OPTUM Care®

HEDIS/STARS guide: Arizona

HEDIS measures – Healthcare Effectiveness Data and Information Set (HEDIS®) is a National Committee for Quality Assurance (NCQA) tool that measures performance in health care where improvements can make a meaningful difference in people's lives.

CMS Part D medication adherence measures – Centers for Medicare & Medicaid Services (CMS) Part D medication adherence measures are used to help increase the number of Medicare members taking their cholesterol (statin), diabetes and/or hypertension (RAS antagonist) medications as prescribed. Members are eligible for a measure if their medication appears on a targeted list provided by the Pharmacy Quality Alliance (PQA).

CMS considers Medicare members adherent if their PDC is 80 percent or more at the end of the measurement period.

Member eligibility and performance within the Part D medication adherence measures is based entirely on prescription claims processed at the pharmacy under the Part D benefit.

Adult body mass index assessment (ABA)

Definition – Percentage of members ages 18–74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

BMI percentile: ICD-10 Diagnosis – Z68.51, Z68.52, Z68.53, Z68.54

Body mass index: ICD-10 Diagnosis – Z68.1, Z68.20, Z68.21, Z68.22, Z68.23, Z68.24,Z68.25, Z68.26, Z68.27, Z68.28, Z68.29, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45

Tips and best practices to help close this care opportunity

- Always clearly document a date of service with the height, weight, and BMI calculation or percentile. The measurements don't have to happen on the same day.
- If your office documents within an electronic medical record (EMR) system:
  - — Please ensure that the height, weight, and calculated BMI or percentile transfers to the vitals sheet or progress notes with a date of service.
- Check that the "calculate BMI" function or reminder flags are turned on within the system.
- If your office documents within paper charts:
- Please calculate and document the BMI or BMI percentile using a BMI wheel or BMI smartphone app.

Breast cancer screening (BCS)

Percentage of female members ages 50–74 who had a mammogram screening Oct. 1 two years prior to the measurement year through Dec. 31 of the measurement year.

Tips and best practices to help close this care opportunity

- Always include a date of service—2 digit month and 4 digit year is acceptable when documenting a mammogram self-reported by a member.
- As an administrative measure, it's important to submit the appropriate ICD-10 diagnosis code that reflects a member's history of bilateral mastectomy, Z90.13.
- If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim.
- If a member isn't new to the care provider, but the member's chart has a documented history of the diagnosis, the ICD-10 diagnosis code should be submitted on any visit claim.

Colorectal cancer screening (COL)

Definition – Percentage of members ages 50–75 who had an appropriate screening for colorectal cancer.

Colonoscopy – Measurement year or nine years prior

CPT /CPT I: 44388-94, 44397, 44401-08, 45355, 45378-93, 45398 HCPCS: G0105, G0121

Computed tomography (CT) colonography – Measurement year or four years prior

CPT /CPT II: 74263

Flexible sigmoidoscopy – Measurement year or four years prior CPT /CPT II: 45330-35, 45337-42, 45345-47, 45349-50 HCPCS: G0104

FIT-DNA Test (Cologuard®) – Measurement year or two years prior CPT /CPT II: 81528 HCPCS: G0464

FOBT – Measurement year CPT /CPT II: 82270, 82274 HCPCS: G0328

Tips and best practices to help close this care opportunity

- Always include a date of service — 4 digit year only is acceptable — when documenting a colonoscopy, flexible sigmoidoscopy, FIT-DNA (Cologuard®) test, CT colonography or FOBT reported by a member.
- It's important to submit any codes that reflect a member's history of malignancy for colorectal cancer, Z85.038 and Z85.048.

- If a member is new to the care provider and the diagnosis is discovered during the history and physical, the code should be submitted with the initial visit claim.
- If a member isn't new to the care provider, but the member's chart has documented history of the diagnosis, the ICD-10 diagnosis code should be submitted on any visit claim.
- Member refusal will not make them ineligible for this measure.
- Please recommend a flexible sigmoidoscopy, FIT-DNA (Cologuard®) or FOBT test if a member refuses or can't tolerate a colonoscopy.
- There are two types of acceptable FOBT tests – guaiac (gFOBT) and immunochemical (iFOBT).
- If you have an account with LabCorp, a UnitedHealthcare laboratory services vendor, you can order iFOBT kits through them.
- The kit includes a take-home collection kit and a requisition form. If you don't have an account with LabCorp, you can get a limited contract that allows you to order the kits.
- Physicians, nurse practitioners and physician assistants can provide the kit to patients during their routine office visits. Patients can then collect the sample at home and send the specimen and requisition form directly to the laboratory services vendor in a postage-paid envelope.

