Care Gap Closure Guide

2025

St. Luke's Health Partners

Care Gap Closure Guide: Knowing Your Population and Closing Care Gaps

[1]
KNOW THE POPULATION AND THEIR NEEDS

[2]
CLOSE GAPS IN THEIR CARE

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INSURE APPROPRIATE UTILIZATION

St. Luke's Health Partners is teaming up with health care providers across the state to provide exceptional patient-centered care at the best value. This guide is designed to provide activities, and descriptions of quality measures, that if deployed in the primary care setting will improve the health and wellness of patients in our communities.

Contents

Comprehensive Wellness Visits and Empanelment

A comprehensive wellness visit, performed annually, provides an opportunity to strengthen the provider and patient relationship, complete preventive screenings, conduct care gap closure and address chronic conditions. The comprehensive assessment performed at these visits results in:

- Early identification of potential health problems leading to early intervention.
- Improved patient outcomes resulting in a reduced need for the patient to utilize the Emergency Department or urgent care settings.
- The creation and maintenance of a comprehensive record of the patient's medical history.
- A more accurate reflection of the complexity of the provider's panel is assured.

To be successful, empanelment and proactive outreach to schedule patients for wellness visits are two important steps in getting to know the population of patients for which you are accountable. Patients attributed to your practice group can be found by accessing the SLHP population health application.

Unless payer contracts require a particular attribution assignment, patients are attributed based on plurality of claims within the last 24 months, following the hierarchical algorithm below:

1. Medical Claims, performed by MD/DO/NP/PA, prioritized by taxonomy of family practice (not including obstetrics and gynecology practitioners), internal medicine, and pediatrics.
2. Obstetrics and gynecology (OB-GYN) medical Claims, performed by MD/DO/NP/PA.
3. Prescription claims based on the prescribing provider and their identified taxonomy (excluding Emergency Department).
4. The most recent encounter and the PCP associated with that encounter in the SLHS HER.
5. The PCP delineated in the payer roster.
6. Medical claims performed by specialists (excluding claims related to Emergency Department visits or inpatient services).
7. If the steps noted above fail to identify an attributed provider, the patient falls into the unattributed category.

The process of empanelment is important. It refers to a process developed within a clinical group to take the list of attributed patients and compare that to what is reflected in the EMR or clinical record. Optimally, that process should also include looking for patients that have switched PCPs, moved or passed away. This work will impact registry accuracy when clinics begin work on chronic disease management. It can also impact how templates are developed for provider schedules in a way that maximizes patient access to care. All of this, when implemented, increases clinical efficiency.

If access is a challenge, patients should be prioritized for outreach based on their complexity and overall health status. SLHP tools are available to help you with this process. The work might seem overwhelming at first, but the population health team at SLHP is here to help.

Introduction: Complete and Accurate Diagnosis, Documentation and Coding

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To fully depict the patient's health status, it is essential to ensure that all chronic conditions are addressed, documented and accurately coded at the time of the patient's visit. Based on provider documentation, clinical resources are deployed to care for the patient. This connects patients with tools and resources to mitigate risks related to social determinants of health.

Complete and accurate documentation also facilitates improved communication of care to other providers along the care continuum. Clear and concise provider documentation is necessary to ensure that appropriate financial resources for the care of the population are appropriately allocated. Poor documentation and nonspecific diagnoses will result in an inaccurate reflection of the illness burden of the patient and an inaccurate allocation of resources for the care of the population.

Calculating the allocation of resources for the care of a population is based on the CMS-HCC (Medicare) or HHS-HCC (Commercial) risk adjustment models. The calculations predict the cost of medical care that a patient might incur. A risk adjustment factor (RAF) or risk score is generated by utilizing patient demographics and the patient's health status or reflected illness burden (chronic conditions documented yearly), during a face-to-face visit with a qualifying provider.

