2018
5-STAR GUIDEBOOK

scan HEALTH PLAN®

For their contributions to this guidebook, SCAN Health Plan® acknowledges:

- DaVita HealthCare Partners
- EPIC Management
- Heritage Provider Network

Contents

Special Notices

This is the 2018 edition of the *5-Star Guidebook*. This edition applies to release 1, version 1, and to all subsequent releases and modifications until otherwise indicated in new editions or technical newsletters.

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Where to Find More Information

For additional information about the measures in this guidebook, visit www.scanhealthplan.com/5Star.

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Preface

This guidebook is intended for provider groups and physicians looking for guidance on how best to improve their performance against a number of measures that the Centers for Medicare and Medicaid Services (CMS) uses to evaluate and reward successful implementation of best practices in healthcare.

CMS employs a five-star rating system to quantify quality and performance for certain plans offered to Medicare beneficiaries. This rating system is used to provide a scored assessment of individual quality components, as well as aggregate overall performance of Medicare Advantage (MA) and/or Prescription Drug Plans (PDP).

The Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act of 2010 introduced quality-based payments and quality bonus payments (QBPs) as an incentive to encourage these plans to accelerate the implementation of quality program improvements.[1]

SCAN recognizes there are different recommendations for screening and care recommendations from different leading organizations. The recommendations included here are based on the CMS 5-Star Guidelines for Medicare Advantage Plans. These guidelines may not apply in all cases but we believe they provide an appropriate clinical framework for the majority of patients.

[1] Framework for Improving Medicare Plan Star Ratings, Academy of Managed Care Pharmacy (AMCP), AMCP Special Projects Committee, Dec. 2011

Terminology

The following terms and acronyms are used in this guidebook:

Term	Description
CAHPS	Consumer Assessment of Healthcare Providers and Systems[1]
CDC	Centers for Disease Control and Prevention
HCPCS	Healthcare Common Procedure Coding System[2]
HEDIS	Healthcare Effectiveness Data and Information Set[3]
HOS	Health Outcome Survey
HRA	Health Risk Assessment
PHQ	Patient healthcare questionnaire

1 Series of patient surveys rating healthcare experiences in the United States.
2 Coders use HCPCS codes to represent medical procedures to Medicare, Medicaid and several third-party payers. The code set is divided into three levels; level one is CPT.
3 Tool used by America's health plans to measure performance on important dimensions of care and service. Consists of 81 measures across five domains of care.

Introduction and General Best Practices

This guidebook provides details and reference material for a subset of the 50 or more measures in the CMS 5-Star Quality Rating System and provides actionable information to impact your patients' care.

The purpose of this guidebook is to provide information to provider groups that can help them determine how best to incentivize their doctors to improve performance against these measures.

SCAN understands not all physicians will agree on a particular guideline or best practice. For each measure we describe in this guidebook, we provide the most commonly used guidelines and best practices selected from the literature for your consideration.

Coding Statement
Please note that this guidebook does not include all 5-Star measure codes. Codes submitted by specialists and imaging centers may be acceptable, though not listed, since we have highlighted the codes that primary care physicians (PCPs) are responsible for submitting.

While not all codes apply to all measures, we consider it good coding practice to code services provided on all patients.

Exclusions Statement
This guidebook includes the most common HEDIS exclusions. For a full listing of the HEDIS measure exclusions, please refer to the HEDIS technical specifications at http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018.

General Best Practices

The following best practices apply broadly across a wide range of 5-Star measures:

- The provider group maintains a registry of relevant patients and systematically reminds those with open gaps in care to assure appropriate services are rendered.
- For patients who have had tests or screenings done prior to becoming your patient (e.g., colonoscopy performed in the last 10 years), document the date in their medical record and request historical records.
- Schedule a comprehensive annual wellness visit with senior patients to address preventive screenings, discuss common geriatric issues such as falls, urinary incontinence and depression and make appropriate referrals to specialists.

Staying Healthy: Screenings, Tests and Vaccinations

Measures described in this section address the conditions most likely to impact the well-being of seniors.

Annual Flu Vaccine

The single best way to protect against influenza is to get vaccinated each year. You may encounter patients who will not get flu shots. You may find it difficult changing their minds as they are misinformed and fearful of the flu vaccine.

Your challenge is to engage these members as partners in their own care, dispel the myths, have them trust and rely on you for the best information for keeping them healthy and prevent the flu from leading to pneumonia and an increased risk of mortality.

Target	How to Improve This Measure	Frequency
All patients	• Remind patients to get flu shot and have standing orders for receiving flu shot during flu season. • Maintain vaccine in all offices. • Provide take-home materials for members' records.	Each flu season

Clinical Guidelines

- Encourage patients to come in early in the flu season for their shots.
- Have standing orders and a process to administer flu shots for walk-ins.
- Stock the vaccine so that you have it available to patients who need it.
- For elderly patients who have a hard time getting around and who have a transportation benefit, encourage them to use the free rides to take them to and from your office to get their shots.

- Enlist the aid of caregivers to encourage your patients to get their flu shots.
- In addition to recommending the flu shot, advise your patients to observe the usual precautions during the flu season, such as avoiding crowded places, people who are ill and washing hands frequently.
- Set up auto-reminder calls to all your patients towards the start of the flu season.
- Consider offering flu shot clinics or even a FLU-FOBT (see page 10).
- Provide take-home materials for patients' records so that they remember receiving their flu shot.
- Medicare and most health plans, including SCAN, allow for vaccinations at contracted pharmacies. This is a convenient option for many patients.

Toolkits and Educational Tools

- The CDC provides a number of tools and materials to drive home the benefits of getting a flu shot. For example, the number of preventable flu illnesses, medical visits and hospitalizations are laid out in a table by the CDC as shown below.[1]
- You can also get the 2017-18 Flu Season Digital Media Toolkit from the CDC.[2]

Estimated number of flu illnesses prevented by flu vaccination during the 2015-2016 flu season:	Estimated number of medical visits prevented by flu vaccination during the 2015-2016 flu season:	Estimated number of flu hospitalizations prevented by flu vaccination during the 2015-2016 flu season:
5 million	**2.5 million**	**71,000**
Equal to the number of people using Denver International Airport in one month.	Equal to the population of Portland, Ore.	Enough to fill every registered hospital bed in the State of Texas.

1 For more information, visit https://www.cdc.gov/flu/ and https://www.cdc.gov/flu/freeresources/print-seniors.htm#Education.
2 For more information, visit https://www.cdc.gov/flu/partners/promote-vaccination.htm.

It is a Medicare requirement that SCAN members be able to get a flu shot without a copayment. However, if the members also see their primary care physicians for other reasons, an office visit copayment can be charged.

Coding and Documentation Guidance

One set of procedure codes is used for the vaccines themselves, and one procedure code is used for the administration of the vaccine.[1]

Documentation should include the type of vaccine, route of administration, location of administration (for injections), batch number of the vaccine and date.

There is a single code for administration of the vaccine, irrespective of route:

CPT Code	Administration
G0008	Seasonal influenza virus vaccine administration

The administration code and one of the codes listed for annual flu vaccines in Appendix: Coding (page 70) should be billed.[2]

1 There is one diagnosis code: Z63 – encounter for immunization.
2 Only one code for the annual flu vaccine should be billed with the administration code.

Body Mass Index (BMI) Assessment

Clinical Basis

BMI predicts health risks in adult patients who are both underweight and overweight.[1] BMI is a safe, non-invasive test, which, when combined with clinical assessment of the patients, can provide critical information regarding patients' nutritional status.

Target	How to Improve This Measure	Frequency
Patients 18-74 years	Record both weight and BMI (kg/height^2) in medical records, describe its significance (see Coding and Documentation Guidance below) and provide diagnosis codes to represent both.	At least annually

Clinical Guidelines

- Although non-physician staff may calculate and record the BMI, it is up to physicians to provide the corresponding diagnosis (e.g., underweight, protein-calorie malnutrition, obesity).
- The combined use of BMI, careful history and exclusion of confounding factors (e.g., ascites) provides a framework for nutritional intervention when necessary.

Coding and Documentation Guidance

The ICD-10 coding rules require that both the BMI and a narrative description of the meaning of the BMI be documented and coded. BMI alone cannot be coded.

Physicians must interpret the BMI in their documentation, noting if patients are of normal weight, underweight, cachectic, obese, morbidly obese, etc.

1 Alpers DH, Klein S. Approach to the Patient Requiring Nutritional Supplementation. In Yamada T, ed. Textbook of Gastroenterology, 4th edition. Baltimore: Lippincott Williams & Wilkins, 2003

Breast Cancer Screening

Clinical Basis

Screening mammography is used for the early detection of breast cancer. The ultimate purpose of screening is not to detect breast cancer at an early stage but to save lives. An added benefit of screening is that small tumors may be treated with less aggressive regimens than larger tumors.[1]

Target	How to Improve This Measure	Frequency
Patients 50-74 years	Mammogram (be sure to document if patients have had a mastectomy)	Every two years

Common Exclusions

- Bilateral mastectomy
- Two unilateral mastectomies with service dates 14 days or more apart
- Absence of the left breast and absence of the right breast on the same or different dates of service

Clinical Guidelines

- The United States Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.[2]
- Ensure no prior authorization is required for mammography.
- Partner with radiology facilities to schedule mammograms.

1 Institute of Medicine (US) and National Research Council (US) Committee on New Approaches to Early Detection and Diagnosis of Breast Cancer; Joy JE, Penhoet EE, Petitti DB, editors. "Saving Women's Lives: Strategies for Improving Breast Cancer Detection and Diagnosis". Washington (DC): National Academies Press (US); 2005. "Benefits and Limitations of Mammography" (http://www.ncbi.nlm.nih.gov/books/NBK22311/)

2 The USPSTF is a nationally recognized authority on preventive health (https://epss.ahrq.gov/ePSS/TopicDetails.do?topicid=198)

Coding and Documentation Guidance

- The results of the screening mammography should be documented in the medical record.
- Any needed referrals or recommendations to patients for follow-up care (e.g., additional imaging, referrals to a surgeon for biopsy) should also be included.
- Document history of bilateral mastectomy to exclude patients from the denominator.
- Related Codes: 3014F - screening mammography results documented and reviewed.

