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HEDIS Guidelines for Health Care Providers

HEDIS data is collected three ways:

- Administrative Data: Obtained from our claims database
- Hybrid Data: Obtained from our claims database and medical record review
- Survey Data: Obtained from CMS member surveys

As a Provider you play a central role in promoting the health of our Patients. You and your office staff can help facilitate the HEDIS process improvement by:

- Providing the appropriate care within the designated timeframes.
- Documenting all care in the patient's medical record.
- Accurately coding all claims. Providing information accurately on a claim may reduce the number of records requested.
- Submitting medical record documentation on a routine scheduled basis.
- Responding to our requests for additional medical records within 5-7 days

Adult BMI Assessment (ABA)

Patients 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

Medical record documentation must include:

- For Patients 20 years and older on the date of service, include documentation of weight and BMI value.
- For Patients younger than 20 years on the date of service, include height, weight, and BMI percentile.

Tips for Success:

- Height and weight are usually documented but calculation of the BMI is often missing. Work with your EMR vendor to update your system with the calculation. Ranges and thresholds are not acceptable for this measure. A distinct BMI value or percentile is required.
- Code appropriately.
- Patients who have a diagnosis of pregnancy during the measurement year or the year prior to the measurement year can be **excluded** from the measure.

ABA Codes

BMI:ICD-10: Z68.1, Z68.20, Z68.21, Z68.22, Z68.23, Z68.24, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45

Controlling High Blood Pressure (CBP)

Patients 18-85 years of age with a second diagnosis of Hypertension (HTN) reported in the measurement year (MY) or the year prior to the measurement year and whose B P was adequately controlled during the measurement year based on the following criteria:

- Patients 18–85 years of age whose BP was <140/90 mm Hg.

Medical record documentation must include:

- The most recent BP reading (date and result) in the measurement year AFTER the second diagnosis of HTN is made.

Tips for Success: when the member's BP is elevated at the visit, be sure to repeat the measurement AND document the new result. The repeat BP is often lower!

CBP Codes Essential Hypertension: ICD-10: I10

Exclusions: Patients with evidence of ESRD or diagnosis of pregnancy during the measurement year.

Comprehensive Diabetes Care (CDC)

Patients 18-75 with diabetes (Type I and Type 2) who had each of the following:

- Hemoglobin A1c testing
  - HbA1c control (<8.0%)
  - HbA1c poor control (>9.0%)
- Eye exam (retinal)
- Medical attention for nephropathy
- BP control <140/90 mm Hg

Medical record documentation must include:

- Most recent blood pressure readings.
- Most recent lab test for HbA1c with date of test and result.
- A nephropathy screening or monitoring test (urine protein) during the measurement year or evidence of nephropathy during the measurement year.
- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Tips for Success:

- Labs indicating “poor” control should be repeated again later in the calendar year. Bring the member back in for testing!
- Document A1c and urine protein lab test results including date of collection.
- The intent of the eye exam indicator is to ensure that Patients with evidence of any type of retinopathy have an eye exam annually.
- Communicate the importance of this exam and help coordinate the scheduling if Indicated:

□Hemoglobin A1c (HbA1c) testing.
□Eye exam (retinal) performed.
□Medical attention for nephropathy.
□BP control (<140/90 mm Hg).

CDC Codes

Exclusions: Gestational diabetes, steroid induced diabetes

Diabetic Retinal Screening:

CPT: 67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043,67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002,92004, 92012, 92014, 92018, 92019, 92134, 92225,92226, 92227,92228, 92230, 92235, 92240, 92250, 92260
HCPCS: S0620, S0621, S3000

Diabetic Retinal Screening Negative:
3072F

Diabetic Retinal Screening with Eye Care Professional
CPT II: 2022F, 2024F, 2026F, S0625

HbA1c

HbA1c Test:
CPT: 83036, 83037

HbA1c Level Less the 7.0:
CPT II: 3044F

HbA1c Level 7.0-9.0:
CPT II: 3045F

HbA1c Level Greater Than 9.0:
CPT II 3046F

Blood Pressure

Diastolic 80-89:
CPT II: 3079F

Diastolic Greater than/Equal to 90:
CPT II: 3080F

Diastolic Less than 80:
CPT II: 3078F

Systolic Greater than/Equal to 140:
CPT II: 3077F

Systolic Less than 140:
CPT II: 3074F, 3075F

Nephropathy

Nephropathy Treatment:
CPT II: 3066F, 4010F

Urine Protein Tests:
CPT: 81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156
CPT II: 3060F, 3061F, 3062F

Dialysis
HCPCS: G0257, S9339

Colorectal Cancer Screening (COL)

Patients 50-75 years of age who had appropriate screening for colorectal cancer.