Premium/Bid x Illness Burden = Financial Support

Individual risk scores are assigned based on:

- Enrollee demographics (age, gender)
- Patient's residence (community or institution)
- Medicaid dual eligibility and disability status
- Certain disease and disease-disability interactions
- Composite of major chronic conditions (HCC - ICD-10 Diagnoses)

If a patient's risk score is low, it indicates to CMS that the patient is healthy and will require fewer clinical resources. For this reason, CMS allocates fewer financial resources for the care of that patient. If the patient's risk score is high, based on clinical documentation of chronic conditions, the patient will likely need more clinical resources which require more financial resources. For this reason, CMS allocates more financial resources for the care of the patient.

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The patient example below demonstrates how complete and accurate documentation has significant clinical and financial impact. As you can see, the funding that corresponds to the full complexity of a patient, which is captured in a more complete and accurate diagnosis, is significant. The clinical care for that patient should be more complex as well. That funding, in turn, supports work like care management and pharmacy services that are made available to providers to maximize care for patients.

The funding listed in the example is not applied by CMS at the individual level, it is a portion of the funding for the total population for which SLHP has assumed accountability. It also directly impacts the financial accountability providers in the network have assumed for that population.

No Conditions (Documented or submitted on a claim)	**Some Conditions** (Documented and submitted on a claim but nonspecific)	**All Conditions** (Documented, accurately coded, and submitted on a claim)
70 years old (Community, Full Benefit, Aged) **0.600**	70 years old (Community, Full Benefit, Aged) 0.600 **Type 2 Diabetes (without complications)** **0.107** **Depression (unspecified)** **0.000** **COPD** **0.430**	70 years old (Community, Full Benefit, Aged) 0.600 **Type 2 Diabetes (with complications; peripheral neuropathy)** **0.340** **Major Depression** **0.299** **COPD** **0.430** **(R) Great Toe Amputation** **0.795** **Respiratory Failure/O2** **0.492** **COPD/Respiratory Failure Disease Interaction** **0.528**
Total RAF 0.600 **$5,600 (~Support)**	Total RAF 1.137 **$10,600 (~Support)**	Total RAF 3.484 **$32,600 (~Support)**

- Poor patient care: Patient likely not engaged with PCP; utilizing urgent care and ED resources.
- Under-documented and undermanaged chronic conditions.
- No allocation of clinical resources.
- Poor communication along the continuum of care.
- Incomplete or nonspecific documentation of chronic conditions; under-represented illness burden.
- Inaccurate allocation of financial resources for the care of the patient.

- Risk interventions (care management, fall, socio-economic etc.) in place.
- Engaged patient; excellent quality of care.
- Management of chronic conditions.
- Accurate representation of the illness burden.
- Accurate allocation of financial resources for care of the patient.

Critical Elements To Achieve Complete and Accurate Documentation

Document and code conditions to the highest level of specificity (e.g., acute or chronic, severity, stage of condition, location).

Document the relationship of complications or conditions secondary to the underlying condition. Use terms like “from,” “related to,” “secondary to,” or “with” to link diagnoses and a causal relationship (e.g., type 2 diabetes with nephropathy).

Avoid “history of” if the patient is receiving ongoing treatment, medication, or intervention and if discontinuation of medication would raise a clinical concern of recurrence. “History of” means patient no longer has the condition. “History of” the condition cannot be coded as an active disease.

If a diagnosis is certain, avoid terms such as: “Consistent with,” “probable,” “possible,” or “likely.” Document and code the signs and symptoms if no definitive diagnosis can be made.

Review and update problem lists. Lists should reflect active medical problems.

Review and update medication lists. Lists should reflect currently prescribed medications and the condition for which it was prescribed.

Identify any complications and document what caused the complication (e.g., chronic kidney disease, stage 4 due to type 2 diabetes mellitus).

Use linking language for related conditions (e.g., “aphagia due to CVA” rather than “aphagia and CVA”).

Acknowledge pertinent laboratory or radiology results in the body of the documentation (e.g., chronic kidney disease (CKD) stage 3, GFR of 48).

