Optum

Measurement Year 2023, Star Year 2025

Quality Measures At-A-Glance

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	CODING**
PREVENTION & SCREENING					
Breast Cancer Screening (BCS-E)^ **^BCS has moved from administrative to ECDS reporting**	50-74	The percentage of women who had a mammogram to screen for breast cancer any time on or between **October 1, 2021,** and **December 31, 2023**	Biopsies, breast ultrasounds, and MRIs do not count towards this measure Document the year (and month if occurred prior to 2022) it was completed in the patient's history	Hospice or palliative care in 2023 Advanced illness w/frailty (2 indications), ISNP, LTI Bilateral or two unilateral mastectomies (right and left) any time during the history through 2023	**Z90.11** – acquired absence of right breast **Z90.12** – acquired absence of left breast **Z90.13** – acquired absence of bilateral breasts CPT – Mammography **77061- 77063; 77065 - 77067**
Colorectal Cancer Screening (COL)	45-75 Stars only reports 50-75	The percentage of patients who received **one** or more of the following screenings: Fecal occult blood test (gFOBT/iFOBT/FIT) **annually** (2023) Stool DNA (sDNA) with Fit Test (Cologuard) every **3 years** (2021 –2023) Flexible Sigmoidoscopy every **5 years** (2019 – 2023) CT Colonography every **5 years** (2019-2023) Colonoscopy every **10 years** (2014 –2023)	Document the specific test and date of the test in the patient's history. A result is **not** required if this is documented in the patient's health history Digital rectal exams (DRE) or FOBT tests performed in an in-office setting do not meet compliance A FIT test is **not** the same as the stool sDNA with Fit Test (Cologuard) test	Hospice, palliative care, or death in 2023 Advanced illness w/frailty (2 indications), ISNP, LTI Colorectal cancer or total colectomy at any time in the patient's history through 2023	**82270** – Hemoccult Slide, (gFOBT) **82274** – Hemoccult Slide, (iFOBT/FIT) **G0328** – Colorectal cancer screening FOBT, immuno-chemical, 1-3 simultaneously **81528** – Stool DNA (sDNA) w/ FIT test **Z85.038** – hx neoplasm large intestine **Z85.048** – hx neoplasm rectum/sigmoid junction/anus

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CARDIAC & DIABETES					
Controlling Blood Pressure (CBP)	18-85	The percentage of patients who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mmHg) during 2023	BP reading for compliance consideration must be the **last of the year** If multiple BP measurements occur on the same date or are noted in the chart on the same date, take the **lowest systolic** and the **lowest diastolic** of the BP readings BP readings taken during an acute inpatient stay, or an ED visit are not acceptable Patient reported BP is acceptable only if taken by a **digital** device	Hospice, palliative care, or death in 2023 Advanced illness w/frailty (2 indications), ISNP, LTI Evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant on or prior to December 31, 2023 Dx of pregnancy in 2023 Patients who had a non-acute inpatient admission during 2023	**3074F** - Most recent systolic BP < 130 **3075F** - Most recent systolic BP 130 to 139 **3077F** - Most recent systolic BP ≥ 140 **3078F** - Most recent diastolic BP < 80 **3079F** - Most recent diastolic BP 80 to 89 **3080F** - Most recent diastolic BP ≥ 90
Hemoglobin A1C Control for Patients with Diabetes (HBD)	18-75	The percentage of patients with diabetes (type 1 and 2) whose most recent HbA1c result in 2023 was <8% (good control) or >9% (poor control) Note: Poor control >9% is an inverse measure (the lower the rate the better the score) Medicare Stars only measures ≤ 9% as under control	Notation of the **most recent** HbA1c screening and result performed in 2023 is the one considered for compliance A patient reported A1c is acceptable if collected by the PCP or managing specialist as part of the patient's history Home test results must be sent to the lab or doctor's office for analysis	Hospice, palliative care, or death in 2023 Advanced illness w/frailty (2 indications), ISNP, LTI Patients who do not have a dx of diabetes and who have a dx of polycystic ovarian syndrome (PCOS), gestational diabetes or steroid-induced diabetes during 2022 and 2023	**3044F**-Most recent A1c level <7.0% **3051F**- Most recent hemoglobin A1c (HbA1c) level ≥7.0% and <8.0% **3052F**- Most recent hemoglobin A1c (HbA1c) level ≥8.0% and ≤9.0% **3046F**- Most recent A1c level >9.0%

