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Stars Rating Quick Reference Guide (MY2022)

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Stars Rating quick reference guide

Let's make sure your practice gets the right rating

(think of this as a quick resource guide to support your overall Stars score)

Your practice should be recognized for all the work you do to keep your patients healthy. So we've put together this resource guide as a quick reference to help you improve your Centers for Medicare & Medicaid Services (CMS) Star Rating.

But first, some best practices (for your practice)

Focus on preventative care. Always encourage patients to prevent illness or catch issues early through annual wellness visits, screenings, and immunizations.

Prescribe a 90-day supply. Whenever it makes sense, prescribe a 90-day supply for your patients' maintenance meds to minimize messages about refills. Plus, your patients will always have what they need so they are more likely to take their meds consistently.

Make time for outreach calls. Every month, help your patients stay on top of things and remind them about important or overdue screenings, tests, and visits.

Bill smarter, not harder. If you haven't tried this yet, add CPT® CAT-II codes to your billing. It provides details about results to your payors, and it reduces the amount of medical record data audits and requests.

Manage your patients' expectations. Show your patients you respect their time by letting them know if your practice experiences appointment delays. Your front office staff can easily explain the cause for the delay, offer reasonable expectations for when the next appointment will be, and give them different time options.

Offer different ways to access care. Try leaving a few appointment slots open each day for urgent visits — including post-inpatient discharge visits. You can also offer visits with a nurse practitioner or a physician's assistant for patients who want to be seen in person on short notice, or schedule convenient, online visits for last-minute issues.

Talk to us about setting up your feed. Chat with your Oscar rep to establish an electronic feed with us. You'll be able to see how your scores improve every month without the usual "claims lag."

Measure Preventive screening	Guidance
BREAST CANCER SCREENING (BCS) **Mammography:** **CPT Codes:** 77055 - 77057, 77061 - 77063, 77065 - 77067 **HCPCS Codes:** G0202, G0204, G0206 UBREV Codes – 401, 403	Measure evaluates the percentage of women **50-74 years of age** who had a mammogram to screen for breast cancer. **Exclusions**: • Members in hospice • Members **66-80 years of age as of Dec 31 of MY2022** with frailty **and** advanced illness • Members **81 years of age or older as of Dec 31 of MY2022** with frailty • Bilateral mastectomy or history • Unilateral mastectomy with a bilateral modifier • Two unilateral mastectomies with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15. **Both of the following (on the same or a different date of service):** • Unilateral mastectomy with a right-side modifier (same date of service). • Unilateral mastectomy with a left-side modifier (same date of service). **Suggestions to improve measure performance:** • Review and clearly document past medical and surgical history as well as diagnostic procedures including dates and results. For example, document “bilateral mastectomy” or specify laterality. If a member had a unilateral mastectomy, a contra unilateral mammogram is needed. • Consider a standing order to mail patients for mammography. • Educate patients on the importance of BCS, and the recommended frequency of routine mammograms is at least once every 24 months for all women ages 50–74. Depending on risk factors, mammograms may be done more frequently. • Evaluate individual patients’ risk for breast cancer based on family history, lifestyle, and comorbid conditions.

	• **Make breast cancer screening a topic of discussion with the patient at every visit**, not just the Annual Wellness visit.
COLORECTAL CANCER SCREENING (COL) **Colonoscopy:** **CPT Codes:** 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **HCPCS**: G0105, G0121 **CT Colonography:** **CPT Codes:** 74261-74263 **FIT-DNA Lab Test:** **CPT Code:** 81528 **HCPCS:** G0464 **Flexible Sigmoidoscopy**: **CPT Codes:** 45330-45335, 45337-45342, 45345-45347, 45349-45350 **HCPCS:** G0104 **FOBT Lab Test:** **CPT Codes:** 82270, 82274 **HCPCS:** G0328 **Exclusions:** **Colorectal Cancer:** **HCPCS:** G0213, G0214, G0215, G0231 **ICD 10:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048	This measure evaluates the percentage of members **50-75 years of age** who had an appropriate screening for colorectal cancer. **Screenings Included in measure** Colonoscopy • within Measurement Year (MY) or 9 years prior • (i.e. MY 2022 valid dates are 2013 through 2022) CT Colonography • within MY or 4 years prior • (i.e. MY 2022 valid dates are 2018 through 2022) FIT - DNA Lab Test (Cologuard) • within MY or 2 years prior • (i.e. MY 2022 valid dates are 2020 through 2022) Flexible Sigmoidoscopy • within MY or 4 years prior • (i.e. MY 2022 valid dates are 2018 through 2022) FOBT Lab Test • during the MY • (i.e. MY 2022 valid dates are 2022) **Exclusions:** • History of Colorectal Cancer • History of Total Colectomy • Members in hospice • Members receiving palliative care • Members 66-80 years of age as of Dec 31 of MY2022 with frailty **and** advanced illness • Members 81 years of age or older as of Dec 31 of MY2022 with frailty **Suggestions to improve measure performance:** • Educate patients on the importance of COL screening and the screening options available. • Clearly document past medical and surgical history as well as any previous colorectal cancer screenings, including dates and results.

