CHI Saint Joseph Health Partners

Quality Measures: 2020 Humana Medicare Advantage

Measure: Breast Cancer Screening

Percentage of women who had a mammogram (including digital breast tomosynthesis) during the measurement period or the prior 15 months (October 1, 2018 – December 31, 2020).

Eligible Population: Females, Age 50 to 74 years old.

Time Frame/Schedule for Coverage *(preventive at 100%):*

- Can be performed annually, between 11 and 13 months;
- Must be performed within the last 27 months that ends December 31, 2020.

Documentation Requirements (codes to identify screenings/tests):

Description	Codes
CPT	77055, 77056, 77057, 77061-77063, 77065-77067
HCPCS	G0202, G0204, G0206
UB Revenue Hospital Codes	0401, 0403

Exclusions:

Patients in hospice or using hospice services; patients 66-75 years old who live long term in an institutional setting AND/OR have frailty and advanced illness; history of bilateral mastectomy or history of both a unilateral left and right mastectomy.

Exclusion Codes:

Description	Codes
Absence of Right Breast	ICD-10: Z90.11
Absence of Left Breast	ICD-10: Z90.12
Bilateral Mastectomy	ICD-10 PCS: 0HTV0ZZ
Bilateral Modifier	50, 09950
Right/Left Modifier	RT/LT
History of Bilateral Mastectomy	ICD-10: Z90.13
Unilateral Mastectomy	CPT: 19180, 19200, 19220, 19240, 19303-19307
Unilateral Mastectomy Right	ICD-10 PCS: 0HTT0ZZ
Unilateral Mastectomy Left	ICD-10 PCS: 0HTU0ZZ

What does not count toward closing the Breast Cancer Screening care gap?

- Counseling and patient refusals for screening mammograms

Measure: Colorectal Cancer Screening

Each eligible member receives an appropriate colorectal screening. Documentation (including date and result) of one or more of these screenings:

Eligible Population: Age 50 to 75 years old.

Time Frame/Schedule for Coverage *(preventive at 100%):*

- **Colonoscopy** once every 10 years **(elapse 119 months*)** non-high risk (G0121)
- **Colonoscopy** once every 2 years **(elapse 23 months*)** high-risk (G0105)
- **FOBT** once every year **(elapse 11 months*)** (82270 [peroxidase activity determination when patient returns a card], 82274 [fecal hemoglobin determination], G0328)
- **Flexible Sigmoidoscopy** once every 5 years **(elapse 59 months*)** (G0104)
- **Cologuard** once every 3 years (81528) with specific criteria

Documentation requirements (codes to identify screenings/tests):

Description	Codes
Colonoscopy	**CPT:** 44388-44394, 44397, 44401-44408, 45355, 45378, 45379, 45380-45393, 45398 **HCPCS:** G0105, G0121
FOBT	**CPT:** 82270, 82274 **HCPCS:** G0328 **LOINC:** 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6
CT Colonography	**CPT:** 74261-74263
FIT-DNA	**CPT:** 81528 **HCPCS**: G0464 **LOINC**: 77353-1, 77354-9
Flexible Sigmoidoscopy	**CPT:** 45330-45335, 45337-45342, 45345-45347, 45349-45350 **HCPCS:** G0104

Exclusions: Members with diagnosis of colorectal cancer or total colectomy. Patients in hospice or using hospice services. Patients 66-75 years old who live long term in an institutional setting AND/OR have frailty or advanced illness**.**

What does not count toward closing the Colorectal Screening care gap?

- Digital Rectal exams (DRE)
- FOBT performed in an office setting (must be sent to Lab) or performed on a sample collected via DRE. "no occult blood", "blood Occult ±", "Heme ±"
- Epi proColon, Septin 9 Gene Methylation Detection
- Documentation using verbiage "colorectal CA screening" without specific type of test and date
- Counseling and/or patient refusals on colorectal cancer screening

Exclusion Codes:

Description	Codes
Colorectal Cancer	**ICD-10-CM:** C18.0–C189.9, C19-C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 **HCPCS:** G0213-G0215, G0231
Total Colectomy	**ICD-10-PCS:** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ **CPT:** 44150-44153, 44155-44158, 44210-44212

Note: *Clear documentation of previous colonoscopy, CT colonography or sigmoidoscopy, including year performed, is required. Chart documentation as part of the medical history of colorectal screening performed within the required time frame. Patients are excluded if medical record documentation supports history of colorectal cancer or total colectomy through Dec. 31, 2019.*

Measure: Diabetes Care – Blood Sugar Controlled

Eligible members that have evidence of:

- HgbA1c during the measurement year
- HgbA1c poor control greater than 9%.

Eligible Population: Ages 18-75 years old with a diagnosis of Diabetes Type I or Type II.

Time Frame: At least once every calendar year.