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	CODING**
CARDIAC & DIABETES (continued)					
Kidney Health Evaluation for Patients with Diabetes (KED)*	18-85 years and older	The percentage of patients with diabetes (type 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR), during 2023 • At least one eGFR is required during 2023 • At least one uACR is required during 2023 identified by either of the following: ○ A quantitative urine albumin test *and* a urine creatinine test with service dates four or less days apart ○ A uACR	Supplemental data can be used to close this measure Utilizing the appropriate CPT codes when ordering labs can reduce the need for chart review A urinalysis or a urine dipstick test can not be used to close this measure The eGFR and uACR do not require the same date of service; however, the measure will not close until both tests are completed	Hospice, palliative care, or death in 2023 Advanced illness w/frailty (2 indications), ISNP, LTI End-stage renal disease (ESRD) or dialysis any time during the patient's history Patients who do not have a dx of diabetes and who have a dx of polycystic ovarian syndrome (PCOS), gestational diabetes or steroid-induced diabetes during 2022 and 2023	**82043** - Quantitative Urine Albumin Lab Test **82570**-Urine Creatinine Lab Test **80047, 80048, 80050, 80053, 80069, 82565**-Estimated Glomerular Filtration Rate Lab Test
Eye Exam for Patients with Diabetes (EED)	18-75	The percentage of patients with diabetes (type 1 and 2) who had a retinal eye exam performed.	A retinal or dilated eye exam (with a positive or negative result) completed or interpreted by an optometrist or ophthalmologist or artificial intelligence in 2023 meets compliance A negative retinal or dilated exam done by an optometrist or ophthalmologist in 2022 meets compliance Bilateral eye enucleation or acquired absence of both eyes meets numerator compliance Fundus photography can be utilized for the diabetic retinopathy exam if it's read by an optometrist or ophthalmologist, and it is in the appropriate timeframe	Hospice, palliative care, or death in 2023 Advanced illness w/frailty (2 indications), ISNP, LTI Patients who do not have a dx of diabetes and who have a dx of polycystic ovarian syndrome (PCOS), gestational diabetes, or steroid-induced diabetes during 2022 and 2023 Blindness is not an exclusion	CPT II: **2022F, 2023F, 2024F, 2025F, 2026, 2033F**-Diabetic Retinal Screening With Eye Care Professional **92229**-Automated Eye Exam

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	NOTES/ BEST PRACTICES
PHARMACY					
Medication Adherence for Cholesterol (MAC)	18 years and older	The percentage of individuals with a statin prescription who met the proportion of days covered (PDC) threshold of **80%** for statins during the treatment period in 2023 Patients enter the denominator with their second fill, but PDC starts tracking from the first fill (start of treatment period) The treatment period begins on the earliest prescription date (first fill in 2023) through either the last day of enrollment during 2023, death, or the end of the 2023	**Only pharmacy claims** are used to identify and close care opportunities for this measure Supplemental data cannot be submitted for this measure Patients must use their health plan ID card to capture a pharmacy claim	Patients receiving hospice any time during 2023 End-stage renal disease (ESRD) during 2023	Prescription fills are captured via pharmacy claims Only prescription fills processed with a patient's health plan ID card can be used to measure a patient's adherence to their medication Avoid using samples Avoid using manufacturer medication assistance programs
Medication Adherence for Diabetes (MAD)	18 years and older	The percentage of patients who met the proportion of days covered (PDC) threshold of **80 %** for diabetes medications during the treatment period in 2023 Patients enter the denominator with their second fill, but PDC starts tracking from the first fill (start of treatment period) The treatment period begins on the earliest prescription date (first fill in 2023) through either the last day of enrollment during 2023, death, or the end of the 2023	**Only pharmacy claims** are used to identify and close care opportunities for this measure Supplemental data cannot be submitted for this measure Patients must use their health plan ID card to capture a pharmacy claim	Patients receiving hospice any time during 2023 End-stage renal disease diagnosis during 2023 Patients with one or more prescription claims for insulin during the treatment period	Prescription fills are captured via pharmacy claims Only prescription fills processed with a patient's health plan ID card can be used to measure a patient's adherence to their medication Avoid using samples Avoid using manufacturer medication assistance programs