Total Colectomy:
CPT Codes: 44150-44153, 44155-44158, 44210-44212
ICD-10: 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

- Code procedures and results.
- For patients hesitant to undergo colonoscopy, offer FIT-DNA / Cologuard testing, which can be completed by the patient in their own home.
- **Make colorectal cancer screening a topic of discussion with the patient at every visit**, not just the Annual Wellness visit.

CONTROLLING HIGH BLOOD PRESSURE (CBP)

Hypertensive ICD 10 Codes: I10, I11.9, I11.0, I13.0, I13.9

BP Control:

CPT-2 Codes:
Most recent:
SBP <130 mm Hg 3074F
SBP 130 to 139 mm Hg 3075F
SBP >=140 mm Hg 3077F
DBP <80 mm Hg 3078F
DBP 80-89 mm Hg 3079F
DBP >=90 mm Hg 3080F

This measure demonstrates the percentage of members **18–85 years of age** who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140 mmHg systolic and <90 mmHg diastolic) during the measurement year.

Exclusions:

- Members in hospice, SNP or LTI flag (ages 66 or older)
- Members receiving palliative care
- Members 66-80 years of age as of Dec 31 of MY2022 with frailty **and** advanced illness
- Members 81 years of age or older as of Dec 31 of MY2022 with frailty
- ESRD
- Pregnancy
- Nonacute Inpatient admission (SNF)

Suggestions to improve measure performance:

- If SBP >139 or DBP >89, repeat BP and document all readings.
- Patient reported blood pressures must be actual readings, not ranges.
- Consider prescribing home BP monitors for patients with uncontrolled or labile hypertension.
- Reinforce best practices with medical staff who perform vital sign collection:
  - Choose the correct cuff size for the patient (i.e. one size does not fit all!)
  - Apply cuff to patient's bare arm
  - Support patient's arm to raise the arm to the level of the heart

- Have the patient empty their bladder prior to vital sign collection
- Ask the patient to refrain from movement and speaking while taking the BP
- Posture matters! Have the patient keep both feet on the ground, legs uncrossed, and seated with back supported

- During telemedicine visits, record the date and result of the member's most recent BP reading on their home device.

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

Atherosclerotic cardiovascular disease (ASCVD):

ICD-10 Codes:
I25.__

The percentage of **males 21-75 years of age and females 40-75 years of age** during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate intensity statin medication during the measurement year.
2. *Statin adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Exclusions:

- Female members with a diagnosis of pregnancy
- In vitro fertilization in the measurement year or year prior
- Dispensed at least one prescription for clomiphene
- ERSD or dialysis
- Cirrhosis
- Myalgia, myositis, myopathy or rhabdomyolysis
- Members in hospice
- Members receiving palliative care

