2022 MEDICARE CARE GAP DOCUMENTATION GUIDE

OptimaHealth®

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Introduction

Preventive and chronic care management are critical steps along the pathway to helping your patients, our members, achieve optimal health. To that end, Optima Health is proud to partner with you to accomplish this very achievable goal. Electronic medical records may provide a means to track gaps in care and reminders of needed services. The Care Gap Documentation Guide is designed to help providers easily document the closure of care gaps.

This resource is organized for ease of use as follows:

- measure definition
- identification of applicable quality program(s)
- helpful tips to achieve performance measure
- codes recommended to document gap closure

For additional information or assistance, you may contact your network management trainer.

BREAST CANCER SCREENING (BCS)

Definition: Women 50-74 years of age (denominator) who had a mammogram to screen for breast cancer (numerator) during measurement year.

Applicable Quality Program(s):
HEDIS
CMS Medicare Advantage Star Rating

Helpful Tips To Achieve Performance Measure:

- Request results of breast cancer screenings from OB/GYN provider.

Exclusion Criteria: Hospice enrollment.

Codes:

ICD-10-CM Codes:

Absence of left breast: Z90.12;
Absence of right breast: Z90.11;
Bilateral mastectomy: OHTV0ZZ;
History of bilateral mastectomy: Z90.13;
Unilateral mastectomy: OHTU0ZZ (left), OHTT0ZZ (right)

- CPT/CPT II: 77061-77063, 77065-77067
- HCPCS: G0202, G0204, G0206

COLORECTAL CANCER SCREENING (COL)

Definition: Adults ages 50-75.

Applicable Quality Program(s):

HEDIS
CMS Medicare Advantage Star Ratings

Helpful Tips To Achieve Performance Measure:

One or more of the following screenings:

- colonoscopy in past 10 years (measurement year and nine years prior)
- flexible sigmoidoscopy in past five years (measurement year and four years prior)
- CT colonography (e.g., virtual colonoscopy) in the past five years (measurement year and four years prior)
- FIT-DNA (e.g., Cologuard) test in the past three years (measurement year and two years prior)
- fecal occult blood test (iFOBT or gFOBT) annually (measurement year)

Exclusion Criteria: Diagnosis of colorectal cancer or total colectomy, hospice enrollment.

Codes:

FOBT:

- CPT/CPT II: 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

FIT-DNA Test:

- CPT/CPT II: 81528. This code is specific to the Cologuard® FIT-DNA test.
- HCPCS: G0464. This code was retired and replaced with CPT/CPT II code 81528 on January 1, 2016.
- LOINC: 77353-1, 77354-9

COLORECTAL CANCER SCREENING (COL) CONTINUED

Flexible Sigmoidoscopy:

- CPT/CPT II:45330-45335, 45337-45342, 45346, 45347, 45349, 45350
- HCPCS: G0104

Computed Tomography (CT) Colonography:

- CPT/CPT II: 74261-74263

Colonoscopy:

- CPT/CPT II: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
- HCPCS: G0105, G0121

COMPREHENSIVE DIABETES CARE (CDC)

Definition: Adults ages 18-75 with diagnosis of diabetes (type 1 or type 2) who had each of the following:

- hemoglobin A1c (HbA1c) testing
- HbA1c poor control (›9.0%)
- HbA1c control (‹8.0%)
- HbA1c control (‹7.0%) for a selected population*
- eye exam (retinal) performed
- medical attention for nephropathy
- blood pressure (BP) control (‹140/90 mm Hg)

Applicable Quality Program(s):
HEDIS
CMS Medicare Advantage Star Rating

Helpful Tips To Achieve Performance Measure:

Eye Exam
Retinal eye exam(date and result from the measurement year or the year prior*)
Note: Diabetic eye exam must be interpreted by an optometrist or ophthalmologist.

