
45378	CPT	Colonoscopy, flexible, proximal to splenic flexure, diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of foreign body
45380	CPT	Colonoscopy, flexible, proximal to splenic flexure, with biopsy, single or multiple
45381	CPT	Colonoscopy, flexible, proximal to splenic flexure, with directed submucosal injection(s), any substance
45382	CPT	Colonoscopy, flexible, proximal to splenic flexure, with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383	CPT	Colonoscopy, flexible, proximal to splenic flexure, with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	CPT	Colonoscopy, flexible, proximal to splenic flexure, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45386	CPT	Colonoscopy, flexible, proximal to splenic flexure, with dilation by balloon, one or more strictures
45387	CPT	Colonoscopy, flexible, proximal to splenic flexure, with transendoscopic stent placement (includes predilation)
45391	CPT	Colonoscopy, flexible, proximal to splenic flexure, with endoscopic ultrasound examination
45392	CPT	Colonoscopy, flexible, proximal to splenic flexure, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
G0105	HCPCS	Colorectal cancer screening, colonoscopy on individual at high risk
G0121	HCPCS	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk
45.22	Procedure	Endoscopy of large intestine through artificial stoma
45.23	Procedure	Colonoscopy
45.25	Procedure	Closed [endoscopic] biopsy of large intestine
45.42	Procedure	Endoscopic polypectomy of large intestine
45.43	Procedure	Endoscopic destruction of other lesion or tissue of large intestine

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HCPCS is the Healthcare Common Procedure Coding System used by the Centers for Medicare & Medicaid Services.
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ICD-10-CM is the International Classification of Diseases, ninth revision, Clinical Modification, developed by the World Health Organization.
LOINC® is the Logical Observation Identifiers Names and Codes database developed by the Regenstrief Institute.

Controlling High Blood Pressure (CBP)

For the commercial, Medicaid and Medicare lines of business

The controlling high blood pressure (CBP) measure evaluates the percentage of patients 18 to 85 years old who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (less than 140/90). The table below outlines ICD-10-CM diagnosis codes that indicate hypertension. The Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications advise adequate control for HTN is indicated in the medical records by both a representative systolic blood pressure of less than 140 mmHg and a representative diastolic blood pressure of less than 90 mmHg (blood pressure in the normal or high-normal range).

Code	Code type	Definition
401.0	Diagnosis	Essential hypertension, malignant
401.1	Diagnosis	Benign hypertension
401.9	Diagnosis	Hypertension not otherwise specified

ICD-10 code

Code	Code type	Definition
I10	Diagnosis	Essential (primary) hypertension

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ICD-10-CM are the International Classification of Diseases, Ninth and 10th revisions, Clinical Modification, developed by the World Health Organization.

Comprehensive Diabetes Care – Eye Exam (CDC-eye)

For the commercial, Medicaid and Medicare lines of business

The comprehensive diabetes care – eye exam (CDC-eye) measure is the percentage of patients 18 to 75 years old with diabetes (Type 1 or 2) who had a retinal eye exam performed. Below are the Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that indicate an eye exam has been performed.

Code	Code type	Definition
67028	CPT	Intravitreal injection of a pharmacologic agent (separate procedure)
67030	CPT	Discission of vitreous strands (without removal), pars plana approach
67031	CPT	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
67036	CPT	Vitrectomy, mechanical, pars plana approach
67039	CPT	Vitrectomy, mechanical, pars plana approach, with focal endolaser photocoagulation
67040	CPT	Vitrectomy, mechanical, pars plana approach, with endolaser panretinal photocoagulation
67041	CPT	Vitrectomy, mechanical, pars plana approach, with removal of preretinal cellular membrane (e.g., macular pucker)
67042	CPT	Vitrectomy, mechanical, pars plana approach, with removal of internal limiting membrane of retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil)
67043	CPT	Vitrectomy, mechanical, pars plana approach, with removal of subretinal membrane (e.g., choroidal neovascularization), includes, if performed, intraocular tamponade (i.e., air, gas or silicone oil) and laser photocoagulation
67101	CPT	Repair of retinal detachment, one or more sessions, cryotherapy or diathermy, with or without drainage of subretinal fluid
67105	CPT	Repair of retinal detachment, one or more sessions, photocoagulation, with or without drainage of subretinal fluid
67107	CPT	Repair of retinal detachment, scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation and drainage of subretinal fluid
67108	CPT	Repair of retinal detachment, with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling and/or removal of lens by same technique
67110	CPT	Repair of retinal detachment, by injection of air or other gas (e.g., pneumatic retinopexy)
67112	CPT	Repair of retinal detachment, by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques
67113	CPT	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling and/or removal of lens
67121	CPT	Removal of implanted material, posterior segment, intraocular