Medical record documentation must include evidence of one of the following:

- Colonoscopy (within last 10 years).
- FOBT (gFOBT or iFOBT in the measurement year).
- Flexible Sigmoidoscopy (within last 5 years).
- FIT-DNA test (Cologuard) during the measurement year or the two years prior to the measurement year.
- CT Colonography during the measurement year or the four years prior to the measurement year.

Tips for Success:

- Providers should review/confirm all preventive health screenings at each visit.
- Dates and results need to be consistently documented. Patient reported data noted on a medical record is sufficient evidence with date. For Colonoscopy or Sigmoidoscopy document the year of the test at a minimum. Example: Colonoscopy 2009. Result not required.
- When colorectal screening is reported, obtain report from specialist to ensure medical record is complete.
- If patient declines colonoscopy then explain benefits of Cologuard testing if appropriate and provide referral for Cologuard on-line if patient agrees. Cologuard will provide follow-up with the patient once referral received!

COL Codes

Colonoscopy

CPT: 44388, 44389, 44390, 44391, 44392, 44393, 44394 ,44397, 44401-44408, 45355,45378,45379, 45380, 45381, 45382, 45383, 45384,45385, 45386,45387, 45391, 45392

HCPCS: G0105, G0121

FOBT

CPT: 82270, 82274
HCPCS: G0328

Flexible Sigmoidoscopy

CPT: 45330-45335, 45337-45342, 45345-45347, 45349-45350
HCPCS: G0104

CT Colonography

CPT: 74261-74263

FIT DNA

CPT: 81528,
HCPCS: G0464

Medication Reconciliation Post-Discharge (MRP)

Patients 18 years and older with discharges (acute and non-acute inpatient) from January ,1 to December ,1 of the measurement year, for whom medications were reconciled the date of discharge through 30 days after discharge (31 days total)

Medical record documentation must include:

- Evidence of medication reconciliation AND the date when it was performed.
- Must be conducted by a prescribing practitioner, clinical pharmacist, or RN.
- Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

Tips for Successful Hybrid Chart Review:

Always ask your patient about any recent hospitalizations and document!

Any of the following meet criteria:

- Documentation that the provider reconciled the current and discharge medications.
- Documentation of the current medication with a notation that references the Discharge medications.
- 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.
- Notation that no medications were prescribed or ordered upon discharge.

Medication Reconciliation (MRP) Codes

CPT: 99495, 99496
CPT II: 1111F, 1159F, 1160F

Transitions of Care (TRC)

Patients 18 years of age and older with discharges (acute and non-acute inpatient) who had documentation by the Provider of each of the following during the measurement year.

Intent: *This measure aims to improve care coordination during care transitions for at-risk populations including older adults and other individuals with complex health needs.*

1. Notification of Inpatient Admission

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
- Documentation in your outpatient record of any tests and treatments ordered during the member's inpatient stay.
- Documentation that the admission was elective and you had performed a preadmission exam or were notified of pre-admission testing results.

2. Receipt of Discharge Information

   Documentation of receipt of discharge information on the day of discharge or the following day.

3. Patient Engagement after Inpatient Discharge

   Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge (does not include the date of discharge).

   Codes

   CPT:99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455-99456

   HCPCS: T1015, G0402, G0438, G0439, G0463

4. Medication Reconciliation Post-Discharge

   Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). (See MRP measure)

Care of Older Adults (COA)

Patients 66+ years old who had each of the following during the measurement year:

1. Advance care planning

Includes a discussion about preferences for resuscitation, life sustaining treatment and end of life care. Examples include:
•Advance Directives
•Actionable Medical Orders
•Living Will

Tips for Success: Explain purpose of HCP to patient and question whether they have designated someone to make decisions for them if unable. Have they executed an AD? Document "discussed HCP and member refused to execute as opposed to documenting "member refused"

Codes:
CPT: 99497
CPT II: 1123F, 1124F, 1157F, 1158F
HCPCS: S0257

2. Medication review

Includes at least one medication review conducted by a prescribing practitioner or clinical pharmacist in the measurement year and the presence of a medication list or includes notation that the member is not taking any medication and the date when it was noted.

Codes:
Medication review Codes:
CPT: 90863, 99605, 99606
CPT II: 1160F

Medication list Codes:
CPT II: 1159F
HCPCS: G8427

Transitional care management services Codes:
CPT: 99495, 99496

3. Functional status assessment

Includes evidence of at least one functional status assessment and the date it was performed as documented by:
•Instrumental Activity of Daily Living (IADL) – or -
•Activities of Daily Living (ADL) – or -
•Results of a standardized functional status assessment tool – or –
•Notation that at least 3 of the 4 following were assessed: notation of functional independence, sensory ability, cognitive status, and ambulatory status

Functional status assessment Codes:
CPT II:1170F

4. Pain assessment

Includes evidence of a pain assessment using a standardized pain assessment tool and the date it was performed

Tips for Success: Documentation of pain at one site such as “chest pain” does not meet the requirement. Documentation of pain or no pain in each component of the systems assessment meets the requirement

Pain assessment Codes:

CPT II: 1125F,1126F

Breast Cancer Screening BCS)

Women 50–74 years of age who had a mammogram to screen for breast cancer.