Codes to identify a patient with diabetes:

Description	Codes
ICD-10 Diagnosis	E10 - E11 (Type 1 and Type 2 Diabetes Mellitus) E13 (Other Specified Diabetes)

Documentation Requirements (codes to identify screenings/tests):

Description	Codes
CPT	83036, 83037
LOINC	4548-4, 4549-2, 17856-6
CPT II	3044F, 3045F, 3046F *CPT II codes count for both the HgbA1c test and HgbA1c level*

Note: *Pathology/laboratory codes count for the HbA1c test measure. They must include the result value to count for the HbA1c poor control measure. A copy of all lab results should be kept in the patient's medical record. Only the most recent results are counted for the measure and a gap in care may reopen with a noncompliant or missing result.*

Exclusions:

Members 66 years of age and older who meet one of these criteria:

- Enrolled in an I-SNP or long-term institutional setting
- Have frailty and advanced illness

Measure: Diabetes Care – Nephropathy

Percentage of diabetic patients 18-75 years old who received medical attention for nephropathy (nephropathy screening test or evidence of nephropathy)* Physicians must ensure/achieve 97% or greater.

Eligible Population: Ages 18-75 years old with a diagnosis of Diabetes Type I or Type II.

Time Frame: At least once during every calendar year.

One or more of the following screenings are required:

1. Nephropathy screening **testing on all diabetic patients in 2020** with a urine protein test;
2. Documented evidence of nephropathy with medical attention for nephropathy;
3. Nephrology **consult in 2020** (include if primary care physician also is a nephrologist);
4. **NEW: PLEASE NOTE** A dispensed prescription for angiotensin- converting enzyme (ACE) inhibitor/angiotensin receptor blockers (ARB) therapy in **2020; MUST PROVE THAT PRESCRIPTION WAS FILLED in 2020.**

SUGGESTION: Use #'s 1, 2, or 3 before using #4 for proof of attention for nephropathy as it has become more difficult to prove.

Codes to identify a patient with diabetes:

Description	Codes
ICD-10 Diagnosis	E10 - E11 (Type 1 and Type 2 Diabetes Mellitus) E13 (Other Specified Diabetes)

Documentation Requirements (codes to identify screenings/tests):

Description	Codes
Nephropathy screening:	
CPT II	Evidence of ACE/ARB therapy: 3060F, 3061F, 3062F; 4010F
Treatment for Nephropathy:	
CPT II	3066F
ICD-10-CM Diagnosis	E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0 – N08, N14.0-4, N17.0-2, N17.8, N17.9, N18.1-6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0-6, Q61.00-02, Q61.11, Q61.19, Q61.2-5, Q61.8, Q61.9, R80.0-3, R80.8, R80.9
Evidence of Nephropathy – CKD Stage 4:	
ICD-10-CM Diagnosis	N18.4
Evidence of Nephropathy – Kidney Transplant:	
ICD-10-CM Diagnosis	Z94.0
Evidence of Nephropathy – ESRD:	
ICD-10-CM Diagnosis	N18.5, N18.6, Z91.15, Z99.2

Pathology/Laboratory Codes:

Description	Codes
Nephropathy screening tests:	
CPT	81000, 81002, 81003, 81005, 82042, 82043, 82044, 84156
LOINC	1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 5804-0, 6941-9, 6942-7, 9318-7, 11218-5, 12842-1, 13705-9, 13801-6, 13986-5, 13992-3, 14956-7, 14957-5, 14958-3, 14959-1, 17819-4, 18373-1, 20454-5, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 29946-1, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49002-9, 49023-5, 50209-6, 50561-0, 50949-7, 51190-7, 53121-0, 53525-2, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 57735-3, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1, 76401-9, 77253-3, 77254-1, 77940-5

Surgery/Hospital/Specialist Codes:

Description	Codes
Evidence of Nephropathy – Kidney Transplant:	
CPT	50300, 50320, 50340, 50360, 50365, 50370, 50380
HCPCS	S2065
ICD-10-CM Procedure	0TY00Z0 – 0TY00Z2, OTY10Z0 – OTY10Z2
UB Revenue	0367
Evidence of Nephropathy – ESRD:	
CPT	36147, 36800, 36810, 36815, 36818 – 36821, 36831 – 36833, 90935, 90937, 90940, 90945, 90947, 90951 – 90970, 90989, 90993, 90997, 90999, 99512
HCPCS	G0257, S9339
ICD-10-CM Procedure	3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z
POS	65
UB Revenue	0800 – 0804, 0809, 0820 – 0825, 0829 – 0835, 0839 – 0845, 0849 – 0855, 0859, 0880 – 0882, 0889
UB TOB	0720 – 0725, 0727, 0728, 072A – 072K, 072M, 072O, 072X – 072Z

NDC Codes: There are several NDC codes for ACE/ARB therapy that indicate compliance (based on received pharmacy claims). NCQA posts a comprehensive list of these NDC codes on its website each year.

Specialist Visits: Any visit with a nephrologist would make a patient compliant with the measure. These claims will be identified by the type of health care provider rendering the service; no specific codes are needed on the claim.