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 • Pravastatin 40-80 mg • Lovastatin 40 mg • Fluvastatin 40-80 mg • Pitavastatin 1-4 mg
HEMOGLOBIN A1C CONTROL FOR PATIENTS WITH DIABETES (HBD) **HgbA1c Control:** **HbA1c Test CPT Codes:** 83036, 83037 **HbA1c Level CPT-2 Codes:** **Level Less Than 7.0:** 3044F **Level between:** **7 and 8:** 3051F **8 and 9:** 3052F **Level Greater Than 9.0:** 3046F	This measure evaluates the percentage of members **18-75 years of age** with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was below 8% during the measurement year: **Exclusions**: • Polycystic Ovarian Syndrome • Steroid Induced Diabetes • Gestational Diabetes • Members in hospice • Members receiving palliative care **Suggestions to improve measure performance:** • Pre-order HgbA1c labs so they can be reviewed during visits. • Order a repeat HgBA1c if >8.0% for 3 months after initial elevated result. • Patient reported A1c values should include test result and approximate date performed. • Clearly document past medical and surgical history. • POC testing must have CPT and CPT II code submitted. • **Home A1c results are not considered compliant unless verified by a lab**.
EYE EXAM FOR PATIENTS WITH DIABETES (EED) **DM ICD-10 Codes:**	The percentage of members **18-75 years of age** with diabetes (types 1 and 2) who had a retinal eye exam. • Retinal eye exam during the measurement year or a negative result from the prior year **Exclusions**:

Type 1 diabetes mellitus without complications: E10.9

Type 2 diabetes mellitus without complications: E11.9

Type 1 DM w/ complication: E10.____

Type 2 DM w/ complication: E11.____

Retinal Screening:

CPT Codes: 67028, 67030, 67031, 67036, 67039, 67040

Diabetic Retinal Screening with Eye Care Professional: CPT Codes: 2022F, 2023F, 2024F, 2025F, 2026F, 2033F

Low risk for retinopathy (no evidence of retinopathy in the prior year) (3072F)

- Polycystic Ovarian Syndrome
- Steroid Induced Diabetes
- Gestational Diabetes
- Members in hospice
- Members receiving palliative care
- Members **66-80 years of age as of Dec 31 of MY2022** with frailty **and** advanced illness
- Members **81 years of age or older as of Dec 31 of MY2022** with frailty

Suggestions to improve measure performance:

- Retinal Eye Exam documentation must include the provider, date, type, and results of the exam or a copy of the exam.
- Clearly document past medical and surgical history.

MONITORING FOR NEPHROPATHY (CDC - NEPH)

DM ICD-10 Codes:

Urine albumin-creatinine ratio (uACR):

Urine microalbumin: 82043

The percentage of members **18-85 years of age** with diabetes (type 1 and type 2) who had an assessment for nephropathy by any of the following:

- Urine test for albumin or protein
- Visit with a nephrologist
- Treatment for nephropathy
- ACEI/ARB therapy
- Nephrectomy

Urine creatinine: 82570
See pg. 11 for a list of common ACE-I / ARB medications

Exclusions:

ESRD ICD 10 N18.5, N18.6, Z99.2

Hospice Care CPT 99377, 99378

HCPCS G0182, G9473 – G9479, Q5003 – Q5010, S9126, T2042 - T2046

Palliative Care ICD 10 Z51.5

HCPCS G9054, M1017

Exclusions:

- Member with evidence of ESRD or dialysis any time during the member's history on or prior to December 31 of the measurement year
- Members in hospice
- Members receiving palliative care

Suggestions to improve measure performance:

- Order an annual urine microalbumin for every diabetic patient.
- Clearly document past medical and surgical history.

STATIN THERAPY FOR PATIENTS WITH DIABETES (SPD)

DM ICD-10 Codes:

Type 1 diabetes mellitus without complications: E10.9

Type 2 diabetes mellitus without complications: E11.9

Type 1 DM w/ a complication: E10.____

The percentage of members **40-75 years of age** during the measurement with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. *Received Statin Therapy*. Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%***.** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Exclusions:

- Members with cardiovascular disease, identified in two ways by event or by diagnosis:
  - Event: MI, CABG, PCI, or other revascularization
  - Diagnosis: Ischemic vascular disease (IVD)
- Female members with a diagnosis of pregnancy
- In vitro fertilization in the measurement year or year prior

Type 2 DM w/ complication:
E11.____

- Dispensed at least one prescription for clomiphene
- ESRD or dialysis
- Cirrhosis
- Myalgia, myositis, myopathy or rhabdomyolysis
- Members in hospice
- Members receiving palliative care

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
- Pravastatin 40-80 mg
- Lovastatin 40 mg
- Fluvastatin 40-80 mg
- Pitavastatin 1-4 mg

Low-Intensity statin therapy:

- Simvastatin 5-10 mg
- Ezetimibe-simvastatin 10 mg
- Pravastatin 10-20 mg
- Lovastatin 10-20 mg
- Fluvastatin 20 mg

Suggestions to Improve measure performance:

- Clearly document past medical history.
- Ensure all diabetic patients are prescribed a statin and remain compliant with their medications.

