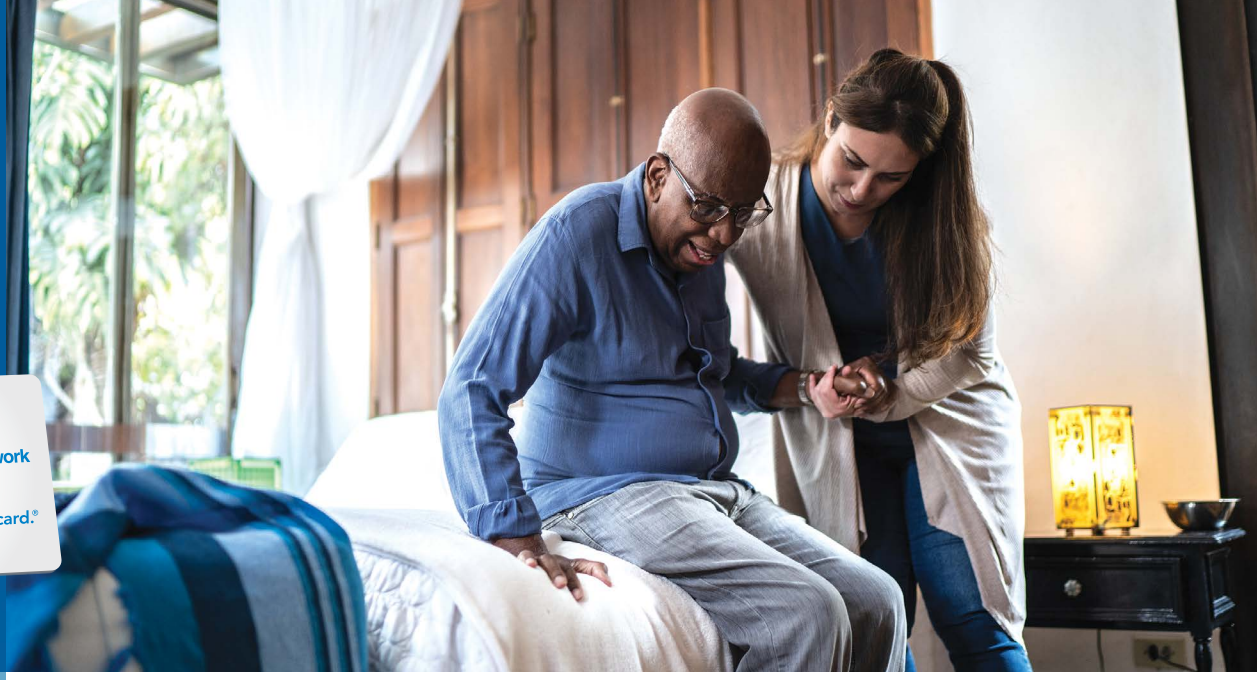
2026 Star Measure Tips



One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

HEDIS® Advanced Illness and Frailty Guide

The National Committee for Quality Assurance (NCQA) allows additional exclusions to Healthcare Effectiveness Data and Information Set (HEDIS®) Star measures for patients with advanced illness and frailty.

- Services measured by NCQA may not benefit older adults with limited life expectancy and advanced illness.
- Unnecessary tests or treatments could burden these patients or even be harmful.
- NCQA encourages practitioners to focus on appropriate care for their patients.

This guide includes:

- Measure specific exclusionary criteria according to age group
- Billing codes and definitions for advanced illness and frailty exclusions
- Dementia medications

Tips for coding

- Appropriate billing and coding can substantially reduce medical record requests for HEDIS® data collection purposes.
- Advanced illness and frailty must be documented in the medical record and billed with the appropriate exclusion codes.
- Virtual care visits are acceptable when used to exclude a patient.
- Appropriate coding must be billed to meet exclusion criteria:
  - **Advanced illness:**
    - At least two different dates of service with an advanced illness diagnosis during the **measurement year or the year prior**

    Or
    - A dispensed dementia medication during the **measurement year or the year prior**
  - **Frailty:**
    - At least two indications of frailty with different dates of service during the **measurement year**

Note: Exception for OMW - both indications of frailty can occur from July 1 of the year prior through December 31 of the measurement year.

continued

Star Measure exclusion criteria	Applicable HEDIS® Star Measure
66 years and older with **both** advanced illness and frailty	• Breast Cancer Screening (BCS-E) • Colorectal Cancer Screening (COL-E) • Eye Exam for Patients with Diabetes (EED) • Glycemic Status Assessment for Patients With Diabetes (GSD) • Statin Therapy for Patients with Cardiovascular Disease (SPC-E)
66-80 years old with **both** advanced illness and frailty	• Controlling High Blood Pressure (CBP) • Kidney Health Evaluation for Patients with Diabetes (KED)
67-80 years old with **both** advanced illness and frailty	• Osteoporosis Management in Women Who Had a Fracture (OMW)
81 years and older with frailty alone	• Controlling High Blood Pressure (CBP) • Kidney Health Evaluation for Patients with Diabetes (KED) • Osteoporosis Management in Women Who Had a Fracture (OMW)

Advanced illness	
ICD-10-CM code	**Definition**
A81.00-01, A81.09	Creutzfeldt-Jakob disease
C25.0-4, C25.7-9	Malignant neoplasm of pancreas
C71.0-9	Malignant neoplasm of brain
C77.0-5, C77.8-9	Secondary and unspecified malignant neoplasm of lymph nodes
C78.00-02	Secondary malignant neoplasm of lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.2	Secondary malignant neoplasm of pleura
C78.30, C78.39	Secondary malignant neoplasm of unspecified or other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80, C78.89	Secondary malignant neoplasm of unspecified or other digestive organs
C79.00-02	Secondary malignant neoplasm of kidney and renal pelvis
C79.10-11, C79.19	Secondary malignant neoplasm of bladder and other urinary organs
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40, C79.49	Secondary malignant neoplasm of unspecified or other parts of nervous system
C79.51-52	Secondary malignant neoplasm of bone or bone marrow
C79.60-63	Secondary malignant neoplasm of ovary

continued

Advanced illness	
ICD-10-CM code	**Definition**
C79.70-72	Secondary malignant neoplasm of adrenal gland
C79.81-82	Secondary malignant neoplasm of breast or genital organs
C79.89, C79.9	Secondary malignant neoplasm of unspecified or other sites
C91.00, C92.00, C93.00, C93.90, C93.Z0, C94.30	Leukemia not having achieved remission
C91.02, C92.02, C93.02, C93.92, C93.Z2, C94.32	Leukemia in relapse
F01.50, F01.511, F01.518, F01.52-F01.54, F01.A0. F01.A11, F01.A18, F01.A2-F01.A4, F01.B0, F01.B11, FO1.B18, F01.B2-F01.B4, F01.C0, F01.C11, F01. C18, F01.C2-F01.C4, F02.80, FO2.811, FO2.818, F02.82-FO2.84, F02.A0, FO2.A11, F02.A18, F02. A2-F02.A4, F02.B0, F02.B11, F02.B18, F02.B2-F02. B4, F02.C0, F02.C11, F02.C18, F02.C2-FO2.C4, F03.90-F03.911, F03.918, F03.92-F03.94, F03.A0, F03.A11, F03.A18, F03.A2-FO3.A4, F03.B0, F03. B11, F03.B18, F03.B2-F03.B4, F03.C0, F03.C11, F03.C18, F03.C2-F03.C4, F10.27, F10.97	Dementia
F04	Amnestic disorder due to known physiological condition
F10.96	Alcohol-induced persisting amnestic disorder
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20.A1, G20.A2, G20.B1, G20.B2, G20.C	Parkinson's disease
G31.01, G31.09, G31.83	Degenerative diseases of the nervous system
G35	Multiple sclerosis
I09.81, I11.0, I13.0, I13.2, I50.1, I50.20-23, I50.30-33, I50.40-43, I50.810-814, I50.82-84, I50.89, I50.9	Heart failure
I12.0, I13.11, I13.2, N18.5, N18.6	Chronic kidney disease, stage 5
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes, and vapers
J84.10, J84.112, J84.170, J84.178	Pulmonary fibrosis
J96.10-12, J96.20-22, J96.90-92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.00-02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
N18.5, N18.6	End stage renal disease

Dementia medications	
Description	**Prescription**
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

continued

Frailty	
CPT® code*	**Definition**
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care

Frailty	
HCPCS code	**Definition**
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147-9	Walker
E0163, E0165, E0167, E0168, E0170, E0171	Commode chair
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-7, E0301-4	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-2	Respiratory assist device
E1130, E1140, E1150, E1160, E1161, E1170, E1171, E1172, E1180, E1190, E1195, E1200, E1220, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-8	Wheelchair
G0162, G0299, G0300, G0493, G0494	Skilled RN/LPN services related to home health/hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124, T1000-5, T1019-22, T1030, T1031	Nursing, respite care and personal care services

Frailty	
ICD-10-CM code	**Definition**
L89.000 - L89.96	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified state
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.2	Difficultly in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R53.1	Weakness
R53.81	Other malaise
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia

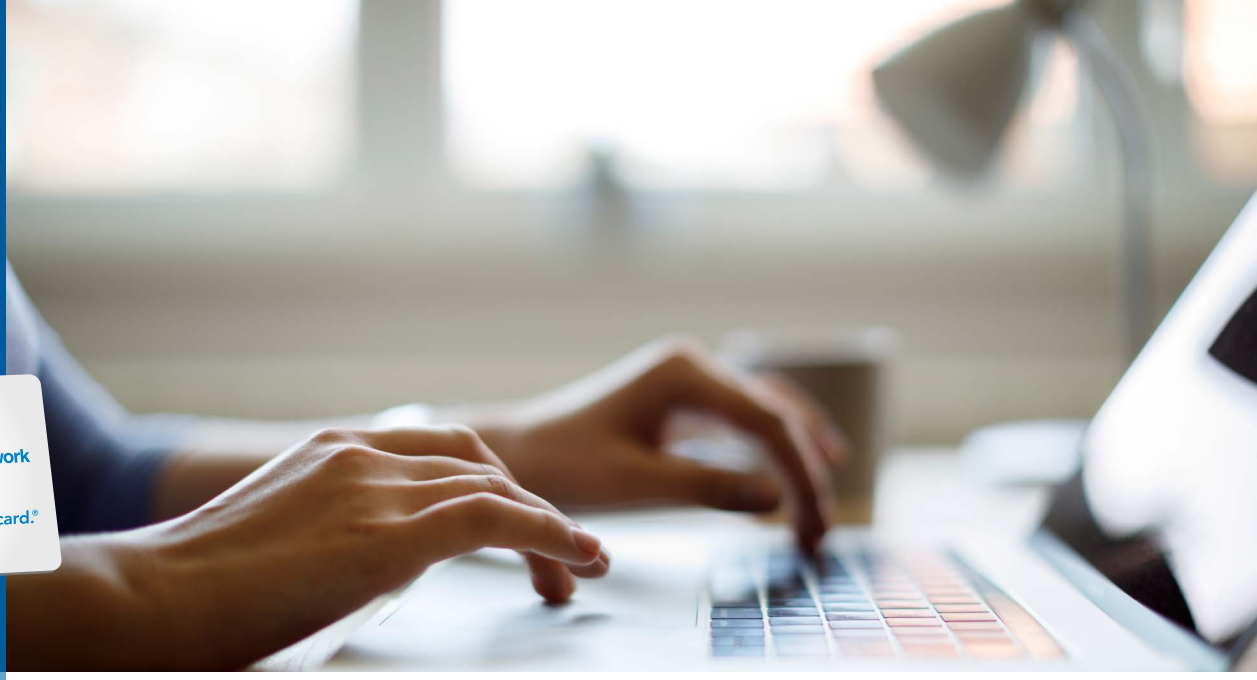
continued

Frailty	
ICD-10-CM code	**Definition**
R29.6, W01.0XXA-W01.198S, W06.XXXA-W06.XXXS, W07.XXXA-W07.XXXS, W08.XXXA-W08.XXXS, W10.0XXA-W10.9XXS, W18.00XA-W18.39XS, W19.XXXA-W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator (ventilator) status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

Resources

1. National Committee for Quality Assurance (NCQA). 2018. "Improving care for those with advanced illness and frailty." **www.ncqa.org/blog/improving-care-advanced-illness-frailty/**

2026 Star Coding Tips



One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Coding for Star Measures: ICD-10-CM, CPT®, CPT®II, and HCPCS

This tip sheet includes commonly used codes for the listed Healthcare Effectiveness Data and Information Set (HEDIS®) Star measures.

ICD-10-CM	Diagnostic codes (International Classification of Diseases)
CPT®	Service and procedure codes (Current Procedural Terminology)
CPT® II	Supplemental tracking codes used for performance measurement
HCPCS	Items/services provided with healthcare delivery (Healthcare Common Procedure Coding System)

Submitting codes on claims can:

- Substantially reduce medical record requests for HEDIS® data collection purposes.
- Significantly decrease administrative burdens on practitioners and staff.
- Exclude patients who are exempt from certain measures.

Refer to the individual measure Star Tip Sheet(s) for additional detail

Includes measure definitions, additional exclusions, gap closure tips and more.

