2021 Provider Guidance

Medicare Stars Playbook

AvMed

MEDICARE STARS
Provider Measures

This document provides Medicare Stars measure-specific information for needed services and directions on how to close gaps in the care of your Patients. You should refer to this document to familiarize yourself with current Stars measures and how to close gaps in care.

HOW TO FILL GAPS IN CARE

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	Member Received or Excluded
BCS - Breast Cancer Screening: Percent of female plan members aged 52-74 who had a mammogram during the past two years.	Members who had a bilateral or two unilateral mastectomies, or members receiving palliative care, or members age 66+ with advanced illness or frailty (refer to Appendix for list of advanced illness and frailty codes)	Contact members who have not had a mammogram in the last two years and provide a referral for a mammogram. Consider scheduling mammograms before the member's next appointment so that you have results at the appointment. Have the member complete mammography. AvMed contracts with mobile mammography vendor Florida Mobile Mammography. Website: https://www.floridamobilemammography.com/ Phone: 877-318-1349 Email: info@floridamobilemammography.com	If the member already had a mammogram in the current year or prior year, submit a copy of the medical record with a notation of the date of member's last mammogram and results, if available. (ex. Progress note showing member's last mammogram was in 2019, WNL) If the member had one bilateral or two unilateral mastectomies, submit appropriate diagnosis codes to indicate a history of bilateral or two unilateral mastectomies: • Absence of left breast: Z90.12 • Absence of right breast: Z90.11 • Hx of Bilateral Mastectomy: Z90.13 Alternatively, you may submit medical record with notation of each mastectomy and the date (ex. medical history section noting member had a bilateral mastectomy in 2010) See page 14 for directions on sending medical records to AvMed.
COL - Colorectal Cancer Screening: Percent of plan members aged 50-75 who had appropriate screening for colon cancer. A colorectal cancer screening as defined below: A colonoscopy every 10 years OR A flexible sigmoidoscopy every 5 years OR A CT colonography every 5 years OR A FIT-DNA test (ColoGuard every 3 years * ColoGuard is non-par and will require a prior authorization for claims payment OR A fecal occult blood test (FOBT) every year * (Quest Insure) available without a prior authorization	Members with dx of colorectal cancer, total colectomy, members receiving palliative care, or members age 66+ with advanced illness or frailty (refer to Appendix for list of advanced illness and frailty codes)	Contact members requiring a colorectal cancer screening and provide a referral for a colorectal cancer screening If member has not had a screening, consider scheduling member's GI visit while they are on the phone to increase likelihood the member will have a colonoscopy.	If member already had a screening, document the type, date and result of screening, if available. If member had an FOBT, the medical record should also indicate number of samples taken. Submit medical record with notation of colorectal cancer screening to AvMed If a member has a history of colorectal cancer or had a total colectomy, submit appropriate diagnosis codes to indicate the member should be excluded from the measure: Z85.038: Personal Hx of malignant neoplasm of large intestine Z85.048: Personal Hx of malignant neoplasm of rectum, rectosigmoid junction, and anus. See page 14 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	Member Received or Excluded
CDC - Comprehensive Diabetes Care HbA1c Poor Control (>9.0%): Percent of plan members with diabetes who had an A1C lab test during the year that showed their average blood sugar is under control.	Member has steroid-induced diabetes, or members receiving palliative care, or members age 66+ with advanced illness/ frailty (refer to Appendix for list of advanced illness and frailty codes)	Order at least one HbA1c and urine protein screening annually and ensure test is completed. Include appropriate CPT codes on claims to indicate member's most recent results and relevant conditions: • HbA1c: 3044F, 3046F, 3051F, 3052F If member does not want to get this done in-office or at a diagnostic center, offer home A1C kit that Quest can mail to them, they complete at home, and then mail back. Kits were sent by Quest in November 2020. To request a new kit, contact Quest: Megan M. Ezeff, Account Manager, 816-896-0237, Megan.M.Ezeff@QuestDiagnostics.com If A1C is out of control (>9%): a. Determine if member has an endocrinologist b. Assist in scheduling with endocrinologist c. Evaluate for enrollment in Disease Management d. Diet and exercise discussion e. In person classes at some of the hospitals. To refer a Medicare member for Diabetes Disease Management send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (Diabetes).	