67141	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, cryotherapy, diathermy
67145	CPT	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions, photocoagulation (laser or xenon arc)
67208	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, cryotherapy, diathermy
67210	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, photocoagulation
67218	CPT	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions, radiation by implantation of source (includes removal of source)
67220	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photocoagulation (e.g., laser), one or more sessions
67221	CPT	Destruction of localized lesion of choroid (e.g., choroidal neovascularization), photodynamic therapy (includes intravenous infusion)
67227	CPT	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions, cryotherapy, diathermy
67228	CPT	Treatment of extensive or progressive retinopathy, one or more sessions, (e.g., diabetic retinopathy), photocoagulation
92002	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, intermediate, new patient
92004	CPT	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, comprehensive, new patient, one or more visits
92012	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, intermediate, established patient
92014	CPT	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, comprehensive, established patient, one or more visits
92018	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, complete
92019	CPT	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination, limited
92134	CPT	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina
92225	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, initial
92226	CPT	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report, subsequent
92227	CPT	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228	CPT	Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
92230	CPT	Fluorescein angioscopy with interpretation and report
92235	CPT	Fluorescein angiography (includes multiframe imaging) with interpretation and report

92240	CPT	Indocyanine green angiography with interpretation and report
92250	CPT	Fundus photography with interpretation and report
92260	CPT	Ophthalmodynamometry
99203	CPT	Office or other outpatient visit for evaluation and management of a new patient, 30 minutes
99204	CPT	Office or other outpatient visit for evaluation and management of a new patient, 45 minutes
99205	CPT	Office or other outpatient visit for evaluation and management of a new patient, 60 minutes
99213	CPT	Office or other outpatient visit for evaluation and management of an established patient, 15 minutes
99214	CPT	Office or other outpatient visit for evaluation and management of an established patient, 25 minutes
99215	CPT	Office or other outpatient visit for evaluation and management of an established patient, 40 minutes
99242	CPT	Office consultation for a new or established patient, 30 minutes
99243	CPT	Office consultation for a new or established patient, 40 minutes
99244	CPT	Office consultation for a new or established patient, 60 minutes
99245	CPT	Office consultation for a new or established patient, 80 minutes
2022F	CPT	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed (DM)
2024F	CPT	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed (DM)
2026F	CPT	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed (DM)
3072F	CPT	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)
S0620	HCPCS	Routine ophthalmological examination including refraction, new patient
S0621	HCPCS	Routine ophthalmological examination including refraction, established patient
S0625	HCPCS	Retinal telescreening by digital imaging of multiple different fundus areas to screen for vision-threatening conditions, including imaging, interpretation and report
S3000	HCPCS	Diabetic indicator, retinal eye exam, dilated, bilateral

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Comprehensive Diabetes Care – A1c Control and Poor Control (CDC-A1c)

For the commercial, Medicaid and Medicare lines of business

Comprehensive diabetes care – hemoglobin A1c testing (CDC-A1c) measures the percentage of patients 18 to 75 years old with diabetes (Type 1 or 2) who had hemoglobin A1c testing and either have their blood sugar controlled or under poor control. Below are the Current Procedural Terminology Category II (CPT® II) codes that indicate the control level.

Code	Code Type	Definition
3044F	CPT II	Most recent hemoglobin A1c level less than 7 percent
3045F	CPT II	Most recent hemoglobin A1c level 7 to 9 percent
3046F	CPT II	Most recent hemoglobin A1c level greater than 9 percent

Comprehensive Diabetes Care – Medical Attention for Nephropathy (CDC-neph)

For the commercial, Medicaid and Medicare lines of business

Comprehensive diabetes care – medical attention for nephropathy (CDC-neph) measures the percentage of patients 18 to 75 years old with diabetes (Type 1 or 2) who have received medical attention for nephropathy through a screening test. Below are the Current Procedural Terminology (CPT®) codes and Logical Observation Identifiers Names and Codes (LOINC®) that indicate the nephropathy screening test has been performed.

Code	Code type	Definition
81001	CPT	Automated, with microscopy
81002	CPT	Nonautomated, without microscopy
81003	CPT	Automated, without microscopy
81005	CPT	Urinalysis; qualitative or semiquantitative, except immunoassays
82042	CPT	Albumin; urine or other source, quantitative, each specimen
82043	CPT	Albumin; urine, microalbumin, quantitative
82044	CPT	Albumin; urine, microalbumin, semiquantitative (e.g., reagent strip assay)
84156	CPT	Protein, total, except by refractometry; urine
3060F	CPT	Positive microalbuminuria test result documented and reviewed (diabetes mellitus)
3061F	CPT	Negative microalbuminuria test result documented and reviewed (diabetes mellitus)
3062F	CPT	Positive macroalbuminuria test result documented and reviewed (DM)
11218-5	LOINC	Microalbumin (mass/volume) in urine by test strip
12842-1	LOINC	Protein (mass/volume) in 12-hour urine
13705-9	LOINC	Albumin/creatinine (mass ratio) in 24-hour urine
13801-6	LOINC	Protein/creatinine (mass ratio) in 24-hour urine
14585-4	LOINC	Albumin/creatinine (molar ratio) in urine
14956-7	LOINC	Microalbumin (mass/time) in 24-hour urine
14957-5	LOINC	Microalbumin (mass/volume) in urine
14958-3	LOINC	Microalbumin/creatinine (mass ratio) in 24-hour urine
14959-1	LOINC	Microalbumin/creatinine (mass ratio) in urine
1753-3	LOINC	Albumin (presence) in urine
1754-1	LOINC	Albumin (mass/volume) in urine
1755-8	LOINC	Albumin (mass/time) in 24-hour urine
1757-4	LOINC	Albumin renal clearance in 24 hours
18373-1	LOINC	Protein (mass/time) in six-hour urine
20454-5	LOINC	Protein (presence) in urine by test strip
20621-9	LOINC	Albumin/creatinine (presence) in urine by test strip
21059-1	LOINC	Albumin (mass/volume) in 24-hour urine
21482-5	LOINC	Protein (mass/volume) in 24-hour urine