Note: *Patients are excluded from many measures if they are deceased or receiving hospice or palliative care services anytime during the measurement year.*

Medical record documentation requirements

- All diagnoses, services and treatments must be appropriately documented to support medical coding on claims.
- Some measures can be patient reported or met with virtual care.
- Thoroughly review medical record for evidence of services provided elsewhere (i.e., specialist notes, consults, urgent care).

continued

Prevention and Screening

BCS-E	Breast Cancer Screening	ICD-10-CM	Exclusions
	– Exclude if the patient has a history of **both** left and right mastectomies, bilateral mastectomy, or gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria.	**Z90.11**	Acquired absence of right breast/nipple
		Z90.12	Acquired absence of left breast/nipple
		Z90.13	Acquired absence of bilateral breasts/nipples
		*** 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**	Gender identity disorder, unspecified
COL-E	**Colorectal Cancer Screening**	**ICD-10-CM**	**Exclusions**
	– Exclude if the patient has a history of colorectal cancer.	**C18.0**	Malignant neoplasm of the cecum
		C18.1	Malignant neoplasm of appendix
		C18.2	Malignant neoplasm of ascending colon
		C18.3	Malignant neoplasm of hepatic flexure
		C18.4	Malignant neoplasm of the transverse colon
		C18.5	Malignant neoplasm of the splenic flexure
		C18.6	Malignant neoplasm of descending colon
		C18.7	Malignant neoplasm of sigmoid colon
		C18.8	Malignant neoplasm of overlapping sites of colon
		C18.9	Unspecified malignant neoplasm of the colon
		C19	Malignant neoplasm of the rectosigmoid junction
		C20	Malignant neoplasm of the rectum
		C21.2	Malignant neoplasm of the cloacogenic zone
		C21.8	Malignant neoplasm: Overlapping lesion of rectum, anus, and anal canal
		C78.5	Secondary malignant neoplasm
		Z85.038	Personal history of other malignant neoplasm of large intestine
		Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus
CBP	**Controlling High Blood Pressure**	**CPT® II**	**Most Recent BP Reading**
	– HEDIS compliance ≤ 139/89 – Submit blood pressure CPT® II codes for each office visit claim. – The last blood pressure of the year is used to determine compliance. – Submit the results on a $0.01 claim with one of the codes as appropriate.	**3074F**	<130 mm Hg — **Systolic** Blood Pressure
		3075F	130- 139 mm Hg — **Systolic** Blood Pressure
		3077F	≥ 140 mm Hg — **Systolic** Blood Pressure
		3078F	<80 mm Hg — **Diastolic** Blood Pressure
		3079F	80- 89 mm Hg — **Diastolic** Blood Pressure
		3080F	≥ 90 mm Hg — **Diastolic** Blood Pressure

continued

Diabetes Measures

GSD	Glycemic Status Assessment	CPT® II	Most recent HbA1c level
	– Star Reporting: HbA1c ≤ 9% – The last HbA1c of the year is used to determine compliance. – Ensure the HbA1c result is reported with the appropriate code on a $0.01 claim.	**3044F**	< 7%
		3046F	>9%
		3051F	≥ 7% and < 8%
		3052F	≥ 8% and ≤ 9%
EED	**Retinal Eye Exam**	**CPT® II**	**Evidence of date, result & eye care provider**
	– When reports are received from an eye care professional review and document results. – Submit the results on a $0.01 claim with one of the codes as appropriate. – When submitting CPT codes 92227, 92228, or 92229 for services, include CPT II codes 2022F or 2023F in addition.	**2022F**	Retinal eye exam **WITH** evidence of retinopathy (compliant for 1 year)
		2023F	Retinal eye exam **WITHOUT** evidence of retinopathy (compliant for 2 years)
		CPT®	**Procedure**
		92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral
		92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral
		92229	Retinal imaging interpreted by artificial intelligence (AI)
KED	**Kidney Health Evaluation**	**CPT®**	**Lab tests**
	– Ensure all 3 CPT codes are submitted to close the measure. (eGFR, uALB, uCREAT) – Labs must be completed annually	**80047 80053 80048 80069 80050 82565**	Estimated Glomerular Filtration Rate (eGFR)
		82043	Quantitative Urine Albumin Test (uALB)
		82570	Urine Creatinine Lab Test (uCREAT)

continued

Statin Therapy and Use

SPC-E	Statin Therapy for Patients with Cardiovascular Disease	ICD-10-CM	Exclusions
	Codes apply to both SPC-E/ SPD-E – Compliance can only be met through a pharmacy claim. – Document exclusion conditions in the medical record and submit the appropriate ICD-10-CM code on claims and bill **annually**. – **Only the codes listed** will exclude the patient from the SPC-E measure.	**M79.10–M79.12** **M79.18**	Myalgia
		M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88-M60.9	Myositis
		G72.0 **G72.2** **G72.9**	Myopathy
		M62.82	Rhabdomyolysis
		K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81	Cirrhosis
		N18.5 **N18.6**	End-stage renal disease (ESRD)
		Numerous (<1,000)	Pregnancy
		CPT® / HCPCS	**Exclusions**
		90935, 90937, 90945, 90947, 90997, 90999, 99512, G0257, S9339	Renal dialysis
		S4015, S4016, S4018, S4020, S4021	In vitro fertilization (IVF)
		SNOMED	**Exclusions**
		787206005 16462851000119106 16524291000119105 16524331000119104	Rhabdomyolysis due to statin Myalgia caused by statin History of myalgia caused by statin History of rhabdomyolysis due to statin

SUPD	Statin Use in Persons with Diabetes	ICD-10-CM	Exclusions
	– Compliance can only be met through a **pharmacy claim**. – Document exclusion conditions in the medical record and submit the appropriate ICD-10-CM code on claims and bill **annually**. – Only the codes listed will exclude the patient from the SUPD measure. **Note:** This is a Pharmacy Quality Alliance measure.	**I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2**	End stage renal disease (ESRD)
		M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9	Myositis*
		G72.0 **G72.89** **G72.9**	Myopathy*
		M62.82	Rhabdomyolysis*
		R73.03	Pre-diabetes
		R73.09	Other abnormal blood glucose
		E28.2	Polycystic Ovarian Syndrome
		Numerous (> 1,000)	Pregnancy and/or Lactation
		K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69	Cirrhosis

**The condition does not need to occur in the same year the code was billed. The patient's medical chart should reflect 'history of.'*

continued

Care Coordination

TRC MRP	Transitions of Care Med Reconciliation Post Discharge	CPT® II	Description
	– **Bill 1111F as soon as medication reconciliation is completed.** It is not necessary to wait for all components of TCM to be met. **See FAQs for applicable reimbursement amounts.* – Patient engagement and medication reconciliation post-discharge must be done within 30 days of inpatient discharge. – Post discharge follow up can be a virtual or face-to-face visit. **Note:** Although care planning/ management services include med reconciliation, there are no coding restrictions for billing both a TCM code and the 1111F for the same patient's discharge.	**1111F**	Discharge medications are reconciled with the most recent medication list in the outpatient medical record • Can be virtual care or in person visit within **31 days** (includes day of discharge)
		CPT®	**Description**
		99483	**Care planning services:** patients with cognitive impairment (including Alzheimer's) • Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk meds
		99495	**Transitional care management requiring:** • Communication within **2 business days** of discharge with patient/caregiver (virtual care or in person) • Face-to-face visit within **14 days** of discharge, decision making of at least **moderate** complexity
		99496	**Transitional care management requiring:** • Communication within **2 business days** of discharge with patient/caregiver (virtual care or in person) • Face-to-face visit within **7 days** of discharge, decision making of at least **high** complexity
		99605	• Medication therapy management services provided by a pharmacist during an initial 15-minute face-to-face encounter
		99606	• Medication therapy management services provided by a pharmacist, during an established face-to-face encounter

MWV	Medicare Wellness Visit	HCPCS	Description
	Custom Measure – This measure can only be met through the appropriate HCPCS codes as listed. – Wellness visits can be anytime throughout a calendar year, regardless of the date of the previous year's visit. **Note:** this applies to MA PPO and BCNA. Be sure to check patient eligibility and benefits in the provider portal (availity.com*) to verify coverage. – Virtual care is acceptable for AWV only. Billing an E/M code along with G0438 or G0439 would require audio and video and should be reported with modifier 25. **Note:** Billing a routine physical alone will **NOT** close this measure.	**G0402**	**Initial Preventive Physical examination (IPPE).** Also known as Welcome to Medicare. • Face-to-face visit • Services limited to new beneficiary during the first 12 months of Medicare enrollment
		G0438	**Initial annual wellness visit (AWV)** includes Personalized Prevention Plan Services (PPPS). • Performed after 12 months of Medicare enrollment
		G0439	**Subsequent annual wellness visit (AWV)** includes Personalized Prevention Plan Services (PPPS)
		G0468	When the AWV/IPPE Visit is performed at a federally qualified health center, bill G0468 with a qualifying visit code (G0402, G0438 or G0439)

continued

Advanced Illness and Frailty Exclusions

The National Committee for Quality Assurance (NCQA) allows additional exclusions to HEDIS® Star measures for patients with advanced illness and frailty.

Advanced illness codes include:

- **At least two different dates of service** with advanced illness diagnosis (virtual or face-to-face) within the **measurement year or the year prior**. Conditions (e.g., metastatic cancer, heart failure, late-stage kidney disease)

OR

- A dementia medication dispensed within the **measurement year or the year prior**.

Frailty codes include:

- At least two indications of frailty (e.g., diagnosis, symptom, device, encounter) with different dates of service (virtual or face-to-face)
  Equipment typically submitted on claims (e.g., hospital beds, wheelchairs, oxygen devices)
  Other frailties often missed (e.g., cane, walker, oxygen, weakness, falls).
- Both indications of frailty must be billed within the **current measurement year only**.

Note: Exception for OMW - both indications of frailty can occur from July 1 of the year prior through December 31 of the measurement year.

This table lists the Star measures impacted by advanced illness and frailty exclusions depending on age.

AIF	Ages	Criteria	Excluded from Measure(s)
Advanced Illness and Frailty	66 years and older	**BOTH** advanced illness and frailty	• Breast Cancer Screening (BCS-E) • Colorectal Cancer Screening (COL-E) • Eye Exam for Patients with Diabetes (EED) • Glycemic Status Assessment for Diabetes (GSD) • Statin Therapy for Patients with Cardiovascular Disease (SPC-E)
	66 to 80 years old	**BOTH** advanced illness and frailty	• Controlling High Blood Pressure (CBP) • Kidney Health Evaluation for Patients with Diabetes (KED)
	67 to 80 years old	**BOTH** advanced illness and frailty	• Osteoporosis Management in Women Who Had a Fracture (OMW)
	81 years and older	Frailty **ONLY**	• Controlling High Blood Pressure (CBP) • Kidney Health Evaluation for Patients with Diabetes (KED) • Osteoporosis Management in Women Who Had a Fracture (OMW)

**For more Information about the advanced illness and frailty exclusions and coding, refer to the Advanced Illness and Frailty Exclusions Guide.*

Resources

1. BCBSM. 2025. "2025 Quality Success Series - CPT® Category II Codes."*
***Unable to provide link to NPI series. Path: Availity/Provider Secured Services/Member Care/Clinical Quality/Clinical Quality Overview*

Blue Cross Blue Shield Blue Care Network of Michigan

Telehealth Summary – 2026 HEDIS® Measures

Topic	Virtual Care Overview
Virtual Care Definition (Telehealth)	1. **Synchronous** telehealth requires real-time interactive audio and video telecommunications. See relevant outpatient and telehealth CPT codes as indicated below. A measure specification will indicate when synchronous telehealth is not eligible for use and should be excluded. 2. **Asynchronous** telehealth sometimes referred to as an online assessment, e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the patient and practitioner. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email. 3. **Telephone:** When the measure indicates a telephone call (real-time interactive), a telephone call is acceptable.
Documentation Requirements	For all virtual care visits, the documentation in the office note must include specific information relative to each HEDIS®/Star/pharmacy measure as well as: • Type of contact (visual, audio, email, portal etc.) • Type of video service (HIPAA compliant platform) • Location of patient and practitioner during the virtual care • Patient informed consent documented (understands and accepts the privacy and security risks of virtual medicine) Even if gaps cannot be directly closed via virtual care, preventive services and exclusions may be discussed, documented, and coded. Orders for labs and procedures may be written and mailed or faxed to support patient gap closure. Prescriptions must be e-prescribed as of January 1, 2023 (all controlled and noncontrolled medications).
Patient Reported Services and Biometric Values	Patient-reported services, exclusions, and biometric values (blood pressure, height, weight, BMI percentile) are acceptable. The information is collected by a practitioner or specialist during a primary care service or while taking a patient's history. To close gaps using patient-reported or biometric data, values must be clearly documented and dated in the medical record. Data can be submitted through approved EMR supplemental data exchange, Health e-Blue (HeB) where applicable, or a claim billed with the appropriate ICD-10-CM, CPT®, CPT®II, or HCPCS codes.
Codes for Telehealth (Virtual Care)	Outpatient and Telehealth (new patient): 98000-98003; Outpatient and Telehealth (established patient): 98004-98007 Telephone visits: 98008-98011 (new patients), 98012-98015 (established patients), 98966-98968 and 99441-99443 Online Assessments: 98016, 98970-98972, 98980, 98981, 99421-99423, 99457, 99458, G0071, G2010, G2012, G2250-G2252 Be sure to consult the Medicare Telehealth Services List. ***Note:*** *codes submitted must be supported by the documentation in the medical record.*
Advanced Illness & Frailty**	*Synchronous, asynchronous, and telephone visit(s) are acceptable to exclude a patient through advanced illness and frailty. The exclusions must be documented and coded properly.* *Measure specific age ranges apply. Other components of the specification must be met and documented:* • **Advanced illness** diagnoses must be billed on at least two different dates of service in the prior year and/or measurement year. • **Frailty** diagnoses must be billed on at least two different dates of service in the measurement year. – Exception for OMW: both indications of frailty can occur from July 1 of the year prior through December 31 of the measurement year. ***Note:*** *for additional definition information, see the Advanced Illness and Frailty Guide* *** All measures this applies to are indicated with a double asterisk under the measure name.*

Blue Cross Blue Shield Blue Care Network of Michigan

Telehealth Summary – 2026 HEDIS® Measures

Measure	Product	Virtual Care Opportunities (*also see Virtual Care Overview on page 1*)
PREVENTION & SCREENING		
Breast Cancer Screening (BCS-E)**	Medicare ★ Commercial	• Virtual care visit(s) can be used to document the service and/or exclusions. • Patient reported mammograms can be closed in HeB when they are clearly documented in the medical record. • Mammograms can be ordered/discussed. The service must be completed to close the gap. • Document and code bilateral or left/right unilateral mastectomies to exclude from the measure.
Colorectal Cancer Screening (COL-E)**	Medicare ★ Commercial	• Virtual care visit(s) can be used to document the service and/or exclusions. • Patient reported previous screenings (e.g., colonoscopy) can be closed in HeB when they are clearly documented in the medical record. • Preventive screenings can be ordered/discussed, or in-home test kit sent (FIT or Cologuard). • Document and code colorectal cancer or total colectomy to exclude from the measure.
CARDIOVASCULAR		
Controlling High Blood Pressure (CBP)**	Medicare ★ Commercial	• Virtual care visit(s) are acceptable for hypertension diagnosis and patient reported blood pressure. • Patient reported BP readings are acceptable if it is taken with a digital (or unknown) device, dated, and documented in the medical record as a distinct value. – The actual digital reading does not need to be seen; the patient can verbally report. • Compliance with appropriate documentation can be met through coding, HeB or approved EMR supplemental data exchange.
Statin Therapy for Patients with Cardiovascular Disease (SPC-E)**	Medicare ★ Commercial	• Virtual care visit(s) can be used to document exclusions and prescribe statins. • The prescription must be filled using their pharmacy benefit. • Gap closure is dependent on pharmacy claims (discount programs, cash claims, VA benefits, and medication samples would not count). • Document and code statin intolerance annually to exclude from the measure.
Persistence of Beta-Blocker Treatment after Heart Attack (PBH)**	Medicare Commercial	• Virtual care visit(s) can be used to document exclusions or prescribe medications. • The prescription must be filled using their pharmacy benefit. • Gap closure is dependent on pharmacy claims (discount programs, cash claims, VA benefits, and medication samples would not count).