CDC - Comprehensive Diabetes Care Kidney Disease Monitoring: Percent of plan members with diabetes who had a kidney function test during the year.	Member has steroid-induced diabetes, or members receiving palliative care, or members age 66+ with advanced illness/ frailty (refer to Appendix for list of advanced illness and frailty codes)	Order at least one urine protein screening annually. Include appropriate CPT codes on claims to indicate member's most recent results and relevant conditions: • Urine Protein: 3060F-3062F • Evidence of nephropathy: 3066F, 4010F If member does not want to get this done in-office or at a diagnostic center, have the member complete and return the microalbumin kit that was sent by Quest. Kits were sent by Quest in November 2020. To request a new kit, contact Quest: Megan M. Ezeff, Account Manager, 816-896-0237 , Megan.M.Ezeff@QuestDiagnostics.com To refer a Medicare Member for Diabetes Disease Management, send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (Diabetes).	If the member already had a visit this year, review the chart and assess if member was prescribed with a statin medication, if they did, follow-up with member, since there is no record of them receiving a statin medicine from the pharmacy. If you have the fill date, you can update the chart and submit back to AvMed. Check diagnosis codes in claim to see if member is excluded from this measure. See page 14 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	Member Received or Excluded
CDC - Comprehensive Diabetes Care Eye Exam: Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	Member has steroid-induced diabetes, or members receiving palliative care, or members age 66+ with advanced illness/ frailty (refer to Appendix for list of advanced illness and frailty codes)	Members can receive Retinal/ Dilated eye exam in-office and in-home. For in-office, refer members to an eye care specialist (optometrist or ophthalmologist) for a Retinal/Dilated eye exam annually: • Document name and specialty of member's eye care professional, date of last eye exam and result (+/- DM retinopathy) in medical record • Submit appropriate CPT codes on claims - If member had eye exam during the current year: 2022F - If member had steroscopic photo interpreted by an eye care specialist: 2024F, 2026F - If member's eye exam in the prior year was negative for retinopathy: 3072F - If member's had bilateral eye enucleation, document so in medical record If member, wants an exam at provider office, Icare does a campaign usually 3rd/ 4th quarter to set up clinics at provider's offices. Icare contacts the members to schedule. If member doesn't belong to provider offering a clinic, offer an in-home visit. Contact ICare: Rosaria Scalise rscalise@myicarehealth.com. To discuss setting up a campaign, contact Kimberlyann Wojick, Director, HEDIS Screening Operations, 855-238-4450 ext 228 HEDIS direct line: 877-991-9998 To refer a Medicare Member for Diabetes Disease Management send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (Diabetes).	If the member already had a screening, submit a copy of the medical record documenting name and specialty of member's eye care professional, date of last eye exam, and result (+/- DM retinopathy). Prior year negative eye exam will count. See page 14 for directions on sending medical records to AvMed.
CBP - Controlling High Blood Pressure: Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.	Members with a history of ESRD or members in palliative care, or members 66+ with advanced illness or frailty (refer to Appendix for list of advanced illness and frailty codes)	If member has not had a visit this year bring them in for a visit and evaluate BP. Take blood pressure a second time if reading is high due to white coat hypertension. Ensure coding staff uses HTN diagnosis code appropriately to avoid incorrectly placing member in measure: • Diagnosis code I10 should only be used if HTN has been formally diagnosed. Include appropriate CPT codes on claims to indicate member's BP reading on every visit: • Systolic: 3074F, 3075F, 3077F • Diastolic: 30778F, 3079F, 3080F ***To be counted as completed**, the last blood pressure reading for the year needs to be <140/90.	If a member already had a visit this year, review the BP reading in the chart and submit a claim with the proper HEDIS BP codes. • Systolic: 3074F, 3075F, 3077F • Diastolic: 30778F, 3079F, 3080F