26801-1	LOINC	Protein (mass/time) in 12-hour urine
27298-9	LOINC	Protein (units/volume) in urine
2887-8	LOINC	Protein (presence) in urine
2888-6	LOINC	Protein (mass/volume) in urine
2889-4	LOINC	Protein (mass/time) in 24-hour urine
2890-2	LOINC	Protein/creatinine (mass ratio) in urine
30000-4	LOINC	Microalbumin/creatinine (ratio) in urine
30001-2	LOINC	Microalbumin/creatinine (ratio) in urine by test strip
30003-8	LOINC	Microalbumin (mass/volume) in 24-hour urine
32209-9	LOINC	Protein (presence) in 24-hour urine by test strip
32294-1	LOINC	Albumin/creatinine (ratio) in urine
32551-4	LOINC	Protein (mass) in unspecified time urine
34366-5	LOINC	Protein/creatinine (ratio) in urine
35663-4	LOINC	Protein (mass/volume) in unspecified time urine
40486-3	LOINC	Protein/creatinine (ratio) in 24-hour urine
40662-9	LOINC	Protein (mass/time) in 12-hour urine-resting
40663-7	LOINC	Protein (mass/time) in 12-hour urine-upright
43605-5	LOINC	Microalbumin (mass/volume) in four-hour urine
43606-3	LOINC	Microalbumin (mass/time) in four-hour urine
43607-1	LOINC	Microalbumin (mass/time) in 12-hour urine
44292-1	LOINC	Microalbumin/creatinine (mass ratio) in 12-hour urine
47558-2	LOINC	Microalbumin/protein total in 24-hour urine
49023-5	LOINC	Microalbumin (mass/time) in unspecified time urine
50561-0	LOINC	Protein (mass/volume) in urine by automated test strip
50949-7	LOINC	Albumin (presence) in urine by test strip
53121-0	LOINC	Protein (mass/time) in one-hour urine
53525-2	LOINC	Protein (presence) in urine by SSA method
53530-2	LOINC	Microalbumin (mass/volume) in 24-hour urine by detection limit 1.0 mg/L or less
53531-0	LOINC	Microalbumin (mass/volume) in urine by detection limit 1.0 mg/L or less
53532-8	LOINC	Microalbumin (mass/time) in 24-hour urine by detection limit 1.0 mg/L or less
56553-1	LOINC	Microalbumin (mass/time) in eight-hour urine
57369-1	LOINC	Microalbumin (mass/volume) in 12-hour urine
57735-3	LOINC	Protein (presence) in urine by automated test strip
5804-0	LOINC	Protein (mass/volume) in urine by test strip
58448-2	LOINC	Microalbumin ug/min (mass/time) in 24-hour urine
58992-9	LOINC	Protein (mass/time) in 18-hour urine
59159-4	LOINC	Microalbumin/creatinine (ratio) in 24-hour urine

60678-0	LOINC	Protein/creatinine (mass ratio) in 12-hour urine
63474-1	LOINC	Microalbumin (mass/time) in 18-hour urine
9318-7	LOINC	Albumin/creatinine (mass ratio) in urine

CPT codes are the Current Procedural Terminology codes developed by the American Medical Association.
HEDIS is a set of standardized performance measures designed to help purchasers and consumers compare the performance of health plans on an "apples-to-apples" basis. HEDIS is a registered trademark of the National Committee for Quality Assurance.
LOINC® is the Logical Observation Identifiers Names and Codes database developed by the Regenstrief Institute.

Osteoporosis Management in Women Who Had a Fracture (OMW)

For the Medicare line of business

Osteoporosis management in women who had a fracture (OMW) measures the percentage of women 67 to 85 years old who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat or prevent osteoporosis in the six months after the fracture. Fractures of fingers, toes, face and skull are not included in this measure. Below are the Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and ICD-10-CM procedure codes that indicate either a BMD test has been performed or a prescription has been given.

Code	Code type	Definition
88.98	ICD9PCS	Bone mineral density studies
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)
77082	CPT	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment
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
G0130	HCPCS	Single energy X-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

ICD-10 codes

Code	Code type	Definition
BP48ZZ1	ICD10PCS	Ultrasonography of right shoulder, densitometry
BP49ZZ1	ICD10PCS	Ultrasonography of left shoulder, densitometry
BP4GZZ1	ICD10PCS	Ultrasonography of right elbow, densitometry
BP4HZZ1	ICD10PCS	Ultrasonography of left elbow, densitometry
BP4LZZ1	ICD10PCS	Ultrasonography of right wrist, densitometry
BP4MZZ1	ICD10PCS	Ultrasonography of left wrist, densitometry
BP4NZZ1	ICD10PCS	Ultrasonography of right hand, densitometry
BP4PZZ1	ICD10PCS	Ultrasonography of left hand, densitometry
BQ00ZZ1	ICD10PCS	Plain radiography of right hip, densitometry
BQ01ZZ1	ICD10PCS	Plain radiography of left hip, densitometry
BQ03ZZ1	ICD10PCS	Plain radiography of right femur, densitometry
BQ04ZZ1	ICD10PCS	Plain radiography of left femur, densitometry