***See Advanced Illness & Frailty on page 1*

★ *indicates a Medicare Star Measure*

Review **Clinical Quality Tip Sheet(s)** *for measure specifics and coding guidelines.*

Blue Cross Blue Shield Blue Care Network of Michigan

Telehealth Summary – 2026 HEDIS® Measures

Measure	Product	Virtual Care Opportunities (*also see Virtual Care Overview on page 1*)
DIABETES		
Glycemic Status Assessment for Patients With Diabetes (GSD)**	Medicare ★ Commercial	• Virtual care visits can be used to document exclusions, order HbA1c / GMI tests, or obtain results. • In-home A1c tests must be processed through a lab. Patient purchased drugstore kits would not be acceptable. • Patient reported HbA1c and GMI results are acceptable with the following documentation: – HbA1c: Lab Date + Value – GMI: Continuous glucose monitoring date range + Value • HbA1c compliance with appropriate documentation can be met through coding, HeB, or approved EMR supplemental data exchange. GMI compliance cannot be reported through claim submission or HeB.
Eye Exam for Patients with Diabetes (EED)**	Medicare ★ Commercial	• Virtual care visit(s) can be used to document the service and exclusions. • Patient reported dilated or retinal eye exam with documented date, result, and eye care professional and credentials is acceptable. • Compliance with appropriate documentation can be met through coding, HeB or approved EMR supplemental data exchange.
Statin Therapy for Patients with Diabetes (SPD-E)**	Medicare Commercial	• Virtual care visit(s) can be used to document exclusions and prescribe statins. • The prescription must be filled using their pharmacy benefit. • Gap closure is dependent on pharmacy claims (discount programs, cash claims, VA benefits, and medication samples would not count). • Document and code statin intolerance annually to exclude from the measure.
Kidney Health Evaluation for Patients with Diabetes (KED)**	Medicare ★ Commercial	• Virtual care visits can be used to document exclusions and order labs. • **Three tests / three codes** are required: – Estimated Glomerular Filtration Rate (eGFR) – urine Albumin – urine Creatinine • Compliance can only be met through claims and approved EMR supplemental data exchange. • When ordering the urine test, be sure that the albumin and creatinine values are being measured, reported, and both codes are being billed.
MUSCULOSKELETAL		
Osteoporosis Management in Women who had a Fracture (OMW)**	Medicare ★	• Virtual care visit(s) can be used to document the diagnosis, exclusions, order BMD testing, or prescribe medications. • When osteoporosis medication therapy is prescribed, gap closure is dependent on pharmacy claims (discount programs, cash claims, VA benefits, and medication samples would not count).

***See Advanced Illness & Frailty on page 1*

★ *indicates a Medicare Star Measure*

Review **Clinical Quality Tip Sheet(s)** *for measure specifics and coding guidelines.*

Blue Cross Blue Shield Blue Care Network of Michigan

Telehealth Summary – 2026 HEDIS® Measures

Measure	Product	Virtual Care Opportunities (*also see Virtual Care Overview on page 1*)
MEDICATION MANAGEMENT & CARE COORDINATION		
Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Medicare ★	• Virtual care visit(s) can be used to document exclusions and the 7-day follow-up service. • Document and code all identified chronic conditions/diagnoses. • Compliance with appropriate documentation can be met through coding or approved EMR supplemental data exchange.
Transitions of Care – Patient Engagement after Inpatient Discharge (TRC-PE)	Medicare ★	• Virtual care visit(s) (audio/video) are acceptable for patient engagement on the day **after** discharge through 30 days post discharge. • Compliance with appropriate documentation can be met through coding or approved EMR supplemental data exchange.
Transitions of Care – Medication Reconciliation Post-Discharge (TRC-M)	Medicare ★	• Virtual care visit(s) are acceptable for medication reconciliation on the date of discharge through 30 days after (31 days total). • **Bill 1111F** as soon as medication reconciliation is completed. Do not wait for all TCM or care planning components to be met.
BEHAVIORAL HEALTH		
Diagnosed Mental Health Disorders (DMH)	Medicare Commercial	• Virtual care visit(s) can be used to report mental health diagnoses.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Medicare Commercial	• Virtual care visit(s) are acceptable for follow up purposes.
Follow-Up After Hosp for Mental Illness (FUH)	Medicare Commercial	• **Only synchronous** visits (real-time audio or visual) are acceptable for follow up.
Follow up Care for Children prescribed ADHD medication (ADD-E)	Commercial	• **Initiation phase:** Only synchronous visits (real-time audio or visual) are acceptable. • **Continuation and maintenance phase:** Virtual care visits are acceptable but only one of the two visits can be asynchronous.

***See Advanced Illness & Frailty on page 1*

★ *indicates a Medicare Star Measure*

Review **Clinical Quality Tip Sheet(s)** *for measure specifics and coding guidelines.*

Blue Cross Blue Shield Blue Care Network of Michigan

Telehealth Summary – 2026 HEDIS® Measures

Measure	Product	Virtual Care Opportunities (*also see Virtual Care Overview on page 1*)
PEDIATRIC		
Use of First-Line Psychosocial Care for Children/Adolescents on Antipsychotics (APP)	Commercial	• Virtual care visit(s) can be used to document services and exclusions.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	Commercial	• Virtual care visit(s) can be used to document and meet the required components below: – BMI Percentile – Counseling for Nutrition – Counseling for Physical Activity • Patient/Parent reported biometric values (height, weight, BMI %) are acceptable if documented. – Calculate BMI percentile according to patient's age and gender. • Compliance with appropriate documentation can be met through coding, HeB or approved EMR supplemental data exchange.
ACCESS/AVAILABILITY OF CARE		
Prenatal and Postpartum Care (PPC)	Commercial	• Virtual care visit(s) can be used to document the prenatal and postpartum components. • Compliance with appropriate documentation can be met through coding or approved EMR supplemental data exchange.

***See Advanced Illness & Frailty on page 1*

indicates a Medicare Star Measure

Review **Clinical Quality Tip Sheet(s)** *for measure specifics and coding guidelines.*

Blue Cross Blue Shield Blue Care Network of Michigan

Telehealth Summary – 2026 HEDIS® Measures

Measure	Product	Virtual Care Opportunities (*also see Virtual Care Overview on page 1*)
PHARMACY MEASURES		
Medication Adherence **Medication Adh – Diabetes** **Medication Adh – Cholesterol** **Medication Adh – HTN**	Medicare ★ Commercial	• Virtual care visit(s) can be used to document exclusions and prescribe medications. • The prescription must be filled using their pharmacy benefit. • Gap closure is dependent on pharmacy claims (discount programs, cash claims, VA benefits, and medication samples would not count).
Statin Use in Persons with Diabetes (SUPD)	Medicare ★	• Virtual care visit(s) can be used to document exclusions and prescribe medications. • The prescription must be filled using their pharmacy benefit. • Gap closure is dependent on pharmacy claims (discount programs, cash claims, VA benefits, and medication samples would not count). • Document and code statin intolerance annually to exclude from the measure.
CUSTOM MEASURE		
Medicare Wellness Visit (MWV)	Medicare	• The **Initial Preventative Physical Exam (IPPE)** must be an in-person visit. Virtual care visits are not acceptable. • The **Annual Wellness Visit (AWV)**, which includes **Personalized Prevention Plan Services (PPPS)**, can be completed using virtual care visit(s). • Compliance with appropriate documentation can be met through coding or approved EMR supplemental data exchange. ***Note:*** *When AWV are completed virtually with an E/M code, both video and audio are required.*

***See Advanced Illness & Frailty on page 1*

★ *indicates a Medicare Star Measure*

Review **Clinical Quality Tip Sheet(s)** *for measure specifics and coding guidelines.*

Blue Cross Blue Shield Blue Care Network of Michigan

Telehealth Summary – 2026 HEDIS® Measures

BCBSM resources available:

- Star tip sheets highlight key measures in the Medicare Star Ratings program
- HEDIS® tip sheets highlight key healthcare performance measures
- Custom measure tip sheets
- Advanced Illness and Frailty Guide
- Network Performance Improvement (NPI) presentations
- Pharmacy tips
- HEDIS and Star measure eLearning overview

https://bcbsmiproviders.pinpointglobal.com/Portal/Login

If you don't already have access to the provider training website, follow these steps:

- Open the registration page: **https://bcbsmiproviders.pinpointglobal.com/portal/users/register**
- Complete the registration. We recommend using the same email you use to communicate with Blue Cross for provider-related needs. This will become your login ID.

If you need assistance creating your login ID or navigating the site, contact **ProviderTraining@bcbsm.com**.

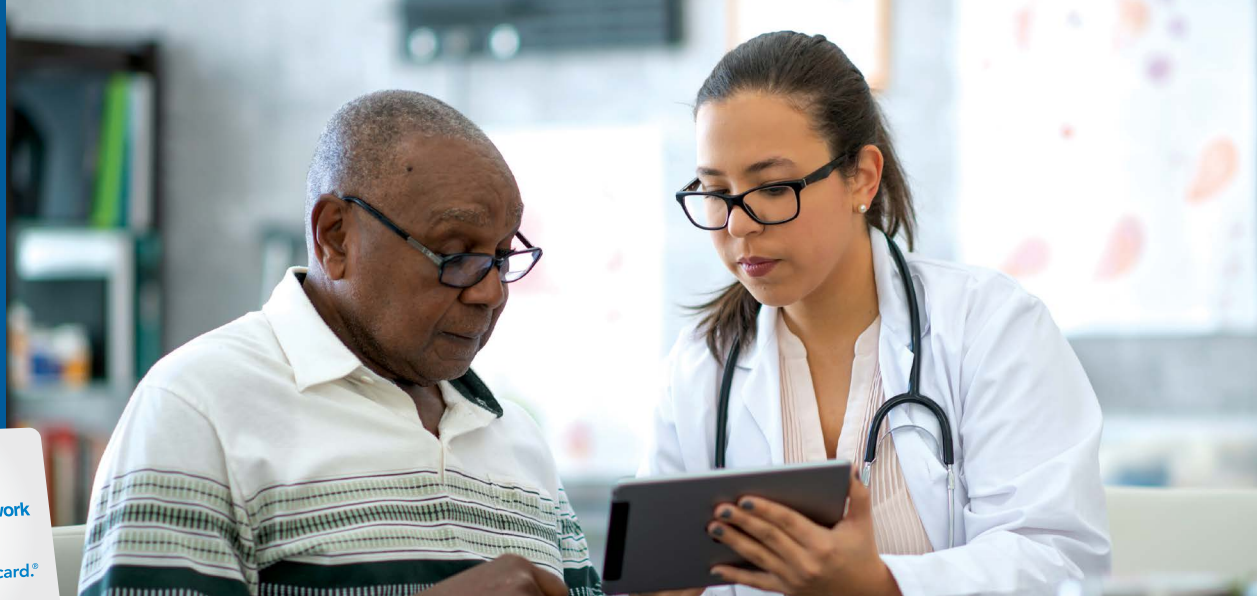
Here's how to find them:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the Availity menu bar.
3. Click the BCBSM and BCN logo.
4. Click *Secure Provider Resources (Blue Cross and BCN)* on the Resources tab.
5. Click *Clinical Quality* on the Member Care tab and choose a topic from the dropdown.
   - Clinical Quality Overview
   - Tip Sheets
   - Pharmacy Clinical Resources

Additional Resources:

1. National Committee for Quality Assurance (NCQA). 2020. "Taskforce on Telehealth Policy (TTP) Findings and Recommendations." **ncqa.org/wp-content/uploads/2020/09/20200914_Taskforce_on_Telehealth_Policy_Final_Report.pdf**
2. Centers for Medicare and Medicaid Services (CMS). 2024. "TELEHEALTH FOR PROVIDERS: WHAT YOU NEED TO KNOW." **cms.gov/files/document/telehealth-toolkit-providers.pdf**
3. American Medical Association (AMA). 2024. "Telehealth resource center: Guides & reports." **ama-assn.org/practice-management/digital-health/telehealth-resource-center-guides-reports**
4. Centers for Medicare and Medicaid Services (CMS). 2025. "List of Telehealth Services." **cms.gov/medicare/coverage/telehealth/list-services**

2026 Custom Measure Tips



Medicare Wellness Visits (MWV)

Medicare Plus Blue℠ and BCN Advantage℠ Custom Measure

Measure description

The percentage of patients that had a Medicare Wellness Visit (MWV) during the measurement year.

Measure population (denominator)

Patients continuously enrolled in Medicare Plus Blue℠ or BCN Advantage℠ plans during the measurement year.

Measure compliance (numerator)

A Medicare Wellness Visit during the measurement year (either IPPE or AWV below).

- Must be appropriately billed with HCPCS code.
- Wellness visits can be anytime throughout a calendar year, regardless of the date of the previous year's visit.

Did you know?

- Health status at midlife is critical to maintaining health while aging and enhancing quality of life.
- A personalized medicine program focuses on promoting healthy lifestyle behaviors, cognitive function and preventing disease.
- Failure to evaluate memory or cognitive complaints can hinder treatment of underlying conditions and may present safety issues.
- The risk of falling and fall-related problems rises with age.

Note: this applies to MA PPO and BCNA. Be sure to check patient eligibility and benefits in the provider portal (availity.com) to verify coverage

Initial Preventive Physical Exam (IPPE)	Annual Wellness Visit (AWV)
• New Medicare patients **within the first 12 months** of Part B enrollment • Also known as "Welcome to Medicare" • Review medical and social history • Provide preventive services education • In person visit	• Existing Medicare patients **after the first 12 months** of Part B enrollment • Develop/update Personalized Prevention Plan (PPP) • Perform a Health Risk Assessment (HRA) • Optional SDOH (cannot be audio only) • Virtual care visits acceptable (video or audio)

Note: A routine physical alone does **not** meet criteria.

This measure applies to Medicare members only.

continued

Exclusions

- Deceased during the measurement year
- Received palliative care during the measurement year
- Received hospice services anytime during the measurement year

Helpful hints

- A routine physical exam is not the same service as an IPPE or AWV, nor do they have the same coverages.
- **Document** and code for any active conditions during the visit.
- **Implement** a system for automated reminders to patients encouraging wellness visit scheduling.
- **Schedule** wellness visits annually, preferably 6-12 months in advance.
- **Subsequent** AWVs can be performed by other medical professionals (eg, health educators, registered dieticians, nutrition professionals or other licensed practitioners) under the direct supervision of a practitioner.
- **Educate** patients on the importance of Medicare Wellness Visits regardless of health status.
- **Review** the patient's Medicare coverage and wellness visit history to determine which type of wellness visit is appropriate.
- **Consult** the Michigan Automated Prescription System (MAPS) to view complete medication profiles for patients and to confirm the current cumulative dosage of opioid medications being prescribed. **michigan.pmpaware.net/login**
  - If outside of Michigan, please consult your state's Prescription Drug Monitoring Program (PDMP).