Always code status conditions when present (amputation, dialysis, ostomy, transplant, etc.).

Document chronic conditions at least once per year; document that each condition was Monitored, Evaluated, Assessed and/or Treated (MEAT). A chronic condition can be documented and coded when stable with treatment (e.g., amputation, transplant, alcoholism). Only one of the four elements of MEAT is needed for each documented condition.

MEAT	Support	Disease Example	Documentation Example
Monitor	Signs, symptoms, disease progression or regression	Congestive heart failure	Congestive heart failure is stable. Will continue same dose of Lasix.
Evaluate	Test results, medication effectiveness, response to treatment	Type 2 diabetes mellitus	Blood sugar log and A1c results reviewed with the patient.
Assess/Address	Order and discuss tests, review records, counseling, status/level of condition	Peripheral neuropathy	Decreased sensation of BLE by monofilament test.
Treat	Prescribe medications/therapies, surgical/ therapeutic interventions, specialist referrals	Chronic kidney disease, stage 3 (new diagnosis)	Referred to nephrology clinic.

Quality Care Gap Closure

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A **quality care gap** is a recommended preventive screening or evidence-based practice in the care of a patient's condition that has not been completed per defined requirements in a specified time.

Key Activities To Close Adult Gaps in Care

Access SLHP data and information platform to identify patients with care gaps.

Provide access for sick and well care.

Proactively reach out to patients and schedule a wellness visit.

- Complete pre-visit planning: pre-populate actionable information for provider to utilize at the time of the visit.
- Update EMR documentation template to support closure of gaps and preventive screening.

Remove barriers to testing/screening (e.g., location, demographics).

Educate and close care gaps at every touch point.

- Develop protocols for staff to provide order recommendations.
- Provide automatic reminder for testing/screening via the electronic medical record.

Ensure that testing/preventive screening was scheduled and completed.

- Educate patients on the importance of screenings and adherence.
- Provide appointment reminders.
- Dispense test kit and send reminders via mail or text to submit the kit.

Refer for home visit if patient does not or is unable to present in person.

Document and code exclusions to testing (e.g., mammograms and mastectomy patients).

- Non-adherence does not close a care gap unless exclusions apply. Exclusions need to be accurately documented and coded.

Utilize team-based care.

- Coordinated, high-quality care team that includes a combination of providers, nurses, pharmacists, social workers, case managers and other health care professionals all using their unique skills to provide the safest, best possible care to patients.
- Key activities include pre-visit planning, registry management, care management, diabetes education, health coaching, nutrition counseling and behavioral health care.

Document and code testing or prior year testing. Consider using CPT II codes for completed.

Quality Care Gap Closure in Adults

Measure	Measure Description	Tips for Gap Closure
Annual Wellness Visit	The percentage of patients who receive their annual wellness visit during the measurement year.	• Pre-visit planning optimizes nursing, provider and patient time. • Ensure care gaps, preventive screening, and chronic conditions to re-assess are available to the provider at the time of the visit.

Breast Cancer Screening (BCS-E)	The percentage of members 50 to 74 years of age who had a mammogram to screen for breast cancer.
	
	Exclusions
	• Patients who had a bilateral mastectomy or **both** right and left unilateral mastectomies at any time during the patient's history through the end of the measurement period. Submit the appropriate ICD-10-CM** diagnosis code(s):
	  • History of bilateral mastectomy.
	  • Z90.13 Acquired absence of bilateral breasts and nipples
	  • Combination of codes that indicate a mastectomy on **both** the left and right side on the same date or different dates of service.
	  • Z90.11 Acquired absence of right breast and nipple
	  • Z90.12 Acquired absence of left breast and nipple
	• Gender-affirming chest surgery, CPT 19318 AND a diagnosis of gender dysphoria any time during the patient's history. Submit the appropriate diagnosis code(s):
	  • F64.1 Dual role transvestism
	  • F64.2 Gender identity disorder of childhood
	  • F64.8 Other gender identity disorders
	  • F64.9 Gender identity disorder, unspecified
	• Z87.890 Personal history of sex reassignment.
		• If documenting a mammogram reported by a patient, specify "mammogram completed" and include the date of service (year and month is acceptable).