BR00ZZ1	ICD10PCS	Plain radiography of cervical spine, densitometry
BR07ZZ1	ICD10PCS	Plain radiography of thoracic spine, densitometry
BR09ZZ1	ICD10PCS	Plain radiography of lumbar spine, densitometry
BR0GZZ1	ICD10PCS	Plain radiography of whole spine, densitometry

FDA-approved osteoporosis therapies

Code	Code type	Definition
J0897	HCPCS	Injection, denosumab, 1 mg
J1740	HCPCS	Injection, ibandronate sodium, 1 mg
J3487	HCPCS	Injection, zoledronic acid (Zometa), 1 mg
J3488	HCPCS	Injection, zoledronic acid (Reclast), 1 mg
J3489	HCPCS	Injection, zoledronic acid, 1 mg
Q2051	HCPCS	Injection, zoledronic acid, not otherwise specified, 1 mg
J0630	HCPCS	Injection, calcitonin salmon, up to 400 units
J0897	HCPCS	Injection, denosumab, 1 mg
J1740	HCPCS	Injection, ibandronate sodium, 1 mg
J3110	HCPCS	Injection, teriparatide, 10 mcg

Note: The National Committee for Quality Assurance (NCQA) has a comprehensive list of medications and National Drug Code (NDC) codes posted at www.ncqa.org.

Disease-modifying Antirheumatic Drug Therapy for Rheumatoid Arthritis (ART)

For Medicaid and Medicare lines of business

This measure evaluates patients 18 years old or older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying antirheumatic drug (DMARD). The tables below outline ICD-10-CM diagnosis codes to identify rheumatoid arthritis and the DMARDs included in the measure.

ICD-10 codes

Code	Code type	Definition
714.0	Diagnosis	Rheumatoid arthritis (RA)
714.1	Diagnosis	Felty's syndrome
714.2	Diagnosis	Other rheumatoid arthritis with visceral or system involvement
714.81	Diagnosis	Rheumatoid lung

The following DMARDs are included in the Stars/Healthcare Effectiveness Data and Information Set (HEDIS®) measure that states "when prescribing DMARDs for your RA patients, please consider if these drugs would be an effective treatment for their personal medical situation."

Code	Description
J0129	Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J0135	Injection, adalimumab, 20 mg
J0717	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1600	Injection, gold sodium thiomalate, up to 50 mg
J1602	Injection, golimumab, 1 mg, for intravenous use
J1745	Injection infliximab, 10 mg
J3262	Injection, tocilizumab, 1 mg
J7502	Cyclosporine, oral, 100 mg
J7515	Cyclosporine, oral, 25 mg
J7516	Cyclosporin, parenteral, 250 mg
J7517	Mycophenolate mofetil, oral, 250 mg
J7518	Mycophenolic acid, oral, 180 mg
J9250	Methotrexate sodium, 5 mg
J9260	Methotrexate sodium, 50 mg
J9310	Injection, rituximab, 100 mg

ICD-10 codes

Code	Code type	Description
M05.00	Diagnosis	Felty's syndrome, unspecified site
M05.011	Diagnosis	Felty's syndrome, right shoulder
M05.012	Diagnosis	Felty's syndrome, left shoulder
M05.019	Diagnosis	Felty's syndrome, unspecified shoulder
M05.021	Diagnosis	Felty's syndrome, right elbow
M05.022	Diagnosis	Felty's syndrome, left elbow
M05.029	Diagnosis	Felty's syndrome, unspecified elbow
M05.031	Diagnosis	Felty's syndrome, right wrist
M05.032	Diagnosis	Felty's syndrome, left wrist
M05.039	Diagnosis	Felty's syndrome, unspecified wrist
M05.041	Diagnosis	Felty's syndrome, right hand
M05.042	Diagnosis	Felty's syndrome, left hand
M05.049	Diagnosis	Felty's syndrome, unspecified hand
M05.051	Diagnosis	Felty's syndrome, right hip
M05.052	Diagnosis	Felty's syndrome, left hip
M05.059	Diagnosis	Felty's syndrome, unspecified hip
M05.061	Diagnosis	Felty's syndrome, right knee
M05.062	Diagnosis	Felty's syndrome, left knee
M05.069	Diagnosis	Felty's syndrome, unspecified knee
M05.071	Diagnosis	Felty's syndrome, right ankle and foot
M05.072	Diagnosis	Felty's syndrome, left ankle and foot
M05.079	Diagnosis	Felty's syndrome, unspecified ankle and foot
M05.09	Diagnosis	Felty's syndrome, multiple sites
M05.10	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified site
M05.111	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of right shoulder
M05.112	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of left shoulder
M05.119	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified shoulder
M05.121	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of right elbow
M05.122	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of left elbow
M05.129	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified elbow
M05.131	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of right wrist
M05.132	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of left wrist
M05.139	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified wrist
M05.141	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of right hand