Tips for coding

HCPCS code	Description
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0438*	Annual wellness visit, includes a personalized prevention plan of service (PPS); initial visit
G0439*	Annual wellness visit, includes a personalized prevention plan of service (PPS); subsequent visit
G0468	When the Medicare Well Visit is performed at a federally qualified health center, you must bill G0468 with a qualifying visit code (G0402, G0438 or G0439)

* G0438 and G0439 can be completed using audio only. Here's the link related to telehealth services that can be found on the CMS website: **cms.gov/medicare/coverage/telehealth/list-services**

Note: When G0438 and G0439 are completed virtually with an E/M code, both video and audio are required and should be reported with modifier 25.

continued

Documentation in the medical record must indicate the date the visit occurred and evidence of the components below:

Wellness Visit Components	
IPPE:	**AWV:**
• Height, weight, Body Mass Index (BMI), blood pressure, balance, gait, visual acuity screen, and other factors deemed appropriate based on history and clinical standards • Medical, social, and family history, as well as diet and activities • Medication review and reconciliation (including supplements) • Potential depression risk factors including current or past experiences with depression or other mood disorders • Functional ability and level of safety • Review of current opioid prescriptions • Screening for potential Substance Use Disorders (SUDs) • Educate, counsel, and refer based on above components • Educate, counsel, and refer for other preventive services • End-of-life planning with patient agreement	• Health risk assessment (HRA) • Medical and family history • Medication review and reconciliation (including supplements) • Height, weight, BMI, blood pressure, and other routine measurements deemed appropriate based on history • List of current providers and specialists providing medical care • Detect any cognitive impairment • Potential depression risk factors, including current or past experiences with depression or other mood disorders • Functional ability and level of safety • Established written screening schedule • List of risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway • Review of current opioid prescriptions • Screen for potential Substance Use Disorders (SUDs) • Personalized health advice and appropriate referrals to educational or counseling services or programs • Advance care planning services at the patient's discretion • **Optional:** Social Determinants of Health Risk Assessment (SDOH)

Note: For additional information on components, see **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html**

Resources

/, National Institutes of Health (NIH). 2023. "Assessing Cognitive Impairment in Older Patients." **nia.nih.gov/health/assessing-cognitive-impairment-older-patients#17**

0, Centers for Medicare and Medicaid Services (CMS). 2023. "List of Telehealth Services." **cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes**

1, BCBSM. 2025. "2025 Quality Success Series - Medicare Wellness Visit (MWV)." **Unable to provide link to NPI series, Path: **Availity/Provider Secured Services/Member Care/Clinical Quality/Clinical Quality Overview**

2, National Institutes of Health (NIH). 2022. "Falls and Fractures in Older Adults: Causes and Prevention." **nia.nih.gov/health/prevent-falls-and-fractures**

3, Centers for Medicare and Medicaid Services (CMS). 2024. "Annual Wellness Visit: Social Determinants of Health Risk Assessment." **cms.gov/files/document/mm13486-annual-wellness-visit-social-determinants-health-risk-assessment.pdf**

** Centers for Medicare and Medicaid (CMS.gov) is dedicated to advancing health equity, expanding coverage and improving health outcomes.*

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Breast Cancer Screening (BCS-E)

Electronic Clinical Data Systems (ECDS) Measure

Measure description

The percentage of patients who were recommended for and then screened for breast cancer.

Measure population (denominator)

Patients ages 40–74 during the measurement year.

Did you know?

- Many patients with breast cancer do not have symptoms, which is why regular breast cancer screenings are so important.
- Breast cancer detection at an early stage has a 93% or higher survival rate.
- The accuracy of mammography improves as individuals age.

Measure compliance (numerator)

Mammogram screening (bilateral or unilateral) performed any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year, as evidenced by the following:

- Documentation indicating a mammogram was completed and the date it was performed.

Note: A breast thermogram **does not** meet criteria for this measure.

Exclusions

- History of mastectomy on both the left and right side on the same or different dates of service (if exact date is unknown, the year is acceptable)
- Gender-affirming chest surgery (CPT code 19318) AND a diagnosis of gender dysphoria any time during the patient's history
- Received hospice services anytime during the measurement year
- Received palliative care during the measurement year
- Deceased during the measurement year
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)

continued

Helpful HEDIS hints

- Review completed screening dates with patients at all visits, including virtual care.
- Obtain dated mammogram reports.
- Follow up on outstanding orders when no report has been received.
- Patient reported mammogram is acceptable. Document date in the history or preventive service section of the medical record.
- If the exact date of the last mammogram is unknown, avoid using words such as "approximate" or "about" when documenting. Instead, document the month/year or year alone.
- Create a standing order to mail to patient for mammography.
- Provide a list of locations where mammogram screenings can be performed.
- Depending on risk factors, mammograms may need to be done more frequently.

Tips for coding

If the patient met exclusion criteria, include the following ICD-10-CM diagnosis codes on the claim as appropriate:

ICD-10-CM code	Description
Z90.11*	Acquired absence of right breast and nipple
Z90.12*	Acquired absence of left breast and nipple
Z90.13	Acquired absence of bilateral breasts and nipples
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

* Both Z90.11 and Z90.12 need to be billed on the same or different dates of service to be excluded

Note: This measure is being collected and reported through electronic clinical data systems (ECDS). ECDS is defined as a health plan that utilizes a network of interoperable data systems to better communicate member health information across various health care service providers.

Resources

1. American Cancer Society. 2025. "American Cancer Society Recommendations for the Early Detection of Breast Cancer." **www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html**
2. American Cancer Society. 2025. "Frequently Asked Questions About the American Cancer Society's Breast Cancer Screening Guideline." **www.cancer.org/cancer/types/breast-cancer/frequently-asked-questions-about-the-american-cancer-society-new-breast-cancer-screening-guideline.html**

December 2025

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W017257

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Colorectal Cancer Screening (COL-E)

Electronic Clinical Data Systems (ECDS) Measure

Measure description

The percentage of patients who had a colorectal cancer screening.

Measure population (denominator)

Patients 45–75 years of age during the measurement year (MY).

Measure compliance (numerator)

Patients who had any of the following:

Type of Screening	During the MY or:
Colonoscopy	9 years prior
Flexible Sigmoidoscopy	4 years prior
sDNA (stool DNA + FIT test) also known as Cologuard®	2 years prior
FOBT (Fecal Occult Blood Test) such as: ***FIT** (Fecal Immunochemical Test) ***gFOBT** (guaiac FOBT)	MY only
CT-Colonography (virtual colonoscopy)	4 years prior

Exclusions

- History of colorectal cancer (cancer of the small intestine doesn't count)
- Total colectomy (partial or hemicolectomies don't count)
- Received hospice services anytime during the measurement year

Did you know?

- A screening test is used to look for a disease when a person doesn't have symptoms.
- Treatment for colorectal cancer in its earliest stage can lead to a 90% survival rate.
- Colorectal cancer screening can detect polyps before they become cancerous or in early stages when treatment is most effective.
- Many adults have not been screened as recommended. Lower screening rates directly contribute to higher death rates from colorectal cancer.

continued

Exclusions *(continued)*

- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)
- Deceased during the measurement year
- Received palliative care during the measurement year

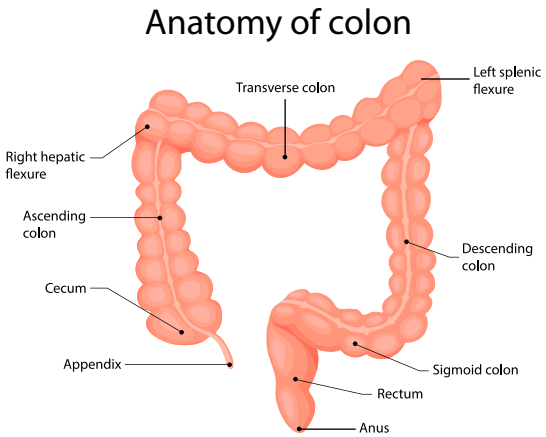
Helpful HEDIS hints

- Discuss the benefits and risks of different screening options and make a plan that offers the best health outcomes for your patient.
- Document the date and type of colorectal screenings or if the patient met exclusion criteria.
  - Pathology reports that indicate the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.
  - Pathology or procedure reports that do **not** indicate type of screening (or if aborted) are acceptable, IF there is evidence the scope advanced:

    * **TO** the cecum = completed colonoscopy

    * **INTO** the sigmoid colon = completed flex sigmoidoscopy

    Note: If the scope advanced anywhere between the cecum and sigmoid colon, it would be considered a flexible sigmoidoscopy.



- Patient reported documentation is acceptable. Be sure to document the type of screening and date in their medical history.
  - Simply documenting "colorectal screening," "colo," or "UTD" does not meet criteria.
- For patients who refuse a colonoscopy, discuss options of noninvasive screenings such as Cologuard® or FIT.
- Have FIT kits readily available to give patients during the visit.
- Samples taken from a digital rectal exam (DRE) or collected in an office setting do not meet screening criteria by the American Cancer Society or HEDIS®.
  - If a patient brings a completed sample into the office, be sure to document this so it's clear it wasn't collected in the office.
- Fecal Immunochemical Test (FIT) and Cologuard® (sDNA + FIT) tests are **not** the same screening.
  - FIT uses antibodies to detect blood in the stool (completed annually).
  - sDNA combines the FIT with a test that detects altered DNA and occult hemoglobin in the stool (completed every 3 years).
- If virtual care is used, discuss current screening status and encourage in-home testing if applicable.

continued

Tips for coding

For exclusions, use the appropriate ICD-10-CM code. Document and bill exclusions annually.

ICD-10-CM	Description
C18.0	Malignant neoplasm of the cecum
C18.1	Malignant neoplasm of appendix
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of the transverse colon
C18.5	Malignant neoplasm of the splenic flexure
C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C18.9	Unspecified malignant neoplasm of the colon
C19	Malignant neoplasm of the rectosigmoid junction
C20	Malignant neoplasm of the rectum
C21.2	Malignant neoplasm of the cloacogenic zone
C21.8	Malignant neoplasm: Overlapping lesion of rectum, anus, and anal canal
C78.5	Secondary malignant neoplasm of large intestine and rectum
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus

For screenings use the appropriate codes:

Screening	Code type	Commonly used billing codes
sDNA (known as Cologuard®/Cologuard Plus™)	CPT®	0464U, 81528
Occult blood test (FOBT, FIT, guaiac)	CPT®	82270, 82274
	HCPCS	G0328

Note: This measure is being collected and reported through Electronic Clinical Data Systems (ECDS). ECDS is defined as a health plan that utilizes a network of interoperable data systems to better communicate member health information across various health care service providers.

Resources

1. American Cancer Society. 2023. "Colorectal Cancer Facts & Figures 2023-2025." **cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2023.pdf**
2. Centers for Disease Control and Prevention (CDC). 2025. "Screening for Colorectal Cancer." **cdc.gov/colorectal-cancer/screening/?CDC_AAref_Val=https://cdc.gov/cancer/colorectal/basic_info/screening/index.htm**
3. Centers for Disease Control and Prevention (CDC). 2024. "About Colorectal Cancer Control Program." **cdc.gov/colorectal-cancer-control/about/?CDC_AAref_Val=https://cdc.gov/cancer/crccp/about.htm**
4. BCBSM. 2025. "2025 Quality Success Series - Colorectal Cancer Screening (COL-E)." **Unable to provide link to NPI series. Path: **Availity/Provider Secured Services/Member Care/Clinical Quality/Clinical Quality Overview**

December 2025

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W017257

2026 Star Coding Tips

Concurrent Use of Opioids and Benzodiazepines (COB)

Pharmacy Quality Alliance-endorsed performance measures.

Measure description

The percentage of patients with concurrent use of prescription opioids and benzodiazepines.

Measure population (denominator)

Patients 18 years and older who meet **BOTH** of the following criteria during the measurement year:

- Two or more opioid prescriptions filled on different dates of service
- Received cumulative supply of opioids for 15 days or more

Measure compliance (numerator)

Patients on opioid medication with BOTH of the following criteria during the measurement year:

- Two or more benzodiazepine prescriptions filled with different dates of service
- Concurrent use of opioids and benzodiazepines for 30 cumulative days or more

NOTE: A lower rate indicates better performance.

Did you know?

- Taking opioids in combination with other central nervous system depressants (like benzodiazepines, alcohol, or xylazine) increases the risk of a life-threatening overdose.
- Opioid prescribing at high dosage, use from multiple prescribers and pharmacies, and concurrent use with benzodiazepines is associated with an increased risk of chronic use, misuse, and in some cases, overdose.

Exclusions

- Diagnosis of cancer or cancer-related pain treatment
- Sickle cell disease
- Received hospice services anytime during the measurement year
- Received palliative care during the measurement year

continued

Helpful hints

- **Determine** when to initiate or continue opioid therapy utilizing CDC Guidelines. **cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm**
- **Discuss** risks and benefits of opioid therapy, including patient and clinician responsibilities.
- **Educate** about the risks of polysubstance use and long-term opioid therapy.
- **Explore** other alternatives such as relaxation techniques, anxiety or cognitive therapy and sleep hygiene.
- **Avoid** initial combination of opioid and benzodiazepine medications.
- **Continue** long-term co-prescribing only when necessary and monitor for abuse or misuse closely.
- **Provide** rescue medication (naloxone) to high-risk patients.
- **Refer** patients to pain management specialists when indicated.

Resources

1. Pharmacy Quality Alliance (PQA). 2024. "PQA Quality Measures." **pqaalliance.org/pqa-measures**
2. National Institutes of Health (NIH). 2022. "Benzodiazepines and Opioids." **nida.nih.gov/research-topics/opioids/benzodiazepines-opioids**
3. Centers for Medicare and Medicaid Services (CMS). 2019. "Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines." **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE19011.pdf**
4. Centers for Medicare and Medicaid Services (CMS). 2022. "CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022." **cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm**

* *Pharmacy Quality Alliance (PQA) is a national quality organization dedicated to improving medication safety, adherence and appropriate use. PQA measures are included in the Medicare Part D Star Ratings.*

December 2025

W017257

2026 Star Measure Tips

One in a series of tip sheets about HEDIS® and other measures that contribute to star ratings of Medicare Advantage plans.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

Patient Perception Star Measure

Why is the CAHPS survey important?

Research shows that a positive health care experience for patients is associated with positive clinical outcomes and better business outcomes, including lower medical malpractice risk and less employee turnover.

CAHPS survey questions and provider impact

Practitioners can significantly impact patient responses to CAHPS survey questions. The table below lists some key CAHPS survey questions with tips to ensure patients have a positive experience.

Measure	Sample survey questions to patient
Annual flu vaccine	Have you had a flu shot since July 1?

Tips for success

- Administer flu shot as soon as it's available each fall.
- Eliminate barriers to accessing flu shots and offer multiple options for patients to get their shot (walk-in appointments, flu shot clinics, flu shots at every appointment type if the patient's eligible).
- Promote flu shots through website, patient portal, and phone greeting.

continued

Measure	Sample survey questions to patient
Getting appointments and care quickly	In the last six months: • When you needed care right away, how often did you get care as soon as you needed? • How often did you get an appointment for routine care as soon as you needed?

Tips for success

- Patients are more tolerant of appointment delays if they know the reasons for the delay. When the practitioner is behind schedule:
  - Front office staff should update patients often and explain the cause for the schedule delay. Offer reasonable expectations of when the patient will be seen.
  - Provide patients with options showing respect for their time (i.e., reschedule, run errands, wait in vehicle).
  - Staff members interacting with the patient should acknowledge the delay with the patient.
- Consider implementing advanced access scheduling (same-day scheduling) or consider:
  - Leaving a few appointment slots open each day for urgent visits, including post-inpatient discharge visits.
  - Offering appointments with a nurse practitioner or physician's assistant to patients who want to be seen on short notice.
  - Offering virtual appointments, making it convenient for patients to connect with the practice.
  - Scheduling patients for follow-up appointments and annual wellness visits in advance.

Measure	Sample survey questions to patient
Overall rating of health care quality	Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?

Tips for success

- Survey your patients, asking how you can improve their health care experience.
- Create a council of patient volunteers to obtain regular feedback on practice processes/procedures.
- Review patient feedback and implement changes for suggested improvements.

