

HEDIS® Lunch and Learn

August 2020
Comprehensive Diabetes Care



What are HEDIS® Lunch and Learns?

HEDIS® News You can Use



Monthly Webinars: 30 minutes, 1 HEDIS topic

Measure Coding

Challenges and Barriers Measure Criteria

Action

Key takeaways to consider for practice

Why still
Gaps
in
Care?

Resources



Diabetes Care and Management (CDC, SPD, KED)



Comprehensive Diabetes (CDC) - Criteria

Who is in the measure (denominator)?

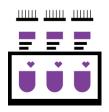
- Members aged 18 75 with Diabetes (Type 1 or Type 2) as of 12/31
- Diagnosis of Diabetes is determined by any of the following in the measurement year (MY) or year prior:
 - Two outpatient, Obs, ER or non-acute inpt encounters with any dx of diabetes
 - One acute inpt encounter with any dx of diabetes
 - One dispensed prescription for insulin or hypoglycemic/antihyperglycemic
- Continuous enrollment = one calendar year



Comprehensive Diabetes Care (CDC) - Criteria (cont.)

What makes the member compliant (numerator)?









HbA1c Testing

Must be most recent in MY

Performed at least annually

HbA1c Control

Must be **most** recent in MY

Goal <8.0%

If no A1c, member is automatically "uncontrolled" or >9.

Blood Pressure

Must be most recent in MY

Performed at least annually

Goal - control <140/<90

2020: Now allows telehealth/self-reported BPs

ER and inpatient BPs do NOT count

Dilated or Retinal Eye Exam

Annual dilated retinal eye exam performed or interpreted by an eye care professional

(Or every other year if negative)



Comprehensive Diabetes Care (CDC)- Coding

HBA1c Test:

• 83036, 83037

Don't forget in-office A1cs!

HBA1c Results:

- **3044F** (<7), **3046F** (>9)
- **3051F** (greater than or equal to 7, and less than 8)
- **3052F** (greater than or equal to 8 and less than or equal to 9)

Can decrease chart review!

Blood Pressure Reading

• Systolic: 3074F, 3075F, 3077F

• Diastolic: 3078F, 3079F, 3080F

Can decrease chart review!

Eye Exam billed by ANY Provider

2022F – 2026F, 2033F, 3072F



ChallengesWhy Gaps in Care?



- No coding, billing or A1c in timeframe (member is classified as "poor control")
- A1c results not found in medical record – sometimes A1c order but no results
- Need to go to another facility for A1c if not able to be performed in-office
- Premature coding of Diabetes diagnosis before confirmed
- Diabetes dx carryover in EMR not always current/accurate



What CDC challenges do you encounter in practice?



- No letter or results of diabetic eye exam from eye care provider in medical record
- Denial for some members a "touch of sugar"
- Member misconception of glucose testing versus HbA1c testing
- Member utilization of community resources without claim submission
- Member misunderstanding of benefits – diabetes eye exams ARE covered under their medical benefit!

- Elevated BPs not retaken
- Members who have an ER visit with Diabetes Dx that result in a diabetes medication end up in measure for 2 years
- Minimal focus on nutrition, exercise and lifestyle changes that can significantly impact A1c and BP control
- ABHWV not receiving all documentation during HEDIS



Take Action!

Take-Away Actions- CDC

Accurate Coding

Compliance + decreases chart review!

Code and bill for A1cs done in-office

Review
Diabetes testing
and screening
needs at every
visit
(including med refill
visits)

Perform or order needed tests

Ensure outside labs and in-office POCT A1c RESULTS are documented and a printable field!

Send all diabetes documentation, including eye exams, during HEDIS

Retake BP during visit if elevated

Control = systolic below 140 <u>AND</u> diastolic below 90

\$25 Member
Diabetic Eye
Exam Incentive

\$25 Provider
Diabetic Eye
Exam Incentive

Diabetes Events

Partner with
ABHWV to host
diabetes community
events

(\$25 member gift card)

If PCP, refer to specialist (Endo, diabetes ed, etc) when needed.