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	Member Received or Excluded
		If the member most recent BP is ≥ 140/90, bring in the member for a follow-up visit to reassess BP. For members diagnosed with HTN, continue to manage member closely and encourage adherence to hypertension medication until their BP is under control. Members who have a digital home blood pressure monitor can take their blood pressure during a telehealth visit and report it to their provider. To refer a Medicare Member for CAD Disease Management send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (CAD).	
SPCR - Statin Therapy for Patients with Cardiovascular Disease (Part C): This rating is based on the percent of plan members with heart disease who get the right type of cholesterol-lowering drugs. Member must receive at least one Moderate or High Intensity statin medication during 2021 CY.	Members with ESRD, cirrhosis, myalgia, myopathy, myalgia, rhabdomyolisis, or members receiving palliative care, or members age 66+ with advanced illness/ frailty (refer to Appendix for list of advanced illness and frailty codes) Allergy and statin intolerance are **not** exclusions.	If the member has not had a visit this year or was not prescribed with a moderate or high intensity statin medication bring in the member for a visit. *****To be counted as completed***, the member needs to fill a one-time statin medication at the pharmacy. **Refer to Appendix for approved statins**. Take the opportunity at every appointment to talk to your members about the importance of taking prescribed medications and address common adherence barriers, such as cost and regimen complexity. To refer a Medicare Member for CAD DM send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (CAD). To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll-free: 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm	If the member already had a visit this year, review the chart and assess if member was prescribed a moderate or high intensity statin medication, if they did, follow-up with member, since there is no record of them receiving a statin medicine from the pharmacy. If you have the fill date, you can update the chart and submit back to AvMed. Check diagnosis codes in claim to see if member is excluded from this measure. See page 14 for directions on sending medical records to AvMed.

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	Member Received or Excluded
SUPD - Statin Therapy for Patients with Diabetes: To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of plan members with diabetes who take the most effective cholesterol-lowering drugs. Plans can help make sure their members get these prescriptions filled.	Members with dx of atherosclerotic cardiovascular disease – ASCVD, MI, CABG, PCI, IVD-ESRD, cirrhosis, myopathy, rhabdomyolisis, or members receiving palliative care, or members a ge 66+ with advanced illness/ frailty (refer to Appendix for list of advanced illness and frailty codes) Allergy and statin intolerance are **not** exclusions.	If the member has not had a visit this year or was not prescribed with a moderate or high intensity statin medication bring in the member for a visit. ***To be counted as completed***, the member needs to fill a one-time statin medication at the pharmacy. **See Appendix for approved statins**. Take the opportunity at every appointment to talk to your members about the importance of taking prescribed medications and address common adherence barriers, such as cost and regimen complexity To refer a Medicare Member for Diabetes DM send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (Diabetes). To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll-free: 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm To address regimen complexity, encourage use of pillbox organizers Since intolerance is not an exclusion criterion, trialing an alternative statin is encouraged when member reports intolerance.	If the member already had a visit this year, review the chart and assess if member was prescribed with a statin medication, if they did, follow-up with member, since there is no record of them receiving a statin medicine from the pharmacy. If you have the fill date, you can update the chart and submit back to AvMed. Check diagnosis codes in claim to see if member is excluded from this measure. See page 14 for directions on sending medical records to AvMed.
Medication Adherence for Diabetes Medications Taking Diabetes Medication as Directed: Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.		Remind members to refill and pick-up their Diabetes Medication. Main reasons behind non-adherence for Diabetes medication are lack of understanding, medication beliefs and cost concerns. Educate your patients on the importance and benefits of taking their medication. To address medical beliefs, think about your patient's perceptions, behaviors, and attitudes when discussing medication. To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll-free: 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm To refer a Medicare Member for Diabetes Disease Management send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (Diabetes).	

