



STAR METRIC	CRITERIA	COMPLIANCE ATTRIBUTION
Breast Cancer Screening (BCS) Eligible (denominator) Female patients age 52–74 Compliant (numerator) Mammogram completed anytime on or between October 1, two years prior to the measurement year, and December 31 of the measurement year	• Mammogram or digital breast tomosynthesis during the measurement year or year prior • Biopsies, breast ultrasounds, of MRIs are not included for this measure Exclude: Patients with a history or bilateral mastectomy or two unilateral mastectomies, patients age 66 and older with frailty and advanced illness	To identify Mammogram: CPT: CPT 77055-77057, 77061-77063, 77065-77067 HCPCS: G0202, G0204, G0206 ICD-9-PCS: 87.36, 87.37 UBREV: 0401, 0403 To identify Double Mastectomy Exclusion: Appropriate coding for bilateral or two unilateral mastectomies must be received
Colorectal Cancer Screening (COL) Eligible (denominator) Patients age 51–75 Compliant (numerator) Appropriate screening for colorectal cancer completed	One or more of the following screenings: • FOBT during measurement year • Flexible sigmoidoscopy in measurement year or prior 4 years • Colonoscopy in measurement year or prior 9 years • Stool DNA FIT in measurement year or prior 2 years • CT colonography in measurement year or prior 4 years Exclude: Patients with a history of colorectal cancer or total colectomy, patients age 66 and older with frailty and advanced illness	To identify FOBT: CPT: 82270, 82274 HCPCS: G0328 LOINC: 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6 To identify Flexible Sigmoidoscopy: CPT: 45330-45335, 45337-45342, 45345-45347, 45349, 45350 HCPCS: G0104 ICD-9-PCS: 45.24 To identify Colonoscopy: CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121 ICD-9-PCS: 45.22, 45.23, 45.25, 45.42, 45.43 To identify Stool DNA FIT: CPT: 81528 LOINC: 77353-1, 77354-9 HCPCS: G0464 To identify CT Colonography: CPT: 74261, 74262, 74263
Care for Older Adults (COA) Eligible (denominator) Special Needs Plan (SNP) patients age 66 and older Compliant (numerator) Patients who have had the following during the measurement year: • Medication Review • Pain Assessment • Functional status assessment	Medication Review: Notation patient is not on any meds or med list in medical record, along with evidence of medication review conducted by clinical pharmacist or prescribing practitioner. Patient does not have to be present or involved. Pain Assessment: Documentation that patient was assessed for pain during the measurement year Functional Status: At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.	To identify Medication Review and List: NOTE: Med Review code and List code must appear on the same claim to meet measure specifications CPT (Med Review): 90863, 99605, 99606 CPT II (Med Review): 1160F CPT II (Med List): 1159F or HCPCS G8427 To identify Pain Assessment: CPT II: 1125F, 1126F CPT II (Functional Status): 1170F
Eye Exam for Patients with Diabetes (EED) Eligible (denominator) Patients age 18–75 with type I or type II diabetes defined as: • Diagnosis or dispensed prescription in the measurement year or year prior • 2 outpatient, obs, ED, or non-acute inpatient visits on different dates of service (1 of 2 visits may be telehealth or online assessment) • OR 1 acute inpatient encounter • OR 1 dispensed prescription for insulin or hypoglycemic/antihyperglycemics Compliant (numerator) Patients who received the following during the measurement year: • Retinal eye exam	Eye Exam (EED): • Retinal exam during the year or negative exam during the year prior • Eye exam must be completed by eye care provider • Bilateral eye enucleation NOTE: Any provider type may complete retinal exam using retinal scanner. Results must be interpreted by an eye care provider. Provider should bill one of the following CPT codes: 92250, 92227, or 92228 along with one of the following CPT II codes: 2022F, 2024F, or 2026F. • Any provider can submit retinopathy status using CPT II 3072F in the year following eye exam to indicate “no retinopathy” Exclude: Patients age 66 and older with frailty and advanced illness	To identify Eye Exam for Patients with Diabetes NOTE: The following codes must be filed by eye care provider: CPT: 67028, 67030, 67031, 67036, 67039, 67040-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 HCPCS: S0620, S0621, S3000 The following codes can be filed by any provider type: CPT II: 3072F, 2022F, 2023F, 2024F, 2025F, 2026F, 2033F

