

# Documentation Standards for Medicare STAR Ratings HEDIS Measures

Accurate and completed documentation ensures that care delivered is counted toward STAR and HEDIS performance. Missing details, even when care was performed, can prevent gap closure and lower quality scores.

## 1. Document the Care Delivered

Every entry must include:

- **Service performed**
- **Date of service**
- **Result/value** (e.g., BP 128/78, A1c 7.2%)
- **Assessment and plan**

If any element is missing, the measure may not count.

## 2. Numerical Values Required

Many MY 2026 measures require exact numbers:

- **CBP:** Systolic & Diastolic BP
- **GSD:** Exact A1c
- **KED:** eGFR + UACR Values

“Normal” or “Stable” is not acceptable.

Repeat measurements when required.

\* A repeat reading requires separate documentation.

## 3. Screening Documentation

Must include:

- **Type of screening**
- **Date performed**
- **Result**

External reports must be scanned or clearly documented. Patient reported dates are acceptable for some measures when documented.

**Exclusions must be explicitly documented.**

## 4. Diagnosis Documentation

Codes must be supported by:

- Clinical evidence
- Assessment notes
- Relevant labs/imaging
- Treatment or monitoring plans

Avoid unspecified diagnoses when a more specific one is supported.

## 5. Medication Documentation

Ensure:

- Accurate medication list
- Start/stop dates
- Reconciliation after transitions of care
- Clear documentation of contraindications/intolerance (e.g., statins)

## 6. Care Coordination

Document:

- Specialist communication
- Follow up on abnormal results
- Medication reconciliation
- Transition of care outreach

## 7. Patient Refusals

Document:

- Refusal
- Date
- Reason (if provided)
- Education/counseling

## 8. Documentation Must Be Complete & Attributable

Include:

- Legible entries
- Provider name & credentials
- Electronic signature/authentication

## 9. Use Accepted Codes

Each measure has a defined set of CPT, CPT II, HPCPS, ICD-10, and value set codes.

Billing Codes DO NOT replace documentation

**If it isn't documented clearly, it doesn't count.** Strong documentation improves STAR Ratings, supports accurate quality reporting, and ensures patients receive the full benefit of the care you provide.