Exclusions:

- Patients in hospice or using hospice services
- Patients 66-75 years old who live long term in an institutional setting AND/OR have frailty and advanced illness

Measure: Diabetes Care – Statin Use in Persons with Diabetes (SUPD)

Percentage of Medicare Part D beneficiaries 40- 75 years old who received at least two diabetes medication fills during the measurement year and who received a statin therapy in 2019.

Eligible Population: Part D beneficiaries, ages 45-75 years old with a diagnosis of Diabetes Type I or Type II, who were dispensed at least 2 diabetes medications.

- Assess diabetic patients for statin therapy in alignment with the 2018 American College of Cardiology/American Heart Association (ACC/AHA) guidelines.

- Use noncompliant patient lists to review medications and evaluate addition of statin therapy to regimen.

No reporting required from health care providers. The health plan evaluates prescription claims data for this measure.

Measure: Medication Adherence for Cholesterol, Diabetes and/or Hypertension

Eligible Population: Part D beneficiaries, ages 18 years or older, who are prescribed medications for cholesterol control, diabetes and/or hypertension.

Each eligible patient should fill prescription(s) 80% of the time designated for taking the medication, for:

- cholesterol (e.g., statins)
- diabetes (In this measure, "diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic or a meglitinide drug. Plan members who take insulin are not included.
- hypertension (e.g., angiotensin-converting enzyme [ACE] inhibitors, angiotensin receptor blockers [ARBs], direct renin inhibitors [DRIs])

Service Needed:

- Assess proactively whether the patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them.
- Encourage adherence by providing 90-day prescriptions for maintenance drugs.
- Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription.
- Refer patients to http://humana.com/takemymedicine for adherence tips and tools.

* Physicians must ensure/achieve 87% or greater.

Measure: 30-Day Readmission Rate

Eligible Population: All assigned/attributed Medicare members who have an acute inpatient admission.

A 30 -day readmission is defined as an acute inpatient admission occurring within 30 days of the discharge date of the previous acute inpatient admission. The only exception to this is a same-day transfer.

Readmission rate = (number of readmissions) ÷ (number of admissions)

This rate will be calculated based on your July 1, 2019 to June 30, 2020 historical results. This calculation includes inpatient admissions to any facility exclusive of, but not limited to, psychiatry, maternity, skilled nursing facility, long-term acute care hospital and rehabilitation admissions. The 30-day readmission rate will be calculated on a year-to-date basis.

Measure: Emergency Room Utilization *(Per 1,000 Patients)*

Eligible Population: All assigned/attributed members.

The emergency room utilization ratio is based on the total number of ER visits not resulting in an inpatient admission or an observation stay per 1,000 Humana-covered assigned/attributed members. The ratio will be calculated quarterly.

This rate will be calculated based on your July 1, 2019 to June 30, 2020 historical results.

Measure: Access to Medical Records

Eligible Population: Patients for whom Humana has requested medical records.

Provider must ensure cooperation with all Humana medical record review requests without additional cost* to Humana. "Cooperation" is defined as:

1. Self-Service -or- On-site Access: Provider mails/faxes medical records directly to Humana or allows Humana onsite access to medical records; and/or
2. Remote Access: Providing Humana with the ability to login to the practice EMR remotely at any time; and/or
3. Electronic Connection: Connection directly through an EMR, other third party population health management platforms or through FTP access.

*If Humana reimburses Provider or Provider's contracted vendor for the cost of providing medical records, Provider will not be eligible for bonus on this measure.

Measure: Annual Bonus – Primary Care Provider Visits

Eligible Population: All assigned/attributed members.

Physician must ensure all assigned/attributed members have at least two primary care provider (PCP) visits during the calendar year. A PCP visit is defined as a sick or well visit with an internal medicine, general medicine, family medicine or geriatric physician or a visit with a nurse practitioner or physician's assistant practicing in these specialties.

*Providers must achieve 75% or greater compliance with assigned member visits to be eligible for this bonus.

Measure: Annual Wellness Visit

**Please see the Humana 2020 Annual Planned Visit Guidelines (*separate from this document*). New for 2020– this is a paid bonus contractual measure based on improvements over last year. Humana MA does identify and measure the percent of members who had an annual visit in the calendar year.

Measure: Patient Experience Rating

Eligible Population: Members who receive a post-provider visit telephone survey from Humana with questions aligned with the following three key areas: access to care, coordination of care and patient discussion with the physician.

Physician must exceed the performance standard on overall patient experience rating. Responses are averaged in each category to create an overall patient experience rating.

- **Access to care** focuses on scheduling and wait times, with patients stating whether they had difficulty scheduling an appointment and whether they waited for more than 15 minutes to see the doctor.
- **Coordination of care** questions ask patients whether their doctor was informed about the care they received from a specialist and the prescription drugs the patient was taking.
- **Patient discussion** focuses on whether the doctor discussed falls, bladder control and physical activity and if the doctor discussed treatment options.

*Providers must achieve 80% or greater.

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