Colorectal Cancer Screening

Clinical Basis

The USPSTF found convincing evidence that screening for colorectal cancer in adults aged 50 to 75 years reduces colorectal cancer mortality. Physician recommendation for screening has been shown to be the greatest influencing factor in achieving patient compliance.

Target	How to Improve This Measure	Frequency
Patients 50-75 years	• Colonoscopy • Sigmoidoscopy • FIT-DNA test • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT)	• Every 10 years • Every five years • Every three years • Annually

Exclusions

Diagnosis of colorectal cancer or total colectomy any time during the patients' history through Dec. 31 of the measurement year.

Clinical Guidelines

- Recommend appropriate colorectal cancer screening to all eligible patients.
- Institute an office policy of colorectal cancer screening.
- Use visual depiction of policy to train office staff.
- If patients have had a colonoscopy within the last 10 years, document the date in the medical records and request historical records.
- Although there are a variety of recommended screening methods, colonoscopy is the only method that will satisfy the measure for 10 years.

Coding and Documentation Guidance

Include documentation of the type of screening test (listed below), date of screening and results:

- Colonoscopy
- Flexible sigmoidoscopy
- CT colonography
- FIT-DNA Test
- FOBT

Additional Guidance

- See the Agency for Healthcare Research and Quality (AHRQ) study Targeted Patient Outreach Can Increase Colon Cancer Screening at http://www.ahrq.gov/news/newsletters/e-newsletter/428.html.
  - An intensive colorectal cancer screening outreach program targeting vulnerable patients dramatically improved screening rates for colorectal cancer, according to an AHRQ-funded study published in the June 2016 issue of Journal of the American Medical Association (JAMA) Internal Medicine.[1] The study found that community health center patients who received outreach via mail, automated phone and text messages and calls by a health center staff member were more than twice as likely to complete an at-home colon cancer screening test. This was the case even though most patients in the Chicago-based study were poor and uninsured and had limited English proficiency and low understanding of health information.
- A FLU-FOBT program allows you to increase access to colorectal cancer screening by offering home tests to patients at the time of their annual influenza shots. You can download these programs from the AHRQ Health Care Innovation Exchange by visiting https://innovations.ahrq.gov/narrow-by-subjects?term=&key=FLU-FIT%20program. Download materials you can use to customize these programs for your clinical setting from the FluFIT website at http://flufit.org/programmaterials.html.

[1] Screening for Colorectal Cancer - US Preventive Services Task Force Recommendation Statement, June 21, 2016. Visit the JAMA Network at http://jamanetwork.com/journals/jama/fullarticle/2529486?result-Click=1.

Improving or Maintaining Mental Health

Clinical Basis

Late-life depression is associated with increased risk of morbidity and suicide and decreased physical and cognitive functioning, as well as greater self-neglect. All of these factors are associated with increased mortality, making detection and treatment critical.[1]

Target	How to Improve This Measure	Frequency
Patients 65 years or older	• Screen patients for depression and anxiety and treat as necessary. • Consider using PHQ-2, GAD-7 and PHQ-9 where appropriate and document using CPT II and HCPCS codes G0444, G8431, G8510, G9212, G9393, G9395, G9396, 3351F, 3352F, 3353F or 3354F.	At least annually

Do not include procedure codes in the documentation. Provide a narrative instead that corresponds to the code(s) (see Documentation and Coding Guidance on page 12).

Clinical Guidelines

- Download and implement the evidence based practices contained in the Evidence-Based Practices Kit, Practitioners' Guide for Working with Older Adults with Depression on the Substance Abuse and Mental Health Services Administration website at https://store.samhsa.gov/shin/content/SMA11-4631CD-DVD/SMA11-4631CD-DVD-Practioners.pdf.
- Look to the improving mood-promoting access to collaborative treatment (IMPACT) model to obtain significant improvement in the care of depression.[2]

[1] Depression in late life: review and commentary, Blazer DG J Gerontol A Biol Sci Med Sci. 2003 Mar; 58(3):249-65

[2] JAMA, a trial that overwhelmingly showed the effectiveness of the IMPACT collaborative care management program for late-life depression in Collaborative Care Management of Late-life Depression in the Primary Care Setting: A Randomized Controlled Trial; Unutzer, et al.; Dec. 11, 2002

Ask the following questions per the patient health questionnaire-2 (PHQ-2):				
Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Coding and Documentation Guidance

Depression and major depression are diseases that require extra time to document appropriately.

- If patients have depression or major depressive disorders, it is imperative that physicians document the patients' current signs, symptoms and treatment.
- In addition, it should be noted if this is the patients' first case of depression or if it is a subsequent/recurrent case.
- The patients' response (or lack thereof) to treatment must also be documented.
- A single incidence of major depressive disorder is coded "F32.9 Major depressive disorder, single episode, unspecified."
- If your documentation indicates that the patients' major depression is ongoing, coding from the "F33 Major depressive disorder, recurrent section" may be appropriate.[1]

[1] See Diagnostic and Statistical Manual of Mental Disorders, DSM-5 at http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596.

Improving or Maintaining Physical Health

Clinical Basis

Multiple factors impact this important and heavily weighted measure, which is captured from the HOS. The HOS question about pain has the highest impact on the score. The other drivers are self-rated health and mobility. Changes are measured over a two-year period.

We recommend a thorough assessment of the above factors as part of the annual wellness exam. Staying active is perhaps the single most important factor in maintaining health. Remaining active improves mobility, reduces pain and improves mood. The mental health of patients is also a factor because the emotional well-being impacts how they perceive their health, how they experience pain and the likelihood of staying active. See Improving or Maintaining Mental Health on page 11.

Target	How to Improve This Measure	Frequency
Patients 65 years or older	• Assess patients' physical health, functional status and activity. • Document appropriately and recommend customized physical activities. • Encourage patients to check if their SCAN plan offers gym benefits. • Assess pain and intervene. Submit CPT II codes 1125F or 1126F.	At least annually

Clinical Guidelines

- Assess and treat pain. Understand how pain is impacting daily activities. See Pain Assessment on page 19.
- Conduct a Functional Status Assessment to understand whether daily activities are limited by their health in any way (see page 18).
- Talk to your patients about their level of physical activity and encourage them to start, maintain or increase activity as appropriate.
- Consider "prescribing" physical activity for your patients.

- Instruct patients on physical activities, such as:
  - Walking, building up to 30 minutes daily. If it's easier for patients, this can be spread across three 10-minute periods throughout the day.
  - Activities to improve balance (e.g., Tai Chi)
  - Exercises they can do in their own home (e.g., in a chair and in front of the TV)
  - Stretching
- Consider physical therapy for patients with pain or functional impairments.
- Follow up and encourage patients to continue being active.

Monitoring Physical Activity

Clinical Basis

Staying active is perhaps the single most important factor in maintaining seniors' quality of life. Regular physical activity protects joints, prevents falls and injuries and reduces risk of disease. It is important to communicate being active does not just mean jogging or going to the gym. For example, low-impact activities, such as gardening, birdwatching or simply walking a little more, can be great ways to stay active.

Target	How the Measure Can Be Improved	Frequency
65 years and older	• Discuss the importance of physical activity – any activity is better than none. • Recommend patients start physical activity or increase or maintain their level of activity. • "Prescribe" exercise using an exercise prescription form.	At least annually

Clinical Guidelines

- Talk to your patients about their level of physical activity. Recommend they start physical activity or increase or maintain their level of activity.
- Thirty minutes per day of aerobic activity is recommended. If it's easier for patients, the activity can be spread across three 10-minute periods throughout the day.
- If talking about exercise with some patients seems difficult, focus on ways to reduce inactivity (e.g., the amount of time spent sitting). Even just walking across the room or standing and stretching several times a day (e.g. during TV commercials) will help.
- Consider physical therapy for patients with pain or functional impairments.
- Follow up on discussions and action plans to encourage patients to continue being active.

Medication Review

Clinical Basis
Creating an accurate medication list is important to patient safety. An annual comprehensive review of all medications (prescription and non-prescription) and supplements being taken can help reduce medication errors.

Target	How to Improve This Measure	Frequency
Patients 65 years or older	Conduct a medication reconciliation annually and maintain a current list of all medications in the medical record. Document medication reconciliation when performed.	At least annually
	Submit **CPT II codes 1159F** (Rx list) **AND 1160F when medication review/reconciliation is performed**.	

Patients may use multiple pharmacies, have co-morbidity factors and multiple prescribing healthcare providers. Medication errors can be avoided by:

- Capturing a complete and accurate list of the medications patients are taking and comparing this list with documentation in the patients' medical record
- Physically looking at the patients' medications at each ambulatory care visit – especially post-facility discharge – and reviewing the physicians' admission, transfer and/or discharge orders in inpatient settings.

Clinical Guidelines
- Arrange to have at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year.
- Instruct your patients to bring all of their medications – including over-the-counter medications and supplements – to every physician visit, especially post-facility discharge.
- Review patients' medications at every visit.
- Encourage your patients to use a single pharmacy to reduce potential drug interactions.
- Reference Eric Coleman's Transitions Program[1] at the time of hospital discharge:
  - Medication self-management
  - Maintenance of personal health record
  - Primary care physician follow-up
  - Alertness to red flags

Documentation and Coding Guidance
Documentation should include a description of the counseling provided and any medication counts (and their significance), as well as documentation that you reviewed or reconciled in the patients' medication list. If any medications are changed or discontinued, this should be documented also.

- The presence of a medication list in the medical record is represented by 1159F.
- A comprehensive review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record, as applicable, is represented by 1160F.

[1] See http://www.caretransitions.org/ for information about this program.

Functional Status Assessment

Clinical Basis

Functional capacity is impacted by changes in three domains:

- Patients' domiciles
- Patients' physical health
- Patients' psycho-social wellbeing

One of the earliest indicators of functional decline is the inability to perform activities of daily living (ADL).

Target	How to Improve This Measure	Frequency
Patients 66 years and older	Functional status assessment ADL/IADL assessment ***OR*** assessment using FSA tool (e.g., SF-36) ***OR*** comprehensive assessment of cognition, ambulation and sensory ability	At least annually
	Submit CPT II code 1170F.	