Comprehensive diabetes care (CDC)—Eye exam

Definition – Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had any one of the following:

- Retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year
- Negative retinal or dilated eye exam in the year prior to the measurement year
- Bilateral eye enucleations any time during their history through Dec. 31 of the measurement year

Test, service or procedure to close care opportunity

- **Bilateral eye enucleation or acquired absence of both eyes**
- **Dilated or retinal eye exam**
- **Fundus photography**
  - — Members without retinopathy should have an eyeexam every two years.
  - — Members with retinopathy should have an eye exam every year.

Tips and best practices to help close this care opportunity

- Always list the date of service, test, and eye care professional's name and credentials together if you're documenting the history of a dilated eye exam in a member's chart and don't have the eye exam report from an eye care professional.
- The use of CPT Category II codes helps UnitedHealthcare identify clinical outcomes such as diabetic retinal screening with an eye care professional. It can also reduce the need for some chart review.
- Documentation of a diabetic eye exam by an optometrist or ophthalmologist isn't specific enough to meet the criteria. The medical record must indicate that a dilated or retinal exam was performed. If the words "dilated" or "retinal" are missing in the medical record, a notation of "dilated drops used" and findings for macula and vessels will meet the criteria for a dilated exam.
- A slit-lamp examination will not meet the criteria for the dilated eye exam measure. There must be additional documentation of dilation or evidence that the retina was examined for a slit-lamp exam to be considered compliant.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results will not be compliant. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- To be reimbursable, billing of fundus photography code 92250 must be submitted globally by an optometrist or ophthalmologist and meet disease state criteria.

Comprehensive diabetes care (CDC)—HbA1c control

Definition – Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had an HbA1c lab test during the measurement year that showed their blood sugar is under control (≤ 9; good control is <8.0%).

HbA1c Level < 7.0%: CPT /CPT II 3044F
HbA1c Level Between >/= 7.0% and <8.0%: CPT /CPT II 3051F

Test, service or procedure to close care opportunity

- A1c, HbA1c, HgbA1c
- Hemoglobin A1c
- Glycohemoglobin A1c
- Glycohemoglobin
- Glycated hemoglobin
- Glycosylated hemoglobin

* HbA1c test must be performed during the measurement year. If multiple tests were performed in the measurement year, the result from the last test is used.

Tips and best practices to help close this care opportunity

- Always list the date of service, result and test together.
- If test result(s) are documented in the vitals section of your progress notes, please include the date of the blood draw with the result. The date of the progress notes will not count.
- The use of CPT Category II codes helps UnitedHealthcare identify clinical outcomes such as the HbA1c level. It can also reduce the need for some chart review.

Comprehensive diabetes care (CDC)—Medical attention for nephropathy

Definition – Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had medical attention for nephropathy during the measurement year, documented as any one of the following services:

- Member prescribed, filled, or is taking an ACE inhibitor or ARB Urine test for protein or albumin:
  - 24-hour urine to test for albumin or protein
  - Timed urine to test for albumin or protein
  - Spot urine to test for albumin or protein for example, urine dipstick or test strip
  - Urine to test for albumin/creatinine ratio
  - 24-hour urine to test for total protein
  - Random urine to test for protein/creatinine ratio
- A visit with a nephrologist
- Member has one of the following diagnoses:
  - Acute renal failure
  - Albuminuria
  - Chronic kidney disease
  - Chronic renal failure
  - Diabetic nephropathy
  - Dialysis
  - End-stage renal disease (ESRD)
  - Hemodialysis
  - Peritoneal dialysis
  - Proteinuria
  - Renal dysfunction
  - Renal insufficiency
- Member has had a kidney transplant