Kidney Disease Monitoring
Medical attention for nephropathy (one of the following during the measurement year):

- nephropathy screening or monitoring test
- ACE/ARB therapy
- evidence of nephropathy (CKD, ESRD, nephrectomy, kidney transplant, visit with a nephrologist)

HbA1c Control (less or greater than 9)
HbA1c testing (most recent date and result from measurement year)

- HbA1c ‹ 8.0 % = control
- HbA1c › 9.0 % = poor control

Blood Pressure (most recent date and result from measurement year)

- BP of ‹ 140/90 = control

COMPREHENSIVE DIABETES CARE (CDC) CONTINUED

Exclusion Criteria:
Members without a diagnosis of diabetes, but with either:

- gestational diabetes (up to two years prior to measurement year)

or

- steroid-induced diabetes (up to two years prior to measurement year)

or

- hospice enrollment

Codes:

HbA1c Test:

- CPT/CPT II: 83036, 83037, 3044F, 3046F, 3051F, 3052F
- LOINC: 17856-6, 4548-4, 4549-2
  - HbA1c level ‹ 7.0: CPT/CPT II 3044F
  - HbA1c level ›/= 7.0-‹8.0: CPT/CPT II 3051F
  - HbA1c level ›/= 8.0-‹9.0: CPT/CPT II 3052F
  - HbA1c level › 9.0: CPT/CPT II 3046F

Evidence of Treatment for Nephropathy:

- CPT/CPT II: 3066F, 4010F
- ICD-10 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, N00.1, N00.2, N00.3, N00.4, N00.5, N00.6, N00.7, N00.8, N00.9, N01.0, N01.1, N01.2, N01.3, N01.4,N01.5, N01.6, N01.7, N01.8, N01.9, N02.0, N02.1, N02.2, N02.3, N02.4, N02.5, N02.6, N02.7, N02.8, N02.9, N03.0,N03.1, N03.2, N03.3, N03.4, N03.5, N03.6, N03.7, N03.8,N03.9, N04.0, N04.1, N04.2, N04.3, N04.4, N04.5, N04.6,N04.7, N04.8, N04.9, N05.0, N05.1, N05.2, N05.3, N05.4,N05.5, N05.6, N05.7, N05.8, N05.9, N06.0, N06.1, N06.2,N06.3, N06.4, N06.5, N06.6, N06.7, N06.8, N06.9, N07.0,N07.1, N07.2, N07.3, N07.4, N07.5, N07.6, N07.7, N07.8,N07.9, N08, N14.0, N14.1, N14.2, N14.3, N14.4, N17.0, N17.1,N17.2, N17.8, N17.9, N18.1, N18.2, N18.3, N18.4, N18.5,N18.6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9,N26.1, N26.2, N26.9, Q60.0, Q60.1, Q60.2, Q60.3, Q60.4, Q60.5, Q60.6, Q61.00, Q61.01, Q61.02, Q61.11, Q61.19, Q61.2, Q61.3, Q61.4, Q61.5, Q61.8, Q61.9, R80.0, R80.1, R80.2, R80.3, R80.8, R80.9

COMPREHENSIVE DIABETES CARE (CDC) CONTINUED

Diabetic Eye Exam:

- CPT/CPT II: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113,67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012,92014, 92018, 92019, 92134, 92201, 92202, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-92205,99213-99215, 99242-99245, 2022F-2026F, 2033F, 3072F
- HCPCS: S0620, S0621, S3000

Urine Protein Test:

- CPT/CPT II: 3060F-3062F, 81000-81003, 81005, 82042-82044, 84156
- LOINC: 11218-5, 12842-1, 13705-9, 13801-6, 13986-5, 13992-3, 14956-7, 14957-5, 14958-3, 14959-1, 1753-3, 1754-1, 1755-8, 1757-4, 17819-4, 18373-1, 20454-5, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 2887-8, 2888-6, 2889-4, 2890-2, 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, 5804-0, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1, 6941-9, 6942-7, 76401-9, 77253-3, 77254-1, 77940-5, 89998-9, 89999-7,90000-1, 9318-7

MEDICATION ADHERENCE FOR CHOLESTEROL (STATINS)

Definition: Any member 18 years or older who has at least two fills of a designated medication(s) as defined in each measure. The measurement is calculated using Proportion of Days Covered (PDC) using Pharmacy Data Encounter (PDE) data. PDC is the number of days the member has medication on hand/is covered by the medication based on the dates of prescription fills (numerator) compared to the number of days in the time period (denominator).