Clinical Guidelines

- Be sure to ask caregivers about the patients' ability to perform ADLs.
- Utilize physician extender to conduct ADL/IADL assessment (can be done over the phone).
- As appropriate, refer to case management, physical therapist home safety evaluation and durable medical equipment (DME).
- Include assessment as part of annual wellness visit.

Pain Assessment

Clinical Basis

Pain should be considered the fifth vital sign and assessed with each visit. Pain management in this population is important because it allows for effective mobilization and functional independence. It also may result in decreased morbidity and healthcare expenditures.

Pain assessment can be particularly difficult in elderly patients for the following reasons:

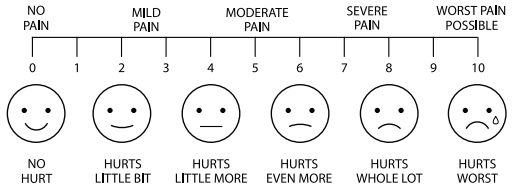
- Underreporting of discomfort because patients do not want to complain
- Use of pain to mask other newly developing physical or cognitive disabilities
- Decreases in hearing and visual acuity

Target	How to Improve This Measure	Frequency
Patients 66 years and older	Conduct and document pain assessment using a standardized pain assessment tool (can be done over the phone). **Note**: Chest pain assessments alone does not count.	At least annually
	Submit CPT II codes 1125F or 1126F. • **1125F: Pain severity quantified, pain present** • **1126F: Pain severity quantified, no pain present**	

Clinical Guidelines

Use both single-dimensional and multi-dimensional scales in the assessment of pain:

- Single-dimensional scales assess a single dimension of pain and, through patient self-reporting, measure only pain intensity; these scales are useful in acute pain when the etiology is clear. For example:



- An alternative to a visual scale is to use a verbal descriptor scale. For example, the Melzack and Torgeson scale uses five descriptors: mild, discomforting, distressing, horrible and excruciating. This may be the easiest tool for the elderly to use because it allows patients to use common words to describe what they are feeling.
- Multi-dimensional scales are useful in complex or persistent acute or chronic pain. These scales measure the intensity, nature and location of pain, as well as, in some cases, the impact that pain is having on patients' activities or moods.
- The WILDA approach offers a concise template for assessment of patients with acute and chronic pain, focusing on:

  Words to describe pain

  Intensity

  Location

  Duration

  Aggravating or alleviating factors

Coding and Documentation Guidance
Documentation should indicate the pain severity quantified (CPT II 1125F) or that pain is absent (CPTII 1126F).

Osteoporosis Screening in Women Who Had a Fracture

Clinical Basis
Women who suffer a fracture are at increased risk of suffering additional fractures. Morbidity and mortality related to osteoporotic fractures are a major health issue.

Target	How to Improve This Measure	Frequency
Patients 67-85 years old	For female patients with fracture diagnosis involving long bones or spine (excluding pathological fractures), perform a bone density test or prescribe bisphosphonates, calcitonin or other medications to treat mineral depletion. Best practice: Assess patients at high risk for osteoporosis, screen with dual-energy X-ray absorptiometry (DEXA).	Within **six months** of fracture

Bisphosphonates should be used as a first-line pharmacologic treatment for osteoporosis (evidence rating A).[1]

In patients who cannot tolerate or whose symptoms do not improve with bisphosphonate therapy, teriparatide (Forteo®) and denosumab (Prolia®) are effective alternative medications to prevent osteoporotic fractures (evidence rating A).

Clinical Guidelines
- Target high-risk women and schedule screening with DEXA.
- For women who have had osteoporotic fractures, request a nurse review to help schedule the DEXA and/or initiate prescription.
- Decrease the dosing frequency. Treatment with longer intervals between doses is more convenient for patients.
- Encourage counseling with nurses. Multiple counseling sessions with nurses showed the greatest improvement in adherence.[2]

[1] For a general discussion of evidence rating systems, visit the American Academy of Family Physicians website at http://www.aafp.org/afpsort.
[2] Cook PF, Emiliozzi S, McCabemm. Telephone counselling to improve osteoporosis treatment adherence: an effectiveness study in community practice settings. Am. J. Med. Qual. 22, 445–456 (2007)

- Ensure no prior authorization is needed for the DEXA scan.
- Arrange for mobile DEXA for homebound patients.
- When clinically appropriate, initiate a one-month trial of the prescription.

Coding and Documentation Guidance

- Do not use traumatic or stress fracture code for historical fracture or pathological fracture.
- Pathological fractures (current) due to osteoporosis are coded using the M80.0 section of the ICD-10-CM.

Ten million Americans have osteoporosis and another 18 million are at risk for osteoporosis due to low bone mass.[1] Eighty percent of people with osteoporosis are women.[2]

Osteoporotic Fractures: Additional Notes

Treatment of osteoporotic fractures is estimated at $10 to $15 billion annually in the United States. In 1995, osteoporotic fractures caused 432,000 hospital admissions, 2.5 million physician visits and 180,000 nursing home admissions. The aging U.S. population is likely to increase the future financial cost of osteoporosis care.

- One study showed that fewer than 5 percent of patients with osteoporotic fractures are referred for medical evaluation and treatment.[3]
- Another retrospective study of over 1,000 postmenopausal women who sustained a fracture of the distal radius found that only 24 percent received either a diagnostic evaluation or treatment for the condition.[4]

1 National Institutes of Health [NIH] Consensus Development Panel on Osteoporosis Prevention, Diagnosis, and Therapy, 2001
2 NIH Consensus Development Panel on Osteoporosis Prevention, Diagnosis, and Therapy, 2001
3 NIH Consensus Development Panel on Osteoporosis Prevention, Diagnosis, and Therapy, 2001
4 Stephen & Wallace, 2001). Evidence for Rationale: National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. Various pages

Osteoporosis Drugs

The following medications are prescribed for managing osteoporosis in women 67 to 85 years of age who have suffered a fracture.

Description	Drug	Tier
Bisphosphonates	Alendronate tablets	1
	Alendronate oral solution	2
	Ibandronate oral	2
	Ibandronate injection*	2
	Risedronate**	3
	Zoledronic acid injection 4mg/5mL	4
	Zoledronic acid injection 5mg/100mL*	2
	Zometa® (zoledronic acid) inj 4mg/100mL	5
Other Agents	Calcitonin nasal spray	2
	Miacalcin® (calcitonin) injection*	4
	Prolia® (denosumab)*	4
	Xgeva® (denosumab)*	5
	Raloxifene***	3
	Forteo® (teriparatide)*	5

* Prior authorization
** Step therapy
*** Quantity limit

Interventions to improve adherence and persistence with osteoporosis medications: A systematic literature review[1] highlights the importance of follow-up interactions with members and the role of patient counseling in helping to improve adherence.

1 Gleeson T, Iversen MD, Avorn J et al. Interventions to improve adherence and persistence with osteoporosis medications: a systematic literature review. Osteoporosis. Int. 20, 2127–2134 (2009)

Reducing the Risk of Falling

Clinical Basis

Thousands of older adults die from fall injuries every year, and about two million are treated for non-fatal fall injuries in emergency departments.[1] Simple home modifications and exercises that improve strength and balance can help reduce the risk of falling.[2]

Target	How to Improve This Measure	Frequency
Patients 65 years and older	Screen patients for any recent falls and discuss fall risk interventions (vision exam, medication reconciliation, exercise, DME, vitamin D, etc.). If positive, provide recommendations and education handout. For more information, visit cdc.gov/steadi/patient.html	At least annually (the Annual Wellness Visit is a good time to include a falls riskassessment)

Ask three simple screening questions:

- Have you fallen in the last year?
- Do you feel unsteady when standing or walking?
- Do you worry about falling?

If patients answer "Yes" to any of these questions, think about using the CDC STEADI (Stopping the Elderly Accidents, Deaths and Injuries)[3] toolkit. Talk with SCAN for toolkit training or you can download the toolkit from the CDC website to get some useful materials for both you and your patients.[3]

Clinical Guidelines

- Provide patients and caregivers with a home environment checklist to ensure safety measures are in place.
- Review footwear (no bare feet or socks) for appropriate fit and use.
- Identify need for DME and prescribe as appropriate with instructions for fitting and use.
- Conduct a medication review with patients. Some medications or combinations of medications (especially psychotropic medications) can have side effects, such as dizziness or drowsiness – increasing fall risk.
- Encourage annual eye exams and regular prescription updates for glasses/contact lenses.
- Consider referral to an occupational therapist for home safety evaluation and modification and encourage exercise, specifically those that increase leg strength and balance.

Coding and Documentation Guidance

- Document plan of care developed to prevent falls.
- Document recent falls or risk of falling and code accordingly, including referral to a physical therapist and/or home health for fall risk and home assessment.

CPT II Code	Description
0518F	Fall plan of care documented
1100F	Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year
1101F	Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year (GER)

1 One in three adults over age 64 falls every year.
2 See www.cdc.gov/prc.
3 Go to the cdc.gov website at www.cdc.gov/injury/STEADI to download these materials. Some of these materials are useful for printing and displaying in your office.

Improving Bladder Control

Clinical Basis

Urinary incontinence, or "overactive bladder," is a common and often challenging problem for seniors. If left untreated, urinary incontinence increases the likelihood of hospital and nursing home admission.[1]

Target	How to Improve This Measure	Frequency
Patients 65 years and older	Screen all patients for urinary incontinence and discuss treatment options if positive. Ask patients: • Have you had any urine leakage in the past _____ months since you've last been seen? • Have you had any falls because you have been rushing to the bathroom?	At least annually

Clinical Guidelines

Urinary incontinence is an embarrassing problem that seniors may not bring to your attention during the office visit. Therefore, it is important to ask about it during the annual evaluation.

- If patients have caregivers, be sure to also ask the caregivers about incontinence as the patients may not reveal that they are having a problem.
- If a drug is suspected as the cause, it should be replaced or discontinued if possible.
- Encourage nursing staff and medical assistants to ask patients about any incidents of urinary incontinence in the past six months. Patients are often too embarrassed to initiate the discussion.
- Educate patients about noninvasive behavioral interventions for incontinence; when necessary, refer for appropriate treatment.
- Make educational materials easily available so patients can use them as discussion starters for more sensitive topics (contact SCAN if you need resources).
- Give patients after-visit summary and/or educational materials to reinforce that urinary incontinence was addressed during the visit.