Tips and best practices to help close this care opportunity

HbA1c Level Between >/= 8.0% and <9.0%: CPT /CPT II 3052F HbA1c > 9: CPT /CPT II 3046F

- Always list the date of service and test together. Results of urine tests are no longer necessary for this measure to be compliant.
- The use of CPT Category II codes helps UnitedHealthcare identify clinical outcomes such as +/-microalbuminuria test or + macroalbuminuria test. It can also reduce the need for some chart review.
  - If you use an in-house lab service and the urine test appears in the vitals section of your progress notes, please ensure that a date of service is documented with the test. The date of the progress note will not count.
  - Glomerular filtration rate (GFR) test will not meet the intent of the nephropathy screening measure.

Controlling high blood pressure (CBP)

Definition – Percentage of members ages 18–85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year

- BP reading must be the latest performed within the measurement year, and on or after the second hypertension diagnosis
- BP readings taken on the same day the member received a common low-intensity or preventive procedure can be used.
- Examples include, but are not limited to:
  - Eye exam with dilating agents
  - Injections
  - Vaccinations
- BP readings taken in the in the following situations will not count toward compliance:
  - During an acute inpatient stay or an emergency department visit
  - On the same day as a diagnostic test, or therapeutic procedure that requires a change in diet or medication on or one day before the day of the test or procedure, with the exception of a fasting blood test.

Tips and best practices to help close this care opportunity

- Always list the date of service and BP reading together.
- It's critical to follow up with a member for a BP check after their initial diagnosis.
  - Members who have an elevated BP during an office visit in August, September or October should be brought back in for a follow-up visit before Dec. 31.
- Talk with members about what a lower goal BP reading is:
  - For example: 130/80mmHg
- If your office uses manual blood pressure cuffs, don't round up the BP reading.
  - For example: 138/89mmHg rounded to 140/90mmHg
- If a member's initial BP reading is elevated at the start of a visit, you can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading. Retake the member's BP after they've had time to rest.

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Definition – Percentage of members who were diagnosed with rheumatoid arthritis and were dispensed at least one ambulatory prescription(s) for a disease-modifying anti-rheumatic drug (DMARD) during the measurement year. Members enrolled on hospice any time during the measurement year.

To comply with this measure, a member must have at least one prescription during the year for any of the following diseasemodifying anti-rheumatic drugs:

Drug category medications 5 – Aminosalicylates

- Sulfasalazine

Alkylating agents

- Cyclophosphamide

Aminoquinolines

- Hydroxychloroquine

Anti-rheumatics

- Auranofin
- Leflunomide
- Methotrexate
- Penicillamine

Immunomodulators
- Abatacept
- Adalimumab
- Anakinra
- Certolizumab
- Certolizumab pegol
- Etanercept
- Golimumab
- Infliximab
- Rituximab
- Tocilizumab

Immunosuppressive agents
- Azathioprine
- Cyclosporine
- Mycophenolate

Janus kinase (JAK) inhibitor
- Baricitinib
- Tofacitinib

Tetracyclines
- Minocycline

Tips and best practices to help close this care opportunity

Proper coding for this measure is important because it helps avoid non-applicable members from appearing in the measure.

— Miscoding issues commonly seen with this measure:
- Coding for rheumatoid arthritis when it's a "rule out work up"
- Coding for rheumatoid arthritis when a member has another condition such as psoriatic arthritis or rheumatism
- Confusion over which code to use — more than 300 ICD-10 diagnosis codes are attributed to rheumatoid arthritis

Osteoporosis management in women who had a fracture (OMW)

Definition – Percentage of women ages 67–85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within six months of the fracture (does not include fractures to the finger, toe, face or skull).

Exclusions
- Members who had a BMD test 24 months prior to the fracture.
- Members who had osteoporosis therapy 12 months prior to the fracture.
- Members who were dispensed a medication or had an active prescription* for medication to treat osteoporosis 12 months prior to the fracture.