Measure	Sample survey questions to patient
Care coordination	In the last six months: • When you visited your personal doctor for a scheduled appointment, how often did they have your medical records or other information about your care? • When your personal doctor 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 those results as soon as you needed them? • How often did you and your personal doctor talk about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about the care you got from specialists?

continued

Tips for success

- Before walking in the exam room, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits.
- Implement a system in your office to ensure timely notifications for both normal and abnormal test results. Ask patients how they would prefer to receive test results and communicate clearly when they'll receive test results.
- Utilize or implement a patient portal to share test results and consider automatically releasing the results once they are reviewed by the practitioner.
- Ask your patients if they saw another practitioner since their last visit. If you know patients receive specialty care, discuss their visit and treatment plan, including new prescriptions. Contact specialty provider and request the medical records.
- Complete a medication reconciliation at every visit. Inform the patients when reviewing their medications and use standardized language, such as, "Let's review the medications you're currently taking."

Measure	Sample survey questions to patient
Getting needed care	In the last six months: • How often did you get an appointment to see a specialist as soon as you needed? • How often was it easy to get the care, tests, or treatment you needed?

Tips for success

- Set realistic expectations around how long it could take to schedule an appointment with the specialist if the appointment is not urgent.
- If applicable, advise your patient on how you can help secure an appointment sooner if your clinic has an established relationship with a specialist.
- Help the patient understand why you are recommending certain types of care, tests or treatments, especially if the patient requested or asked about other types.
- Review with patients what role they play in securing care, tests or treatment (e.g., scheduling timely appointments with specialists).

Resources

1. Agency for Healthcare Research and Quality (AHRQ). 2023. "The CAHPS Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience." **ahrq.gov/cahps/quality-improvement/improvement-guide/improvement-guide.html**
2. Centers for Medicare & Medicaid Services (CMS). 2025. "Consumer Assessment of Healthcare Providers & Systems." **cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Controlling High Blood Pressure (CBP)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of patients with hypertension whose blood pressure was adequately controlled.

Measure population (denominator)

Patients 18-85 years of age with a diagnosis of hypertension on at least two different dates of service between January 1 of the year prior and June 30 of the measurement year.

Measure compliance (numerator)

The **final** blood pressure reading of the measurement year is adequately controlled (≤ 139/89 mm Hg).

Note: The BP reading must occur *on or after* the date of the second diagnosis of hypertension.

Did you know?

- Hypertension (high blood pressure) increases the risk of heart disease and stroke, which are the leading causes of death in the United States.
- Controlling high blood pressure is important in preventing heart attacks, stroke and kidney disease.
- Approximately one in four adults with hypertension have their condition under control.
- Lifestyle changes such as diet, exercise, smoking cessation and stress reduction can significantly impact blood pressure.

Exclusions

- Nonacute inpatient admission during the measurement year
- End stage renal disease, dialysis, nephrectomy or kidney transplant any time during the patient's history
- Pregnancy diagnosis during the measurement year
- Are age 81 or older with frailty (for additional definition information, see the Advanced Illness and Frailty Guide)
- Are age 66-80 with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)

continued

Exclusions *(continued)*

- Received hospice services anytime during the measurement year
- Received palliative care during the measurement year
- Deceased during the measurement year

Helpful HEDIS hints

- Document all blood pressure readings and the dates they were obtained.
  - Report the lowest systolic and lowest diastolic pressures if more than one reading is taken on the same date.
- The final blood pressure reading of the year will be used to determine HEDIS measure compliance.
- Document exact readings; do not round up blood pressure readings. Ranges and thresholds are not acceptable.
- A BP noted as an "average BP" (e.g., "average BP: 139/70") is eligible for use. Must be documented as a distinct value.
- Blood pressure readings can be captured during a virtual care visit.
- Patient reported blood pressures taken with a digital device are acceptable and should be documented in the medical record. The provider does not need to see the digital reading.
- Prescribe single-pill combination medications whenever possible to assist with medication compliance.
- BP readings can be captured from a specialty or urgent care visit if the consult note is part of the patient's medical record.

  Note: BP readings taken from an acute inpatient stay, ED visit or the same day as a diagnostic or therapeutic procedure that requires a change in diet or medication are not acceptable.

Tips for coding

Blood pressure CPT® II codes should be billed as a $0.01 claim.

- BP readings should be reported with each office visit; this includes telehealth, telephone, e-visits or virtual visits.
- BP readings can also be billed alone if taken outside of a visit (nurse visits, etc.).

CPT® II code	Most recent systolic blood pressure
3074F	< 130 mm Hg
3075F	130–139 mm Hg
3077F	≥ 140 mm Hg
CPT® II code	**Most recent diastolic blood pressure**
3078F	< 80 mm Hg
3079F	80–89 mm Hg
3080F	≥ 90 mm Hg

continued

Tips for taking a blood pressure

- Ensure proper cuff size (placed on bare arm), feet are flat on the floor, back is supported and elbow is at the level of the heart. Encourage the patient to empty their bladder first and advise them not to talk during the measurement.
- Improper positioning can raise the systolic pressure up to 12 mm Hg.
- Take it twice. If the blood pressure is greater than 139/89, retake and record it at the end of the visit. Consider switching arms for subsequent readings.

Tips for patient education

One of the biggest challenges is convincing patients of the importance of maintaining a healthy blood pressure.

- Educate patients on the importance of blood pressure control and the risks when blood pressure is not controlled.
- Encourage blood pressure monitoring at home and ask patients to bring a log of their readings to all office visits. Educate patients on how to properly measure blood pressure at home.
- If the patient does not own a digital blood pressure cuff, instruct them to use their local pharmacy for a blood pressure reading.
- Discuss the importance of medication adherence at every visit. According to the Centers for Disease Control and Prevention (CDC):
  - Approximately one in four adults with hypertension have their condition controlled.
  - Many patients with Medicare Part D prescription coverage are not taking their blood pressure medication as prescribed.
- Advise patients not to discontinue blood pressure medication before contacting your office. If they experience side effects, another medication can be prescribed.
- If patients have an abnormal reading, schedule follow-up appointments for blood pressure management.
- Encourage lifestyle changes such as diet, exercise, smoking cessation and stress reduction.

Resources

1. National Committee for Quality Assurance (NCQA). 2025. "Controlling High Blood Pressure (CBP)." **ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/controlling-high-blood-pressure-cbp**
2. Centers for Disease Control and Prevention (CDC). 2025. "Hypertension Management Program (HMP) Toolkit." **cdc.gov/high-blood-pressure/hcp/hmp-toolkit/index.html**
3. Centers for Disease Control and Prevention (CDC). 2025. "High Blood Pressure Facts. **cdc.gov/high-blood-pressure/data-research/facts-stats**
4. American Medical Association (AMA). 2021. "The one graphic you need for accurate blood pressure reading." **ama-assn.org/delivering-care/hypertension/one-graphic-you-need-accurate-blood-pressure-reading**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Eye Exam for Patients with Diabetes (EED)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of diabetic patients who had a dilated or retinal eye exam.

Measure population (denominator)

Patients 18-75 years old with diabetes (Type 1 or Type 2).

Either of the following during the measurement year or the year prior to the measurement year:

- **Encounter data:** at least two diagnoses of diabetes on different dates of service
- **Pharmacy data:** dispensed insulin or hypoglycemics/antihyperglycemics AND have at least one diagnosis of diabetes
  - This includes semaglutides

Did you know?

- Diabetic retinopathy is the leading cause of blindness among adults.
- Anyone with diabetes is at risk for diabetic-related eye disease such as diabetic retinopathy, macular edema, glaucoma, and cataracts.
- Diabetic retinopathy is projected to affect 16 million people with diabetes by 2050.

Diabetes medications			
Alpha-glucosidase inhibitors	Amylin analogs	Antidiabetic combinations	Biguanides
Insulin	Meglitinides	Sulfonylureas	Thiazolidinediones
Glucagon-like peptide-I (GLP I) agonists	Dipeptidyl peptidase-4 (DDP-4) inhibitors	Sodium glucose cotransporter 2 (SGLT2) inhibitor	

continued

Measure compliance (numerator)

- Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist)
  - Negative eye exam during the measurement year or year prior
  - Positive eye exam during the measurement year (must be done **annually**)

  Note: Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure. The intent is to ensure members with any type of retinopathy have an annual dilated/retinal eye exam.

Exclusions

- Received hospice services anytime during the measurement year
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)
- Deceased during the measurement year
- Received palliative care during the measurement year
- Bilateral eye enucleation any time during the patient's history through the measurement year

  Note: Blindness is **not** an exclusion for a diabetic eye exam.

Helpful HEDIS hints

- A retinal or dilated eye exam must be performed by an eye care professional **annually** for patients with **positive retinopathy**, and every two years for patients without evidence of retinopathy.
  - Required documentation: date of service, eye exam results, and eye care professional's name with credentials are required.
  - Patient reported eye exams are acceptable with the above documentation.
  - If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.
- Review the report and document abnormalities in the active problem list.
- Eye exam result documented as unknown does not meet criteria.
- Evidence of prosthetic eye(s) is acceptable for enucleation.
  - Unilateral enucleation would still require an exam on the other eye.
- Refer patients to an optometrist or ophthalmologist for a dilated or retinal eye exam annually and explain why this is different than a routine eye exam.
  - Routine eye exams for glasses, glaucoma or cataracts do not count. Must be a dilated/retinal exam.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- Diabetic eye exams are covered under the patient's medical insurance and may be subject to copays and deductibles.
- Optical coherence tomography is considered imaging and is eligible for use. The fundus/retinal photography must have the date, result and eye care professional with credentials documented.
  - Artificial intelligence (AI) interpretation of retinal imaging is also acceptable.

continued

Tips for coding

When results are received from an eye care professional, or the patient reports an eye exam, submit the results on a $0.01 claim with the appropriate CPT® II code:

CPT® II code	Retinal eye exam findings
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** **Note:** 2023F closes the EED gap for two years: current and next measurement year
CPT® code	**Description**
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral (interpreted by artificial intelligence)

- When submitting CPT codes 92227, 92228, or 92229 for services, include CPT II codes 2022F or 2023F in addition.
- Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).

Resources

1. National Eye Institute. 2025. "Diabetic Retinopathy." **nei.nih.gov/learn-about-eye-health/eye-conditions-and-diseases/diabetic-retinopathy**
2. American Diabetes Association (ADA). 2025. "Eye Health." **diabetes.org/health-wellness/eye-health**
3. Centers for Disease Control and Prevention (CDC). 2024. "Promoting Eye Health." **cdc.gov/diabetes/hcp/clinical-guidance/promote-eye-health.html**
4. BCBSM. 2025. "2025 Quality Success Series - Eye Exam for Patients with Diabetes (EED)." **Unable to provide link to NPI series. Path: **Availity/Provider Secured Services/ Member Care/Clinical Quality/Clinical Quality Overview**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Glycemic Status Assessment for Patients with Diabetes (GSD)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of diabetic patients whose glycemic status was adequately controlled.

Did you know?

- Small changes in diet and exercise can significantly impact diabetes.
- Diabetes is one of the nation's leading causes of death and disability.
- Type 1 diabetes occurs at every age and in people of every race, shape and size.

Measure population (denominator)

Patients 18-75 years old with diabetes (Type 1 or Type 2).

Either of the following during the measurement year or the year prior to the measurement year:

- **Encounter data:** at least two diagnoses of diabetes on different dates of service
- **Pharmacy data:** dispensed insulin or hypoglycemics/antihyperglycemics AND have at least one diagnosis of diabetes
  - This includes semaglutides

Diabetes medications			
Alpha-glucosidase inhibitors	Amylin analogs	Antidiabetic combinations	Biguanides
Insulin	Meglitinides	Sulfonylureas	Thiazolidinediones
Glucagon-like peptide-I (GLP I) agonists	Dipeptidyl peptidase-4 (DDP-4) inhibitors	Sodium glucose cotransporter 2 (SGLT2) inhibitor	

Measure compliance (numerator)

The last glycemic status assessment of the measurement year. The result must be ≤ 9% to show evidence of control. Documentation of either of the following that includes the result and date performed are acceptable:

- Hemoglobin A1c (HbA1c)
- Glucose Management Indicator (GMI)

continued

Exclusions

- Received hospice services any time during the measurement year
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)
- Deceased during the measurement year
- Received palliative care during the measurement year

Helpful HEDIS hints

- HbA1c should be completed two to four times each year and include the result date and distinct numeric result.
- Order labs to be completed prior to patient appointments.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- Patient-reported HbA1c results are acceptable as long as the date and result are documented in the medical record.
- The glucose management indicator (GMI) value is acceptable from:
  - A continuous glucose monitor (CGM)
  - Patient reported

The date range used must be documented. The last date in the range should be used to assign the GMI date. (GMI is only captured through LOINC codes)

Note: HbA1c home kits (e.g., patient purchased from drug store) are not acceptable. The test must be processed in a lab.

Tips for coding

When HbA1c reports are received, or the patient reports their HbA1c results, submit the appropriate CPT® II code on a $0.01 claim.

CPT® II code	Most recent HbA1c
3044F	< 7%
3046F	> 9%

CPT® II code	Most recent HbA1c
3051F	≥ 7% and < 8%
3052F	≥ 8% and ≤ 9%

Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).

Resources

1. American Diabetes Association (ADA). 2025. "The Path to Understanding Diabetes Starts Here." **diabetes.org/about-diabetes**
2. Centers for Disease Control and Prevention (CDC). 2024. "Testing for Diabetes and Prediabetes: A1c." **cdc.gov/diabetes/diabetes-testing/prediabetes-a1c-test.html**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Kidney Health Evaluation for Patients with Diabetes (KED)

Effectiveness of Care HEDIS® Measure

Measurement description

Percentage of diabetic patients who received a kidney health evaluation.

Measure population (denominator)

Patients 18-85 years old with diabetes (Type 1 or Type 2).

Either of the following during the measurement year or the year prior to the measurement year:

- **Encounter data:** at least two diagnoses of diabetes on different dates of service
- **Pharmacy data:** dispensed insulin or hypoglycemics/antihyperglycemics AND have at least one diagnosis of diabetes
  - This includes semaglutides

Did you know?

- Diabetes and high blood pressure are the most common causes of kidney disease.
- Adequate control of blood sugar and blood pressure have been shown to lower the risk of developing kidney disease.
- Kidney disease often develops slowly, consequently many are unaware until the disease is advanced and requires dialysis or a kidney transplant.
- Kidney disease is more common in women, people over 65, as well as Black and Hispanic adults.

Diabetes medications			
Alpha-glucosidase inhibitors	Amylin analogs	Antidiabetic combinations	Biguanides
Insulin	Meglitinides	Sulfonylureas	Thiazolidinediones
Glucagon-like peptide-I (GLP I) agonists	Dipeptidyl peptidase-4 (DDP-4) inhibitors	Sodium glucose cotransporter 2 (SGLT2) inhibitor	

continued

Measure compliance (numerator)

Diabetic patients who received ***both*** of the following during the measurement year:

1. Serum estimated glomerular filtration rate (eGFR)
2. Urine albumin creatinine ratio (uACR) identified by *either* of the following:
   - **Both** a quantitative urine albumin test **and** a urine creatinine test from the same urine sample

Or

   - Urine albumin creatinine ratio test (uACR). Closed by LOINC codes only.