[1] For an overview of this problem, see http://www.aafp.org/test/fpcomp/FP-E_430/learning_objectives.html: 2016 FP Comprehensive, Urogynecologic Conditions, March 2015.

Drugs obtained over the counter also can be contributing factors. Diuretics increase urine production and may lead to worsening urge urinary incontinence and stress urinary incontinence as bladder filling and volume increase. Reversible etiologies are found in one-third of elderly ambulatory patients and contribute to half of the urinary incontinence among hospitalized elderly patients.[1]

Coding and Documentation Guidance

- Document the assessment for urinary incontinence.
- If a urinary incontinence plan of care is implemented and documented, submit CPT II code 0509F.

Urinary Incontinence: Additional Notes

Consider five types of urinary incontinence:

- **Stress:** Leakage on effort, exertion, sneezing or coughing
- **Urge:** Sudden, intense urge to urinate followed by an involuntary loss of urine caused by abnormal bladder contraction
- **Mixed:** Leakage associated with urgency and also with exertion, effort, sneezing or coughing (stress and urge incontinence together)
- **Overflow:** Leakage of urine from an over distended bladder
- **Overactive bladder:** One or more of the following symptoms:
  - Urgency with or without urge incontinence
  - Urinary frequency
  - Nocturia in the absence of infection or other proven pathology

[1] 15.Imam KA. The role of the primary care physician in the management of bladder dysfunction. Rev Urol. 2004;6(Suppl 1):S38-S44

Identifying the Common Etiologies of Reversible Urinary Incontinence Using "DIAPPERS"

Reversible urinary incontinence typically has been present for less than six weeks and had a sudden onset. The classic mnemonic DIAPPERS is applicable for identifying the common etiologies of reversible urinary incontinence:

Delirium

Infection (urinary tract)

Atrophic urethritis and vaginitis

Pharmaceuticals

Psychological disorders

Excessive urine output

Restricted mobility

Stool impaction[1]

[1] Khandelwal C, Kistler C. Diagnosis of urinary incontinence. Am Fam Physician. 2013;87(8):543-550

Diabetes Care

More than a quarter of patients over the age of 65 have diabetes, and this number is expected to grow rapidly in the coming decades.

Older individuals with diabetes have higher rates of premature death, functional disability and coexisting illnesses such as hypertension, coronary heart disease and stroke than those without diabetes.

Older adults with diabetes are also at greater risk than other older adults for several common geriatric syndromes, such as polypharmacy, cognitive impairment, urinary incontinence, injurious falls and persistent pain.

Screening

Screening for diabetes complications in older adults should be individualized and periodically revisited because the results of screening tests may impact therapeutic approaches and targets For example:

- Diabetes management may require assessment of medical, functional, mental and social domains. This may provide a framework to determine targets and therapeutic approaches.
- Special attention should be paid to complications that can develop over short periods of time, paying particular attention to complications that would significantly impair functional status, such as visual and lower extremity complications.
- Refer to the American Diabetes Association (ADA) consensus report "Diabetes in Older Adults" for details.[1]

[1] American Diabetes Association. Older adults. Sec. 10. In Standards of Medical Care in Diabetes—2016. Diabetes Care 2016;39(Suppl. 1):S81–S85

ADA Evidence-Grading System for Standards of Medical Care in Diabetes[1]

Evidence grades for diabetes care are described in the following table:

Grade	Meaning
A	• Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered, including evidence from a well-conducted multicenter trial • Evidence from a meta-analysis that incorporated quality ratings in the analysis • Compelling non-experimental evidence, e.g., "all or none" rule developed by the Centre for Evidence-Based Medicine at the University of Oxford • Supportive evidence from well-conducted randomized controlled trials that are adequately powered, including evidence from a well-conducted trial at one or more institutions or evidence from a meta-analysis that incorporated quality ratings in the analysis
B	• Supportive evidence from well-conducted cohort studies including evidence from a well-conducted prospective cohort study or registry or evidence from a well-conducted meta-analysis of cohort studies • Supportive evidence from a well-conducted case-control study

[1] American Diabetes Association. Microvascular complications and foot care. Sec. 9. In Standards of Medical Care in Diabetes - 2016. Diabetes Care 2016; 39(Suppl. 1):S72–S80

Blood Sugar Controlled

Clinical Basis

Patients with well-controlled sugars have better clinical outcomes as well as morbidity and mortality.

Two primary techniques are available for health providers and patients to assess the effectiveness of the management plan on glycemic control: (1) Patient self-monitoring of blood glucose (SMBG) and (2) A1C continuous glucose monitoring (CGM), or interstitial glucose may be a useful adjunct to SMBG in selected patients.

Target	How to Improve This Measure	Frequency
Patients 18-75 years old	Test HbA1c, control to keep A1c < 9%.	At least annually or quarterly, if uncontrolled

Exclusions

- Patients with gestational diabetes
- Patients with steroid induced diabetes

Clinical Guidelines[1]

- Refer to endocrinology.
- Refer all diabetics to diabetes self-management and education counseling at least once.
- Diabetic patients should be evaluated at least quarterly.
- Target very poorly controlled diabetics with insulin, when appropriate.

Note: Evidence grades ([X]) are explained on page 30.

- When prescribed as part of a broader educational context, SMBG results may help to guide treatment decisions and/or self-management for patients using less frequent insulin injections [B] or noninsulin therapies.

[1] American Diabetes Association. In Standards of Medical Care in Diabetes - 2016. Diabetes Care 2016; 39(Suppl. 1):S39

- When prescribing SMBG, ensure that patients receive ongoing instruction and regular evaluation of SMBG technique, SMBG results and their ability to use SMBG data to adjust therapy.
- When used properly, CGM in conjunction with intensive insulin regimens is a useful tool to lower A1C in selected adults (aged 25 years or older) with type 1 diabetes [A].
- Although the evidence for A1C lowering is less strong in children, teens and younger adults, CGM may be helpful in these groups. Success correlates with adherence to ongoing use of the device [B].
- Given variable adherence to CGM, assess individual readiness for continuing CGM use prior to prescribing.
- Ensure diabetics receive all preventative immunizations (e.g., flu, pneumococcal, zoster vaccine)

Eye Exam

Clinical Basis

Diabetic retinopathy is a highly specific vascular complication of both type 1 and type 2 diabetes with prevalence strongly related to both the duration of diabetes and the level of glycemic control. It is the most frequent cause of new cases of blindness among adults aged 20 to 74 in developed countries. Glaucoma, cataracts and other disorders of the eye occur earlier and more frequently in people with diabetes.

Target	How to Improve This Measure	Frequency
Patients 18-75 years old	Retinal or dilated eye exam by an eye care professional to check for damage from diabetes	Annually

Clinical Guidelines

- Optimize glycemic control to reduce the risk or slow the progression of diabetic retinopathy [A].
- Optimize blood pressure and serum lipid control to reduce the risk or slow the progression of diabetic retinopathy [A].

Screening Recommendations[1]

- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis [B].
- If there is no evidence of retinopathy for one or more annual eye exams, then exams every two years may be considered.
  - If any level of diabetic retinopathy is present, subsequent dilated retinal examinations for patients with type 1 or type 2 diabetes should be repeated at least annually by an ophthalmologist or an optometrist.
  - If retinopathy is progressing or sight-threatening, then examinations will be required more frequently [B].

[1] American Diabetes Association. Microvascular complications and foot care. Sec. 9. In Standards of Medical Care in Diabetes - 2016. Diabetes Care 2016; 39(Suppl. 1):S72–S80

Coding and Documentation Guidance
Refer patients to optometrist/ophthalmologist for dilated retinal exam. In addition to documenting the type of eye exam performed (including findings), submit from the following CPT II codes and HCPCS procedure codes based on report received from optometrist/ophthalmologist:

CPT II:
- 2022F: Dilated eye exam w/interpretation by an ophthalmologist or optometrist documented and reviewed
- 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
- 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
- 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)

Kidney Disease Monitoring

Clinical Basis
Diabetic kidney disease, or kidney disease attributed to diabetes, occurs in 20 percent to 40 percent of patients with diabetes. Diabetic kidney disease is the leading cause of end-stage renal disease (ESRD).

Target	How to Improve This Measure	Frequency
Patients 18-75 years old	Urine microalbumin, random urine for protein/ creatinine, or 24-hour urine for total protein and creatinine clearance test	At least annually

Clinical Guidelines
- Optimize glucose control to reduce the risk or slow the progression of diabetic kidney disease [A].
- Optimize blood pressure control (< 140/90mmHg) to reduce the risk or slow the progression of diabetic kidney disease [A].
- For patients with non-dialysis-dependent diabetic kidney disease, dietary protein intake should be 0.8g/kg body weight per day (this is the recommended daily allowance). For patients on dialysis, higher levels of dietary protein intake should be considered [A].
- For treatment of non-pregnant patients with diabetes and modestly elevated urinary albumin excretion (30-299mg/day), either an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker is recommended [B].
- For treatment of patients with urinary albumin excretion ≥ 300mg/day and/or estimated glomerular filtration rate < 60 mL/min/1.73m2, either an ACE inhibitor or an angiotensin receptor blocker is strongly recommended [A].
- Periodically monitor serum creatinine and potassium levels for the development of increased creatinine or changes in potassium when ACE inhibitors, angiotensin receptor blockers or diuretics are used.

- Monitor the urinary albumin-to-creatinine ratio in patients with albuminuria treated with an ACE inhibitor or an angiotensin receptor blocker to assess the response to treatment and progression of diabetic kidney disease.
- An ACE inhibitor or an angiotensin receptor blocker is not recommended for the primary prevention of diabetic kidney disease in patients with diabetes who have normal blood pressure, normal urinary albumin-to-creatinine ratio (< 30mg/g) and normal estimated glomerular filtration rate [B].
- Evaluate and manage potential complications of chronic kidney disease when the estimated glomerular filtration rate is < 60 mL/min/1.73m2.
- Refer patients for evaluation for renal replacement treatment if they have estimated glomerular filtration rate < 30 mL/min/1.73m2 [A].
- Promptly refer patients to a physician experienced in the care of kidney disease when there is [B]:
  - Uncertainty about the etiology of kidney disease
  - Difficulty with management issues
  - Rapidly progressing kidney disease

Screening Recommendations

Screen members once a year as follows [B]:

- All patients with type 2 diabetes
- All patients with comorbid hypertension.