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps Member Never Received and Qualifies	Member Received or Excluded
Medication Adherence for Cholesterol (Statins) Taking Cholesterol Medication as Directed: Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.		Main reasons behind non-adherence for Statins are lack of understanding, forgetfulness, medication beliefs, no refills remaining and discontinued medication. Educate your patients on the importance and benefits of taking their medication. To address forgetfulness, provide medication calendars or schedules that specify the day and time to take medications, comprehensive drug cards or medication charts that have information on the medications the patient is taking, and on when and how these should be taken, unit-of-use packaging such as daily or weekly pill boxes and medication containers with alarms that alert the patient when it's time for their medication. To address medical beliefs, think about your patient's perceptions, behaviors, and attitudes when discussing medication. To refer a Medicare Member for CAD Disease Management send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (CAD).	
Medication Adherence for Hypertension (Renin Angiotensin System (RAS) Antagonists) – Percent of members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to take the medication.	Members with ESRD or members receiving palliative care or members with one or more prescriptions for sacubitril/valsartan	Remind members to refill and pick-up their Medication. Main reasons behind non-adherence for medication are lack of understanding, medication beliefs and cost concerns. Educate your patients on the importance and benefits of taking their medication. To address medical beliefs, think about your patient's perceptions, behaviors, and attitudes when discussing medication. To address cost: Switch members to less expensive and more convenient 90-day refill options; Shift to lower-cost generic options, when available; Refer members to the Social Security Administration to apply for Extra Help with Medicare Prescription Drug Plan Costs. Toll-free: 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm Do not provide brand drug samples to members. This may cause gaps in refill history and lower member's adherence percentage below 80%. Member needs to be prescribed a generic since they are zero dollar cost share and relatively inexpensive to the plan. To refer a Medicare Member for Hypertension DM send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition (Hypertension).	
MTM – Medication Therapy Management Program: Percent of eligible Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period.	Members receiving palliative care or members enrolled in the contract's MTM program for less than 60 days and did not receive a CMR within this timeframe. A member who is enrolled in two different contracts' MTM programs for 30 days each is therefore excluded from both contracts' CMR rates.	Refer members to AvMed's MTM Vendor, SinfoniaRx, at 1-844-866-3735 or TTY/TDD users: 1-800-367-8939 The MTM program will help them manage their drugs. The assessment includes a discussion between the member and a pharmacist about all the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and use his or her medications.	

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	Member Received or Excluded
MRP - Medication Reconciliation Post-Discharge: the percent of plan members whose medication records were updated within 30 days after leaving the hospital. To update the record, a doctor or other health care professional looks at the new medications prescribed in the hospital and compares them with the other medications the patient takes. Updating medication records can help to prevent errors that can occur when medications are changed		When provider receives notification of discharge from a hospital, effort should be made to schedule a visit with the patient within 30 days of discharge. If visit within 30 days is not possible, medication reconciliation can be completed telephonically with the member by a nurse and documented in member's chart. Be sure to document medications lists were reconciled using the following codes: • Medication Reconciliation Encounter 99483, 99495, 99496 • Medication Reconciliation Intervention 1111F	Be sure to document medications lists were reconciled using the following codes: • Medication Reconciliation Encounter 99483, 99495, 99496 • Medication Reconciliation Intervention 1111F See page 14 for directions on sending medical records to AvMed.
OMW - Osteoporosis Management: Percent of female plan members who broke a bone (not including fractures of finger, toe, face and skull) and got screening or treatment (bone mineral density test or osteoporosis prescription) for osteoporosis within 6 months.	Members who had a BMD test during the 24 months prior to the fracture or members who had a claim for osteoporosis therapy during the 12 months prior to the fracture or members who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the fracture or members receiving palliative care, or members age 67+ with advanced illness/ frailty (refer to Appendix for list of advanced illness and frailty codes).	Have the member complete a bone mineral density test or fill an osteoporosis prescription within 6 months (180 days) of fracture date. Review claims to determine if there was a fracture. *****To be counted as completed***, the member needs to fill a one-time OMW medication at the pharmacy. **Refer to Appendix for approved OMW medications.** If member wants in-home bone density, send order to AlliedHealth at concierge@amxdx.com. Ensure use CPT code 76977, code for mobile bone density test.	If member was on osteoporosis medication within the 12 months preceding the fracture, submit medical record to AvMed indicating date medication was dispensed, administered or sample/ compassionate care given (if known) If member has had a bone density test within the 24 months preceding the fracture, submit medical record indicating date of bone density test to AvMed See page 14 for directions on sending medical records to AvMed.
Plan All-Cause Readmissions: Percent of members discharged from a hospital stay or outpatient setting who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason		Prevent readmissions by knowing members, diagnoses and habits; identifying members' needs and addressing them and ensuring after hours recordings or answering services do not tell members to go to the ED after the office is closed (unless it is a medical emergency). Have receptionists always ask callers if they've been recently discharged from a facility so that the appointments post discharge are made according to recommendations below. 1. See high risk discharge patients within 2 days of discharge to develop a 30 day care plan 2. See moderate risk discharge patients within 5 days of discharge develop a 30 day care plan	