Test, service or procedure to close care opportunity

BMD test:
- BMD test must take place within six months of the fracture.
- If the fracture resulted in an inpatient stay, a BMD test administered during the stay will close the care opportunity.
- Osteoporosis therapies identified through pharmacy data:
  — Osteoporosis medication must be dispensed within six months of the fracture.
  — Documentation that the medications aren't tolerated is not an exclusion for this measure.
  — If the fracture resulted in an inpatient stay, long-acting osteoporosis therapy administered during the stay will close the care opportunity.

Tips and best practices to help close this care opportunity
- The post-fracture treatment period to close this care opportunity is only six months. Please see patients for an office visit as soon as possible after an event occurs.
- Osteoporosis medication must be filled using a member's Part D prescription drug benefit.
- To help prevent women from being included in this measure incorrectly, please check that fracture codes are used appropriately—and not before a fracture has been verified through diagnostic imaging.
- A referral for a BMD will not close this care opportunity.

Medication adherence for cholesterol (MAC)

Definition – Percentage of members ages 18 and older who adhere to their cholesterol (statin) medication at least 80 percent of the time in the measurement period.

Compliance

To comply with this measure, a member must have a proportion of days covered (PDC) of 80 percent or higher for their statin medication in the measurement period.

Medication adherence for diabetes medications (MAD)

Definition – Percentage of members ages 18 or older who are adherent to their diabetes medications at least 80 percent of the time in the measurement period.

Compliance

To comply with this measure, a member must have a proportion of days covered (PDC) of 80 percent or higher for their diabetes medication(s) in the measurement period. These classes of diabetes medications are included in this measure:
- Biguanides
- DPP-4 inhibitors
- Incretin mimetics
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

Medication adherence for hypertension (RAS Antagonists) (MAH)

Definition – Percentage of members ages 18 or older who adhere to their hypertension (RAS antagonist) medication at least 80 percent of the time in the measurement period.

RAS antagonist medications include:

- Angiotensin II receptor blockers (ARBs)
- Angiotensin-converting enzyme (ACE) inhibitors
- Direct renin inhibitors

Tips and best practices to help close these medication adherence care opportunities

- **Improve health literacy.** Talk with members about why they're on these medications, and how it's important to take their medication as prescribed and get timely refills.
- **Assess medication adherence barriers.** Discuss medication adherence barriers at each visit and ask open-ended questions about concerns related to health benefits, side effects and cost.
- **Consider extended days' supply prescriptions.** When clinically appropriate, consider writing 90-day prescriptions for chronic conditions to help improve adherence and minimize frequent trips to the pharmacy
  — especially if getting to the pharmacy is an issue. UnitedHealthcare Medicare Advantage benefit plans include coverage for a 90-day supply of prescriptions that can be delivered to a patient's home or picked up at a retail pharmacy.
- **Prescribe low-cost generics.** When clinically appropriate, prescribe low-cost generic medications to help reduce out-of-pocket costs.
- **Confirm instructions.** Check that the directions on your patients' prescriptions match your instructions. If the dose or frequency is changed, please void the old prescription and send a new one to the patient's pharmacy.
- **Use prescription benefit at the pharmacy.** Remind your patients who are UnitedHealthcare members to use their health plan ID card at the pharmacy to get the best value. Only prescription fills processed with a member's health plan ID card can be used to measure a member's adherence to their medication.
- **Try home delivery.** If getting to a pharmacy is difficult, ask your patients about the possibility of filling their prescriptions through a UnitedHealthcare network mail order pharmacy so they can get their medication delivered to their home. For more information, please call OptumRx at 800-791-7658.

Medication home delivery

UnitedHealthcare is offering $0 co-pays for Tier 1 and Tier 2 medications for most plans when members use their preferred home delivery pharmacy benefit through OptumRx®, our pharmacy services administrator. That means they pay $0 for the most commonly used maintenance medications, and standard shipping is offered at no added cost.

Home delivery can help:

1. Improve medication adherence: Research shows that medication adherence is higher among patients who fill their prescriptions through home delivery versus a retail pharmacy.
2. Overcome access challenges: Patients with limited mobility or transportation don't need to worry about traveling to a pharmacy.
3. Reduce refills: With home delivery, patients receive a 90/100- day supply of their maintenance medication, so they only have to refill three/four times a year.
4. Control costs: Prescriptions often cost less through home delivery than they do at a retail pharmacy.
5. Simplify refills and renewals: Patients can visit OptumRx.com or call 1-800-791-7658 to order refills. We'll work with you to handle new prescription requests as well.