Stages of Chronic Kidney Disease

Stage	Description/Glomerular Filtration Rate (GFR) (mL/min/7.37m2)
1	Kidney damage[1] normal or increased eGFR ≥ 90 normal or increased estimated GFR (eGFR) ≥ 90
2	Kidney damage mildly decreased eGFR 60-89
3	Moderately decreased eGFR 30-59
4	Severely decreased eGFR 15-29
5	Kidney failure < 15 or dialysis

Statin Use in Persons with Diabetes (SUPD)

Clinical Basis

Evidence supports the use of moderate-intensity statin therapy in persons with diabetes who are 40 to 75 years of age.[2] For example, in adults with diabetes without cardiovascular disease, moderate-dose statin therapy reduced the relative risk for cardiovascular events by 27 percent per 38.7mg/dL LDL-C reduction.[3]

Because diabetics are at high risk for cardiovascular disease, the revised standards of medical care recommend statins for diabetics older than 40 years of age.[4]

Target	How to Improve This Measure	Frequency
Patients 40-75 years old	Prescribe a statin in patients with diabetes according to American College of Cardiology/ American Heart Association (ACC/AHA) guidelines. Refer to the table on page 68 for a list of Formulary alternatives.	As needed

Exclusions

- ESRD
- Hospice

Moreover, individuals with comorbidities experience greater morbidity and worse survival rates after the onset of clinical ASCVD. In persons with diabetes who are younger than 40 years of age or over 75 years of age or whose LDL-C is < 70mg/dL, statin therapy should be individualized on the basis of four considerations:

- ASCVD risk-reduction benefits
- Potential for adverse effects
- Drug interactions
- Patient preferences[1]

The ACC/AHA guideline recommends moderate- or high-intensity statins for patients with diabetes.[1]

Clinical Guidelines

- Simplify the treatment regimen if possible.
- Explain the rationale of treatment to patients.
- Implement one or more medication adherence management tools from Lipids.org: https://www.lipid.org/sites/default/files/adherence_toolkit.pdf.

[1] Kidney damage is defined as abnormalities on pathological, urine, blood or imaging tests.

[2] 2013 ACC/AHA Prevention Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014;129:S1-S45

[3] Cholesterol Treatment Trialists' Collaboration, Kearney PM, Blackwell L, et al. Efficacy of cholesterol-lowering therapy in 18,686 people with diabetes in 14 randomised trials of statins: a metaanalysis. Lancet 2008;371:117–25

[4] Pharmacy Quality Alliance (PQA). Statin use in persons with diabetes. Springfield (VA): Pharmacy Quality Alliance (PQA); 2015

[1] As some patients may experience statin-associated side effects, SUPD permits low-intensity statins.

High-, Moderate- and Low-Intensity Statin Therapy
Intensities for statin therapies are distinguished by high, moderate or low as indicated in the following table[1]:

High	Moderate	Low
Daily dosage lowers LDL-C, on average, by approximately ≥ 50%	Daily dosage lowers LDL-C, on average, by approximately 30% to 50%	Daily dosage lowers LDL-C by < 30% average
Atorvastatin (Lipitor®), **40* to 80mg**	Atorvastatin 10-20mg	
Rosuvastatin 20-40mg	**Rosuvastatin** (5) **10mg**	
	Simvastatin 20-40mg**	*Simvastatin 10mg*
	Pravastatin 40-80mg	**Pravastatin 10-20mg**
	Lovastatin 40mg	**Lovastatin 20mg**
	Fluvastatin XL 80mg	
	Fluvastatin 40mg bid	*Fluvastatin 20-40mg*
	Pitavastatin 2-4mg	*Pitavastatin 1mg*

Notes: Statins and doses shown in bold and italics are explained as follows:

- **Bold:** These are statins and doses that were evaluated in random controlled trials (RCTs) (17,18,46-48,64-67,69-78) included in CQ1, CQ2 and the CTT 2010 meta-analysis included in CQ3 (20). All of these RCTs demonstrated a reduction in major cardiovascular events.
- *Italics:* These are statins and doses that are approved by the U.S. Food and Drug Administration (FDA) but were not tested in the RCTs reviewed are.

* Evidence from 1 RCT only down-titration if unable to tolerate atorvastatin 80mg in IDEAL (47).

** Although simvastatin 80mg was evaluated in RCTs, initiation of simvastatin 80mg or titration to 80mg is not recommended by the FDA due to the increased risk of myopathy, including rhabdomyolysis.

[1] Adapted with permission from Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology / American Heart Association Task Force on Practice Guidelines. Circulation. 2014;129(25 suppl 2):S13. Visit http://www.aafp.org/afp/2014/0815/p260.html for additional information.

Additional notes:

- Individual responses to statin therapy varied in the RCTs and should be expected to vary in clinical practice. There might be a biological basis for a less-than-average response.
- Evidence from one RCT only; down-titration if unable to tolerate atorvastatin, 80mg, in Incremental Decrease through Aggressive Lipid Lowering study.

Coding and Documentation Guidance
Statin use is determined through medication claims data, and no physician coding is required.

However, it is important to document discussions with patients regarding the need for statins.

In addition, documentation regarding compliance or non-compliance with prescribed treatment should be done at the time of the office visit and also when medication reconciliation is performed.

Use G9664 for patients who are currently statin therapy users or received an order (prescription) for statin therapy.

Controlling Blood Pressure

Clinical Basis

Hypertension is the number one risk factor for heart disease and stroke. Ninety percent of the adult population will have hypertension in their lifetime, so it is an important risk factor to manage.

Target	How to Improve This Measure	Frequency
Hypertensive patients 18-85 years old	Diagnosis of hypertension and target blood pressure: • Patients 18-59 years old < 140/90 • Patients 60-85 years old with diabetes < 140/90 • Patients 60-85 years old < 150/90	At least annually

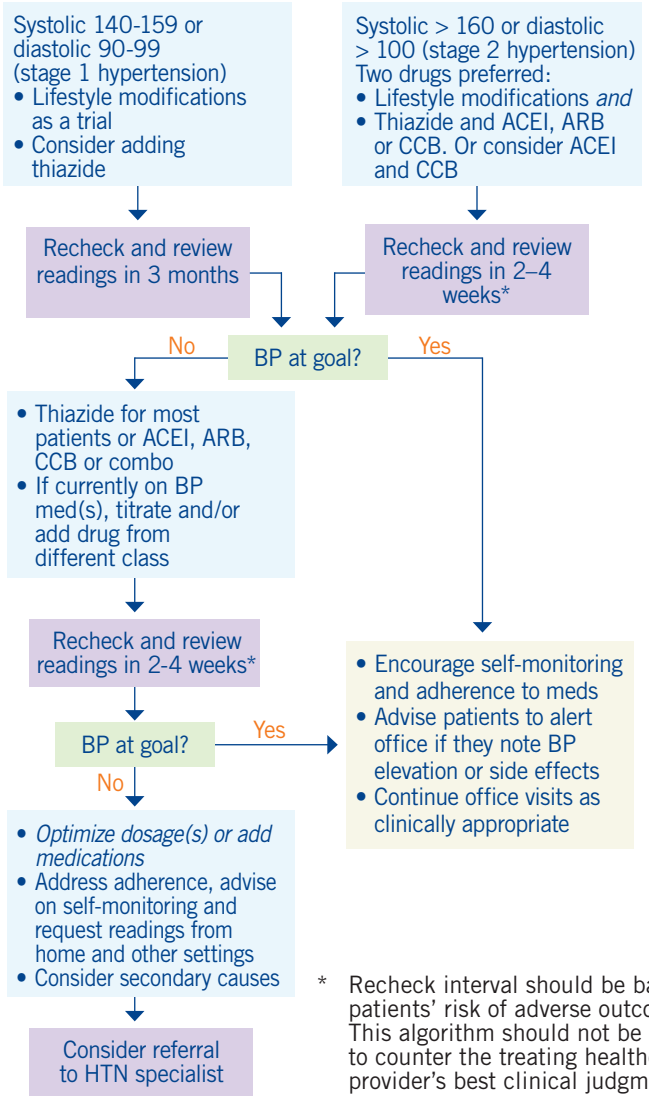
Common Exclusion: Members with evidence of ESRD.

Clinical Guidelines

Follow the chart provided in a science advisory from the AHA, ACC and the CDC[1] on the next page for controlling hypertension in adults.

[1] An Effective Approach to High Blood Pressure Control. A Science Advisory from the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention Alan S. Go, MD; et al, J Am Coll Cardiol. 2014;63(12):1230-1238. doi:10.1016/j.jacc.2013.11.007, © 2013 The Authors

Controlling Hypertension in Adults



* Recheck interval should be based on patients' risk of adverse outcomes. This algorithm should not be used to counter the treating healthcare provider's best clinical judgment.

Rheumatoid Arthritis Management

Clinical Basis

Rheumatoid arthritis (RA) is the most common autoimmune inflammatory arthritis in adults. RA has a significant negative impact on the ability to perform daily activities, activities – including work and household tasks – and health related quality of life and it increases mortality.[1]

Target	How to Improve This Measure	Frequency
Patients 18 years and older	Refer patients to rheumatology, confirm diagnosis and prescribe a disease-modifying anti-rheumatic drug (DMARD) when appropriate (see table). Consider ICD-10 M25.50 for generalized joint pain until RA diagnosis is confirmed.	Ongoing, once diagnosed

Common Exclusion: A diagnosis of HIV (HIV value set) any time during the member's history through Dec. 31 of the measurement year.

Clinical Guidelines

- For a comprehensive review, see the 2015 ACR Guideline for the Treatment of Rheumatoid Arthritis at www.rheumatology.org.
- Confirm RA diagnosis versus osteoarthritis or joint pain.
  - Use ICD-10 codes, such as M25.50, for generalized joint pain while the pain is being investigated. Use ICD-10 codes M05.- and M06.- once RA is confirmed.
  - Refer patients to a rheumatologist to confirm diagnosis and/or co-management.
  - If RA diagnosis is incorrect, contact the medical group to rectify.