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	**Member Received or Excluded**
		3. Ensure that all discharged patients know to call your office (including evenings and weekends) with any questions or concerns before going to an emergency room unless it is a medical emergency. 4. Ensure prompt access to your office for visits for those recently discharged patients for the first 30 days. 5. Keep a current running list of recently discharged patients for the office staff to know. 6. Care plan essentials: a. Ensure all medications are filled and being taken as prescribed. Perform a medication reconciliation and code it b. Ensure weekly contact with high and moderate risk patients at least once a week for the first month. c. Ensure patient understanding of care plan and what to do if something occurs * These action steps above can be billed for Medicare patients via transitional care management (TCM) codes 99495 and 99496. To refer a Medicare Member for Disease Management (COPD, CAD, CHF, Asthma, Diabetes) send a secure email to AvMedMD.DisMngmnt.Referral@optum.com Please include the Members name, DOB, AvMed ID number and Condition. Nurse On Call line: Available to all members 24 hours a day, seven days a week. Members call in to 888-866-5432 to speak with a nurse.	
Urinary Incontinence (HOS Survey Improving Bladder Control)		Ask patients annually if they are experiencing any issues with urinary incontinence. Discuss treatment options including Kegel exercises, medications or other options.	

HOW TO FILL GAPS IN CARE (Cont.)

Quality Measure	Exclusion Criteria	How to Fill the Gaps	
		Member Never Received and Qualifies	Member Received or Excluded
Fall Risk (HOS Survey Reducing the Risk of Falling)		Ask patients annually if they have balance issues or other medical concerns that could increase risk of falling. Discuss ways to be proactive at preventing falls.	
Physical Activity (HOS Survey Improving or Maintaining Physical Health)		Ask patients annually how often they exercise and which exercises they do. Inform patient about AvMed SilverSneakers® program. Staying physically active can help reduce symptoms of depression, diabetes and heart disease, and help patients be happier. At SilverSneakers.com, there are on-demand workout videos plus fitness and nutrition tips. Find participating locations at SilverSneakers.com/Blog/Feel-Happier/1-888-423-4632 (TTY 711)	

Appendix

Advanced Illness Exclusions

ICD-10 Code	Definition
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0-4, 7-9	Malignant neoplasm of pancreas
C71.0-9	Malignant neoplasm of brain
C77.0-5, 8-9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00-2	Secondary malignant neoplasm of lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30, C78.39	Secondary malignant neoplasm of unspecified or other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80, C78.89	Secondary malignant neoplasm of unspecified or other digestive organs
C79.00-2,	Secondary malignant neoplasm of kidney and renal pelvis
C79.10-1, C79.19	Secondary malignant neoplasm of bladder and other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40, C79.49	Secondary malignant neoplasm of unspecified or other parts of nervous system
C79.51-2	Secondary malignant neoplasm of bone or bone marrow
C79.60-2	Secondary malignant neoplasm of ovary
C79.70-2	Secondary malignant neoplasm of adrenal gland
C79.81-2	Secondary malignant neoplasm of breast or genital organs
C79.89, C79.9	Secondary malignant neoplasm of unspecified or other sites
C91.00, C92.00, C93.00, C93.90, C93.70, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse
F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27,F10.97, G31.09, G31.83	Dementia
F04	Amnestic disorder due to known physiological condition
F10.96	Alcohol-induced persisting amnestic disorder
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G31.01	Pick's disease
I09.81, I11.0, I13.0, I13.2, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83,I50.84, I50.89, I50.9	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage 5
I50.1	Left ventricular failure, unspecified
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes, and vapors
J84.10, J84.112, J84.17	Pulmonary fibrosis