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	NOTES/ BEST PRACTICES
PHARMACY (continued)					
Medication Adherence for Hypertension (MAH)	18 years and older	The percentage of individuals with a hypertension (Renin Angiotensin System (RAS) antagonist) prescription who met the proportion of days covered (PDC) threshold of **80%** during the treatment period in 2023 Patients enter the denominator with their second fill, but PDC starts tracking from the first fill (start of treatment period) The treatment period begins on the earliest prescription date (first fill in 2023) through either the last day of enrollment during 2023, death, or the end of the 2023	**Only pharmacy claims** are used to identify and close care opportunities for this measure Supplemental data cannot be submitted for this measure Patients must use their health plan ID card to capture a pharmacy claim	Patients receiving hospice any time during 2023 End-stage renal disease (ESRD) during 2023 Any individual with ≥1 prescription claim for sacubitril/valsartan (Entresto) during the treatment period in 2023	Prescription fills are captured via pharmacy claims Only prescription fills processed with a patient's health plan ID card can be used to measure a patient's adherence to their medication Avoid using samples Avoid using manufacturer medication assistance programs
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Male 21-75 Female 40-75	The percentage of patients who were identified as having clinical atherosclerotic cardiovascular disease and met the following criteria: • Were dispensed at least one moderate or high-intensity statin* • Complied with therapy at least 80% of the treatment period *Only the first dispensing requirement is needed to fulfill Stars compliance	If an approved supplemental data process is in place: Documentation of the patient's name, date of birth, medication name/dose/quantity and date it was dispensed is required A pharmacy receipt of medication administration record is evidence to show medication was dispensed	Hospice, palliative care, or death in 2023 Patients who experience any of the following in 2022 or 2023: • Pregnancy • Invitro fertilization • Dispensed at least one prescription for clomiphene • ESRD or dialysis • Cirrhosis Myalgia, myositis, myopathy, or rhabdomyolysis in 2023 Advanced illness w/frailty (2 indications), ISNP, LTI	Prescription fills are captured via pharmacy claims Only prescription fills processed with a patient's health plan ID card can be used to measure a patient's adherence to their medication Avoid using samples Avoid using manufacturer medication assistance programs

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	CODING**
PHARMACY (continued)					
Statin Use in Persons with Diabetes (SUPD)	40-75	The percentage of patients who filled at least two diabetes medications and received statin therapy in 2023	Patients should be dispensed at least one statin of any intensity Supplemental data cannot be submitted for this measure This measure can only be met by pharmacy claims	Any of the following in 2023: Hospice End stage renal disease (ESRD) Pregnancy Lactation Fertility medication: at least one prescription claim Cirrhosis Pre-diabetes Polycystic ovary syndrome (PCOS) Rhabdomyolysis or myopathy	Prescription fills are captured via pharmacy claims Only prescription fills processed with a patient's health plan ID card can be used to measure a patient's adherence to their medication Avoid using samples Avoid using manufacturer medication assistance programs
MUSCULOSKELETAL					
Osteoporosis Management in Women who had a Fracture (OMW)	67-85	The percentage of female patients who had a fracture and who had either a bone mineral density (BMD) test or a prescription fill or a drug to treat osteoporosis within **six months** after the fracture	Fractures of fingers, toes, face, and skull do **not** fall into this measure If the fracture resulted in an inpatient stay, a BMD test or a long-acting osteoporosis therapy administered during the stay will close the care opportunity A notation of a BMD completed within 6 months post fracture that includes a date/result meets compliance	Hospice, palliative care, or death in 2023 Patients who had a bone mineral density (BMD) test during 24 months prior to the fracture Patients who had osteoporosis therapy or a prescription to treat osteoporosis during 12 months prior to the fracture Advanced illness w/frailty (2 indications), ISNP, LTI	**76977** - Peripheral site **77078** - CT axial skeleton **77080** - DXA axial skeleton **77081** - DXA appendicular skeleton **77085** - DXA axial skeleton, (e.g., hips, pelvis, spine), including vertebral fracture assessment **77086** - Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	CODING**
CARE OF OLDER ADULTS (SNP and MMP only)					
Care for Older Adults (COA)- Functional Status Assessment*	66 years and older	The percentage of adults who had evidence of a functional status assessment (FSA) during 2023	• Functional status assessment conducted in an acute inpatient setting will not meet compliance • The FSA can be done via telephone • Standardized assessment tools can be used • If assessing manually, 4 iADLs or 5 ADLs must be assessed • Documentation of "incontinence" does not meet criteria for assessing toileting	Hospice or death any time in 2023	**1170F** - Functional status assessed **G0438** - Initial annual wellness visit; includes a personalized prevention plan of service **G0439** - Subsequent annual wellness visit; includes a personalized prevention plan of service **99483** - Comprehensive evaluation of new or existing patient with signs/symptoms of cognitive impairment
Care for Older Adults (COA)- Medication Review	66 years and older	The percentage of adults who had a medication review by a clinical pharmacist or prescribing practitioner with the presence of a medication list in the medical record in 2023	• Must be done by a **prescribing provider** or **clinical pharmacist** • The review and med list must be from same visit • A medication list alone signed and dated during 2023 will meet criteria • Documentation that the medications aren't tolerated does **not** meet compliance • A review of side effects for a single medication does **not** meet compliance • Medication review conducted in an acute inpatient setting will **not** meet compliance	Hospice or death any time in 2023	**1159F**- Medication list documented **1160F**- Review of all medications, including prescriptions, OTC's, herbal therapies, and supplements **G8427**- Eligible clinician attests they obtained, updated, or reviewed the patient's current medications **90863, 99483, 99605, 99606** - Medication review CPT codes **99495, 99496** - Transitional Care Management Services (TCM) CPT codes
Care for Older Adults (COA)- Pain Assessment	66 years and older	The percentage of adults who were assessed for pain during 2023	• A pain assessment in an acute inpatient setting is **not** compliant • A pain management plan or pain treatment alone will **not** meet compliance • Documentation of chest pain only does **not** meet compliance • A pain assessment related to a single body part (except for chest pain) meets compliance • Date and notation of "no pain" does meet compliance	Hospice or death any time in 2023	**1125F** - Pain present, pain severity quantified **1126F** - Pain not present, pain severity quantified