Cervical Cancer Screening (CCS-E)	• The percentage of members 21-64 years of age who were screened for cervical cancer. • Members 21-64 years of age who had cervical cytology performed within the last 3 years. • Members 30-64 years of age who had cervical, high-risk human papillomavirus testing performed within the last 5 years. • Members 30-64 years of age who had cervical cytology/high risk human papillomavirus co-testing within the last 5 years. **Exclusions** • Hysterectomy in combination with documentation that the patient no longer needs pap testing or cervical cancer screening or has no residual cervix. • Patients who have had a total, complete, vaginal or radical hysterectomy (partial does not qualify), cervical agenesis or acquired absence of cervix.	• Biopsies are not valid for primary cervical cancer screening.
Colorectal Cancer Screening (COL-E)	The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer. **Exclusions** • Patients who had colorectal cancer at any time during the patient's history through December 31 of the measurement year. • Patients who had a total colectomy at any time during the patient's history through December 31 of the measurement year.	One or more of the following screenings will close the gap (document date, type of screening and result): • Fecal occult blood test (FOBT) during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years before the measurement period. • CT colonography during the measurement year or the four years before the measurement period. • Stool DNA with FIT test during the measurement year or the 2 years before the measurement period.

Chlamydia Screening (CHL)	The percentage of members 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	• Pre-visit planning optimizes nursing, provider and patient time. • Billing chlamydia screening under prenatal or postpartum global billing might not be captured in claims. • Chlamydia screening test CPT* codes: 87110, 87270, 87320, 87490, 87491, 87492, 87810.
Care for Older Adults (COA)	The percentage of adults 66 years and older who had both of the following during the measurement year: • Medication Review • Functional Status Assessment **Exclusions** Services provided in an acute inpatient setting.	• Pre-visit planning optimizes nursing, provider and patient time. • A medication review over the phone must be completed and dated by a prescribing practitioner or clinical pharmacist. Notation that says the member is **not** taking any medications will also satisfy the medication review. • The medication review must include prescription, over-the-counter meds, herbal or supplemental therapies and signed and dated by the prescribing practitioner or clinical pharmacist. • At least **one** functional status assessment tool with results can be conducted over the phone by any care provider type. Documentation of the service in the medical record must be completed and dated • Standardized functional status assessment tools include: 1. Assessment of Instrumental Activities of Daily Living (IADL) or **at least four** of the following assessed: ▪ Shopping for groceries; driving or using public transportation; using the telephone; cooking or meal preparation; housework; home repair; laundry; taking medications; handling finances. 2. Activities of Daily Living (ADL) or **at least five** of the following assessed: ▪ Bathing, dressing, eating, transferring (e.g., getting in

		and out of chairs), using restroom, walking. **CPT II Coding** • 1159F Medication list documented in medical record. • 1160F Review of all medications by a prescribing practitioner or clinical pharmacist (such as prescriptions, OTCs, herbal therapies and supplements) documented in the medical record. • **Both** 1159F and 1160F must be reported to satisfy the medication review component of the COA measure. • 1170F Functional status assessed.
Advance Care Planning (ACP)	The percentage of adults 66-80 years of age with advanced illness, an indication of frailty, or who are receiving palliative care, and adults 81 years of age and older who had advanced care planning during the measurement year.	• A discussion or documentation about preferences for resuscitation, life sustaining treatment and end of life care should be documented in the EMR. **CPT II Coding** • 1123F Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record. • 1124F Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. • 1157F Advance care plan or similar legal document present in the medical record. • 1158F Advance care planning discussion documented in the medical record.