Applicable Quality Program(s):
CMS Medicare Advantage Star Ratings

Helpful Tips To Achieve Performance Measure:

The measurement is calculated using Proportion of Days Covered (PDC) using Pharmacy Data Encounter (PDE) data. PDC is the number of days the member has medication on-hand/ is covered by the medication based on the dates of prescription fills (numerator) compared to the number of days in the time period (denominator). Members will only be recognized when filling medication through Optima Health Plan.

This measure is calculated daily and is not a “gap” that can be closed.

- **Write for 90-day supplies** – This will ensure that a member is “covered” for 90 days. This gives the member a better chance to make the 80% PDC threshold throughout the year.
- **Update prescriptions** – If the dose changes, make sure to update the prescription with the new directions.
- **Ask members about barriers to medication use** – Cost of medications is well-known as a barrier, but other factors are just as prevalent. Can members get to the pharmacy? Can members read the small labels? Do members know how to take the medications?

MAC Medication Inclusion: Statin medications

Exclusion Criteria: Hospice enrollment, ESRD diagnosis or coverage dates.

MEDICATION ADHERENCE FOR DIABETES MEDICATIONS

Definition: Any member 18 years or older who has at least two fills of a designated medication(s) as defined in each measure. The measurement is calculated using Proportion of Days Covered (PDC) using Pharmacy Data Encounter (PDE) data. PDC is the number of days the member has medication on hand/is covered by the medication based on the dates of prescription fills (numerator) compared to the number of days in the time period (denominator).

Applicable Quality Program(s):
CMS Medicare Advantage Star Ratings

Helpful Tips To Achieve Performance Measure:

This measure is calculated daily and is not a "gap" that can be closed.

- **Write for 90-day supplies** – This will ensure that a member is "covered" for 90 days. This gives the member a better chance to make the 80% PDC threshold throughout the year.
- **Update prescriptions** – If the dose changes, make sure to update the prescription with the new directions.
- **Ask members about barriers to medication use** – Cost of medications is well-known as a barrier, but other factors are just as prevalent. Can members get to the pharmacy? Can members read the small labels? Do members know how to take the medications?
- Only medications filled through Optima Health Plan will be recognized.
- This measure is calculated daily and is not a "gap" that can be closed.

Medication Inclusion: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Exclusion Criteria: Hospice enrollment, ESRD diagnosis or coverage dates, one or more prescriptions for insulin.

MEDICATION ADHERENCE FOR HYPERTENSION (RAS ANTAGONISTS)

Definition: The measurement is calculated using Proportion of Days Covered (PDC) using Pharmacy Data Encounter (PDE) data. PDC is the number of days the member has medication on hand/is covered by the medication based on the dates of prescription fills (numerator) compared to the number of days in the time period (denominator).

Applicable Quality Program(s):
CMS Medicare Advantage Star Ratings

Helpful Tips To Achieve Performance Measure:

Any member 18 years or older who has at least two fills of a designated medication(s) as defined in each measure. The measurement is calculated using PDC using PDE data. PDC is the number of days the member has medication on hand/ is covered by the medication based on the dates of prescription fills (numerator) compared to the number of days in the time period (denominator). Only medications filled through Optima Health Plan will be recognized.

This measure is calculated daily and is not a “gap” that can be closed.

- **Write for 90-day supplies** – This will ensure that a member is “covered” for 90 days. This gives the member a better chance to make the 80% PDC threshold throughout the year.
- **Update prescriptions** – If the dose changes, make sure to update the prescription with the new directions.
- **Ask members about barriers to medication use** – Cost of medications is well-known as a barrier, but other factors are just as prevalent. Can members get to the pharmacy? Can members read the small labels? Do members know how to take the medications?

Medication Inclusion: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications.

Exclusion Criteria: Hospice enrollment, ESRD diagnosis or coverage dates, one or more prescriptions for sacubitril/valsartan.

TRANSITIONS OF CARE (TRC)

Description: The percentage of discharges for members 18 years of age and older who had each of the following four rates reported.

