2026 CMS STARS
Quick Reference Guide

IEHP DualChoice

CODING TOOL

ADVANCED CARE PLANNING (ACP)	
Description	Code
ACP discussed and documented Advance Care Plan or surrogate decision maker documented in the medical record	1123F
ACP discussed and documented in the medical record, Patient did not wish or was not able to name a surrogate decision maker or provide an Advance Care Plan	1124F
Advance Care Plan or similar legal document present in the medical record	1157F
Advance Care Planning discussion documented in the medical record	1158F
Do not resuscitate	Z66
ANNUAL WELLNESS VISIT (AWV)	
Reminder: In addition to coding for the Annual Wellness Visit, there are other elements for the AWV that should be individually coded. For example, COA- Medication Review and Functional Status Assessment	
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	G0402
Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.	G0438
Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit	G0439
CARE FOR OLDER ADULTS (COA)	
Functional Status Assessment	
Functional status assessed	1170F
Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit	G0439
Medication Review	
Requires two codes: One for **Medication Review** **and** one for **Medication List** provided during the same visit by a prescribing practitioner or clinical pharmacist. (Ex. Code for both 1160F and 1159F).	
Review of All Medications By A Prescribing Practitioner Or Clinical Pharmacist (Such As, Prescriptions, Otcs, Herbal Therapies And Supplements) Documented In The Medical Record	1160F
Medication list documented in medical record	1159F
Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	G8427
TRANSITIONS OF CARE - MEDICATION RECONCILIATION POST DISCHARGE	
Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/ or caregiver within 2 business days of discharge, At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge	99495
Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge	99496
Discharge medications reconciled with the current medication list in outpatient medical record (COA) (GER)	1111F
CONTROLLING HIGH BLOOD PRESSURE	
Systolic B/P < 130 (indicates controlled)	3074F
Systolic B/P 130 - 139 (indicates controlled)	3075F
Systolic B/P ≥ 140 (indicates NOT controlled)	3077F
Diastolic B/P < 80 (indicates controlled)	3078F
Diastolic B/P 80 - 89 (indicates controlled)	3079F
Diastolic B/P ≥ 90 (indicates NOT controlled)	3080F
Essential (primary) hypertension	I10

DIABETES EYE EXAM	
Description	Code
Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2022F
Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2023F
7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2024F
7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2025F
Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy	2026F
Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	2033F
Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)	3072F
Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral	92229
GLYCEMIC STATUS ≤ 9.0%	
HbA 1 C Level < 7% (indicates controlled)	3044F
HbA 1 C Level ≥7% and < 8% (indicates controlled)	3051F
HbA 1 C Level ≥ 8% and ≤9% (indicates controlled)	3052F
HbA 1 C Level > 9% (indicates not controlled)	3046F
FLU VACCINE	
Influenza Vaccine (IIV), Split Virus, Preservative Free, Enhanced Immunogenicity Via Increased Antigen Content, for intramuscular use	90662
Influenza Vaccine, Quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 Ml dosage, for intramuscular use	90674
Influenza Vaccine, Quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	90682
Influenza Vaccine, Quadrivalent (IIV4) Split Virus, preservative free, 0.5Ml dosage, for intramuscular use	90686
Influenza Vaccine, Quadrivalent (IIV4) Split Virus, 0.5 Ml dosage, for intramuscular use	90688
Influenza Vaccine, Quadrivalent (aIIV4), Inactivated, Adjuvanted, Preservative Free, 0.5 Ml dosage, for intramuscular use	90694
Influenza Vaccine, Quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 Ml dosage, for intramuscular use	90756
POST DISCHARGE FOLLOW-UP	
Straightforward MDM^^ or Time 15 minutes must be met or exceeded - New patient	99202
Low Level MDM^^ or Time 30 minutes must be met or exceeded - New patient	99203
Moderate Level MDM^^ or Time 45 minutes must be met or exceeded - New patient	99204
High Level MDM^^ or Time 60 minutes must be met or exceeded - New patient	99205
Office Visit for E/M. Physician or QHP* not required - Established patient	99211
Straightforward MDM^^ or Time 10 minutes must be met or exceeded - Established patient	99212
Low Level MDM^^ or Time 20 minutes must be met or exceeded - Established patient	99213
Moderate Level MDM^^ or Time 30 minutes must be met or exceeded - Established patient	99214
High Level MDM^^ or Time 40 minutes must be met or exceeded - Established patient	99215
Clinic visit/encounter, all-inclusive	T1015
Telephone Encounter by a nonphysician qualified health care professional; 5-10 min. medical discussion - Established patient	98966
Telephone Encounter by a nonphysician qualified health care professional; 11-20 min. medical discussion - Established patient	98967
Telephone Encounter by a nonphysician qualified health care professional; 21-30 min. medical discussion - Established patient	98968

Note: The IEHP Direct Stars Coding Resource and the Direct Stars Program Guide are reference tools to assist providers with billing/coding Direct Stars Program measures. These resource tools include recommended codes and do not reflect the complete list of codes available for these measures. Providers should ensure that billing/coding practices reflect the appropriate standard of care delivered to meet the unique health needs of each member.