Controlling High Blood Pressure (CBP)	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	• The most recent BP of the year is utilized to determine if the patient's BP is adequately controlled (e.g., a BP taken in December of the calendar year will replace a BP taken in October of the calendar year). • The BP reading must occur on or after the date of the second diagnosis of hypertension. • The date of service and BP reading must be recorded together. • Patient-reported blood pressures can be utilized if a digital device is used. • Patient-reported blood pressures must accompany education or counseling related to blood pressure control. • If multiple BP measurements occur on the same date, report the lowest systolic and lowest diastolic BP reading on that date. **CPT II Coding** • 3074F Most recent systolic blood pressure <130 mm Hg. • 3075F Most recent systolic blood pressure 130-139 mm Hg. • 3077F Most recent systolic blood pressure >/=140 mm Hg. • 3078F Most recent diastolic blood pressure <80 mm Hg. • 3079F Most recent diastolic blood pressure 80-89 mm Hg. • 3080F Most recent diastolic blood pressure >/=90 mm Hg.

Glycemic Status Assessment for Patients With Diabetes (GSD)	The percentage of members 18-75 years of age whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) shows that the patient's blood sugar is under control. **Adequate Control: HbA1c < 8**	If multiple tests were performed in the measurement year, the most recent result is reported. If using CPT II codes to report the result, a copy of the lab results must be included in the medical record. **CPT II Coding** • 3044F HbA1c test < 7%. • 3051F HbA1c test ≥ 7% and < 8%. • 3052F HbA1c test ≥ 8% and ≤ 9 %. • 3046F HbA1c test > 9%. ***Note:*** *Report CPT II codes with the date of service, not the date the test was reviewed.*
Kidney Health Evaluation for Patients With Diabetes	The percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.	Both of the following during the measurement year on the same or different dates of service will result in compliance: • At least one eGFR lab test value set. • At least one uACR identified by either of the following: ▪ ***Both*** a quantitative urine albumin test (quantitative urine albumin lab test value set) *and* a urine creatinine test (urine creatinine lab test value set) *with* service dates four or less days apart. ***For example:*** *if the service date for the quantitative urine albumin test was Dec. 1 of the measurement year, then the urine creatinine test must have a service date on or between Nov. 27 and Dec. 5 of the measurement year.* ▪ A uACR lab test value set.

Eye Exam for Patients With Diabetes (EED)	The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had **one** of the following: • A retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year. • A negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year.	At a minimum, documentation in the medical record must include one of the following: • A note or letter prepared by an ophthalmologist, optometrist, PCP, or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results. • A chart or photograph indicating the date when the fundus photography was performed and one of the following: ▪ Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. ▪ Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. **CPT II Coding** • 2022F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed, with evidence of retinopathy. • 2023F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy. • 2024F 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, with evidence of retinopathy. • 2025F 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy.

		• 2026F Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos, results documented and reviewed, with evidence of retinopathy. • 2033F Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos, results documented and reviewed, without evidence of retinopathy. • 3072F Low risk for retinopathy (no evidence of retinopathy in prior year). ***Note:*** *Report CPT II codes with the date of the eye exam, not the date when the report was reviewed.*

Additional information can be found in the Medicare 2025 Star Ratings technical notes at 2025-star-ratings-technical-notes.pdf.

Closing Gaps in Care in Pediatrics

Key Activities To Close Pediatric Gaps in Care

- Give immunizations at any visit in addition to well-child visits. Provide access for sick and well care.
- Proactively reach out to patients and schedule a wellness visit.
- Complete pre-visit planning: pre-populate actionable information for provider to utilize at the time of the visit.
- Update EMR documentation template to support closure of gaps and preventive screening.
- Send reminders to parents/guardians (texts, postcards, letters, portal notifications). Participate in the state's immunization registry (IRIS).