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation

Definitions:

- Medication Reconciliation: A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
- Medication List: A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications, and herbal or supplemental.

Applicable Quality Program(s):
HEDIS
CMS Medicare Advantage Star Rating

Helpful Tips To Achieve Performance Measure:

1. Notification of Inpatient Admission

- Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days)
- Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).
- Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:
  - communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax)
  - communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax)

TRANSITIONS OF CARE (TRC) CONTINUED

- communication about admission to the member's PCP or ongoing care provider through a health information exchange, an automated admission, or discharge and transfer (ADT) alert system
- communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system
  - When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through two days after the admission (three total days) meets criteria.
- communication about admission to the member's PCP or ongoing care provider from the member's health plan
- indication that the member's PCP or ongoing care provider admitted the member to the hospital
- indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider
- indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay
- documentation that the PCP or ongoing care provider performed a pre-admission exam or received communication about a planned inpatient admission
  - The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through two days after the admission (three total days); documentation that the PCP or ongoing care provider performed a pre-admission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or pre-admission exam must clearly pertain to the denominator event.

2. Receipt of Discharge Information

- Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days)
- Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through two days after the discharge (three total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following:

TRANSITIONS OF CARE (TRC) CONTINUED

- the practitioner responsible for the member's care during the inpatient stay
- procedures or treatment provided
- diagnoses at discharge
- current medication list
- testing results, or documentation of pending tests or no tests pending
- instructions for patient care post-discharge

3. Patient Engagement After Inpatient Discharge

- Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.
- Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:
  - an outpatient visit, including office visits and home visits
  - a telephone visit
  - a synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication
  - an e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider)

4. Medication Reconciliation Post Discharge

- Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).
- Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria:
  - documentation of the current medications with a notation that the provider reconciled the current and discharge medications
  - documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)

TRANSITIONS OF CARE (TRC) CONTINUED

- documentation of the member's current medications with a notation that the discharge medications were reviewed
- documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service
- documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review - Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record - There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- notation that no medications were prescribed or ordered upon discharge.

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE (OMW)

Definition: Women ages 67-85.

Applicable Quality Program(s):
HEDIS
CMS Medicare Advantage Star Ratings

Helpful Tips To Achieve Performance Measure:

Suffered a fracture and had either:

- a bone mineral density (BMD) test

or

- a prescription for a drug to treat osteoporosis in the six months after the fracture

Exclusion Criteria: Hospice enrollment

Codes:

Bone Mineral Density Tests:

- CPT/CPT II: 76977, 77078, 77080, 77081, 77085, 77086
- ICD-10 procedure: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
- HCPCS codes for osteoporosis meds: J0897; J1740; J3110; J3489

Osteoporosis Medications:

- HCPCS: J0897, J1740, J3110, J3111, J3489

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

Definition: Males ages 21-75 and females ages 40-75.

Applicable Quality Program(s):
HEDIS
CMS Medicare Advantage Star Ratings

Helpful Tips To Achieve Performance Measure:

Identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

Two rates are reported:

1. received statin therapy: members who were dispensed at least one high or moderate-intensity statin medication during the measurement year
2. statin adherence 80%: members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period (from prescription date through end of year)

Exclusion Criteria: Cirrhosis, ESRD, hospice enrollment, myalgia, myositis, myopathy, pregnancy, and rhabdomyolysis.

Moderate or High-intensity Statin Therapy:

Atorvastatin: 10-80mg (Tier 1)
Amlodipine-atorvastatin: 10-80mg (Tier 2)
Rosuvastatin: 5-40mg (Tier 1)
Simvastatin: 20-80mg (Tier 1)
Ezetimibe-simvastatin: 20-80mg (Tier 2)
Pravastatin: 40-80mg (Tier 1)
Lovastatin: 40mg (Tier 1)
Fluvastatin: 40- 80mg (Tier 4)
Livalo (pitavastatin): 2-4mg (Tier 3) (Requires Step Therapy)

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC) CONTINUED

Codes:

Myalgia/Myositis/Myopathy:
ICD-10: G72.0, G72.2, G72.9, M60.80-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, M62.82, M79.11, M79.10-M79.12, M79.18

Below are the exclusion codes for this measure. They will exclude the member from this measure if the provider codes any of these:

ICD-10 codes for myalgia, myositis, myopathy: G72.0, G72.2, G72.9, M60.80-M60.9, M62.82, M79.1, M79.10, M79.11, M79.12, M79.18

STATIN USE FOR PERSONS WITH DIABETES (SUPD)

Definition: Patients ages 40-75 who were dispensed at least two diabetes medication fills, or patients ages 40-75 who were dispensed at least two diabetes medication fills who also received a statin medication.

Applicable Quality Program(s):
CMS Medicare Advantage Star Ratings

Helpful Tips To Achieve Performance Measure:

Identified as having diabetes and does not have clinical atherosclerotic cardiovascular disease who met the following criteria:

Two rates are reported:

1. received statin therapy: members who were dispensed at least one statin medication of any intensity during the measurement year
2. statin adherence 80%: members who remained on a statin medication of any intensity for at least 80% of the treatment period (from prescription date through end of year)

Most statin medications are the lowest cost share copay (Tier 1) on Optima Medicare Advantage. Those medications include:

a. Atorvastatin
b. Lovastatin
c. Rosuvastatin
d. Simvastatin

Exclusion Criteria: Hospice enrollment, ESRD diagnosis, or ESRD coverage during measurement period.

For example, if a 65-year-old member has two fills of insulin in a calendar/benefit year, they should also have a statin fill during that same time frame in order to count in the numerator. Only one statin fill is needed to meet the numerator of the measure. Once the member fills the statin two times in the benefit year, he or she also qualifies for the statin adherence measure.

The American College of Cardiology/American Heart Association (ACC/AHA) guidelines recommend a moderate-to-high intensity statin for primary prevention for persons age 40-75 with diabetes. This recommendation is also supported by the American Diabetes Association (ADA) and the National Lipid Association (NLA).

STATIN USE FOR PERSONS WITH DIABETES (SUPD)

Codes:

Members with the following ICD-10-CM codes are not excluded from the SUPD measure. This is due to how these measures are calculated by CMS. Documentation of these codes will provide accurate patient information and help with other measures.

Myalgia/Myositis/Myopathy:

G72.0, G72.2, G72.9, M60.80-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, M62.82, M79.11, M79.19

Glossary

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Attributed Member: Member for whom the provider is held accountable in regards to care.

CPT Category II Code: Tracking codes, ending with an "F," which facilitate data collection related to quality and performance measurement.

CPT Code: Medical code set used to report medical, surgical, diagnostic procedures, and other services by physicians/providers/facilities to health insurance companies and accreditation organizations.

Denominator: The number of members who qualify for the measure criteria.

Drug Tiers: A way for insurance providers to determine medicine costs. The higher the tier, the higher the cost of the medicine for the member in general.

HCPCS Code: Healthcare Common Procedure Coding System (often pronounced hick picks) – a set of codes beginning with a letter used to report supplies, materials, drugs, procedures, and other services.

HEDIS: Health Care Effectiveness Data and Information Set – standardized performance measures developed by NCQA (National Committee for Quality Assurance).

ICD-10-CM (Diagnosis Code): A code system used by physicians and other healthcare providers to classify and code all diagnoses, signs, and symptoms.

ICD-10 (Procedure Code): A code system used to report procedures performed by physicians and other healthcare providers in a facility/hospital setting.

Numerator: The number of members who meet compliance criteria.

PMPM: Per member per month – usual unit of measure that payers remit to providers.

Glossary

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Measurement Year: January 1 through December 31.

Stars: CMS rating system used to measure how well Medicare Advantage and Part D plans perform in several areas, including quality of care and customer satisfaction. Stars ratings range from one to five, with one being the lowest score and five being the highest.

Step Therapy: Trying less expensive options before “stepping up” to drugs that cost more.

OptimaHealth®

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Provider Customer Service

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1-800-229-8822

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1-800-648-8420

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