Appendix

Advanced Illness Exclusions

ICD-10 Code	Definition
J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
L89.0-9	Pressure ulcer
N18.6	End stage renal disease

Frailty Exclusions

CPT Code	Definition
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care

HCPCS Codes	Definition
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147-9	Walker
E0163, E0165, E0167-71	Commode chair
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-7, E0301-4	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-2	Respiratory assist device
E0561, E0562	Humidifier used with positive airway pressure device
E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-8	Wheelchair
G0162, G0299, G0300, G0493, G0494	Skilled RN services related to home health/ hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124,T1000-5,T1019-22,T1030,T1031	Nursing, respite care, and personal care services
ICD10 Codes	**Definition**
L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified state
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.0	Ataxic gait
R26.1	Paralytic gait
R26.2	Difficulty in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R41.81	Age-related cognitive decline
R53.1	Weakness
R53.81	Other malaise
R53.83	Other fatigue

HOW TO FILL GAPS IN CARE (Cont.)

Frailty Exclusions

ICD10 Codes	Definition
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA – W01.198S W06.XXXA – W10.9XXS W18.00XA – W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator [ventilator] status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

Relevant Mediations by Measure

Osteoporosis Therapies (OMW)

Description	Prescription	J-codes
Bisphosphonates	Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid	J1740, J3489
Other Agents	Abaloparatide, Denosumab, Raloxifene, Romosozumab, Teriparatide	J3110, J0897

Statins

High-Intensity Statins	Moderate-Intensity Statins
Atorvastatin 40-80 mg	Atorvastatin 10-20 mg
Amlodipine-atorvastatin 40-80 mg	Amlodipine-atorvastatin 10-20 mg
Rosuvastatin 20-40 mg	Rosuvastatin 5-10 mg
Simvastatin 80 mg	Simvastatin 20-40 mg
Ezetimibe-simvastatin 80 mg	Ezetimibe-simvastatin 20-40 mg
	Pravastatin 40-80 mg
	Lovastatin 40 mg
	Fluvastatin 40-80 mg
	Pitavastatin 2–4 mg

CARE OPPORTUNITY REPORT PROVIDER RESPONSE FORM

HEDIS measures are used to gauge the quality of care health plan members are receiving. The AvMed Care Opportunity Report provides you pertinent information regarding your patient's compliance status for selected measure.

Having proper coding practices is the best way to close member gaps in your Care Opportunity Report and reduces the need for medical record reviews.

You may have relevant information regarding a member that you are unable to submit via a claim. When this is the case, you can close the gap by submitting the medical record indicating the member has already received the relevant service within the correct time frame, or has a condition that excludes them from the measure.

All medical records should show the member's name, date of birth and date of service.

Fax all medical records, along with this completed cover page, to AvMed Corporate Quality Improvement at 1-800-331-3843. Use additional pages if necessary.

Records may also be uploaded to AvMed's secure portal at https://transfer.AvMed.org.
The UserName is hedis2019 and the Password is F3qid2[Z, then select the files to be uploaded.

Member Name:	**Member ID:**
Provider Name:	**Provider ID:**
List measure(s) for which medical record is being submitted (ex."Breast Cancer Screening" or "BCS"):	Describe information being submitted (ex."Member had bilateral mastectomy in 2010"):
Clinician Signature:	Date
Clinician Credentials:	

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Notes

If you have any questions, please contact Cindy Rosenbaum at
954-627-6291 or at **Cindy.Rosenbaum@AvMed.org.**