M05.142	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of left hand
M05.149	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified hand
M05.151	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of right hip
M05.152	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of left hip
M05.159	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified hip
M05.161	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of right knee
M05.162	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of left knee
M05.169	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified knee
M05.171	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of right ankle and foot
M05.172	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of left ankle and foot
M05.179	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of unspecified ankle and foot
M05.19	Diagnosis	Rheumatoid lung disease with rheumatoid arthritis of multiple sites
M05.20	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified site
M05.211	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of right shoulder
M05.212	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of left shoulder
M05.219	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified shoulder
M05.221	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of right elbow
M05.222	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of left elbow
M05.229	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified elbow
M05.231	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of right wrist
M05.232	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of left wrist
M05.239	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified wrist
M05.241	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of right hand
M05.242	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of left hand
M05.249	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified hand
M05.251	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of right hip
M05.252	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of left hip
M05.259	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified hip
M05.261	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of right knee
M05.262	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of left knee
M05.269	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified knee
M05.271	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of right ankle and foot
M05.272	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of left ankle and foot
M05.279	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of unspecified ankle and foot
M05.29	Diagnosis	Rheumatoid vasculitis with rheumatoid arthritis of multiple sites
M05.30	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified site
M05.311	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of right shoulder

M05.312	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of left shoulder
M05.319	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified shoulder
M05.321	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of right elbow
M05.322	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of left elbow
M05.329	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified elbow
M05.331	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of right wrist
M05.332	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of left wrist
M05.339	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified wrist
M05.341	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of right hand
M05.342	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of left hand
M05.349	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified hand
M05.351	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of right hip
M05.352	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of left hip
M05.359	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified hip
M05.361	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of right knee
M05.362	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of left knee
M05.369	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified knee
M05.371	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of right ankle and foot
M05.372	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of left ankle and foot
M05.379	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of unspecified ankle and foot
M05.39	Diagnosis	Rheumatoid heart disease with rheumatoid arthritis of multiple sites
M05.40	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified site
M05.411	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of right shoulder
M05.412	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of left shoulder
M05.419	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified shoulder
M05.421	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of right elbow
M05.422	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of left elbow
M05.429	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified elbow
M05.431	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of right wrist
M05.432	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of left wrist
M05.439	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified wrist
M05.441	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of right hand
M05.442	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of left hand
M05.449	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified hand
M05.451	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of right hip
M05.452	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of left hip
M05.459	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified hip

M05.461	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of right knee
M05.462	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of left knee
M05.469	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified knee
M05.471	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot
M05.472	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of left ankle and foot
M05.479	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of unspecified ankle and foot
M05.49	Diagnosis	Rheumatoid myopathy with rheumatoid arthritis of multiple sites
M05.50	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site
M05.511	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of right shoulder
M05.512	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of left shoulder
M05.519	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified shoulder
M05.521	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of right elbow
M05.522	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of left elbow
M05.529	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified elbow
M05.531	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of right wrist
M05.532	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of left wrist
M05.539	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified wrist
M05.541	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of right hand
M05.542	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of left hand
M05.549	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hand
M05.551	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of right hip
M05.552	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of left hip
M05.559	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hip
M05.561	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of right knee
M05.562	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of left knee
M05.569	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee
M05.571	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot
M05.572	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot
M05.579	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified ankle and foot
M05.59	Diagnosis	Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites
M05.60	Diagnosis	Rheumatoid arthritis of unspecified site with involvement of other organs and systems
M05.611	Diagnosis	Rheumatoid arthritis of right shoulder with involvement of other organs and systems
M05.612	Diagnosis	Rheumatoid arthritis of left shoulder with involvement of other organs and systems
M05.619	Diagnosis	Rheumatoid arthritis of unspecified shoulder with involvement of other organs and systems
M05.621	Diagnosis	Rheumatoid arthritis of right elbow with involvement of other organs and systems
M05.622	Diagnosis	Rheumatoid arthritis of left elbow with involvement of other organs and systems
M05.629	Diagnosis	Rheumatoid arthritis of unspecified elbow with involvement of other organs and systems

M05.631	Diagnosis	Rheumatoid arthritis of right wrist with involvement of other organs and systems
M05.632	Diagnosis	Rheumatoid arthritis of left wrist with involvement of other organs and systems
M05.639	Diagnosis	Rheumatoid arthritis of unspecified wrist with involvement of other organs and systems
M05.641	Diagnosis	Rheumatoid arthritis of right hand with involvement of other organs and systems
M05.642	Diagnosis	Rheumatoid arthritis of left hand with involvement of other organs and systems
M05.649	Diagnosis	Rheumatoid arthritis of unspecified hand with involvement of other organs and systems
M05.651	Diagnosis	Rheumatoid arthritis of right hip with involvement of other organs and systems
M05.652	Diagnosis	Rheumatoid arthritis of left hip with involvement of other organs and systems
M05.659	Diagnosis	Rheumatoid arthritis of unspecified hip with involvement of other organs and systems
M05.661	Diagnosis	Rheumatoid arthritis of right knee with involvement of other organs and systems
M05.662	Diagnosis	Rheumatoid arthritis of left knee with involvement of other organs and systems
M05.669	Diagnosis	Rheumatoid arthritis of unspecified knee with involvement of other organs and systems
M05.671	Diagnosis	Rheumatoid arthritis of right ankle and foot with involvement of other organs and systems
M05.672	Diagnosis	Rheumatoid arthritis of left ankle and foot with involvement of other organs and systems
M05.679	Diagnosis	Rheumatoid arthritis of unspecified ankle and foot with involvement of other organs and systems
M05.69	Diagnosis	Rheumatoid arthritis of multiple sites with involvement of other organs and systems
M05.70	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement
M05.711	Diagnosis	Rheumatoid arthritis with rheumatoid factor of right shoulder without organ or systems involvement
M05.712	Diagnosis	Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement
M05.719	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified shoulder without organ or systems involvement
M05.721	Diagnosis	Rheumatoid arthritis with rheumatoid factor of right elbow without organ or systems involvement
M05.722	Diagnosis	Rheumatoid arthritis with rheumatoid factor of left elbow without organ or systems involvement
M05.729	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified elbow without organ or systems involvement
M05.731	Diagnosis	Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement
M05.732	Diagnosis	Rheumatoid arthritis with rheumatoid factor of left wrist without organ or systems involvement
M05.739	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified wrist without organ or systems involvement
M05.741	Diagnosis	Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems
M05.742	Diagnosis	Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement
M05.749	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified hand without organ or systems involvement
M05.751	Diagnosis	Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement

M05.752	Diagnosis	Rheumatoid arthritis with rheumatoid factor of left hip without organ or systems involvement
M05.759	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified hip without organ or systems involvement
M05.761	Diagnosis	Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement
M05.762	Diagnosis	Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement
M05.769	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified knee without organ or systems involvement
M05.771	Diagnosis	Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement
M05.772	Diagnosis	Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement
M05.779	Diagnosis	Rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot without organ or systems involvement
M05.79	Diagnosis	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M05.80	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified site
M05.811	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of right shoulder
M05.812	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of left shoulder
M05.819	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified shoulder
M05.821	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of right elbow
M05.822	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of left elbow
M05.829	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified elbow
M05.831	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of right wrist
M05.832	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of left wrist
M05.839	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified wrist
M05.841	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of right hand
M05.842	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of left hand
M05.849	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified hand
M05.851	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of right hip
M05.852	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of left hip
M05.859	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified hip
M05.861	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of right knee
M05.862	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of left knee
M05.869	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified knee
M05.871	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of right ankle and foot
M05.872	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of left ankle and foot
M05.879	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of unspecified ankle and foot
M05.89	Diagnosis	Other rheumatoid arthritis with rheumatoid factor of multiple sites

M05.9	Diagnosis	Rheumatoid arthritis with rheumatoid factor, unspecified
M06.00	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified site
M06.011	Diagnosis	Rheumatoid arthritis without rheumatoid factor, right shoulder
M06.012	Diagnosis	Rheumatoid arthritis without rheumatoid factor, left shoulder
M06.019	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified shoulder
M06.021	Diagnosis	Rheumatoid arthritis without rheumatoid factor, right elbow
M06.022	Diagnosis	Rheumatoid arthritis without rheumatoid factor, left elbow
M06.029	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified elbow
M06.031	Diagnosis	Rheumatoid arthritis without rheumatoid factor, right wrist
M06.032	Diagnosis	Rheumatoid arthritis without rheumatoid factor, left wrist
M06.039	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified wrist
M06.041	Diagnosis	Rheumatoid arthritis without rheumatoid factor, right hand
M06.042	Diagnosis	Rheumatoid arthritis without rheumatoid factor, left hand
M06.049	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified hand
M06.051	Diagnosis	Rheumatoid arthritis without rheumatoid factor, right hip
M06.052	Diagnosis	Rheumatoid arthritis without rheumatoid factor, left hip
M06.059	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified hip
M06.061	Diagnosis	Rheumatoid arthritis without rheumatoid factor, right knee
M06.062	Diagnosis	Rheumatoid arthritis without rheumatoid factor, left knee
M06.069	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified knee
M06.071	Diagnosis	Rheumatoid arthritis without rheumatoid factor, right ankle and foot
M06.072	Diagnosis	Rheumatoid arthritis without rheumatoid factor, left ankle and foot
M06.079	Diagnosis	Rheumatoid arthritis without rheumatoid factor, unspecified ankle and foot
M06.08	Diagnosis	Rheumatoid arthritis without rheumatoid factor, vertebrae
M06.09	Diagnosis	Rheumatoid arthritis without rheumatoid factor, multiple sites
M06.1	Diagnosis	Adult-onset Still's disease
M06.20	Diagnosis	Rheumatoid bursitis, unspecified site
M06.211	Diagnosis	Rheumatoid bursitis, right shoulder
M06.212	Diagnosis	Rheumatoid bursitis, left shoulder
M06.219	Diagnosis	Rheumatoid bursitis, unspecified shoulder
M06.221	Diagnosis	Rheumatoid bursitis, right elbow
M06.222	Diagnosis	Rheumatoid bursitis, left elbow
M06.229	Diagnosis	Rheumatoid bursitis, unspecified elbow
M06.231	Diagnosis	Rheumatoid bursitis, right wrist
M06.232	Diagnosis	Rheumatoid bursitis, left wrist
M06.239	Diagnosis	Rheumatoid bursitis, unspecified wrist
M06.241	Diagnosis	Rheumatoid bursitis, right hand

