

★ Medicare Star Program
 Disease-Modifying Anti-Rheumatic Drug
 Therapy for Rheumatoid Arthritis (ART)



Q: Which members are included in the sample?

A: Adults 18 years and older with a diagnosis of rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) in 2016.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: *None.* This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

Q: What documentation is needed in the medical record?

A: Evidence from claim/encounter/pharmacy data

- A date of service for any outpatient visit or a non-acute inpatient discharge with a diagnosis of rheumatoid arthritis, and a prescription for DMARD in 2016

DMARDs:

Description	Prescription
5-Aminosalicylates	• Sulfasalazine
Alkylating agents	• Cyclophosphamide
Aminoquinolines	• Hydroxychloroquine
Anti-rheumatics	• Auranofin • Gold sodium thiomalate • Leflunomide • Methotrexate • Penicillamine
Immunomodulators	• Abatacept • Adalimumab • Anakinra • Certolizumab • Certolizumab pegol • Etanercept • Golimumab • Infliximab • Rituximab • Tocilizumab

★ Medicare Star Program
Disease-Modifying Anti-Rheumatic Drug
Therapy for Rheumatoid Arthritis (ART)



Q: What documentation is needed in the medical record?

Description	Prescription
Immunosuppressive agents	• Azathioprine • Cyclosporine • Mycophenolate
Janus kinase (JAK) inhibitor	• Tofacitinib
Tetracyclines	• Minocycline

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Evidence of a diagnosis of HIV or pregnancy - *documentation will assist in excluding members from the HEDIS sample.*

★ Medicare Star Program
**Disease-Modifying Anti-Rheumatic Drug
 Therapy for Rheumatoid Arthritis (ART)**



SAMPLE CODES

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<http://www.lacare.org/providers/provider-resources/hedis-resources>

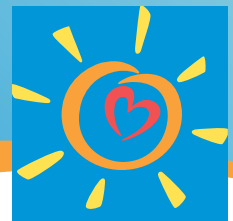
ICD-10 codes	
Refer to Rheumatoid Arthritis Value Set	

CPT codes	
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

HCPCS codes	
Outpatient	G0402, G0438, G0439, G0463, T1015
DMARD	J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310

Exclusion codes	
Refer to HIV Value Set, HIV Type 2 Value Set, Pregnancy Value Set	

★ Medicare Star Program Care for Older Adults (COA)



L.A. Care
HEALTH PLAN®

Q: Which members are included in the sample?

A: Adults 66 years and older who had *each* of the following in **2016**:

- Advance care planning
- Medication review
- Functional status assessment
- Pain assessment

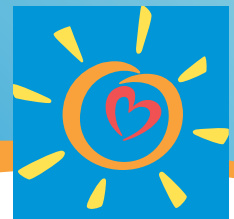
Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A:

- Advanced Care Planning** – evidence must include either the presence of advanced care plan in the medical record *or* documentation of advance care planning discussion with the provider and the date when it was discussed
- Evidence of Medication Review** – must include medication list in the medical record, and evidence of a medication review and the date when it was performed *or* notation that the member is not taking any medication and the date when it was noted
- Evidence of Functional Status Assessment** – documentation must include evidence of functional status assessment *and* the date when it was performed
- Evidence of Pain Assessment** – documentation must include evidence of a pain assessment (may include positive or negative findings for pain) and the date when it was performed



Q: What type of medical record is acceptable?

A:

Advanced Care Planning:

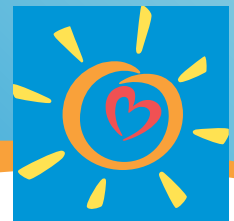
- Advance Directives
- Actionable medical orders
- Copy of Living Wills, Medical Power of Attorney
- Copy of documentation of surrogate decision maker
- Notation of advance care planning discussion with a provider in 2016
- Evidence of oral statements noted in the medical record in 2016

Medication Review:

- Current medication list in 2016
- Notation of medication review in 2016
- Date and notation that the member is not taking any medication in 2016

Functional Status Assessment:

- Progress notes, IHSS forms, HRA forms, AWE form
- Notation that Activities of Daily Living (ADL) were assessed or that at least 5 of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or that at least 4 of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
- Result of assessment using a standardized functional status assessment tool
- Notation of cognitive status, ambulation status, sensory ability (hearing, vision and speech) and, other functional independence (e.g., exercise)



Q: What type of medical record is acceptable?