[1] Arthritis Care & Research DOI 10.1002/acr.22783 2015, Traditional Cardiovascular Risk Factor Management in Rheumatoid Arthritis Compared to Matched Non-Rheumatoid Arthritis in a US Managed Care Setting, American College of Rheumatology: 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis, Singh et al. www.rheumatology.org, 2015 guidelines

- Prescribe a DMARD when patients have diagnosed with RA. A sample DMARD dispensed in the office will satisfy the measure, but you must record in the medical record that a DMARD was dispensed. IMPORTANT: The record must include all of the following:
  - Prescriber's signature
  - Drug name
  - Strength, days' supply
  - Dispensed date
- For more from the American College of Rheumatology, visit http://www.rheumatology.org/Practice-Quality/Clinical-Support/.

Disease Modifying Anti-Rheumatic Drugs
The following medications are prescribed for managing rheumatoid arthritis.[1]

Description	Drug	Tier
5-aminosalicylates	Sulfasalazine	2
Alkylating agents	Cyclophosphamide capsules*	2
Aminoquinolines	Hydroxychloroquine	2
Anti-rheumatics	Auranofin (Ridaura®)	5
	Leflunomide**	2
	Methotrexate	2
	Penicillamine (Cuprimine®, Depen®)	4
Immunomodulators	Adalimumab (Humira®)*	5
	Anakinra (Kineret®)*	
	Etanercept (Enbrel®)*	
	Infliximab (Remicade®)*	
	Rituximab (Rituxan®)*	
Immunosuppressive agents	Azathioprine*	2
	Cyclosporine*	
	Mycophenolate tablets, capsules*	
	Mycophenolate suspension*	5
Janus kinase (JAK) inhibitor	Tofacitinib (Xeljanz®)*	5
Tetracyclines	Minocycline (immediate release)	2

* Prior authorization
** Quantity limit

Coding and Documentation Guidance
Document the prescription of DMARDs and submit code 4187F.

CPT Code	Description
4187F	Disease modifying anti-rheumatic drug therapy prescribed or dispensed (RA)

[1] For a summary of AHRQ's comparative effectiveness review of drug therapy for rheumatoid arthritis (RA) in adults—an update, see J. Managed Care Pharm, 2012 May 18 (4 Supp C): S1 – 18, Singh JA1, Cameron.

Statin Therapy for Patients with Cardiovascular Disease

Target	How the Measure Can Be Improved	Frequency
• ASCVD patients • Males, 21-75 years • Females, 40-75 years	Prescribe a moderate- to high- intensity statin. Refer to the table on page 40 for low-, moderate- or high- intensity statin daily dose requirements and page 68 for a list of Formulary alternatives.	As needed

Exclusions
- Cirrhosis
- Clomiphene use
- ESRD
- Hospice
- In vitro fertilization
- Myalgia, myositis, myopathy or rhabdomyolysis
- Pregnancy

Important guidelines for your practice
The ACC/AHA guideline emphasizes that lifestyle modification remains a critical component of ASCVD reduction.[1, 2]

Statin therapy is recommended in the following four groups:[3]
- Patients with any form of clinical ASCVD
- Patients with primary LDL-C levels of 190mg per dL or greater
- Patients with diabetes mellitus, 40 to 75 years of age, with LDL-C levels of 70 to 189mg per dL
- Patients without diabetes, 40 to 75 years of age, with an estimated 10-year ASCVD risk of at least 7.5 percent

[1] ACC/AHA Release Updated Guideline on the Treatment of Blood Cholesterol to Reduce ASCVD Risk, Am Fam Physician. 2014 Aug 15;90(4):260-265
[2] Also see the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines, Stone NJ, et. al., Circulation, November 12, 2013.
[3] See section 4, Statin Treatment Recommendations in the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults for a discussion of individual treatment options.

The guideline recommends reducing ASCVD risk with the maximum tolerated statin intensity rather than achieving a specific LDL-C target. Statin intensity depends on the percent change in LDL-C from baseline rather than absolute LDL-C reduction.

Risk assessment for 10-year and lifetime risk is recommended using an updated ASCVD risk calculator (http://my.americanheart.org/cvriskcalculator).

Recommendations resulted from expert panel reviews of evidence including:

- In adults with coronary heart disease, statin therapy reduced the relative risk for cardiovascular events by 21 percent per 38.7mg/dL LDL-C reduction.[1]
- In adults with and without cardiovascular disease who received more intensive statin therapy or statin therapy compared with placebo, the risk for cardiovascular disease mortality was reduced by 14 percent per 38.7mg/dL LDL-C reduction.[1]

High-intensity statins are recommended for patients with clinical ASCVD. As some patients may experience statin-associated side effects, SPC permits moderate-intensity statins.

[1] Cholesterol Treatment Trialists' Collaboration, Baigent C, Blackwell L. Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170,000 participants in 26 randomized trials. Lancet 2010;376:1670–81

Patient Experience

Engaged patients lead to improved clinical outcomes. For example:

- Patients who understand their doctors are more likely to acknowledge health problems, understand their treatment options, modify their behavior accordingly and follow their medication schedules.[1]
- Patient-centered communication has a positive impact on important outcomes, including patient satisfaction, adherence to recommended treatment and self-management of chronic disease.[2]
- Patient communication improves clinical outcomes in the management of diabetes, hypertension and cancer.[3]

Survey Measures Background: What is CAHPS?

- Typically mailed each year to plan members between March and June
- Asks members about aspects of quality, such as provider communication skills and ease of healthcare services
- Overseen by the Agency for Healthcare Research and Quality

Group Best Practices

- Encourage patients to respond to survey.
- Develop a new patient onboarding program that covers important access-to-care issues, including urgent care and referrals.
- Have an after hour on-call system available (nurse advice line, physician on call).
- Provide non-traditional care access options, such as an e-portal with self-service capabilities and a 24-hour nurse advice line.

[1] Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995;15(9):1423-1433.
[2] S, Kaplan S, Ware JE Jr.. Expanding patient involvement in care: effects on patient outcomes. Ann Intern Med. 1985;102(4):520–8.
[3] Doctor-patient communication and satisfaction with care in oncology. Curr Opin Oncol. 2005;17(4):351–4

Care Coordination

CAHPS Asks Patients
In the last six months:

- When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- How often did you and your personal doctor talk about the prescription medicines you were taking?
- When your physician ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- When your personal doctor ordered a blood test, x-ray or other test for you, how often did you get the results as soon as you needed them?
- How often did your personal doctor seem informed and up to date about the care you got from specialists?
- Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?

Target	How to Improve This Measure	Frequency
All patients	• Discuss lab results, prescription medications and recommendations from specialists in a timely manner. • Encourage patients to use patient portal, if available. • Train staff to communicate expectations to patients about lab results.	At each visit

PCP Best Practices
You probably know all relevant information about your patients' medical history – but do your patients know you know? Make sure they do – it's a quick way to improve patient satisfaction with doctor-patient communication.

- Ask if patients have seen any other providers. If you are aware specialty care has occurred, mention it and discuss as needed.
- Tell your patients when they should expect test results and who will give them the results – a staff member, your medical assistant, you?
- Let patients know when test results are normal and tell your patients they can call your office if they still want to check results.
- If your practice offers a patient portal, encourage web-savvy patients (or caregivers) to make use of it so they can stay on top of their care.
- Encourage patients to bring in their medications to each visit.

Group Best Practices

- Integrate PCP and specialist offices through electronic medical record or fax to get patient reports in a timely manner.
- Identify high-risk patients and help coordinate care through case management and care navigation programs.

Getting Appointments and Care Quickly

CAHPS Asks Patients

In the last six months:

- When you needed care right away, how often did you get care as soon as you thought you needed it?
- Not counting the times when you needed care right away, how often did you get an appointment for your healthcare at a doctor's office or clinic as soon as you thought you needed?
- How often did you see the person you came to see within 15 minutes of your appointment time?

Target	How to Improve This Measure	Frequency
All patients	• Assist patients in scheduling appointments and offer alternate ways to schedule, such as patient portal and after-hour phone numbers. • Triage calls from patients to identify those who require office visits and those whose needs can be addressed virtually. • Support patients during the referral and authorization process. • Ensure patients receive staff attention if provider is delayed beyond "15-minute" timeframe – measure vitals, address falls, urinary incontinence, mental health, physical activity, etc.	As needed

Clinical Guidelines

- Ensure a few appointments each day are available to accommodate urgent visits.
- Maintain an effective triage system to ensure that frail and/or very sick patients are seen right away or provided alternate care via phone or urgent care.
- For patients who want to be seen on short notice but cannot be seen by their doctor, offer appointments with a nurse practitioner or physician assistant.
- Encourage patients to make their routine appointments for checkups or follow-up visits as soon as they can – weeks or even months in advance.
- Address the "15-minute" timeframe by ensuring patients are receiving staff attention if provider is delayed. Measure vitals, engage in discussions related to HOS questions (urinary incontinence, fall risk, mental health, physical activity), etc.
- Keep patients informed if there is a wait and give them the opportunity to reschedule.

Getting Needed Care

CAHPS Asks Patients

In the last six months:

- How often was it easy to get appointments with specialists?
- How often was it easy to get the care, tests or treatment you needed through your health plan?

Target	How to Improve This Measure	Frequency
All patients	• Ensure timely referrals to specialists and appointments for tests and treatments. • Train staff to set expectations and communicate referral process with new and existing patients.	As needed

Best Practices

- Educate your patients about the referral process.
- Make alternative access methods available to patients, such as a nurse advice line, patient portal and urgent care locations.
- Ensure there are open appointments for patients recently discharged from a facility.
- For urgent specialty appointments, office staff should help coordinate with the appropriate specialty office.

Preventing Hospitalizations

Hospitalizations for Potentially Preventable Complications

Clinical Basis

Ambulatory care-sensitive conditions are acute and chronic health conditions that can be managed or treated in the outpatient setting. Appropriate access to care, high-quality care coordination, a focus on chronic disease self-management and connection to community resources can reduce the probability that individuals with these chronic and acute conditions will develop complications or exacerbations that result in hospitalization.