M06.242	Diagnosis	Rheumatoid bursitis, left hand
M06.249	Diagnosis	Rheumatoid bursitis, unspecified hand
M06.251	Diagnosis	Rheumatoid bursitis, right hip
M06.252	Diagnosis	Rheumatoid bursitis, left hip
M06.259	Diagnosis	Rheumatoid bursitis, unspecified hip
M06.261	Diagnosis	Rheumatoid bursitis, right knee
M06.262	Diagnosis	Rheumatoid bursitis, left knee
M06.269	Diagnosis	Rheumatoid bursitis, unspecified knee
M06.271	Diagnosis	Rheumatoid bursitis, right ankle and foot
M06.272	Diagnosis	Rheumatoid bursitis, left ankle and foot
M06.279	Diagnosis	Rheumatoid bursitis, unspecified ankle and foot
M06.28	Diagnosis	Rheumatoid bursitis, vertebrae
M06.29	Diagnosis	Rheumatoid bursitis, multiple sites
M06.30	Diagnosis	Rheumatoid nodule, unspecified site
M06.311	Diagnosis	Rheumatoid nodule, right shoulder
M06.312	Diagnosis	Rheumatoid nodule, left shoulder
M06.319	Diagnosis	Rheumatoid nodule, unspecified shoulder
M06.321	Diagnosis	Rheumatoid nodule, right elbow
M06.322	Diagnosis	Rheumatoid nodule, left elbow
M06.329	Diagnosis	Rheumatoid nodule, unspecified elbow
M06.331	Diagnosis	Rheumatoid nodule, right wrist
M06.332	Diagnosis	Rheumatoid nodule, left wrist
M06.339	Diagnosis	Rheumatoid nodule, unspecified wrist
M06.341	Diagnosis	Rheumatoid nodule, right hand
M06.342	Diagnosis	Rheumatoid nodule, left hand
M06.349	Diagnosis	Rheumatoid nodule, unspecified hand
M06.351	Diagnosis	Rheumatoid nodule, right hip
M06.352	Diagnosis	Rheumatoid nodule, left hip
M06.359	Diagnosis	Rheumatoid nodule, unspecified hip
M06.361	Diagnosis	Rheumatoid nodule, right knee
M06.362	Diagnosis	Rheumatoid nodule, left knee
M06.369	Diagnosis	Rheumatoid nodule, unspecified knee
M06.371	Diagnosis	Rheumatoid nodule, right ankle and foot
M06.372	Diagnosis	Rheumatoid nodule, left ankle and foot
M06.379	Diagnosis	Rheumatoid nodule, unspecified ankle and foot
M06.38	Diagnosis	Rheumatoid nodule, vertebrae
M06.39	Diagnosis	Rheumatoid nodule, multiple sites

M06.80	Diagnosis	Other specified rheumatoid arthritis, unspecified site
M06.811	Diagnosis	Other specified rheumatoid arthritis, right shoulder
M06.812	Diagnosis	Other specified rheumatoid arthritis, left shoulder
M06.819	Diagnosis	Other specified rheumatoid arthritis, unspecified shoulder
M06.821	Diagnosis	Other specified rheumatoid arthritis, right elbow
M06.822	Diagnosis	Other specified rheumatoid arthritis, left elbow
M06.829	Diagnosis	Other specified rheumatoid arthritis, unspecified elbow
M06.831	Diagnosis	Other specified rheumatoid arthritis, right wrist
M06.832	Diagnosis	Other specified rheumatoid arthritis, left wrist
M06.839	Diagnosis	Other specified rheumatoid arthritis, unspecified wrist
M06.841	Diagnosis	Other specified rheumatoid arthritis, right hand
M06.842	Diagnosis	Other specified rheumatoid arthritis, left hand
M06.849	Diagnosis	Other specified rheumatoid arthritis, unspecified hand
M06.851	Diagnosis	Other specified rheumatoid arthritis, right hip
M06.852	Diagnosis	Other specified rheumatoid arthritis, left hip
M06.859	Diagnosis	Other specified rheumatoid arthritis, unspecified hip
M06.861	Diagnosis	Other specified rheumatoid arthritis, right knee
M06.862	Diagnosis	Other specified rheumatoid arthritis, left knee
M06.869	Diagnosis	Other specified rheumatoid arthritis, unspecified knee
M06.871	Diagnosis	Other specified rheumatoid arthritis, right ankle and foot
M06.872	Diagnosis	Other specified rheumatoid arthritis, left ankle and foot
M06.879	Diagnosis	Other specified rheumatoid arthritis, unspecified ankle and foot
M06.88	Diagnosis	Other specified rheumatoid arthritis, vertebrae
M06.89	Diagnosis	Other specified rheumatoid arthritis, multiple sites
M06.9	Diagnosis	Rheumatoid arthritis, unspecified

Note: The National Committee for Quality Assurance (NCQA) has a comprehensive list of medications and National Drug Code (NDC) codes at www.ncqa.org.

Adult BMI Assessment (ABA)

For commercial, Medicaid and Medicare lines of business

This Healthcare Effectiveness Data and Information Set (HEDIS®) measure records the patient's body mass index (BMI), a statistical measure of a person's weight scaled according to height. The ICD-10-CM diagnosis codes below are used to identify BMI. Please make sure when capturing height and weight to also calculate and document BMI in the medical record. Also, please include the appropriate diagnosis and Healthcare Common Procedure Coding System (HCPCS) codes when submitting a claim.