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	CODING**/BEST PRACTICES
CARE COORDINATION					
Advance Care Planning (ACP)*	66-81	The percentage of adults 66–80 years of age with advanced illness, an indication of frailty, or who are receiving palliative care; and adults 81 years of age and older who had advance care planning during 2023	Presence of an advance care plan (e.g., living will, health care power of attorney, health care proxy) **--OR--** Actionable medical orders regarding end-of-life treatment (e.g., POLST, Five Wishes) or written document designating someone as a surrogate decision maker **--OR--** Documentation of an ACP discussion with the provider and the date when it was discussed in 2023 **--OR--** Notation that the member previously executed an advance care plan	Hospice or death any time during 2023	**1123F** – ACP discussed/documented or surrogate decision maker documented in medical record **1124F** – ACP discussed/documented; no surrogate named, or no ACP provided in medical record **1157F** – ACP or similar legal document present in medical record **1158F** – ACP discussion documented in the medical record **99483** – Assessment of and care planning for a patient with cognitive impairment **99497**– Advance care planning including the explanation and discussion of advance directives **Z66** – Do not resuscitate **S0257** - Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	18 years and older	The percentage of ED visits for Medicare patients with multiple high-risk chronic conditions who received appropriate follow-up care within seven days of discharge **Chronic Conditions:** • COPD and asthma • Alzheimer's disease and related disorders • Chronic kidney disease (CKD) • Depression • Heart failure • Acute myocardial infarction • Atrial fibrillation • Stroke and transient ischemic attack (TIA)	Patients must have been seen in the emergency department (ED) for treatment between January 1, 2023-December 24, 2023 This measure is based on ED visits, not on members 7-day follow-up post ED visits can include any of the following and can take place the day of ED discharge (8 days total): outpatient, telephone, telehealth, observation visit, e-visit, virtual check-in, etc.	Hospice or death any time during 2023 ED visits that result in an acute inpatient (hospital) stay are not included ED visits that result in an admission to an acute or nonacute inpatient care setting on the date of discharge or within 7 days after the ED visit, regardless of the principal admission diagnosis are not included	**Best Practices** Check ADT feeds daily to identify recent ED discharges Develop a daily process to schedule follow-up visits with the patient's PCP post emergency room visits Educate patients on appropriate use of the emergency room Encourage patients to have regular office visits with their PCP to manage their chronic conditions Submit timely claims and include the appropriate codes for diagnosis, health conditions, and the services provided