Exclusions

- Are age 66–80 with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)
- Received hospice services anytime during the measurement year
- Are age 81 or older with frailty (for additional definition information, see the Advanced Illness and Frailty Guide)
- Received palliative care during the measurement year
- End stage renal disease (ESRD) or dialysis anytime during the patient's history
- Deceased during the measurement year

Helpful HEDIS hints

- If using an in-office analyzer for urine testing, be sure to confirm the type of urine albumin test that is performed. Some analyzers only measure semi-quantitative urine albumin, require a different CPT code, and will **not** close this measure.
- Lab test reports should indicate both an eGFR and uACR were performed during the measurement year on the same or different dates of service.
- Order labs to be completed prior to patient appointments.
- Ensure labs are ordered at least annually, preferably at the beginning of the year.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- When ordering the urine test, be sure that the albumin and creatinine values are being measured, reported, and **both codes are being billed (82043, 82570)**.

Tips for coding

To ensure gap closure, verify the practitioner orders and lab facilities include all three tests below:

Note: Measure can only be closed through claims or EMR supplemental data feed.

CPT® code	Laboratory Test
80047, 80048, 80050, 80053, 80069, 82565	Estimated Glomerular Filtration Rate Lab Test (eGFR)
82043	Quantitative Urine Albumin Test
82570	Urine Creatinine Lab Test

Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).

Resources

1. Centers for Disease Control and Prevention (CDC). 2024. "Chronic Kidney Disease." **cdc.gov/diabetes/diabetes-complications/diabetes-and-chronic-kidney-disease.html**
2. Centers for Disease Control and Prevention (CDC). 2024. "Chronic Kidney Disease in the United States, 2023". **cdc.gov/kidney-disease/php/data-research/"cdc.gov/kidney-disease/php/data-research/**
3. Centers for Disease Control and Prevention (CDC). 2024. "Preventing Chronic Kidney Disease." **cdc.gov/kidney-disease/prevention/**
4. BCBSM. 2025. "2025 Quality Success Series - Kidney Health Evaluation for Patients with Diabetes (KED)." **Unable to provide link to NPI series. Path: **Availity/Provider Secured Services/ Member Care/Clinical Quality/Clinical Quality Overview**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients who had a follow-up service following an emergency department (ED) visit.

Measure population (denominator)

Patients 18 years of age and older with **two or more** different high-risk chronic conditions that had an ED visit between January 1 and December 24 of the measurement year.

Note: If a patient has more than one ED visit, they could be in the measure more than once.

Did you know?

- Patients are at a higher risk of complications following emergency department visits because of their functional limitations and multiple chronic conditions.
- Studies have found that older adults have increased mortality rates and readmissions rates within the first three months after the emergency department visit.

High-risk chronic conditions (diagnosed prior to ED visit during measurement year or year prior)		
Alzheimer's disease and related disorders	COPD, asthma, or unspecified bronchitis	Myocardial infarction - acute
Atrial fibrillation	Depression	Stroke and transient ischemic attack
Chronic kidney disease	Heart failure	

continued

Measure compliance (numerator)

A follow-up service within seven days on or after the emergency department visit (eight total days).

The following meet criteria for follow-up:

- Outpatient visit
- Virtual care visit
- Behavioral health visit
- Case management visit
- Electroconvulsive therapy
- Substance use disorder service
- Community mental health center visit
- Complex Care Management Services
- Intensive outpatient or partial hospitalization
- Transitional care management (TCM) services

Exclusions

- Admitted to an acute or nonacute inpatient facility on or within seven days after the ED visit, regardless of the principal diagnosis for admission
- Received hospice services anytime during the measurement year
- Deceased during the measurement year

Helpful HEDIS hints

- Contact patient as soon as ED discharge notification is received and schedule follow-up visit.
  - Discuss the discharge summary; verify understanding of instructions and that all new prescriptions were filled.
  - Complete a thorough medication reconciliation with the patient and/or caregiver.
- The diagnosis for the follow-up visit does not need to match that of the ED visit. Also, it does not need to be associated with the chronic conditions that put the patient into the denominator.
- Virtual care visits are acceptable for follow-up (audio and/or video, e-visits, virtual check-ins).
- Keep open appointments so patients with an ED visit can be seen within seven days of their discharge.
- Instruct patients to call their practitioner with any concerns or worsening of symptoms.

Resources

1. Department of Health and Human Services (HHS). 2010. "Multiple Chronic Conditions: A Strategic Framework." **hhs.gov/sites/default/files/ash/initiatives/mcc/mcc_framework.pdf**
2. National Institutes of Health (NIH). 2020. "Ambulatory Follow-up and Outcomes Among Medicare Beneficiaries After Emergency Department Discharge." **pubmed.ncbi.nlm.nih.gov/33034640/**
3. National Institutes of Health (NIH). 2019. "Emergency Department Interventions for Older Adults: A Systemic Review." **pubmed.ncbi.nlm.nih.gov/30875098/**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Health Outcomes Survey (HOS)

Patient perception star measures

Why is the HOS important?

The goal of the HOS is to gather clinically meaningful health status data from Medicare Advantage patients to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

HOS questions and provider impact

Practitioners can significantly impact how patients assess their health care experience in response to HOS questions.

Examples of HOS questions and tips for success are listed in the table below:

Measure	Sample survey questions to patient
Improving or maintaining physical health	• In general, how would you rate your health? • Does your health now limit you in these activities? – Moderate activities like vacuuming or bowling – Climbing several flights of stairs • During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? – Accomplished less than you would like – Were limited in the kind of work or other activities you were able to perform • During the past four weeks how much did pain interfere with your normal work?

Tips for success

- Ask patients if they have pain and if it is affecting their ability to complete daily activities. Ask what goals the patient has, then identify ways to lessen the patient's pain.
- Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist or other specialist.
- Consider physical therapy and cardiac or pulmonary rehab when appropriate.

continued

Measure	Sample survey questions to patient
Improving or maintaining mental health	• During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems? – Accomplished less than you would like – Didn't do work or other activities as carefully as usual • How much of the time during the past four weeks: – Have you felt calm and peaceful? – Did you have a lot of energy? – Have you felt downhearted or blue? • During the past four weeks, how much of the time have your physical or emotional problems interfered with your social activities?

Tips for success

- Empathize with the patient.
- Annual depression screening (PHQ-2 or PHQ-9) can be incorporated into any visit.
- Discuss options for therapy with a mental health provider, when appropriate.
- Develop a plan with your patient to take steps to improve mental health. Consider exercise, sleep habits, volunteering, attending religious services, identifying stress triggers, reducing alcohol or caffeine intake, meditation, connecting with supportive family and friends.
- Schedule a check-in to discuss progress with this plan.
- Consider a hearing test when appropriate, as loss of hearing can feel isolating.
- Provide patients the *988 Suicide & Crisis Lifeline* information (formerly known as the *National Suicide Prevention Lifeline*, 1-800-273-TALK).

Monitoring physical activity	• In the past 12 months, did: – You talk with a doctor or other health care provider about your level of exercise or physical activity? – A doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?

Tips for success

- Talk to patients about their physical activity and the health benefits of staying active. Studies show that having patients fill out a questionnaire is not enough to gauge their activity level. Show interest in ensuring patients remain active.
- Develop a plan with your patient to take steps to start or increase physical activity. Offer suggestions based on the patient's physical ability, interests and access.
  - Schedule a check-in to discuss progress on this plan.
- Refer patients with limited mobility to physical therapy to learn safe and effective exercises.

Improving bladder control	• In the past six months, have you experienced leaking of urine? – There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?

continued

Measure	Sample survey questions to patient
Tips for success • Ask patients if they have any trouble holding their urine. If yes, ask the following questions: – When do you notice leaking (exercise, coughing, after urinating)? – Is there urgency associated with the leaking? – Do you have any issues emptying your bladder (incomplete, takes too long, pain)? – How often do you empty your bladder at night? During the day? – Do you have pain when you urinate? – Have you noticed a change in color, smell, appearance or volume of your urine? – How impactful are your urinary issues to your daily life? • For men, ask all the same questions, plus: – Is there any change in stream? – Any sexual dysfunction (new, historical, or changing)? • Urinary problems can be common as we grow older, but there are treatments that can help. Discuss potential treatment options such as behavioral therapy, exercises, medications, medical devices and surgery. • Use informational brochures and materials as discussion starters for this sensitive topic.	
Reducing the risk of falling	• In the past 12 months, did you talk with your doctor or other health practitioner about falling or problems with balance or walking? • Did you fall in the past 12 months? • In the past 12 months, have you had a problem with balance or walking? • Has your doctor or health practitioner done anything to help you prevent falls or treat problems with balance or walking?
Tips for success • Promote exercise, physical therapy and strengthening and balance activities (tai chi, yoga). • Review medications for any that increase fall risk. • Discuss home safety tips such as removing trip hazards, installing handrails and using nightlights. • Suggest the use of a cane or walker, if needed. • Recommend a vision or hearing test.	

Resources

1. Health Services Advisory Group (HSAG). 2025. "Welcome to the Medicare Health Outcomes Survey (HOS) Website." **hosonline.org**
2. Substance Abuse and Mental Health Services Administration (SAMHSA). 2025. "988 Suicide & Crisis Lifeline." **samhsa.gov/find-help/988**
3. Centers for Medicare & Medicaid Services (CMS). 2024. "Health Outcomes Survey (HOS)." **cms.gov/data-research/research/health-outcomes-survey**

2026 Star Measure Tips

Medication Adherence

Pharmacy Quality Alliance-endorsed performance measures

Measure description

Percentage of patients with a prescription for diabetes, hypertension or cholesterol medications and who were adherent with their prescribed course of treatment.

The three measures are:

- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS Antagonists)
- Medication Adherence for Cholesterol (Statins)

Did you know?

- Medication adherence can reduce total annual health care spending primarily through decreased inpatient hospital days and emergency department visits.
- Medications are arguably the single most important health care intervention to prevent illness, disability and death in the older population.
- The consequences of medication nonadherence in older adults may be more serious, less easily detected and less easily resolved than in younger age groups.

Measure population (denominator)

Patients 18 years and older who were dispensed at least two prescriptions on different dates of service during the measurement year.

Medications included in each measure

Diabetes	Hypertension	Cholesterol
• Biguanides • Sulfonylureas • Thiazolidinediones • Dipeptidyl peptidase (DPP)-IV inhibitors • Incretin mimetics • Meglitinides • Sodium glucose cotransporter 2 (SGLT2) inhibitors	Renin-angiotensin system (RAS) antagonists: • Angiotensin converting enzyme (ACE) inhibitors • Angiotensin II receptor blockers (ARBs) • Direct renin inhibitors	Statins

continued

Measure compliance (numerator)

Patients who filled their prescribed medication often enough to cover 80% or more of the treatment period.

Note: Patients must use their Medicare Part D pharmacy benefit as gap closure is dependent on pharmacy claims.

Exclusions

- Received hospice services anytime during the measurement year
- Patients with end stage renal disease diagnosis
- Diabetes measure only: prescription for insulin
- Hypertension measure only: prescription for sacubitril/valsartan (Entresto)

Helpful hints

- Instruct patients to fill prescriptions using their pharmacy benefit.
  - Claims filled through pharmacy discount programs, cash claims and medication samples will not count.
  - Gap closure is dependent on pharmacy claims.
  - Medication costs are often less when they use their pharmacy benefit.
  - Consider adding a directive to prescriptions instructing the pharmacy to run through the patient's Medicare Part D pharmacy benefit, especially when utilizing a discount program or VA benefit.
- Provide short and clear instructions for all prescriptions.
- Emphasize the benefits of taking the medication and the risks of not taking the medication. The benefits should outweigh the risks.
- At each visit, ask your patients about their medication habits:
  - What side effects have you had from the medication, if any?
  - How often, on average, do you miss doses or take them at different times than usual?
  - What financial barriers prevent you from obtaining your prescriptions?
  - What else, if anything, makes if difficult for you to refill or obtain your medications?
- Offer recommendations for adherence improvement:
  - Suggest the use of weekly or monthly pillboxes, smart phone apps with medication reminder alerts and placing medications in a visible area (in properly closed containers and safely out of reach of children or pets).
  - Instruct patients to contact their practitioner if experiencing side effects. Discuss alternative medications when appropriate.
  - Encourage patients to enroll in auto-refill program or utilize mail-order options.
- Once patients are stable on regimen, write 90-day supplies of maintenance medications.
- Schedule a follow-up visit within 30 days when prescribing a new medication to assess effectiveness and any barriers.

Resources

1. Pharmacy Quality Alliance (PQA). 2025. "PQA Measure Use in CMS' Part D Quality Programs: Medicare Part D Star Ratings." **pqaalliance.org/medicare-part-d**
2. Adult Meducation. 2012. "Improving Medication Adherence in Older Adults." **adultmeducation.com**
3. National Library of Medicine. 2021. "A study of medication compliance in geriatric patients with chronic illness." **ncbi.nlm.nih.gov/pmc/articles/PMC8144798/**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of women who suffered a fracture and received appropriate testing or treatment for osteoporosis.

Measure population (denominator)

Female patients ages 67–85 who suffered a fracture from July 1 of the year prior through June 30 of the measurement year.

Note: Fractures of the finger, toe, face or skull are not included in this measure.

Measure compliance (numerator)

Received appropriate treatment or testing within six months after the fracture, as defined by either of the below:

- A bone mineral density (BMD) test on the fracture date or within 180 days (six months) after the fracture
  - BMD tests during an inpatient stay are acceptable.
- A prescription to treat osteoporosis that's filled on the fracture date or within 180 days (six months) after the fracture. Patients must use their pharmacy benefit to close this measure
  - Long-acting osteoporosis medications used during an inpatient stay are acceptable

Did you know?

- The U.S. Preventive Services Task Force recommends BMD screening for women starting at age 65 to reduce the risk of fractures and postmenopausal women < 65 if they are at high risk.
- Osteoporosis is a bone disease characterized by low bone mass, which leads to bone fragility and increased susceptibility to fractures.
- Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life and increased mortality.

continued

Category	Prescription	
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate	• Risedronate • Zoledronic acid
Others	• Abaloparatide • Denosumab • Raloxifene	• Romosozumab • Teriparatide

Exclusions

- Received hospice services anytime during the measurement year
- Received palliative care from July 1 of the prior year through December 31 of the measurement year
- Are deceased during the measurement year
- Are age 67–80 with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*)
- Are age 81 or older with frailty diagnoses from July 1 of the year prior through December 31 of the measurement year (for additional definition information, see the *Advanced Illness and Frailty Guide*)

Helpful HEDIS hints

- Discuss osteoporosis prevention including calcium and vitamin D supplements, weight-bearing exercises and modifiable risk factors.
- Ask patients if they've had any recent falls or fractures, since treatment may have been received elsewhere.
- If virtual care is used instead of in-person visits, discuss the need for a bone mineral density test or medication therapy.
- Discuss fall prevention such as:
  - The need for assistive devices (e.g., cane, walker)
  - Removing trip hazards, using night lights and installing grab bars
- Promote exercise, physical therapy, strengthening and balance activities (e.g., yoga, tai chi).
- **Bone Mineral Density Testing**
  - Discuss the need and mail an order to patients that includes the location and phone number of a testing site.
  - Encourage patients to complete the screening and follow up to ensure the test was performed.
- **Medication Therapy**
  - Mail or e-Scribe a prescription to treat or prevent osteoporosis if applicable.
  - Patients should fill prescriptions using their pharmacy benefit.
  - Gap closure is dependent on pharmacy claims.
  - Discount programs, VA benefits, cash claims and medication samples will not count.