ICD-10 codes

Code	Code type	Definition
V85.0	Diagnosis	Body mass index less than 18.9, adult
V85.1	Diagnosis	Body mass index 19 to 24.9, adult
V85.21	Diagnosis	Body mass index 25 to 25.9, adult
V85.22	Diagnosis	Body mass index 26 to 26.9, adult
V85.23	Diagnosis	Body mass index 27 to 27.9, adult
V85.24	Diagnosis	Body mass index 28 to 28.9, adult
V85.25	Diagnosis	Body mass index 29 to 29.9, adult
V85.30	Diagnosis	Body mass index 30 to 30.9, adult
V85.31	Diagnosis	Body mass index 31 to 31.9, adult
V85.32	Diagnosis	Body mass index 32 to 32.9, adult
V85.33	Diagnosis	Body mass index 33 to 33.9, adult
V85.34	Diagnosis	Body mass index 34 to 34.9, adult
V85.35	Diagnosis	Body mass index 35 to 35.9, adult
V85.36	Diagnosis	Body mass index 36 to 36.9, adult
V85.37	Diagnosis	Body mass index 37 to 37.9, adult
V85.38	Diagnosis	Body mass index 38 to 38.9, adult
V85.39	Diagnosis	Body mass index 39 to 39.9, adult
V85.41	Diagnosis	Body mass index 40 to 44.9, adult
V85.42	Diagnosis	Body mass index 45 to 49.9, adult
V85.43	Diagnosis	Body mass index 50 to 59.9, adult
V85.44	Diagnosis	Body mass index 60 to 69.9, adult
V85.45	Diagnosis	Body mass index 70 and greater, adult

ICD-10 codes

Code	Code type	Definition
Z68.1	Diagnosis	Body mass index (BMI) 19 or less, adult
Z68.20	Diagnosis	Body mass index (BMI) 20.0 to 20.9, adult
Z68.21	Diagnosis	Body mass index (BMI) 21.0 to 21.9, adult

Z68.22	Diagnosis	Body mass index (BMI) 22.0 to 22.9, adult
Z68.23	Diagnosis	Body mass index (BMI) 23.0 to 23.9, adult
Z68.24	Diagnosis	Body mass index (BMI) 24.0 to 24.9, adult
Z68.25	Diagnosis	Body mass index (BMI) 25.0 to 25.9, adult
Z68.26	Diagnosis	Body mass index (BMI) 26.0 to 26.9, adult
Z68.27	Diagnosis	Body mass index (BMI) 27.0 to 27.9, adult
Z68.28	Diagnosis	Body mass index (BMI) 28.0 to 28.9, adult
Z68.29	Diagnosis	Body mass index (BMI) 29.0 to 29.9, adult
Z68.30	Diagnosis	Body mass index (BMI) 30.0 to 30.9, adult
Z68.31	Diagnosis	Body mass index (BMI) 31.0 to 31.9, adult
Z68.32	Diagnosis	Body mass index (BMI) 32.0 to 32.9, adult
Z68.33	Diagnosis	Body mass index (BMI) 33.0 to 33.9, adult
Z68.34	Diagnosis	Body mass index (BMI) 34.0 to 34.9, adult
Z68.35	Diagnosis	Body mass index (BMI) 35.0 to 35.9, adult
Z68.36	Diagnosis	Body mass index (BMI) 36.0 to 36.9, adult
Z68.37	Diagnosis	Body mass index (BMI) 37.0 to 37.9, adult
Z68.38	Diagnosis	Body mass index (BMI) 38.0 to 38.9, adult
Z68.39	Diagnosis	Body mass index (BMI) 39.0 to 39.9, adult
Z68.41	Diagnosis	Body mass index (BMI) 40.0 to 44.9, adult
Z68.42	Diagnosis	Body mass index (BMI) 45.0 to 49.9, adult
Z68.43	Diagnosis	Body mass index (BMI) 50 to 59.9, adult
Z68.44	Diagnosis	Body mass index (BMI) 60.0 to 69.9, adult
Z68.45	Diagnosis	Body mass index (BMI) 70 or greater, adult

Care for Older Adults (COA)

For the Medicare line of business

One prevention and screening measure for the Centers for Medicare & Medicaid Services (CMS) Star ratings system and the Healthcare Effectiveness Data and Information Set (HEDIS®) is care for older adults (COA). This measure evaluates the percentage of adults 66 years old or older who had each of the following during the measurement year: medication review, functional status assessment and pain assessment. Below are the Current Procedural Terminology (CPT®), Current Procedural Terminology Category II (CPT II) and Healthcare Common Procedure Coding System (HCPCS) codes that indicate these services have been performed.

Code	Code type	Definition
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy
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 document in the medical record
1170F	CPT II	Functional status assessed
1125F	CPT II	Pain severity quantified; pain present
1126F	CPT II	Pain severity quantified; no pain present
1157F	CPT II	Advance care plan or similar legal document present in the medical record
1158F	CPT II	Advance care planning discussion 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
S0257	HCPCS	Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)

CPT codes are the Current Procedural Terminology codes developed by the American Medical Association.
HEDIS® is a set of standardized performance measures designed to help purchasers and consumers compare the performance of health plans on an "apples-to-apples" basis. HEDIS is a registered trademark of the National Committee for Quality Assurance.