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	BEST PRACTICES
CARE COORDINATION (continued)					
Transitions of Care (TRC)- Receipt of Notification of Inpatient Admission (NIA)	18 years and older	Documentation of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days)	The outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received and filed (accessible in the outpatient record) Documentation that **does not** count for notification of admission or discharge: • Patient or patient's family notifying the patient's PCP of the admission • Notification that does not include evidence of a time frame or date when the documentation was received and filed	Hospice or death any time during 2023	Review hospital discharge reports daily Sign-up for hospital EMR portals to access your patient's records Advise patients to supply their PCP contact information to their admitting provider
Transitions of Care (TRC)- Receipt of Discharge Information (RDI)	18 years and older	Documentation of discharge notification on the day of discharge through 2 days after the discharge (3 total days)	Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence when the documentation was received and filed (accessible in the outpatient record) Discharge documentation **must** include: • Date of discharge and the date the documentation was received • The practitioner responsible for the patient's care during the inpatient stay • Procedures or treatment provided • Diagnoses at discharge • Current medication list • Testing results, or documentation of pending tests or no tests pending • Instructions for patient care post-discharge.	Hospice or death any time during 2023	Review hospital discharge report daily Check on hospitalized patients to anticipate discharge date and transition needs Sign-up for hospital EMR portals to access your patient's records Outreach to patient or caregiver within 2 business days of discharge Note: If the PCP is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge (3 total days)

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	CODES**
CARE COORDINATION (continued)					
Transitions of Care (TRC)- Medication Reconciliation Post Discharge (MRP)	18 years and older	The percentage of acute or non-acute inpatient discharges for patients who had a medication reconciliation performed on the date of discharge through 30 days after discharge in 2023	Documentation of medication reconciliation can be done by a prescribing practitioner, physician assistant, clinical pharmacist, or an RN The outpatient record must include a current medication list, a notation that the provider reconciled a current medication list with discharge medications, and documentation of the recent hospital discharge	Hospice or death any time during 2023	CPT II code - **1111F-** Discharge medications reconciled with current medication list in outpatient record CPT codes - **99483, 99495, 99496**-Post DC visit with moderate-high complexity of care
Transitions of Care (TRC)- Patient Engagement After Inpatient Discharge (PE)	18 years and older	Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge	**Do not** include patient engagement that occurs **on** the date of discharge Visits may include: outpatient, telephone, telehealth, observation visit, e-visit, virtual check-in, etc.	Hospice or death any time during 2023	**Transitional Care Management:** CPT- 99495-96 **Outpatient Visits, Patient Engagement:** CPT codes – 99201-99205, 99211-15, 99241-45, 99341-45, 99347-50, 99381-87, 99391-97, 99401-04, 99411-12, 99429, 99455-56, 99483 HCPCS codes – G0402, G0438-39, G0463, T1015 **Telephone Visits:** CPT Codes – 98966-68, 99441-43 **Online Assessment (e-visit/virtual check-in):** CPT Codes – 98969-72, 99421-23, 99444, 99457-58 HCPCS codes – G0071, G2010, G2012, G2061, G2062, G2063,G2250-52

MEASURE NAME	AGE	DESCRIPTION	DOCUMENTATION TIPS	EXCLUSIONS	BEST PRACTICES
RISK ADJUSTED UTILIZATION					
Plan All-Cause Readmissions (PCR)	18 years and older	The number of acute inpatient (hospital) and observation stays during 1/1-12/1/2023 that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission PCR is an inverse measure- a lower rate indicates a better score Note: For commercial and Medicaid, only patients 18–64 years of age are reported	If applicable, document that the patient died during the hospital stay Document patients who are receiving hospice care in 2023 Remember to document for Transitions of Care indicators: Receipt of Inpatient Admission and Discharge, Patient Engagement After Discharge within 30 days and Medication Reconciliation on day of discharge through 30 days after discharge **Supplemental data may not be used for this measure except for required exclusions for hospice or death**	Hospice any time during 2023 Patients who died during the hospital stay Patients with a principal diagnosis of pregnancy or a condition originating in the perinatal period on the discharge claim Patients where date of admission is the same as the date of discharge (same day) High utilizers are removed and reported as outliers Planned admissions for principal diagnosis of maintenance chemotherapy, rehabilitation, or organ transplant Non-acute (SNF) inpatient stay A potentially planned procedure without a principal acute diagnosis	Code for suspect conditions annually Be aware of patients who are high hospital utilizers and those at high risk for readmissions; provide transitional care management Offer care coordination/case management services Partner with hospitals to improve care coordination at discharge and obtain the discharge summary Develop a process to identify patients who have been discharged from acute facilities using daily discharge census. Outreach to these patients within one week to schedule follow-up care and medication reconciliation For a planned hospitalization, schedule a follow-up appointment prior to the admission Remind patients of the importance of keeping appointments with their PCP and other specialists

*CMS has not included as a Stars measure for MY2023
**Coding is informational only and does not guarantee payment

Resources: HEDIS® MY2023 Vol 2 Technical Specs _HUG Version | Pharmacy Quality Alliance. February 2022. PQA Measure Manual.

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