It's easy to help your eligible patients who want to get started:

- Call the number on the back of their member ID card to confirm that they have a preferred home delivery pharmacy benefit
- Write each long-term prescription for a 90-day supply, plus three refills

Statin Use in Persons With Diabetes (SUPD)

Definition – Percentage of Medicare members with diabetes ages 40–75 who receive at least one fill of a statin medication in the measurement year.

Members with diabetes are defined as those who have at least two fills of diabetes medications during the measurement year.

Compliance

To comply with this measure, a member with diabetes must have a fill for at least one statin or statin combination medication in any strength or dose using their Part D benefit during the measurement year. The statins shown here are on a member's UnitedHealthcare Medicare Advantage formulary.

- Tier 1: Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, Simvastatin
- Tier 2: Amlodopine-atorvastatin, Fluvastatin
- Tier 3: Ezetimibe-simvastatin, Livalo®

Tips and best practices to help close this care opportunity

Consider prescribing a statin, as appropriate. If you determine a statin medication is appropriate, please send a prescription to the member's preferred pharmacy.**

Statin therapy for patients with cardiovascular disease (SPC)

Definition – Percentage of males ages 21–75 and females ages 40–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

- **Received statin therapy** – Members who were dispensed at least one high- or moderate-intensity statin

medication during the measurement year

- **Statin adherence 80 percent** – Members who remained on a high- or moderate-intensity statin medication for at least 80 percent of the treatment period

Important note: The **treatment period** is defined as the earliest prescription dispensing date in the measurement year for any statin medication of at least moderate intensity through the last day of the measurement year.

Compliance

To comply with this measure, one of the following medications must have been dispensed:

- **High Intensity statin therapy:**
  - Atorvastatin 40-80 mg
  - Amlodipine-atorvastatin 40-80 mg
  - Rosuvastatin 20-40 mg
  - Simvastatin 80 mg
  - Ezetimibe-simvastatin 80 mg
- **Moderate-intensity statin therapy:**
  - Atorvastatin 10-20 mg
  - Amlodipine-atorvastatin 10-20 mg
  - Rosuvastatin 5-10 mg
  - Simvastatin 20-40 mg
  - Ezetimibe-simvastatin 20-40 mg

Tips and best practices to help close this care opportunity

Consider prescribing a high- or moderate-intensity statin, as appropriate. If you determine medication is appropriate, please send a prescription to the member's preferred pharmacy.

Medication reconciliation post-discharge (MRP)

Definition – Percentage of discharges from Jan. 1 – Dec. 1 of the measurement year for members ages 18 or older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 days total).

Tips and best practices to help close this care opportunity

- Outpatient medications reconciled and documented in the outpatient medical record
- Current medications and medication list reviewed and documentation of any of the following:
  - Status of discharge medications
  - Notation of current medications and that discharge medications were reviewed
  - Review of discharge medication list
  - Notation if no medications were prescribed at discharge
  - Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.
  - Medication reconciliation must be completed on the date of discharge through 30 days afterward.
  - Medication reconciliation can be documented if there is evidence that:
  - A member was seen for a post-discharge follow-up.
  - Medication review or reconciliation was completed at the appointment.
  - A medication list must be present in the outpatient record to fully comply with the measure.

Health Outcomes Survey (HOS)

This health plan member survey is used to gather valid, reliable and clinically meaningful health status data in the Medicare Advantage program for use in quality improvement activities, pay for performance, program oversight, public reporting and improving health. All managed care organizations with Medicare Advantage contracts must participate. The survey looks at physical and mental health outcomes measures, urinary incontinence in older adults, physical activity in older adults, fall risk management, and osteoporosis testing in older women.

Frequency

- Annually between April and July

Survey questions include the following categories for the Medicare Advantage population and have a look-back period of six months::

- Improving Bladder Control
- Improving or Maintaining Mental Health
- Improving or Maintaining Physical Health
- Monitoring Physical Activity
- Reducing the Risk of Falling

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