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW)

Measure evaluates the percentage of women **67-85 years of age** who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Exclusions:

- Members who have had a BMD or were dispensed medications to treat osteoporosis within 24 months of a fracture
- Members in hospice
- Members receiving palliative care
- Members 66-80 years of age as of Dec 31 of MY2022 with frailty **and** advanced illness
- Members 81 years of age or older as of Dec 31 of MY2022 with frailty

Suggestions to improve measure performance:

- If there is no evidence of an active fracture, the billing provider can submit a corrected claim.
- Routinely order a BMD every 24 months, especially after a diagnosis of fracture.
- If appropriate, prescribe osteoporosis treatment (bisphosphates).

Bone Mineral Density Test:

CPT Codes: 76977, 77078, 77080, 77081, 77085

Osteoporosis Medications:

HCPCS: J0897, J1740, J3110, J3489

Long-Acting Osteoporosis Medications during Inpatient Stay:

HCPCS: J0897, J1740, J3110, J3111 J3489

CARE COORDINATION

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CONDITIONS (FMC)

The percentage of emergency department (ED) visits for members **18 years of age and older** who have multiple high-risk chronic conditions who had a follow-up within 7 days of the ED visit.

Exclusions:

- Members in hospice

Eligible Chronic Condition diagnosis:

- COPD and asthma
- Alzheimer's disease and related disorders
- Chronic Kidney Disease
- Depression
- Heart Failure

- Acute Myocardial infarction (Heart attack)
- Atrial fibrillation
- Stroke and transient ischemic attack

7-day Follow-up: 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 services
- Complex Care Management service
- An outpatient or telehealth behavioral health visit
- A community mental health center visit
- A telehealth visit
- An observation visit
- A substance use disorder service
- An e-visit or virtual check-in

[MEDICATION ADHERENCE FOR DIABETES MEDICATIONS (MAD)

Measure evaluates the percentage of members **18 years and older** with a prescription for non-insulin diabetes medication who fill their prescription
often enough to cover 80% or more of the time they are supposed to be taking the medication. Includes the following drug classes:

- Biguanides
- Sulfonylureas
- Thiazolidinediones
- Dipeptidyl Peptidase (DPP)-4 Inhibitors
- GLP-1 receptor agonists
- Meglitinides
- Sodium glucose cotransporter 2 (SGLT2) inhibitors
    - **Does not include insulin**

Exclusions:

- Hospice enrollment

	• ESRD diagnosis or dialysis coverage dates • One or more prescriptions for insulin
MEDICATION ADHERENCE FOR CHOLESTEROL MEDICATIONS (STATINS) - (MAC)	Measure evaluates the percentage of members **18 years and older** with a prescription for a statin medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. Includes all statins and combination statin medications, such as: • Atorvastatin (Lipitor) • Lovastatin (Altoprev) • Pitavastatin (Livalo, Zypitamag) • Pravastatin (Pravachol) • Rosuvastatin (Crestor, Ezallor) • Simvastatin (Zocor) **Exclusions:** • Hospice enrollment • ESRD diagnosis or dialysis coverage dates
MEDICATION ADHERENCE FOR HYPERTENSION (RAS ANTAGONISTS) (MAH)	Measure evaluates the percent of members **18 years and older** with a prescription for a RASA blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. Includes all ACE-I, ARB and combination RASA medications, such as: • captopril • candesartan • telmisartan • enalapril • valsartan • fosinopril • irbesartan • ramipril • olmesartan • losartan • lisinopril

- benazepril

Exclusions:

- Hospice enrollment
- ESRD diagnosis or dialysis coverage dates
- One or more prescriptions for sacubitril/valsartan

Suggestions to improve measure performance:

- Consider writing 90-day prescriptions for chronic conditions to reduce the number of refills needed.
- Prescribe low-cost generics to help reduce out-of-pocket costs.
- Discuss medication adherence barriers at every visit.
- Ask patients to bring medications to every visit.
- Educate patients on why they were prescribed the medication and the importance of getting refilled on time.