Tips for Success:

- Document date mammogram completed and Provider name or location if available.
- Request a copy of the Mammogram results and maintain in the patient record.

STAR MEASURE
Medication Adherence (Diabetes, RAS, Statin)

As a Provider what you can do to assist with adherence:

- Prescribe 90 day supply of all chronic medications with 3 refills Including, but not limited to, statins, RAS (Renin-Angiotensin-System), and diabetes medications.
- Reinforce importance of adhering to medication regimen.
- Discuss adherence issues and identify barriers to adherence. Identify an action plan based on the barriers.
- Change medication if experiencing unwanted side effects.
- Identify formulary medications that have lower cost/copay.

How to Improve your HEDIS Rates

•Timely submission of all claims and encounter data

•Complete and accurate coding of all services performed

•Document all services and care provided in the medical record

•Schedule patients for their annual screenings and check- ups

•Continually monitor patients with chronic conditions

•Understand the HEDIS measure criteria and the standard practice guidelines

CMS Surveys: CAHPS and HOS

Many of your patients receive the Medicare Health Outcomes Survey (HOS) or the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in the mail each spring. Your interaction with your patients can directly impact the ratings reflected in the HOS/CAHPS measures.

Helpful Provider Hints on How to Improve HOS Ratings Measures

Be familiar with the HOS measures and questions so that you will know what you should be asking your patients.

1. Monitoring physical activity: Measure of patients indicating that their provider discussed exercise with them and that the patient was advised to start, increase, or maintain their physical activity during the year.
2. Improving bladder control: Measure of patients indicating their provider discussed urinary incontinence problems with them. Measure of patients indicating their provider discussed treatment for urinary incontinence with them.
3. Reducing risk of falling: Measure of Patients with a problem falling, walking or balancing who report a discussion of the problem with their provider and received treatment for it during the year.

Helpful Provider Hints on How to Improve CAHPS Ratings Measures

What can I do as a Provider?

Provide the following for your patient:

Annual Flu Vaccine
Pneumonia Vaccine
Medication Reconciliation
Advice on smoking cessation

Discuss the following with your patient:

Physical Activity/Exercise
Evaluate risk for falls and discuss
Urinary incontinence

Be familiar with the questions on the survey that reflect on you as a Provider:

- How often did your personal doctor explain things in a way that was easy to understand?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor show respect for what you had to say?
- How often did your personal doctor spend enough time with you?
- 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?
- How often did you and your personal doctor talk about all the prescription medicines you were taking?
- How often were you advised to quit smoking or using tobacco by a doctor or other health provider?

Office Visit Checklist:

Regardless of the primary reason for the visit, ask questions to assess your patient's physical and mental status at each visit.

- Have a checklist with HOS related questions to be given at check-in for the patient to complete in the waiting room (see sample below). The patient should hand the completed checklist to the provider in the exam room.
- The checklist should get the patient thinking about the specific HOS measures and questions.
- Print the checklist on brightly colored paper so the patient will not overlook.

Today's Visit - Checklist

Patient name _____

Date: ____ /____/_____

Main reason for today's visit: _____

Other concerns you would like to discuss if there is time: _____

1. Over **the past 12 months**, have you experienced any of the following? *(Check all that apply)*

	Physical health limiting moderate activities
	Physical health limiting climbing stairs
	Pain interfering with normal activities
	Unusual tiredness or having little energy
	Problem with balance or walking
	Dizziness
	Accidentally leaked urine

2. Over the **past 2 weeks**, how often have you been bothered by any of the following?

   a. Little interest or pleasure in doing things

      1. Not at all
      2. Several days
      3. More than half the days
      4. Nearly every day

   b. Feeling down, depressed or hopeless

      1. Not at all
      2. Several days
      3. More than half the days
      4. Nearly every day

3. Have you fallen in the past 12 months?
   1. Yes
   2. No

4. Are you afraid of falling?
   1. Yes
   2. No

5. During the past 4 weeks, has your physical or emotional health limited your social activities with family friends, neighbors, or groups?
    1. All of the time
    2. Most of the time
    3. Some of the time
    4. A little of the time
    5. None of the time

6. Do you exercise for about 20 minutes three or more days a week?
    1. Yes, most of the time
    2. Yes, some of the time
    3. No, I usually do not exercise this much
    4.
7. Has your living situation changed?
    1. Y e s
    2. N o

If “Yes”,
describe:_____
_____
_____
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Patient Signature: _____

Date: _____