Measure	Measure Description
Immunizations for Adolescents (IMA-E)	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine; one tetanus, diphtheria toxoids, acellular pertussis (Tdap) vaccine; and have completed the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Childhood Immunization Status (CIS-E)	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophiles influenza type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
Child and Adolescent Well-Care Visits (WCV)	The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider or OB-GYN practitioner during the measurement year.
Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: **Well-child visits in the first 15 months.** Children who turned 15 months old during the measurement year: *Six or more well-child visits on or before the 15-month mark, spaced at least 14 days apart.* **Well-child visits for age 15 months-30 months.** Children who turned 30 months old during the measurement year: *Two or more well-child visits, spaced at least 14 days apart.*

CPT* Category II Codes

Category II codes do not have a relative value associated with them and are not reimbursable. Their value is in tracking and submitting the completion of preventive care and describing clinical components included in E&M or clinical services, ensuring that providers receive credit for the care being provided.

- The code is a 5-character alpha-numeric code that always end with the character “F.”
- CPT II codes close gaps in care, supporting accurate outcome tracking.
- Facilitates internal tracking of patient preventive care completion.
- Reduces the need for administrative chart reviews and medical record requests by payers.
- If clinical and documentation requirements are met, there is no limitation on how often these codes can be submitted.

Using CPT Codes in Support of Closing Adult Gaps in Care

Work with your EMR system vendor to add these codes into the practice management system.

- Inquire about automation. Some systems can automatically translate clinical data elements into CPT II codes and ensure these codes are included on the claim.

Develop workflows for clinical office staff, billers and coders for proper code submission.

CPT II codes can be submitted on claims with other applicable codes. They are entered in the procedure code field, just like your regular CPT codes are billed.

- Check payer specific guidelines for submitting Category II codes. Some payers might require a professional service is performed on the date the Category II services are reported.

Verify the charge amount criteria with your EMR/Practice Management and Clearinghouse vendors. CPT II codes are typically entered with either a .00 or .01 charge amount.

HEDIS+ Measure Name and Documentation Guidelines	CPT II code	CPT Category II Code Description	Charge Amount
Controlling High Blood Pressure (CBP) Medical record stating hypertension diagnosis and the following blood pressure screening documentation: • Date and most recent results of the blood pressure reading. • The blood pressure reading must occur on or after the date of the second diagnosis of hypertension. • Documentation must be from provider managing the condition. ***Note:*** *Two codes (one from 3074F-3077F and one from 3078F-3080F) must be reported to identify the lowest systolic and lowest diastolic reading to satisfy the CBP measure.*	3074F	Most recent systolic blood pressure <130 mm Hg	.00 or .01
	3075F	Most recent systolic blood pressure 130-139 mm Hg	.00 or .01
	3077F	Most recent systolic blood pressure >/=140 mm Hg	.00 or .01
	3078F	Most recent diastolic blood pressure <80 mm Hg	.00 or .01
	3079F	Most recent diastolic blood pressure 80-89 mm Hg	.00 or .01
	3080F	Most recent diastolic blood pressure >/=90 mm Hg	.00 or .01
Eye Exam for Patients with Diabetes (EED) Medical record stating a confirmed diagnosis of diabetes to include the following retinal eye exam documentation: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that a retinal or dilated eye exam was completed by an eye care professional (optometrist or ophthalmologist). • Evidence of bilateral or unilateral eye enucleation anytime during the patient's history through 12/31 of the current calendar year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care specialist in the year prior ***Note:*** *Any provider can report the appropriate CPT Category II code. Report 2022F-2033F with date of eye exam, not the date of service (DOS) when the report was reviewed. Report 3072F with the current year DOS. An eye exam result documented as "unknown" does not meet criteria.*	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	.00 or .01
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	.00 or .01
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, with evidence of retinopathy	.00 or .01
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy	.00 or .01
	2026F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed, with evidence of retinopathy	.00 or .01
	2033F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos, results documented and reviewed, without evidence of retinopathy	.00 or .01
	3072F	Low risk for retinopathy (no evidence of retinopathy in prior year)	.00 or .01
Glycemic Status Assessment for Patients with Diabetes (GSD) Medical record stating a confirmed diagnosis of diabetes to include the following HbA1c screening documentation: • Document the date and result(s) or provide a copy of the lab report with the most recent HbA1c control indictor used regardless of data source.	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%	.00 or .01
	3046F	Most recent hemoglobin A1c level greater than 9.0%	.00 or .01
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	.00 or .01
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	.00 or .01

