

Clinical HEDIS Medicare Stars Quick Reference Guide

MEASURE	SPECIFICATIONS
Adult BMI Assessment (ABA)	<p>The percentage of members 18 – 74 years of age who had an outpatient visit and whose weight and body mass index was documented during the measurement year or the year prior.</p> <p>Documentation in the medical record <u>must indicate</u> the weight and BMI value, dated in measurement year or year before.</p> <p>For members younger than 19 on the date of service, documentation of BMI percentile also meets criteria:</p> <ul style="list-style-type: none"> • BMI percentile documentation as a value (e.g., 85th percentile) • BMI percentile plotted on a growth chart <p>Notes:</p> <ul style="list-style-type: none"> ♦Notation of height & weight only is not compliant! ♦Weight & BMI must be from the same data source but may be from different dates of service ♦Ranges and thresholds do not meet criteria. BMI documentation of >99% or <1% If a distinct BMI percentile is evident, e.g., 100% or 0%, it <u>DOES</u> meet criteria.
Breast Cancer Screening (BCS)	<p>The percentage of women 50-74 years of age who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.</p> <p><u>Exclusions:</u> Women who have had bilateral mastectomy or 2 unilateral mastectomies. Unilateral mastectomies must have service dates 14 or more days apart.</p> <p>Note: Do not count biopsies, ultrasounds or MRIs</p>
Care for Older Adults (COA) SNP only	<p>The percentage of adults 66 and older who had each of the following during the measurement year:</p> <ul style="list-style-type: none"> • <u>Advance care planning:</u> a discussion about preferences for resuscitation, life sustaining treatment and end of life care. Evidence of advanced care planning must include: <ul style="list-style-type: none"> • The presence of an advanced care plan in the record or • Documentation of an advance care planning discussion with the provider and a date in the measurement year or • Notation that member has previously executed an advance directive <p>Examples of advance care plan include:</p> <p style="margin-left: 40px;"><i>Advance directive-</i> e.g. living will, power of attorney, healthcare proxy</p> <p style="margin-left: 40px;"><i>Actionable medical orders:</i> written instructions regarding initiation, continuation, withholding or withdrawing of life sustaining treatment</p>

Living will: Legal document denoting preferences for life sustaining treatment and end of life care

Surrogate decision maker: A written document designating someone else to make future medical treatment choices

Examples of advance care planning discussion include:

Notation in the medical record of a discussion in the measurement year, **or** oral statements: Conversations with relatives or friends about life sustaining treatment and end of life care, documented in the medical record in the measurement year

- **Medication review**: At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and a medication list in the medical record. Documentation must come from the same medical record and must include :
 - A medication list in the medical record **and** evidence of a medication review conducted by a prescribing practitioner or clinical pharmacist and the date it was performed
 - Notation that the member is not taking any medication and the date it was noted
- Note: A review of side effects for a single medication at the time of Rx is not sufficient. An outpatient visit is not required

- **Functional status assessment**: At least one functional status assessment during the measurement year as documented by:
 - Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking. **OR**
 - Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.
OR
 - Results of assessment using a standardized functional status assessment tool (SF-36, ALSAR, ADLS, B-ADL, ILS, KELS, etc.) **OR**
 - Notation that the following components (**at least three of the four**) were assessed:
 1. Notation of functional independence (e.g. exercise, ability to perform job)
 2. Sensory ability (hearing, vision, speech) **need all three**
 3. Cognitive status (e.g. alert, oriented)
 4. Ambulatory status (e.g. walks with cane, gait)

Note: An assessment limited to an acute or single condition, event or body system (e.g. lower back, leg) does not meet criteria for a comprehensive functional status assessment.