Target	How to Improve This Measure	Frequency
Members ≥ 67 years old	• Focus on chronic conditions and preventable acute issues. • Promote care management and disease management. • Educate patients on accessing after hour care via resources, such as nurse lines and urgent care centers. • Confirm all chronic condition diagnoses have been well documented for coding accuracy.	At least quarterly

Hospital and inpatient care is the largest component of total healthcare costs for older adults (24 percent of Medicare spending, approximately $129 billion dollars in 2013).[1] Hospitalization also poses several risks for older adults who frequently develop serious conditions as a result of hospitalization, such as delirium, infection and decline in functional ability.[2]

Reducing the rate of hospitalization for potentially preventable complications of acute and chronic conditions for older adults will improve patient health, reduce costs and improve quality of life.

[1] Kaiser Family Foundation, 2015
[2] Gillick, Serrell, & Gillick, 1982; Covinsky, Pierluissi, & Johnston, 2011

Measure Notes

Ambulatory care sensitive conditions (ACSC) are acute or chronic health conditions that can be managed or treated in an outpatient setting. These include:

- Conditions for which the provision of timely and effective outpatient care is likely to have little impact on the need for hospital admission
- Conditions for which timely and effective outpatient care can help reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition or managing a chronic disease or condition
- Referral-sensitive surgeries defined as high-cost/high-technology surgical procedures for which impediments to access or referral to specialty care may reduce the chances of having the surgery.[1]

The ACSCs included in this measure are:

- Chronic ACSC:
  - Diabetes short-term complications
  - Diabetes long-term complications
  - Uncontrolled diabetes
  - Lower-extremity amputation among patients with diabetes
  - COPD
  - Asthma
  - Hypertension
  - Heart failure
- Acute ACSC:
  - Bacterial pneumonia
  - Urinary tract infection
  - Cellulitis
  - Pressure ulcer

[1] National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

Clinical Guidelines

Strategies to avoid these hospitalizations may include offering after hour care, optimal use of ambulatory services, intensified monitoring of high-risk patients and initiatives to improve patients' willingness and ability to seek timely help, as well as patients' medication adherence.

Implications for primary care practice teams:

- Identification of patients at high risk for hospitalization for ACSCs by complementing predictive modeling with assessment of patients' social situation, medication adherence and self-management capabilities
- Regular medication review, easy-to-read medication schedules and shared treatment plan among patients, caregivers and physicians to improve adherence
- Regular (telephone) monitoring of symptoms and treatment adherence in high-risk patients (case management)
- Self-management training of patients and caregivers (should enable them to manage acute deterioration or to seek timely help of primary care resources)
- Identification of existing social support systems (family, friends, neighbors) and community resources
- Health technology systems (recall system for monitoring, updated links to community resources and ambulatory services, shared medical records between primary care practices and hospitals/after hour care)
- Enhanced communication between physicians across sectors (e.g., treating physicians and external physicians in after hour care, admission and discharge management and easy access to colleagues to ask for advice in case of diagnostic uncertainty)[1]
- Availability of appointments for high-risk patients and links to urgent care in the patients' geographical area to avoid emergency room or hospital admission

[1] Annals of Family Medicine, www.annfammed.org, Vol. 11, No. 4, July/August 2013, p 368

Medication Reconciliation Post-Discharge

Clinical Basis
Medication reconciliation is a critical part of post-discharge care coordination for all patients taking prescription medications. Patients who have more than one chronic condition are likely to take more medications; therefore, ensuring proper medication reconciliation is imperative to preventing unintended complications.[1]

Target	How to Improve This Measure	Frequency
Patients 18 years and older	Perform medication reconciliation of discharge medications with outpatient medications within 30 days from the date of discharge. Who can conduct it? • PCP, NP, PA, RN, clinical pharmacist • Can be done over the phone	All discharges
	In order to satisfy this measure, document and code appropriately: **1111F, 99495** or **99496.**	

It is best practice to conduct the medication reconciliation within **seven** days of discharge.

Coding and Documentation Guidance

CPT Code	Description
1111F	Discharge medications reconciled with the current medication list in outpatient medical record
99495	Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
99496	Transitional care management services with high medical decision complexity (face-to-face visit within seven days of discharge)

[1] National Quality Measures Clearinghouse (NQMC). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2015 Oct 01. [cited 2016 Nov 15] Go to https://www.qualitymeasures.ahrq.gov for additional information.

Hospital Best Practices
The Joint Commission identifies five steps in the medication reconciliation process:

1) Obtain a list of out-patient medications.
2) Obtain the list of medications prescribed at discharge.
3) Compare the medications on the two lists.
4) Make clinical decisions based on the comparison.
5) Communicate the new list to appropriate caregivers and to patients.

Group Best Practices
Prior to discharge, schedule a PCP appointment with patients within seven days:

- This is the best time to do medication reconciliation.
- The reconciliation may be conducted by a PCP, NP, PA, RN or clinical pharmacist and may be done telephonically.

PCP Best Practices

- Document the reconciliation in the medical record.
- Include a dated progress note stating, "Hospital (or skilled nursing facility) discharge medications were reconciled with the current outpatient medications."
- Be sure to include a signed and dated list of current medications.

Plan All-Cause Readmissions

Clinical Basis

Discharge from a hospital is a critical transition point in patients' care. Poor care coordination at discharge can lead to adverse events for patients and avoidable re-hospitalization.

Target	How to Improve This Measure	Frequency
All seniors discharged from acute or skilled nursing facility for non-elective admissions	• Schedule a follow-up visit within seven days of discharge. This is one of the best interventions you can provide to avoid readmissions. • Ensure all discharge instructions are reviewed with patients/caregivers at follow-up visit. • Refer patients to care transition program. • Confirm all chronic condition diagnoses have been well documented for diagnostic accuracy.	Every discharge

Hospitalization readmissions may indicate poor care or missed opportunities to coordinate better care. Research shows that specific hospital-based initiatives established to improve communication with beneficiaries and their caregivers, coordinate care after discharge and improve the quality of care during the initial admission can avert many readmissions.

There is extensive evidence about adverse events in patients, and the measure aims to distinguish readmissions from complications of care and pre-existing comorbidities.[1]

Best Practices

Best practices for plan all-cause readmissions fall into four groups, namely 1) hospital visits or stays not counted as readmissions, 2) patient characteristics for readmission risk, 3) PCP best practices and 4) group best practices.

[1] Gallagher, Cen, & Hannan, 2005

Hospital Visits or Stays Not Counted as Readmissions

- Exclude hospital stays in which the index admission date is the same as the index discharge date.
- Exclude hospital stays for the following reasons:
  - Patients died during the stay
  - A principal diagnosis of pregnancy (pregnancy value set)
  - A principal diagnosis of a condition originating in the perinatal period (perinatal conditions value set)
- Any hospital stay as an index hospital stay if the admission date of the first stay within 30 days meets any of the following criteria:
  - A principal diagnosis of maintenance chemotherapy (chemotherapy value set)
  - A principal diagnosis of rehabilitation (rehabilitation value set)
  - An organ transplant (kidney transplant value set, bone marrow transplant value set, organ transplant other than kidney value set)
  - A potentially planned procedure (potentially planned procedures value set) without a principal acute diagnosis (acute condition value set)

Patient Characteristics for Readmission Risk

Identify and target high-risk patients. The following are characteristics of high-risk:

- Socio-demographic: age, gender, poverty, unstable living situation, low literacy, language barrier
- Recent admission, frequent emergency room visits
- Disease burden: eight or more medications, CHF/diabetes/COPD, depression/psychosis, cancer, kidney disease, alcohol or drug dependency
- Physical status: disabled, frail, poor nutrition, inability to perform ADLs

PCP Best Practices

- Identify your high-risk and highly complex patients, document adequately and refer to appropriate complex case management programs.
- See patients within seven days of discharge.
- Target high-risk patients and ensure frequent communication across the whole care team.
- Teach patients and families how to manage their conditions.
- Reconcile medications on discharge instructions with those on the list of patients' outpatient medications (document code 1111F).
- Leverage office staff for readmission prevention by asking pertinent questions to patients and their caregivers:
  - Do you have family or friends who can help you with your care?
  - Do you have transportation to pick up your prescriptions or get to your appointments?
  - Do you need additional help to care for yourself at home?
- Set up the following procedures for your office staff:
  - Same-day appointments for patients who have been discharged within the past 30 days
  - Request discharge summary from hospital and/or call patients to remind them to bring their discharge summary to their appointment.

Group Best Practices

- Use information technologies as tools to improve quality, integrate care and ease patient transitions.
- Begin case management and discharge planning early, target high-risk patients and ensure frequent communication across the whole care team.
- Maintain a "lifeline" with high-risk patients after discharge.
- Align the efforts of hospital and community providers to ease transitions across care settings.
- Initiate discharge planning on day of admission

- Key post-discharge items you should review with your patients:
  - Identify the primary caregiver.
  - Review the discharge instructions with your patients and their caregivers and ask them to repeat the instructions back to you in order to verify they understand them.
  - Provide your patients and their caregivers with the following information:
    - > Let them know there is urgent/emergent/postoperative care available to them. Patients should be aware of out-patient facilities they can contact or go to if they have a problem. You should include addresses, maps and phone numbers to those locations.
    - > Give your patients a number they can call for any post discharge issues.
    - > Let your patients know when to call a physician, when to take medications and when and where to access care.
  - What to ask patients and their caregivers:
    - > Do you have family or friends who can help with care?
    - > Do you have adequate transportation (are you able to transport yourself)?

When you care for patients correctly, readmission rates fall, performance on quality measures improves and savings are realized as byproducts.

Coding and Documentation Guidance

On the first visit after discharge from any inpatient facility, the reason for and outcome of the hospitalization should be documented. When documented, code the patients discharge and reconciliation of any changes to medication as a result of the hospitalization.

CPT Code	Description
1110F	Patients discharged from an inpatient facility (hospital, skilled nursing facility, rehabilitation facility) within the last 60 days
1111F	Discharge medications reconciled with the current medication list in outpatient medical records

Medication Adherence

Clinical Basis

Doctors cite poor medication adherence with diminished health benefits of pharmacotherapy.[1] Patients with multiple medical conditions often require treatment with multiple medications, increasing the risk of non-adherence.