***Note**: Report CPT Category II code with the date of the A1c test, not the date of the office visit when the test was reviewed.*			
Advanced Care Planning (ACP) Medical record should include the following discussions between a qualified health care professional and the patient: • Discuss the patient's health care wishes if they become unable to make decisions about their care with or without completing legal forms. This may include living wills, instruction directives, health care proxy, health care power of attorney.	1123F	Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record	.00 or .01
	1124F	Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	.00 or .01
	1157F	Advance care plan or similar legal document present in the medical record	.00 or .01
	1158F	Advance care planning discussion documented in the medical record	.00 or .01
Care for Older Adults (COA) Functional Status • Notation that activities of daily living (bathing, dressing, eating, walking, etc.) or instrumental activities of daily living (grocery shopping, driving, meal preparation, laundry, taking medications, etc.) were assessed or documentation of result of assessment using a standardized functional status assessment.	1170F	Functional status assessed	.00 or .01
Care for Older Adults (COA) Medication List **Care for Older Adults (COA)** Medication Review Medication list and evidence of medication review by prescribing practitioner or clinical pharmacist, including date when performed or notation that member in not taking any medication and date when noted, which may include transitional care management services during the same outpatient visit. ***Note:** Both 1159F and 1160F must be reported to satisfy the medication review component of COA measure.*	1159F	Medication list documented in medical record	.00 or .01
	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record	.00 or .01
Prenatal and Postpartum Care (PPC) Stand Alone Prenatal Visits ***See details under CPT Category II Code Description****	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]).	.00 or .01
	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)	.00 or .01
	0502F	Subsequent prenatal care visit [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal	.00 or .01

		care (e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care)]	
Prenatal and Postpartum Care (PPC) Postpartum Visits	0503F	Postpartum care visit	.00 or .01
Transitions of Care (TRC)-Medication Reconciliation Post-Discharge Medical record should include a medication reconciliation by a qualified health care professional post-discharge in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. • The medication list may include medication names only or may include medication names, dosages, and frequency, over the counter (OTC) medications and herbal or supplemental therapies. ***Notes:*** *The medication reconciliation must be documented on the date of discharge through 30 days after the discharge (31 days total).* *1111F can be reported when the post-discharge medication reconciliation is done during a telephone call or during the transitional care management (TCM).*	1111F	Discharge medications reconciled with the current medication list in outpatient medical record	.00 or .01

Closing Medication Adherence Gaps

Definition of Adherence: The adherence percentage is calculated as the number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80 percent or higher across the delineated classes of medications during the measurement period (**numerator**) divided by the number of member-years of enrolled beneficiaries 18 years and older with at least two fills of corresponding medication(s) on unique dates of service during the measurement period (**denominator**).

Key Activities To Support Medication Adherence

- When access to a pharmacy is a concern, try mail order or home delivery options offered by the patient's insurance.
- Try at least 90-day supply of medications; many MA plans allow for 100-day fills.
- Encourage patients to work with their pharmacy on medication synchronization to allow all the patient's medications to be filled at the same time of the month.
- Inquire about pill box use; if patient is using ask "how many doses have you missed in the past week?" If the patient is not using a pill box, encourage use to help remember doses.
- Update the prescription with dosing changes to reflect accurate adherence.
- If a patient's chart states they are intolerant to statins, consider a rechallenge with a reduced dose of a different statin.
- For patients who have had muscle pain with a statin, try a more hydrophilic statin such as rosuvastatin or pravastatin. Consider lower or less-frequent dosing and slowly up titrate the dose.
- For patients who prefer red yeast rice, inform them the supplement might contain a chemical that is identical to lovastatin and the FDA has issued warnings about taking this supplement due to lack of standardized preparation.
- When patients are concerned about reports of increased risk of dementia when taking statins, remind them there is no data to support this claim.
- If cost is a concern, use a generic statin. Most generic statins are very low cost, sometimes with a $0 copay.
- When a patient is taking amlodipine, remember the drug interaction with simvastatin and prescribe a statin that does not interact, such as atorvastatin or rosuvastatin.
- If a patient is unable to take a statin due to muscle pain or another contraindication, submit associated diagnosis code at least annually and it might exclude the patient from the measure.
- Refer to the following ADA Standards of Medical Care page S196-199 for pharmacological approaches when cost is a major issue:

  Standards of Care in Diabetes – 2025 Abridged for Primary Care Providers. Clin Diabetes 2025, 48(1). https://doi.org/10.2337/cd25-aint

Medication Adherence Measures (HEDIS+)

Measure	Adherence Measure Description: Members 18 years and older who adhere to their prescribed drug therapy.
Medication Adherence for Cholesterol (Statins)	**Numerator:** The number of members 18 years and older who fill their prescribed statin cholesterol medications often enough to cover 80 percent or more of the time they are supposed to be taking the medication. **Denominator:** The number of members 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period.
Medication Adherence for Diabetes	**Numerator:** The number of members 18 years and older who fill their prescribed diabetes medications (biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase-4 (DPP-4) inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose cotransporter 2 (SGLT-2) inhibitors) often enough to cover 80 percent or more of the time they are supposed to be taking the medication. **Denominator:** The number of members 18 years and older with at least two diabetes medication fills on unique dates of service during the measurement period.
Medication Adherence for Hypertension (RAS antagonists)	**Numerator:** The number of members 18 years and older who fill their renin angiotensin system (RAS) antagonists often enough to cover 80 percent or more of the time they are supposed to be taking the medication. **Denominator:** The number of members 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period.

+**HEDIS®** The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA. The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for internal quality improvement purposes.

Statin Therapy

Measure	Measure Description and Exclusions
Statin Therapy for Patients With Cardiovascular Disease (SPC)	The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
Exclusions:	To exclude patients who cannot tolerate statin medications, a claim MUST be submitted annually using the appropriate ICD-10-CM code. Only the codes listed below will exclude the patient from the SPC measure. These codes are intended to close Star measure gaps and do not apply to payment or reimbursement.

Condition	Exclusion Codes
Myalgia	M79.10-M79.12, M79.18

	Myositis	M60.80, M60.811-M60.819, M60.821-M60.829, M60.831-M60.839, M60.841-M60.849, M60.851-M60.859, M60.861-M60.869, M60.871-M60.879, M60.88-M60.9
	Myopathy	G72.0, G72.2, G72.9
	Rhabdomyolysis	M62.82
	Cirrhosis	K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
	End-stage renal disease (ESRD) or dialysis	N18.5, N18.6, Z99.2

Statin Therapy for Patients With Diabetes (SUPD)

The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one statin medication of any intensity during the measurement year.

Exclusions:

To exclude patients who cannot tolerate statin medications, a claim MUST be submitted annually using the appropriate ICD-10-CM code. Only the codes listed below will exclude the patient from the SUPD measure. These codes are intended to close Star measure gaps and do not apply to payment or reimbursement.

Condition	Exclusion Codes
End-stage renal disease (ESRD)	I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
Cirrhosis	K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69
Polycystic ovarian syndrome	E28.2
Pre-diabetes	R73.03
Other abnormal glucose	R73.09
Myopathy, drug induced*	G72.0
Myopathy, other specified*	G72.89
Myositis, other*	M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879
Myositis, unspecified*	M60.9
Rhabdomyolysis*	M62.82

**The condition the code refers to does not necessarily need to occur in the same year the code was billed. The member's medical chart should reflect something such as "history of," or "treating drug-induced myopathy by not putting patient on a statin."*

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Standards of Care in Diabetes – 2025 Abridged for Primary Care Providers. *Clinical Diabetes*, cd25aint. https://doi.org/10.2337/cd25-aint

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