Tips for coding

- Document and bill exclusions annually (see the *Advanced Illness and Frailty Guide* for details).
- Bill the ICD-10 code to identify how the fracture happened (e.g., fall).

Resources

1. National Institutes of Health (NIH). 2022. "Osteoporosis." **Niams.nih.gov/health-topics/osteoporosis**
2. Office on Women's Health (OASH). 2025. "Osteoporosis." **womenshealth.gov/a-z-topics/osteoporosis**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Plan All-Cause Readmissions (PCR)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients that were readmitted to the hospital within 30 days of discharge.

Measure population (denominator)

Patients 18 years and older who had an acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year.

- This measure is based on discharges.
- Patients may appear in the denominator more than once.
- Includes acute discharges from any type of facility.

Did you know?

- Unplanned readmissions are associated with increased mortality and higher health care costs.
- Readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.

Measure compliance (numerator)

The number of patients who had an unplanned acute readmission for any diagnosis within 30 days following an acute discharge.

Exclusions

- Diagnosed with pregnancy or a condition originating in the perinatal period
- Received hospice services anytime during the measurement year
- Deceased during the hospital stay

continued

Helpful HEDIS hints

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of discharge.
  - If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
  - Request patients bring all prescriptions, over-the-counter medications and supplements to the post-discharge visit, and complete the medication reconciliation.
- Connect with your state's automated electronic admission, discharge and transfer (ADT) system to receive admission, discharge and transfer notifications for your patients. Michigan Health Information Network (MiHIN). **https://mihin.org/**
- Perform transitional care management for recently discharged patients.
- Consider implementing a post-discharge process to track, monitor and follow up with patients.
  - Obtain and review all discharge summaries.
  - Obtain any test results that were not available when patients were discharged and track tests that are still pending.
  - Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients or caregivers to recite the care plan back to you to demonstrate understanding.
- Document and date the medication reconciliation in the outpatient medical record.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future
- Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
  - Start as-needed or PRN medications
  - Call their doctor (during or after office hours)
  - Go to the emergency room

Tips for coding

- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period to be submitted on a claim.
- Document and date the medication reconciliation in the outpatient medical record.
  - Submit an 1111F claim as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.

Resources

1. John Hopkins Medicine. 2024. "Hospital Readmissions." **hopkinsmedicine.org/patient-safety/readmissions**
2. Centers for Medicare and Medicaid Services (CMS). 2025. "Hospital Readmissions Reduction Program (HRRP)." **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program**

2026 Star Measure Tips

One in a series of tip sheets about HEDIS® and other measures that contribute to star ratings of Medicare Advantage plans.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)

Pharmacy Quality Alliance-endorsed performance measures

Did you know?

- Anticholinergics have also been associated with increased risk of dementia.
- Anticholinergic drugs may cause cognitive disorder symptoms which may be mistaken as normal manifestations of aging.
- Long-term continued use of anticholinergic drugs could induce brain changes partially comparable to those present in Alzheimer's disease.

Measure description

The percentage of patients with concurrent use of two or more unique anticholinergic medications.

Measure population (denominator)

Patients ≥ 65 years and older with two or more prescriptions filled for the same anticholinergic medication on different dates of service during the measurement year.

Measure compliance (numerator)

Patients with concurrent use of two or more unique anticholinergic medications filled for at least a 30-day supply on different dates of service.

NOTE: A lower rate indicates better performance

continued

Antidepressant Medications	
• amitriptyline	• doxepin (>6 mg/day)
• amoxapine	• imipramine
• clomipramine	• nortriptyline
• desipramine	• paroxetine

Antihistamine Medications	
• brompheniramine	• doxylamine
• chlorpheniramine	• hydroxyzine
• cyproheptadine	• meclizine
• dimenhydrinate	• triprolidine
• diphenhydramine (oral)	

Antiparkinsonian Agent Medications	
• benztropine	• trihexyphenidyl

Antispasmodic Medications	
• atropine (excludes ophthalmic)	• homatropine (excludes ophthalmic)
• clidinium-chlordiazepoxide	• hyoscyamine
• dicyclomine	• scopolamine (excludes ophthalmic)

Antiemetic Medications	
• prochlorperazine	• promethazine

Antimuscarinic Medications (urinary incontinence)	
• darifenacin	• solifenacin
• fesoterodine	• tolterodine
• flavoxate	• trospium
• oxybutynin	

Antipsychotic Medications	
• chlorpromazine	• olanzapine
• clozapine	• perphenazine

Skeletal Muscle Relaxant	
• cyclobenzaprine	• orphenadrine

Exclusions

- Received hospice services anytime during the measurement year

Helpful hints

- **Avoid** the use of anticholinergic medications in older adults without first considering safer alternatives or non-drug measures.
- **Assess** for side effects including confusion, dry mouth, blurry vision, constipation, urinary retention, decreased perspiration, and excess sedation.
- **Discuss** risks and side effects of anticholinergic medications
- **Continue** long-term co-prescribing only when necessary and monitor closely.

Resources

1. Pharmacy Quality Alliance (PQA). 2024. "PQA Quality Measures." pqaalliance.org/medication-safety
2. National Institutes of Health (NIH). 2019. "Anticholinergic Drugs in Geriatric Psychopharmacology." ncbi.nlm.nih.gov/pmc/articles/PMC6908498/
3. American Academy Family Physician (AAFP). 2024. "Don't recommend highly anticholinergic medications in older adults without first considering safer alternatives or non-drug measures." www.aafp.org/pubs/afp/collections/choosing-wisely/484.html

Pharmacy Quality Alliance (PQA) is a national quality organization dedicated to improving medication safety, adherence and appropriate use. PQA measures are included in the Medicare Part D Star Ratings.

December 2025

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2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Statin Therapy for Patients with Cardiovascular Disease (SPC-E)

Electronic Clinical Data Systems (ECDS) Measure

Measure description

The percentage of patients with clinical atherosclerotic cardiovascular disease (ASCVD) receiving statin therapy.

Measure population (denominator)

Patients 21-75 years of age during the measurement year and identified as having ASCVD via *either* of the following:

- Any of the following in the year prior to the measurement year:
  - Myocardial infarction (MI)
  - Coronary artery bypass graft (CABG)
  - Percutaneous coronary intervention (PCI)
  - Other revascularization procedure
- At least two diagnoses of ASCVD on different dates of service during the measurement year or the year prior.

Did you know?

- Cardiovascular disease is the leading cause of death in the United States.
- Unhealthy cholesterol levels places patients at a significant risk for developing ASCVD.
- Effective statin therapy can dramatically reduce deaths from coronary artery diseases.

Measure compliance (numerator)

Patients dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

Note: Patients must use their Medicare Part D pharmacy benefit to close this measure.

Category	Medication	
High-intensity	• Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40–80 mg • Rosuvastatin 20–40 mg	• Ezetimibe-simvastatin 80 mg • Simvastatin 80 mg
Moderate-intensity	• Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg	• Pravastatin 40–80 mg • Lovastatin 40–60 mg • Fluvastatin 40–80 mg • Pitavastatin 1-4mg

Exclusions

- Myalgia, myositis, myopathy or rhabdomyolysis during the measurement year
  - Patients on low dose statins that cannot tolerate moderate or high intensity statins may be excluded if one of these conditions apply
- Myalgia or rhabdomyolysis caused by a statin any time during the patients history
- Received hospice services anytime during the measurement year
- Received palliative care during the measurement year
- Deceased during the measurement year
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the Advanced Illness and Frailty Guide)
- Any of the following during the **measurement year or the year prior**
  - Pregnancy diagnosis, IVF or at least one prescription for clomiphene (estrogen agonists)
  - End stage renal disease or dialysis
  - Cirrhosis

Helpful HEDIS hints

- **Educate** patients on the importance of statin medication adherence.
- **Instruct** patients to contact their practitioner if they are experiencing adverse effects.
  - Document any adverse effects from statin therapy.
  - Determine if the signs/symptoms qualify as an exclusion.
  - Try reducing the dose or frequency.
  - Consider trying a different statin.
- **Encourage** patients to obtain 90 day supplies at their pharmacy, once they have demonstrated they can tolerate statin therapy.
- **Consider** adding directives to prescriptions instructing the pharmacy to run it through the patient's pharmacy benefit, especially when utilizing discount programs.

- **Instruct** patients to fill prescriptions using their pharmacy benefit.
  - Gap closure is dependent on Medicare Part D pharmacy claims.
  - Discount programs, VA benefits, cash claims and medication samples will not count.
- **Document** any past evidence of a myalgia reaction to statins (e.g.muscle pain, muscle cramps).

Tips for coding

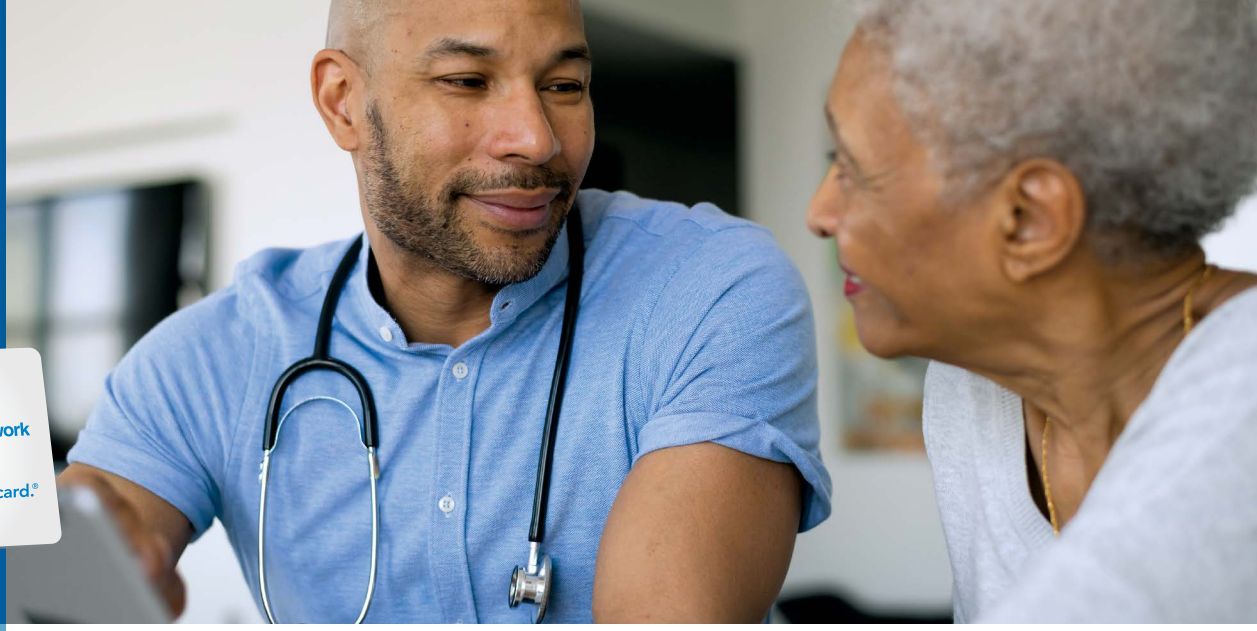
- In order to exclude patients who cannot tolerate statin medications, a claim **MUST** be submitted **annually** using the appropriate ICD-10-CM code.
- These codes are intended to close Star measure gaps and do not apply to payment or reimbursement. Only the codes listed below will exclude the patient from the SPC measure.
- Providers may contact the patient to confirm and document the diagnosis in the medical record. They should then bill the non-reimbursable HCPCS code G9781 for $0.01 with the applicable ICD-10 code attached to process the claim and remove the patient from the Star measure.

Condition	ICD-10-CM Codes
Myalgia	M79.10–M79.12, M79.18
Myositis	M60.80, M60.811, M60.812, M60.819, M60.821, M60.822, M60.829, M60.831, M60.832, M60.839, M60.841, M60.842, M60.849, M60.851, M60.852, M60.859, M60.861, M60.862, M60.869, M60.871, M60.872, M60.879, M60.88, M60.89, 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)	N18.5, N18.6
Pregnancy	Numerous > 1k
Condition	**CPT® and HCPCS Codes**
Dialysis	90935, 90937, 90945, 90947, 90997, 90999, 99512, G0257, S9339
Condition	**HCPCS Codes**
In vitro fertilization (IVF)	S4015, S4016, S4018, S4020, S4021
Condition	**SNOMED Codes**
Rhabdomyolysis due to statin	787206005
Myalgia caused by statin	16462851000119106
History of myalgia caused by statin	16524291000119105
History of rhabdomyolysis due to statin	16524331000119104

Resources

1. American Heart Association (AHA). 2025. "2025 Heart Disease and Stroke Statistics Update Fact Sheet." **heart.org/en/-/media/PHD-Files-2/Science-News/2/2025-Heart-and-Stroke-Stat-Update/2025-Statistics-At-A-Glance.pdf?sc_lang=en**
2. American College of Cardiology. 2022. "Statin Use for Primary Prevention of CVD: USPSTF Recommendation." **acc.org/Latest-in-Cardiology/ten-points-to-remember/2022/08/23/22/22/Statin-Use-for-the-Primary-Prevention**

2026 Star Measure Tips



Statin Use in Persons with Diabetes (SUPD)

Pharmacy Quality Alliance-endorsed performance measures

Measure description

Percentage of patients who were dispensed a diabetes medication and are receiving statin therapy.

Measure population (denominator)

Patients age 40–75 years old who were dispensed at least two diabetes medication fills during the measurement year.

Measure compliance (numerator)

Patient dispensed at least one statin medication of **any** intensity during the measurement year using their Medicare Part D benefit.

Did you know?

- Patients with diabetes have an increased prevalence of lipid abnormalities, which contributes to their increased risk of cardiovascular disease.
- Statins are effective at lowering cholesterol and protecting against a heart attack and stroke.
- The American College of Cardiology/American Heart Association (ACC/AHA) and the American Diabetes Association guidelines all recommend using statins in patients with diabetes for cardiovascular risk reduction.

Statin Medications: Generic and Brand Names			
Atorvastatin (Lipitor, Caduet)	**Lovastatin** (Altoprev)	**Pravastatin** (Pravachol)	**Simvastatin** (Zocor, Vytorin)
Fluvastatin (Lescol XL)	**Pitavastatin** (Livalo, Zypitamag)	**Rosuvastatin** (Crestor, Ezallor), Roszet)	

Note: Patients must use their Medicare Part D pharmacy benefit as gap closure is dependent on pharmacy claims. Statins found in combination medications (i.e., Caduet, Vytorin, and Roszet) meet the measure.

continued

Exclusions

- Myositis, myopathy or rhabdomyolysis during the measurement year
- Prediabetes
- End stage renal disease (ESRD)
- Cirrhosis
- Pregnant, lactating or undergoing fertility treatment
- Polycystic ovarian syndrome (PCOS)
- Received hospice services anytime during the measurement year

Helpful hints

- Prescribe at least one statin medication during the measurement year to patients age 40-75 diagnosed with diabetes.
- Educate patients on the importance of statin medications for patients with diabetes age 40-75, regardless of LDL levels.
- Discuss with patients the importance of taking their medications as prescribed.
- Once patients demonstrate that they tolerate statin therapy, encourage them to obtain 90-day supplies through their pharmacy or mail-order pharmacy.
- Consider adding directives to prescriptions instructing the pharmacy to run it through the patients' Medicare Part D pharmacy benefit, especially when utilizing discount programs.
- Instruct patients to fill prescriptions using their Medicare Part D pharmacy benefit.
  - Discount programs, VA or commercial benefits, cash claims, and medication samples will not close an SUPD gap.
  - Gap closure is dependent on Medicare Part D pharmacy claims.
- Medication costs are often less when patients use their pharmacy benefit.
- Remind patients to contact their practitioner if experiencing medication adverse effects.
- Consider trying a different statin or reducing the dose or frequency if patients are experiencing adverse effects.