^^ Medical Decision Making (MDM)
* Qualified Healthcare Professional

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DOCUMENTATION GUIDE

Transitions of Care around acute or nonacute inpatient stays

Notification of inpatient admission

- Signed/stamped and dated documentation in the outpatient chart of acknowledgement of admission within 2 days after admission.

Receipt of discharge notification

- Signed/stamped and dated documentation in the outpatient chart of discharge information within 2 days after discharge. May be in shared EMR. Must include the discharge summary or documentation of ALL of the following:
  - Attending provider for inpatient stay
  - Procedures and treatment provided
  - Discharge diagnoses
  - Current medication list
  - Testing results, documentation of pending tests or documentation of no pending tests
  - Post-discharge instructions

Follow-up visit must occur within 30 days of discharge, and not on the day of discharge

Submit appropriate visit code(s) for the follow-up visit (see other side)

Medication Reconciliation Post-Discharge must occur on or after the discharge date and up to 30 days after discharge

Submit appropriate code for medication reconciliation (see other side)

- Document in the outpatient chart either of the following
  - Current medications with a notation that provider completed the reconciliation
  - Notation that no medications were prescribed or ordered on discharge

Follow-up After ED Visit for People with Multiple Chronic Conditions

For Members with more than one chronic condition such as those listed below

- COPD, asthma, or unspecified bronchitis
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure and cardiomyopathy
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

Best practice

For members with more than one chronic condition who had an ED visit, the Provider should complete a follow-up visit within seven days of the ED discharge.

Annual Wellness Visit

Annual Wellness Visits should be completed every 12 months for Members with Medicare

- Initial Preventive Physical Exam (IPPE) - within the first 12 months of Part B coverage
- Initial Annual Wellness Visit - first annual wellness visit
- Subsequent Annual Wellness Visit - annual update

Components

- Review Health Risk Assessment (HRA) including demographic data, health status self-assessment, psychosocial & behavioral risk, ADLs, IADLs
- Review of medical/family history
- Establish current providers, suppliers and prescriptions
- Review opioid prescriptions, potential risk factors and pain management plan, as applicable
- Obtain height, weight, blood pressure, BMI and other routine measurements
- Assess functional ability, patient safety, fall risk, hearing and vision impairment
- Screen for depression and substance use disorder
- Assess for SDOH risk (optional)
- Review and establish risk factors and treatment for appropriate preventive services
- Perform cognitive impairment screening
- Prepare a personalized prevention plan
- Advance Care Planning, as appropriate

Preventive Services Addressed During Annual Wellness Visit

- Abdominal Aortic Aneurysm (AAA) Screening
- Adult Immunizations (AIS-E)- Influenza, Tdap, Zoster, Pneumococcal and Hepatitis B vaccines
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Colorectal Cancer Screening (COL)
- Osteoporosis Management in Women who had a Fracture (OMW)
- Depression Screening
- Diabetes Screening
- Counseling to Prevent Tobacco Use
- Monitoring Physical Activity
- Osteoporosis screening
- Reducing the Risk of Falling
- Improving Bladder Control

Best Practices

- **Verify eligibility:** Ensure 12 months have passed since last AWV/IPPE
- **Ask patients to prepare for the visit:** Complete self-assessments; bring list of providers, suppliers and medications
- **Document thoroughly:** Include HRA, vitals, screening results, and plan
- **Schedule enough time to review all components:** Use shared decision-making about prevention
- **Capture all coding for services provided:** Ensure all elements of visit are properly coded for related HEDIS and Medicare Stars measures
- **Avoid routine physical codes:** Medicare doesn't recognize 99381–99397 as an AWV
- **During the visit schedule follow-up appointments to address needed screenings or disease management.**

Refer to the IEHP P4P Guide for more details about AWVs and other IEHP Direct Star measures https://www.providerservices.iehp.org/en/programs-and-services/provider-incentive-programs/pay-for-performance-program
Refer to the CMS website,for additional details for Medicare Wellness Visits https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

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