	<p>The components of the functional status assessment may take place during separate visits within the measurement year.</p> <ul style="list-style-type: none"> • Pain assessment: At least one pain assessment during the measurement year must include one of the following: <ul style="list-style-type: none"> • Documentation that the patient was assessed for pain (which may include positive or negative findings for pain) • Result of assessment using a standardized pain assessment tool <p>Notes:</p> <ul style="list-style-type: none"> • Notation of a pain management plan alone does not meet criteria. • Notation of a pain treatment plan alone does not meet criteria. • Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.
<p>Colorectal Cancer Screening (COL)</p>	<p>The percentage of members 50-75 years of age who had one or more of the following screenings for colorectal cancer:</p> <ul style="list-style-type: none"> • <u>Fecal occult blood test FOBT</u> during the measurement year. There are two types, guaiac (gFOBT) and immunochemical (iFOBT). • <u>Sigmoidoscopy</u> during the measurement year or four years prior • <u>Colonoscopy</u> during the measurement year or in the nine years prior <p>Notes:</p> <ul style="list-style-type: none"> -Documentation <u>must include the date the colorectal screening was performed</u> (not just ordered). -Digital rectal exam (DRE) does not count. <p>Exclusion: Members with a diagnosis of colorectal cancer or total colectomy (removal most (all) of the large bowel) occurring before December 31 of the measurement year.</p>
<p>Comprehensive Diabetes Care (CDC)</p>	<p>The percentage of members 18 – 75 with diabetes (type 1 and type 2) who had each of the following:</p> <ul style="list-style-type: none"> • HbA1c good control <9% (8.9 or lower) • Eye exam (retinal) performed • Medical attention for nephropathy <p>HbA1c: Results of the last HbA1c performed in measurement year documented in a lab report or provider’s note which includes the date and result of the test</p> <p>Retinal Eye Exam: A dilated or retinal eye exam done by an eye care professional in the measurement year or a negative retinal exam (no evidence of retinopathy) done in the year prior</p> <p>Medical Attention for Nephropathy:</p> <ul style="list-style-type: none"> • Look for written documentation of a visit to a nephrologist or a note that

	<p>addresses any of the following in measurement year:</p> <ul style="list-style-type: none"> ○ Diabetic nephropathy ○ Renal Transplant ○ End stage renal disease (ESRD) ○ Chronic renal failure (CRF) ○ Chronic kidney disease (CKD) ○ Renal insufficiency ○ Proteinuria ○ Albuminuria ○ Renal dysfunction ○ Acute renal failure (ARF) ○ Dialysis, hemodialysis or peritoneal dialysis <ul style="list-style-type: none"> ● Macroalbumin – Any of the following tests done in measurement year: <ul style="list-style-type: none"> ○ Urinalysis positive (random, spot or timed) for protein ○ Positive urine dipstick ○ Positive tablet reagent for urine protein ○ Positive result for albuminuria ○ Positive for macroalbuminuria ○ Positive for proteinuria ○ Positive for gross proteinuria <p>Note: “trace” urine macroalbumin test results are not considered positive.</p> <ul style="list-style-type: none"> ● Microalbuminuria –Any of the following tests in measurement year: <ul style="list-style-type: none"> ○ 24-hour urine for microalbumin ○ Timed urine for microalbumin ○ Spot urine for microalbumin ○ Urine for microalbumin/creatinine ratio ○ 24-hour urine for total protein ○ Random urine for protein/creatinine ratio ● Evidence of ACE Inhibitor/ARB therapy during measurement year
<p>Controlling High Blood Pressure (CBP)</p>	<p>The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:</p> <ul style="list-style-type: none"> ● Members 18-59 years of age whose BP was <140/90 ● Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 ● Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	<p>The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).</p> <p><u>Exclusions (optional):</u></p> <ul style="list-style-type: none"> • Members with a diagnosis of HIV any time during the member’s history through the measurement year. • Members with a diagnosis of pregnancy during the measurement year.
Medication Reconciliation Post-Discharge (MRP)	<p>The percentage of discharges from Jan 1 – Dec 1 of the measurement year for members 66 and older for whom medications were reconciled on or within 30 days of discharge conducted by a prescribing practitioner, clinical pharmacist, or RN.</p> <p>Any of the following evidence meets criteria:</p> <ul style="list-style-type: none"> • Notation that the medications prescribed upon discharge were reconciled with the current medications in the outpatient record • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications • Notation that no medications were prescribed upon discharge
Osteoporosis Management in Women Who Had a Fracture (OMW)	<p>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.</p> <p>Intake period: A 12 month (1 year) window that begins on July 1 of the year prior to the measurement year and ends June 30 of the measurement year. The intake period is used to capture the first fracture.</p> <p><u>Exclusions required:</u> Members who had a BMD test during the 730 days (24 months) prior to the fracture. Members who had a claim/encounter for osteoporosis therapy or received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to the fracture.</p>

Amerivantage is an HMO plan with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in Amerivantage depends on contract renewal.