Tips for coding

- To exclude patients who cannot tolerate statin medications, a claim **must** be submitted **annually** using the appropriate ICD-10-CM code.
- These codes are intended to close Star measure gaps and do not apply to payment or reimbursement. Only the codes listed below will exclude the patient from the SUPD measure.
- Providers may use virtual care to confirm and document the exclusion diagnosis in the medical record. They should then bill the non-reimbursable HCPCS code G9781 for $0.01 with the applicable ICD-10 code attached to process the claim and remove the patient from the Star measure.

Condition	ICD-10-CM code
Cirrhosis	K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69
ESRD	I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
Pregnancy and/or Lactation	Numerous > 1k
Polycystic Ovarian Syndrome	E28.2
Pre-diabetes	R73.03
Other abnormal blood glucose	R73.09
Myopathy, drug induced *	G72.0
Myopathy, Other specified *	G72.89
Myopathy, unspecified *	G72.9
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

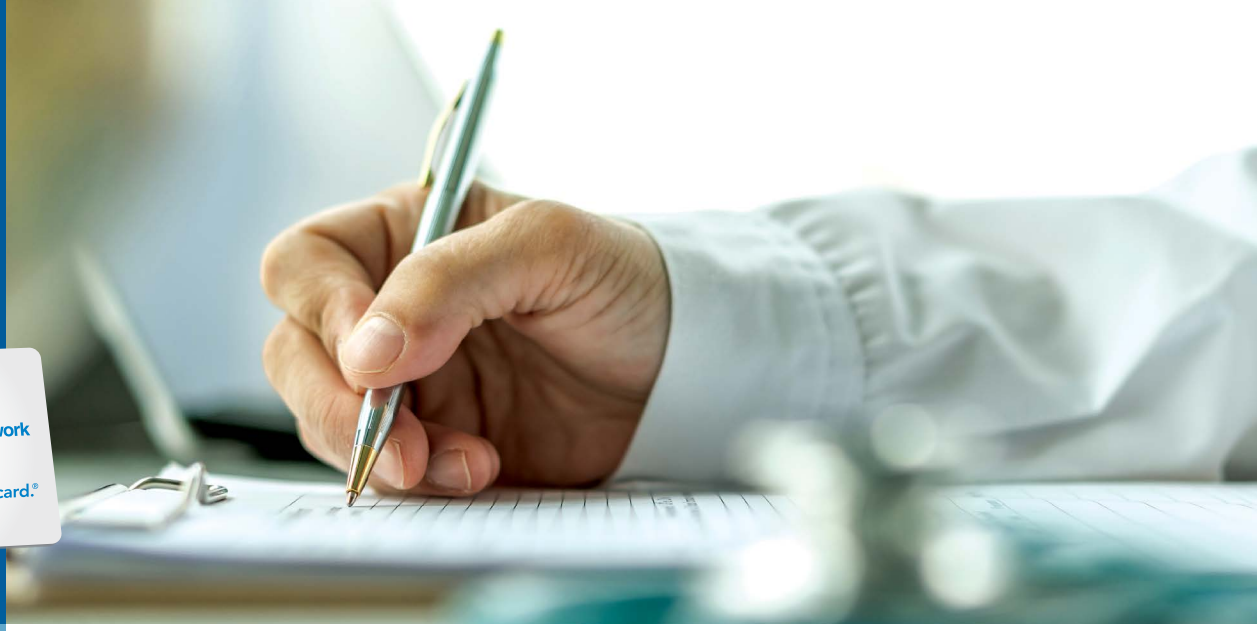
**The condition the code refers to does not necessarily need to occur in the same year the code was billed. The member's medical chart should reflect 'history of'.*

Resources

1. American College of Cardiology (ACC) / American Heart Association (AHA). 2019. "ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease." **jacc.org/doi/10.1016/j.jacc.2019.03.010?_ga=2.111587588.1694140041.1718720098-1154138379.1718720098**
2. Mangione, Carol M. 2022. "Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: US Preventive Services Task Force Recommendation Statement." JAMA : the Journal of the American Medical Association (0098-7484), 328 (8), p. 746. **https://jamanetwork.com/journals/jama/fullarticle/2795521**
3. American Diabetes Association Professional Practice Committee. 2025. "10. Cardiovascular disease and risk management: Standards of Care in Diabetes—2025." **diabetesjournals.org/care/article/48/Supplement_1/S207/157549/10-Cardiovascular-Disease-and-Risk-Management?searchresult=1**

Pharmacy Quality Alliance (PQA) is a national quality organization dedicated to improving medication safety, adherence and appropriate use. PQA measures are included in the Medicare Part D Star Ratings.

2026 Star Measure Tips



One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of patients that received continuity of health care following an inpatient discharge.

Measure population (denominator)

Patients 18 years and older with an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

Note: If patients have multiple discharges, they could appear in the measure more than once.

Measure compliance (numerator)

Patients that had **all** four of the following components completed and documented in the **outpatient** medical record (see medical record requirements in table below).

1. Notification of inpatient admission (NOIA)
2. Receipt of discharge information (ROD)
3. Patient engagement after inpatient discharge (PE)
4. Medication reconciliation post-discharge (MRP)

Exclusions

- Received hospice services anytime during the measurement year
- Deceased during the measurement year

Did you know?

- Inadequate care coordination and poor care transitions result in billions of unnecessary medical expenses.
- Transitions of care has emerged as an important point of vulnerability in the health care system where medical errors and clinical deterioration can occur.
- The period between discharge and first outpatient appointment is recognized as a vulnerable time for patients when adverse events can occur.
- Patients are unaware of how to seek help if a question arises or a new event occurs, leading to overuse of the emergency department.

continued

Helpful HEDIS hints

Documentation of **all four** components must be in the **outpatient** record and accessible to the PCP or managing specialist within the required timeframe:

Component	Criteria	Outpatient medical record requirements
1. Notification of inpatient admission	Receipt of notification of inpatient admission and evidence that the information was integrated in the appropriate medical record on the day of admission through two days after admission (**three days total**). **Note:** Can only be met through medical record review.	Must include the date of receipt and **any** of the following criteria: • Communication from inpatient practitioner, hospital staff or emergency department regarding admission (phone call, email or fax). Referral to an emergency department does not meet criteria. • Documentation that the PCP or managing specialist admitted the patient, or a specialist admitted with PCP or managing specialist notification. • Communication about admission through a health information exchange: an admission, discharge and transfer alert system (ADT) or a shared electronic medical record (EMR) • Documentation indicating the PCP or managing specialist placed orders for tests and treatments any time during the patient's inpatient stay • Documentation of a preadmission exam or a planned admission prior to the admit date. The exam must reference the planned admission (not just pre-op or pre-surgical). • Communication from the member's health plan regarding admission **Note:** Documentation the patient/caregiver notified the PCP or managing specialist of the admission does **not** count.
2. Receipt of discharge information	Receipt of discharge information and evidence that the information was integrated in the appropriate medical record on the day of discharge through two days after discharge (**three days total**). **Note:** Can only be met through medical record review. • Pay attention to discharge disposition and request the SNF/SAR discharge summary if indicated	Must include the date of receipt and **all** the following criteria: 1. The practitioner responsible for the patient's care during the inpatient stay 2. Procedures or treatment provided 3. Diagnoses at discharge 4. Current medication list 5. Testing results, documentation of pending tests or documentation of no tests pending 6. Instructions for patient care post discharge **Note:** Documentation the patient/caregiver notified the PCP or managing specialist of the discharge does **not** count.

continued

Component	Criteria	Outpatient medical record requirements
3. Patient engagement after inpatient discharge	Patient engagement provided within **30 days after discharge**. Do not include patient engagement that occurs on the date of discharge.	Must include the date of engagement with **any** of the following criteria: • An outpatient visit including office visits and home visits • Virtual care visits (asynchronous or synchronous) • Documentation indicating a conversation occurred with the patient, regardless of practitioner type. For example, medical assistants and registered nurses may perform the patient engagement. • Interactions between the patient's caregiver and practitioner
4. Medication reconciliation post-discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (**31 days total**). • Must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse. Other staff members (e.g., MA or LPN) may conduct the medication reconciliation, but it must be signed off by the required practitioner type. • Must be in the outpatient medical record, but an outpatient face-to face visit is not required • Documentation of "post-op/ surgery follow-up" without a reference to "hospitalization," "admission," or "inpatient stay" does not count.	Must include the date performed **AND** specific documentation of inpatient hospitalization with any of the following criteria: • Current medication list with a notation that the practitioner reconciled the current and discharge medications • Current medication list with reference to discharge medications (e.g., no changes in meds post discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed) • Current medication list and discharge medication list with evidence both lists reviewed on same date of service • Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review • Discharge summary medication list indicates reconciled with current meds. Must be filed in the outpatient record within 30 days after discharge. • Documentation that no medications were prescribed or ordered upon discharge

- Utilize Michigan Health Information Network's (MiHIN) admission, discharge, transfer (ADT) notifications to support TRC components. **mihin.org/**
- Request discharge summary from the inpatient facility when discharge ADT notification is received.
- Request discharge summary from SNF, SAR, etc., if indicated.
- You can reduce errors at the time of discharge by using the computer order entry system to generate a list of medication used before and during the hospital admission.
- Assess patient or caregiver comprehension of discharge instructions.
- Contact patients immediately following discharge to conduct medication reconciliation (e.g., over the phone if possible) and to schedule an appointment.

continued

Tips for coding

- Transitional care management (TCM) codes will satisfy both the Patient Engagement and Medication Reconciliation Post-Discharge components.
- Bill 1111F as soon as medication reconciliation is completed.
  - 1111F can be billed alone or with an associated visit.
  - Bill 1111F for $35 reimbursement for Medicare Plus Blue℠ and BCN Advantage.

Note: There is no member cost share associated with 1111F for Medicare Plus Blue or BCN Advantage.

- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
CPT® codes	**Description**
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **moderate** complexity and a face-to-face (in-person or audio/video telehealth) visit within **14 days** of discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **high** complexity and a face-to-face (in-person or audio/video telehealth) visit within **seven days** of discharge.
99605	Medication therapy management services provided by a pharmacist during an initial 15-minute face-to-face encounter.
99606	Medication therapy management services provided by a pharmacist, during an established face-to-face encounter.

Note: In addition to the Care Planning Service and TCM codes above, there are several additional codes that will satisfy the patient engagement component of TRC.

Resources

1. National Committee for Quality Assurance (NCQA). 2025. "Transitions of Care (TRC)." **ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/transitions-of-care-trc/**
2. JAMA Network Open. 2023. "Transitional Care Interventions From Hospital to Community to Reduce Health Care Use and Improve Patient Outcomes: A Systematic Review and Network Meta-Analysis." **pubmed.ncbi.nlm.nih.gov/38032642/**
3. Michigan Health Information Network Shared Services (MiHIN). 2025. "Transitions of Care Service." **mihin.org/transitions-of-care-service/**
4. BCBSM. 2025. "2025 Quality Success Series – Transitions of Care (TRC) ." **Unable to provide link to NPI series. Path: **Availity/Provider Secured Services/Member Care/Clinical Quality/Clinical Quality Overview**

2026 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Medication Reconciliation Post-Discharge (TRC-M)

A component of Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients who had their medications reconciled following an inpatient discharge.

Measure population (denominator)

Patients 18 years and older with an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

Note: If patients have multiple discharges, they could appear in the measure more than once.

Measure compliance (numerator)

Medications reconciled on the date of discharge through 30 days after (31 days total).

Did you know?

- Inadequate care coordination and poor care transitions result in billions of unnecessary medical expenses.
- Lack of communication between inpatient and outpatient providers may result in unintentional medication changes, incomplete diagnostic workups and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow up needs.
- Patient safety is compromised and medication errors result from inadequate medication reconciliation during care transitions.

Exclusions

- Received hospice services anytime during the measurement year
- Deceased during the measurement year

continued

Helpful HEDIS hints

- Medication reconciliation must be conducted or cosigned by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse.
  - Medication reconciliation may be performed by other medical professionals (e.g., MA, LPN) if signed off by an acceptable practitioner.
- Evidence of medication reconciliation must be in the outpatient medical record, but an outpatient face-to face visit is not required. A medication reconciliation performed without the member present meets criteria.
- Performing medication reconciliation after every discharge ensures that patients understand all their medications: new, current and discontinued.
- Request patients' discharge summary with medication list and any discharge instructions from the inpatient facility.
- A post discharge visit is encouraged to support patient engagement (office, home or virtual care visit). Ask patients to bring all medications (prescription, over-the counter, herbal, topical, etc.).
- Documentation of medication reconciliation **must** include the date performed, current medication list, and evidence of any of the following:
  - Notation that the practitioner reconciled the current and discharge medications
  - Notation that references the discharge medications (e.g., no change in medications since discharge, same medications at discharge, discontinue all discharge medications)
  - Evidence the practitioner was aware of the patient's hospitalization and a post-discharge hospital follow-up with medication reconciliation or review

    Note: Documentation of post op visit/surgical procedure **without** specifying there was a "hospitalization," "admission," or "inpatient stay" does not count.
  - Discharge medication list with evidence that both lists were reviewed on the same date of service
  - Notation that no medications were prescribed or ordered upon discharge

continued

Tips for coding

When any of the following CPT® codes are billed within 30 days of discharge, it will close the treatment opportunity, reducing medical record requests:

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
CPT® codes	**Description**
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **moderate** complexity and a face-to-face (in-person or audio/video telehealth) visit within **14 days** of discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **high** complexity and a face-to-face (in-person or audio/video telehealth) visit within **seven days** of discharge.
99605	Medication therapy management services provided by a pharmacist during an initial 15-minute face-to-face encounter.
99606	Medication therapy management services provided by a pharmacist, during an established face-to-face encounter.

- Bill 1111F as soon as medication reconciliation is completed.
  - 1111F can be billed alone ***OR*** with an associated visit.
  - Bill 1111F for $35 reimbursement for Medicare Plus Blue and BCN Advantage.

  Note: There is no member cost share associated with 1111F for Medicare Plus Blue and BCN Advantage.
- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

Resources

1. National Committee for Quality Assurance (NCQA). 2025. "Medication Reconciliation Post-Discharge (MRP)." **ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/medication-reconciliation-post-discharge-mrp/**
2. Michigan Health Information Network Shared Services (MiHIN). 2024. "Discharge Medication Reconciliation." **mihin.org/wp-content/uploads/2024/08/MiHIN-IG-Discharge-Medication-Reconciliation-v13-6-24-2024.pdf**
3. BCBSM. 2025. "2025 Quality Success Series – Transitions of Care (TRC) ." **Unable to provide link to NPI series Path: **Availity/Provider Secured Services/ Member Care/Clinical Quality/Clinical Quality Overview**