A: Pain Assessment:

- ☑ Progress notes – notation of a pain assessment (which may include positive or negative findings for pain)
- ☑ Result of assessment using a standardized pain assessment tool
- ☑ Numeric rating scales (verbal or written)
- ☑ Pain Thermometer
- ☑ Pictorial Pain Scales
- ☑ Visual Analogue Scale
- ☑ Brief Pain Inventory
- ☑ Chronic Pain Grade
- ☑ PROMIS Pain Intensity Scale
- ☑ Pain Assessment in Advanced Dementia (PAINAD) Scale

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claims and encounter data
- ☑ Ensure complete and appropriate documentation in medical record
- ☑ Timely submission of AWE Forms that are complete and accurate

★ Medicare Star Program Care for Older Adults (COA)



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ICD-10 Codes

N/A

CPT Codes

Advance Care Planning	99497
Medication Review	90863, 99605, 99606
TCM 14 day	99495
TCM 7 day	99496

CPT II Codes

Pain Assessment	1125E, 1126F
Advance Care Planning	1157E, 1158F
Medication List	1159F
Medication Review	1160F
Functional Status Assessment	1170F

★ Medicare Star Program
Care for Older Adults (COA)



HCPCS codes

Medication List	G8427
Advance Care Planning	S0257

Exclusions codes

N/A

★ Medicare Star Program

Osteoporosis Management in Women Who Had a Fracture (OMW)



Q: Which members are included in the sample?

A: Women 67-85 years of age who suffered a fracture (7/1/2015 - 6/30/2016), and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Q: What codes are used?

A: Please reference attached sample codes and Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: None. This measure requires **claim/encounter data** submission only using the appropriate Value Set Codes.

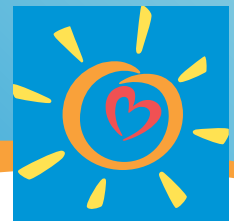
Q: What type of document is acceptable?

- A:** Evidence of claims/encounter data
- BMD (bone mineral density) test, in any setting, on the IESD or in the 180-day (6 month) period after the IESD. If IESD was an inpatient, a BMD test during inpatient stay.
 - Osteoporosis therapy on the IESD or in the 180-day (6 month) period after IESD. If the IESD was an inpatient, long-acting osteoporosis therapy during the inpatient stay.
 - A dispensed prescription to treat osteoporosis on the IESD or in the 180-day (6 month) period after IESD
 - A dispensed prescription to treat osteoporosis
 - Fracture
 - Visit type

Osteoporosis Therapies:

Description	Prescription
Biphosphonates	<ul style="list-style-type: none"> • Alendronate • Alendronate-cholecalciferol • Ibandronate • Risedronate • Zoledronic acid
Other agents	<ul style="list-style-type: none"> • Calcitonin • Denosumab • Raloxifene • Teriparatide

★ Medicare Star Program Osteoporosis Management in Women Who Had a Fracture (OMW)



L.A. Care
HEALTH PLAN®

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ **Required Exclusions:**
 - Members who had a BMD test during the 730 days (24 months) prior to IESD*
 - Members who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to IESD*
 - Member who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to IESD*
 - *IESD: Index Episode Start Date [The earliest date of service for any encounter during the Intake Period (7/1/15 – 6/30/16) with a diagnosis of fracture]

Note: *Fractures of finger, toe, face and skull are not included.*

★ Medicare Star Program
**Osteoporosis Management in
 Women Who Had a Fracture (OMW)**



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ICD-10 codes

Refer to Fractures Value Set

CPT codes

Bone Mineral Density Tests	76977, 77078, 77080, 77081, 77082, 77085
Fractures	Refer to Fractures Value Set
Observation	99217-99220
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
ED	99281-99285

HCPCS codes

Bone Mineral Density Test	G0130
Fractures	S2360
Long-Acting Osteoporosis Medications	J0897, J1740, J3487-J3489, Q2051

★ Medicare Star Program
Osteoporosis Management in
Women Who Had a Fracture (OMW)



L.A. Care
HEALTH PLAN®

HCPCS codes

Osteoporosis Medications	J0630, J0897, J1740, J3110, J3487-J3489, Q2051,
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes

Refer to Bone Mineral Density Tests Value Set, Osteoporosis Medications Value Set