STAR METRIC	CRITERIA	COMPLIANCE ATTRIBUTION
Hemoglobin A1c Control for Patients with Diabetes (HBD) Eligible (denominator) Patients age 18–75 with type I or type II diabetes defined as: • Diagnosis or dispensed prescription in the measurement year or year prior • 2 outpatient, obs, ED, or non-acute inpatient visits on different dates of service (1 of 2 visits may be telehealth or online assessment) • OR 1 acute inpatient encounter • OR 1 dispensed prescription for insulin or hypoglycemic/antihyperglycemics Compliant (numerator) Patients who received the following during the measurement year: • HbA1c screen with controlled result <=9	HbA1c Screen with Result <=9: • Most recent lab value during the year will be representative value • Patients without screening are considered noncompliant Eye Exam (DRE): • Retinal exam during the year or negative exam during the year prior • Eye exam must be completed by eye care provider • Bilateral eye enucleation NOTE: Any provider type may complete retinal exam using retinal scanner. Results must be interpreted by an eye care provider. Provider should bill one of the following CPT codes: 92250, 92227, or 92228 along with one of the following CPT II codes: 2022F, 2024F, or 2026F. • Any provider can submit retinopathy status using CPT II 3072F in the year following eye exam to indicate “no retinopathy” Exclude: Patients age 66 and older with frailty and advanced illness	To identify HbA1c Screening and Value: CPT: 83036, 83037 CPT II: (7.0-8.0 use 3051F), (8.0-9.0 use 3052F), (>9 use 3046F), (<7 use 3044F) LOINC: 17856-6, 4548-4, 4549-2
Controlling High Blood Pressure (CBP) Eligible (denominator) Patients age 18–85 who had at least 2 visits on different dates of service with a Dx of hypertension during measurement year or prior year Compliant (numerator) Final BP reading of the year defined as: • < 140/90 (Goal 139/89)	• Identify the most recent BP reading noted during the measurement year • The reading must occur on or after the date when the second diagnosis of hypertension was confirmed • Multiple readings can be documented for the same DOS, with lowest systolic and diastolic from different readings combined as representative BP • Do not count BP taken during an ED or inpatient visit, or obtained the same day as an outpatient visit where a diagnostic test or surgical procedure was performed • Include patient-reported BP readings taken from a digital device Exclude: Patients with evidence of ESRD, kidney transplant, dialysis, diagnosis of pregnancy, non-acute inpatient admission; patients age 81 and older with frailty, and 66–80 with frailty and advanced illness	To identify Hypertension: ICD-10-CM: I10 Systolic < 130: CPT II: 3074F Diastolic < 80: CPT II: 3078F Systolic 130-139: CPT II: 3075F Diastolic 80–90: CPT II: 3079F Systolic ≥ to 140: CPT II: 3077F Diastolic ≥ to 90: CPT II: 3080F NOTE: BP can be submitted via claims CPT II codes and P4Q data entry. A new administrative method for reporting has been added so the measure can be reported administratively and from HEDIS MRR.
Osteoporosis Fracture Management (OMW) Eligible (denominator) Female patients age 67–85 who had a fracture during the intake period (July 1 of year prior to June 30 of measurement year) Compliant (numerator) Bone mineral density (BMD) test or dispensed prescription to treat osteoporosis within 180 days or 6 months post fracture	• BMD completed on date of fracture or 180-day (six-month) period after • Dispensed prescription to treat osteoporosis on date of fracture or 180-day (six-month) period after • Fractures of finger, toe, face, and skull not included Exclude: Patients who had a BMD test within 730 days (24 mo.) prior to fracture, patients with active prescription for osteoporosis within the 365 days or (12 mo.) prior to fracture, patients enrolled in I-SNP or living long term in any institution during measurement year, patients age 81 and older with frailty, and 66–80 with frailty and advanced illness	To identify BMD test: CPT: 76977, 77078, 77080-77082, 77085, 77086 HCPCS: G0130 ICD-9PCS: 88.98 ICD-10PCS: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 To identify Osteoporosis meds: HCPCS: J0630, J0897, J1740, J3110, J3487-J3489, Q2051
Statin Therapy for Patients with Cardiovascular Disease (SPC) Eligible (denominator) Males age 21–75 and females 40–75 identified as having clinical atherosclerotic cardiovascular disease (ASCVD) Compliant (numerator) Patients dispensed at least one high-intensity or moderate-intensity statin during measurement year	• Identify patients as having ischemic vascular disease (IVD) who met at least one of the following criteria during both the measurement year and prior year › At least one outpatient visit with an IVD diagnosis › A telephone visit with an IVD diagnosis › An online assessment with an IVD diagnosis › At least one acute inpatient encounter with an IVD diagnosis without telehealth • Patients identified by claim/encounter or pharmacy data as having ASCVD Exclude: Patients with diagnosis of pregnancy, ESRD, cirrhosis, myalgia, myositis, myopathy, or rhabdomyolysis, patients who had in vitro fertilization or have taken clomiphene in the measurement year or year prior, patients, 66 and older with frailty and advanced illness	To identify ASCVD: Any of the following during the year prior to the measurement year: • Any diagnosis of myocardial infarction • CABG, PCI or other revascularization procedure • Any diagnosis of IVD during the measurement year or year prior
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) Eligible (denominator) Patients age 18-64 as of the ED visit with 2+ of following chronic conditions: COPD/asthma, Alzheimer’s disease/dementia, CKD, depression, heart failure, acute MI, A-fib or stroke Compliant (numerator) Follow up visit within 7 days following the ED visit	Identify patients having 2 or more chronic conditions prior to the ED visit on or between January 1 and December 24 of the measurement year, and provide a follow up visit in the 7 days following the ED visit. Exclude: Patients receiving hospice services	To identify patient engagement: A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. The following meet criteria for follow-up: An outpatient visit, a telephone visit, transitional care management services, case management visits, complex care management services, etc.