Target	How to Improve This Measure	Frequency
Patients 18 years or older	Refer to the table on pages 65-66 for questions to ask your patients about their medications and for tailored solutions to offer based on your patients' barriers.	At each visit

How to talk to your patients:

- Ask open-ended questions to determine if your patients understand why they have been prescribed a certain medication and how to take it.
- Assess whether your patients are actually taking the prescribed medications properly. Ask the following questions:
  - In the last month, how many times have you missed taking your medication?
  - How are you currently taking your medication?
  - When was the last time you took your medication?
  - What side effects, if any, are you currently experiencing?
  - Do you sometimes not take your medication when you feel better?
  - Do you sometimes not take your medication because you're worried about side effects?

[1] Lee JK, Grace KA and Taylor JA, Effect of a Pharmacy Care Program on Medication Adherence and Persistence, Blood Pressure, and Low-Density Lipoprotein Cholesterol A Randomized Controlled Trial, JAMA December 6, 2006, Vol 296, No. 21

- Show empathy and build trust:
  - Comments, such as "It's hard taking your medication when you don't feel like it's making you any better," can help build trust, which can help improve patient adherence.
  - When patients trust you, they are more likely to reveal whether they are taking their medications or not.
- Set expectations. Make sure your patients understand what the medication is for, what its preventative effects are and how long they will need to take the medication.
- Ask your patients which medications need additional refills.

Refer to the table below for solutions based on your patients' barriers to adherence.

Barrier	Solution
Forgetfulness	• Encourage patients to create a consistent routine: – Use reminder tools such as sticky notes, a pillbox to organize medications, medication calendar, alarms on phone/clock/watch, sign up for text message reminders (www.scriptyourfuture.org), pre-sorted dose packaging (e.g., PillPack Pharmacy). – Combine taking medication with daily task, such as brushing teeth or eating dinner. • Suggest auto-refill, refill reminder and medication synchronization programs at patients' pharmacy. • Simplify medication regimen and reduce pill burden. Prescribe combo pills and ER/XR formulations for once-daily dosing when appropriate • Reduce polypharmacy. • Encourage mail order prescriptions. • Prescribe 90-day supply.

Cost	• Prescribe generic and/or lower tier drugs on the SCAN Formulary • Prescribe 90-day supply. Most SCAN members pay only two copays for a three-month supply of Tier 1 and 2 medications and receive a $10 discount for Tiers 3 and 4. Please refer to online Formulary for the most up-to-date information: https://www.scanhealthplan.com/helpful-tools/formulary-search. • Encourage mail order prescriptions through ESI Home Delivery for savings on prescriptions. • SCAN patients pay lower copays at SCAN Preferred pharmacies: – Preferred pharmacies include but are not limited to Walgreens, Rite Aid, Walmart, Costco, Ralphs, Safeway, Albertsons and Express Scripts Home Delivery • Tell patients to call MyAdvocate to find out if they qualify for Extra Help (1-866-866-0871).
Side Effects	• Discuss ways patients can manage the side effects so they continue taking the medication. • Prescribe an alternative medication with fewer or no side effects.
Transportation	• Get prescriptions through ESI Home Delivery. • Prescribe 90-day supply to reduce number of trips to pharmacy. • Encourage enrollment in medication synchronization at pharmacies to refill medications on same day. • Have patients call SCAN Member Services to see if their plan includes the transportation benefit.
Unwillingness	• Provide further education on importance of taking medications and connect with controlling chronic conditions. • If depression is present, consider using PHQ-2 or PHQ-9 where appropriate and refer as indicated by results.
Poor health literacy	• Avoid medical jargon and use visual aids. • Use interpreter services when needed. • Provide medical information at a sixth-grade level or lower.

Medication Adherence for Diabetes Medications

Refer to the following table for the adherence diabetes medications.

Tier 1 (preferred generic drugs)	**Tier 2** (generic drugs)	**Tier 3** (preferred brand drugs)
Glimepiride Glipizide Glipizide ER Metformin Metformin ER Pioglitazone	Glimepiride & pioglitazone*** Glipizide & metformin Piogllazone & metformin Repaglinide Nateglinide	Bydureon®* Byetta®* Farxiga®** Invokamet®** Invokamet® XR** Invokana®** Janumet® Janumet® XR Januvia® Kombiglyze® XR Onglyza® Victoza®* Xigduo® XR**

* Prior authorization
** Step therapy
***Quantity limit

Medication Adherence for Cholesterol (Statins)

Tier 1 (preferred generic drugs)	Tier 2 (generic drugs)
Atorvastatin Lovastatin Pravastatin Simvastatin	Amlodipine & atorvastatin Rosuvastatin**

** Step therapy

- **Moderate-intensity** statin (daily dose): lovastatin 40mg, pravastatin 40-80mg, simvastatin 20-40mg, atorvastatin 10-20mg per day.
- **High-intensity** statin (daily dose): atorvastatin 40-80mg per day; rosuvastatin 20-40mg per day.

Medication Adherence for Hypertension (RAS Antagonists)

High-quality blood pressure management is multifactorial requiring patient engagement, care givers, providers and the healthcare delivery system. A high level of medication adherence and adequate follow up are critical to success. The following table provides a list of Formulary alternatives for your consideration.

Tier 1 (preferred generic drugs)	Tier 2 (generic drugs)	Tier 3 (preferred brand drugs)
Amlodipine & benazepril Perindopril Ramipril Trandolapril *Also available in combination with HCTZ:* Benazepril Captopril Enalapril Fosinopril Irbesartan Lisinopril Losartan Moexipril Quinapril Valsartan	Olmesartan & Amlodipine* Valsartan & Amlodipine Valsartan & Amlodipine & HCTZ*	Olmesartan* Olmesartan-HCTZ* Tekturna®* Tekturna-HCTZ®*

* Step therapy

Appendix: Coding

Breast Cancer Screening

3014F Screening mammography results documented and reviewed

Colorectal Cancer Screening

3017F Colorectal cancer screening results documented and reviewed

G0328 FOBT

Note: Z12.11 is the diagnosis code for screening for malignant neoplasm of the colon.

Annual Flu Vaccines

90630 Influenza split virus vaccine, quadrivalent, preservative free, for intradermal use

90653 Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use

90654 Influenza virus vaccine, split virus, preservative-free, for intradermal use

90656 Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals three years and older, for intramuscular use

90660 Influenza virus vaccine, live, for intranasal use

90661 Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use

90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

90672 Influenza virus vaccine, quadrivalent, live, for intranasal use

90673 Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

90686 Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals three years of age and older, for intramuscular use

90688 Influenza virus vaccine, quadrivalent, split virus, when administered to individuals three years of age and older, for intramuscular use

Q2035 Influenza virus vaccine, split virus, when administered to individuals three years of age and older, for intramuscular use (Afluria®)

Q2036 Influenza virus vaccine, split virus, when administered to individuals three years of age and older, for intramuscular use (Flulaval®)

Q2037 Influenza virus vaccine, split virus, when administered to individuals three years of age and older, for intramuscular use (Fluvirin®)

Q2038 Influenza virus vaccine, split virus, when administered to individuals three years of age and older, for intramuscular use (Fluzone®)

Q2039 Influenza virus vaccine, when administered to individuals three years of age and older, intramuscular use (not otherwise specified)

Annual Flu Vaccines - Administration

G0008 Seasonal Influenza Virus Vaccine Administration

G8482 Influenza immunization administered or previously received

G8483 Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)

G8484 Influenza immunization was not administered, reason not given

Improving or Maintaining Physical Health

1170F Functional status assessed

Improving or Maintaining Mental Health

G8431 Screening for depression is documented as being positive and a follow-up plan is documented

3351F Negative screen for depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)

3352F No significant depressive symptoms as categorized by using a standardized depression assessment tool (MDD)

3353F Mild to moderate depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)

3354F Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)

3725F Screening for depression performed

G0444 Annual depression screening, 15 minutes

G8510 Screening for depression is documented as negative, a follow-up plan is not required

G9212 DSM-IVTM criteria for major depressive disorder documented at the initial evaluation

G9393 Patient with an initial PHQ-9 score greater than nine who achieves remission at 12 months as demonstrated by a 12-month (+/- 30 days) PHQ-9 score of less than five

G9395 Patient with an initial PHQ-9 score greater than nine who did not achieve remission at 12 months as demonstrated by a 12-month (+/- 30 days) PHQ-9 score greater than or equal to five

G9396 Patient with an initial PHQ-9 score greater than nine who was not assessed for remission at 12 months (+/- 30 days)

Adult BMI Assessment

G8417 BMI is documented above normal parameters and a follow-up plan is documented

G8418 BMI is documented below normal parameters and a follow-up plan is documented

G8419 BMI documented outside normal parameters, no follow-up plan documented, no reason given

G8420 BMI is documented within normal parameters and no follow-up plan is required

G8421 BMI not documented and no reason is given

G8422 BMI not documented, documentation the patient is not eligible for BMI calculation

COA – Medication Review

G8427 Eligible clinician attests to documenting in the medical record they obtained, updated or reviewed patients' current medications

1159F Medication list documented in medical record

1160F Review of all meds by prescriber or clinical pharmacists documented in medical record

G8428 Current list of medications not documented as obtained, updated or reviewed by the eligible clinician, reason not given

G8430 Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated or reviewed by the eligible clinician

Medication Adherence Tips

1159F Medication list documented in medical record

1160F Medication list documented in medical record

COA - Functional Status Assessment

1170F Functional status assessed

COA – Pain Assessment

G8442	Pain assessment not documented as being performed, documentation patients are not eligible for a pain assessment using a standardized tool
1125F	Pain severity quantified; pain present
1126F	Pain severity quantified; no pain present

Improving Bladder Control

0509F	Urinary incontinence plan of care documented or
0509F-8P	Urinary incontinence plan of care not implemented, no reason given

Diabetes Care – Eye Exam

2022F	Dilated eye exam with interpretation
2024F	Seven standard field stereoscopic photos with interpretation
2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

Hypertension – Controlling Blood Pressure

G8473	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed
G8474	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ACE inhibitor, diseases of the aortic or mitral valve, other medical reasons, patient declined, other patient reasons, lack of drug availability, other reasons attributable to the healthcare system)
G8475	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not given
G8476	Most recent blood pressure has a systolic measurement of < 140mm Hg and a diastolic measurement of < 90mm Hg
G8477	Most recent blood pressure has a systolic measurement of >=140mm Hg and/or a diastolic measurement of >=90mm Hg section
G8478	Blood pressure measurement not performed or documented, reason not given

G10077 12/17