HEDIS SPECIFICATION OVERVIEW 2020

Cigna

STAR METRIC	CRITERIA	COMPLIANCE ATTRIBUTION
Adult BMI Assessment (ABA) ★ **Eligible (denominator)** Patients age 18–74 with an outpatient visit during the measurement year or year prior to the measurement year **Compliant (numerator)** Body Mass Index (BMI) documented through either administrative data or medical record review	• Patients age 20 and older, BMI and weight documented in the medical record in the measurement year or year prior • Patients younger than age 20, BMI percentile, height, and weight documented in the medical record in the measurement year or year prior • The weight, height, and BMI or BMI percentile must come from the same source **Exclude:** Female patients with a diagnosis of pregnancy during the measurement year or year prior	**To identify BMI (Adult):** **ICD-10CM:** Z68.1, Z68.20-Z68.39, Z68.41-Z68.45 **To identify BMI (Pediatric):** **ICD-10CM:** Z68.51-Z68.54
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, or 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 (see *Note below)	**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 (see *Note below)	**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; **ICD9PCS:** 45.24 **To identify Colonoscopy: CPT:** 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398; **HCPCS:** G0105, G0121; **ICD9PCS:** 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
Comprehensive Diabetes Care (CDC) ★ **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 ❸ • Retinal eye exam • Medical Attention for Nephropathy	**HbA1c screen with result <9: ❸** • 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" **Attention for nephropathy:** • Urine test for protein or albumin • Dispensed ACE/ARB medication • Documentation of visit to nephrologist • Documentation of renal transplant • Documentation of medical attention for: ESRD, diabetic nephropathy, CRF, CKD, ARF, renal insufficiency, proteinuria, albuminuria, renal dysfunction, dialysis **Exclude:** Patients age 66 and older with frailty and advanced illness (see *Note below)	**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 **To identify Kidney Function Test**: **CPT:** 81000-81003, 81005, 82042-82044, 84156; **CPT II:** 3060F-3062F, 3066F, 4010F (ACE/ARB treatment) **LOINC examples (all codes are not listed):** 11218-5, 12842-1, 13705-9, 13801-6, 14956-7, 14957-5, 14958-3, 14959-1, 1753-3, 1754-1, 1755-8, 1757-4, 18373-1, 20454-5, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 2887-8, 2888-6, 2889-4, 2890-2, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43607-1, 44292-1, 47558-2, 49023-5, 50561-0, 50949-7, 53121-0, 53525-2, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 57735-3, 5804-0, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1, 76401-9, 77253-3, 77254-1, 9318-7 **To identify Diabetic Retinal Screening** **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

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Rheumatoid Arthritis Management (ART) **Eligible (denominator)** Patients age 18 and older with rheumatoid arthritis (RA) defined as: • 2 or more diagnoses of RA on 2 different dates of service during the measurement year (1 of 2 visits may be telehealth or online assessment) **Compliant (numerator)** Patients dispensed one or more prescriptions for a DMARD during measurement year	• Patients who had at least one ambulatory prescription dispensed for a DMARD during the measurement year • Patients identified by claim/encounter or pharmacy data **Exclude:** Patients with a diagnosis of HIV any time during the patient's history, or female patients with a diagnosis of pregnancy	**To identify Rheumatoid Arthritis diagnosis:** **ICD-10CM:** • RA Dx codes from categories M05 and M06 • Please code to highest specificity • For a complete code set, contact the Provider Stars Clinical Operations team or your Cigna representative
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: • Functional Status Assessment • Medication Review • Pain Assessment	**Functional Status Assessment (FSA):** Documentation of at least 5 ADLs, 4 IADLs, completion of a standardized FSA tool. **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 **Pain Assessment:** Documentation that patient was assessed for pain during the measurement year	**To identify Functional Status Assessment:** **CPT II:** 1170F **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
Controlling High Blood Pressure (CBP) ❸ ★ **Eligible (denominator)** Patient 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 patient-reported BPs, 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 BP readings from remote monitoring devices that are digitally stored and transmitted to the provider **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 (see *Note below)	**To identify Hypertension:** **ICD-10CM:** I10 **Systolic < 130: CPT II:**3074F **Systolic 130-139: CPT II:** 3075F **Systolic ≥ to 140: CPT II:** 3077F **Diastolic < 80: CPT II:** 3078F **Diastolic 80–90: CPT II:** 3079F **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 (see *Note below)	**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

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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 the following day. **Receipt of Discharge Information:** • Documentation of receipt of discharge information on the day of discharge or the following day. **Patient Engagement After Inpatient Discharge:** • Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. **Medication Reconciliation Post-Discharge (MRP):** • Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	**Notification of Inpatient Admission:** Documentation must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria: • Communication between inpatient providers or the health plan and the member's PCP or ongoing care provider (e.g., phone call, email, fax) notifying them of admission on the day of admission or the following day. • Indication that the member's PCP or ongoing care provider admitted the member to the hospital. • Indication that the PCP or ongoing care provider placed orders for tests and treatments anytime during the member's inpatient stay. • Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. **Receipt of Discharge:** Documentation must include evidence of receipt of discharge information on the day of discharge or the following day 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 to the PCP or ongoing care provider for patient care. Discharge instructions provided to the member to follow up with their PCP does not meet criteria. **Patient Engagement:** Documentation 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. **MRP:** • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • 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. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge. • Only documentation in the outpatient chart meets the intent of the rate, but an outpatient visit is not required.	**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

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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 (see *Note below)	**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

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

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

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

KEY: ★ Denotes HEDIS hybrid Medical Record Review (MRR) measure
❸ Indicates triple weight measure

NOTE: Hospice is an exclusion for all measures.
Revised February 2020