STAR METRIC	CRITERIA	COMPLIANCE ATTRIBUTION	
Transition of Care (TRC) Eligible (denominator) Patients age 18 and older who had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year Compliant (numerator) - Notification of Inpatient Admission: - Documentation of receipt of notification of inpatient admission on the day of admission or through 2 days after the admission (3 total days). - Receipt of Discharge Information: - Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). - Patient Engagement After Inpatient Discharge: - Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. - Medication Reconciliation Post-Discharge (MRP): - Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).	Notification of Inpatient Admission: Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days) with evidence of the date when the documentation was received. Any of the following examples meet criteria: - Communication between inpatient providers or staff and the member’s PCP or ongoing care provider (e.g., phone call, email, fax) - Communication about admission between emergency department and the member’s PCP or ongoing care provider (e.g., phone call, email, fax) - Communication about admission to the member’s PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system - Communication about admission with the member’s PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a “received date” is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria. - Communication about admission to the member’s PCP or ongoing care provider from the member’s health plan - Indication that the member’s PCP or ongoing care provider admitted the member to the hospital - Indication that a specialist admitted the member to the hospital and notified the member’s PCP or ongoing care provider - Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member’s inpatient stay Receipt of Discharge: Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following: - The practitioner responsible for the member’s care during the inpatient stay - Procedures or treatment provided - Diagnoses at discharge - Current medication list - Testing results, or documentation of pending tests or no tests pending - Instructions for patient care post-discharge	NOTE: If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge (3 total days). When using a shared EMR system, documentation of a “received date” in the EMR is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria. Patient Engagement: Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria: - An outpatient visit, including office visits and home visits - A telephone visit - A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication - An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider) NOTE: If the member is unable to communicate with the provider, interaction between the member’s caregiver and the provider meets criteria. MRP: Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria: - Documentation of the current medications with a notation that the provider reconciled the current and discharge medications - Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications) - Documentation of the member’s current medications with a notation that the discharge medications were reviewed - Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service - Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member’s hospitalization or discharge	To identify patient engagement: Outpatient: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483 Telephone visits: 98966-98968, 99441-99443 Transitional Care Management Services: 99495, 99496 To identify Medication Reconciliation: CPT: 99495, 99496, 99483 CPT II: 1111F

NOTE: The codes below apply to the BCS, COL, CDC, ART, CBP, OMW, and SPC.

Example codes to identify Frailty: CPT: 99504, 99509 | ICD-10PCS: L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90, M62.50, M62.81, M62.84, R26.0, R26.1, R26.2, R26.89, R26.9 | HCPCS: E0100, E0105, E0130, E0135, E0140, E0141, E0143

Example codes to identify Advanced Illness: ICD-10PCS: A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.2, C78.39, C78.4