If a specialist, send consult notes and lab results to PCP

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Take-Away Actions- CDC

Educate regarding the difference

Between glucose checks and A1c

Partner with ABHWV

We can help outreach to your members to assist getting members in

Educate regarding all aspects of diabetes care

Including healthy nutrition, exercise & lifestyle

Contact members on GIC report

Schedule visits upon outreach

Ensure Diabetes dx coding

is current and accurate

Appointment reminders

Follow-up to reschedule if no-show

ABHWV Case Management

Utilize Diabetes CM program / refer members

Statin Therapy for Patients with Diabetes (SPD)



Statin Therapy for Patients with Diabetes - Criteria

Who is in the measure (denominator)?

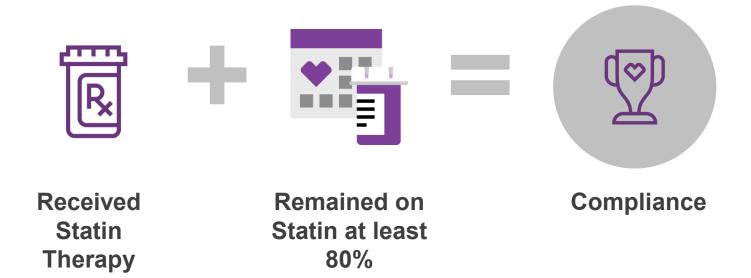
- Members age 40 75 as of 12/31
- · Diagnosis of Diabetes determined by:
 - Same criteria as CDC!
- Continuous Enrollment MY + year prior to MY

What makes the member compliant (numerator)?

- Received Statin Therapy Dispensed at least one statin medication (of any intensity) during the MY
- Statin Adherence 80% Remained on statin medication for at least 80% of treatment period
 - Treatment period = first day med is prescribed through 12/31



Statin Therapy for Patients with Diabetes - Criteria





Statin Therapy for Patient with Diabetes - EXCLUSIONS

- 1. Anyone with MI, CABG, PCI or other revascularization in the prior year
- 2. Diagnosed with Ischemic Vascular
 Disease during at least one
 outpatient/inpatient visit in MY AND also
 one outpatient/inpatient visit in prior year
- 3. Pregnancy, In Vitro Fertilization, Rx for clomiphene, or a diagnosis of ESRD, Cirrhosis during MY or year prior to MY
- 4. Diagnosis of Myalgia, Myositis, Myopathy, or Rhabdomyolysis during MY

Statin therapy
for members
with ASCVD
are covered
under a different
HEDIS measure
(SPC)



ChallengesWhy Gaps in Care?



- No statin therapy ordered at all
- Premature coding of Diabetes diagnosis before confirmed
- Diabetes dx carryover in EMR not always current/accurate
- No chart review allowed!



What SPD challenges do you encounter in practice?



- Misunderstanding medication regime instructions
- Non-compliance not taking as prescribed (time, dose, frequency)
- Side effects
- Stop taking medication without consulting physician

- Transportation/access to appointments and perhaps pick up prescriptions
- Members who have an ER visit with Diabetes Dx that result in a diabetes medication end up in measure for 2 years



Take Action!

Take-away Actions - SPD

Ensure
Diabetes dx
coding

is current and accurate

Review
Medication list
and compliance
at every visit

Maximize opportunities

Assess medication understanding

Assess transportation circumstances

Diabetes Events

Partner with ABHWV to host diabetes events

(\$25 member gift card)

Educate to never stop taking medication

without consulting with their doctor ABHWV Integrated Care Management

Educate to regarding side effects

and importance of reporting side effects to doctor

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Kidney Health Evaluation for Patients with Diabetes (KED)



Kidney Health Evaluation - Criteria

NEW 2020 Measure (replaces Attention for Nephropathy)

Who is in the measure (denominator)?

- Members 18-85 years of age with diabetes (Type 1 or Type 2)
- Diabetes Dx = same criteria as CDC and SPD
- Continuous enrollment = the measurement year
- No chart review allowed!

What makes the member compliant (numerator)?

A Kidney Health Evaluation during the measurement year:

- Estimated Glomerular Filtration Rate (eGFR)
 AND
- Urine albumin-creatinine ratio (uACR) identified by:
 - Quantitative albumin test, AND
 - Urine creatinine test



Kidney Health EvaluationCoding

Estimated Glomerular Filtration Rate (eFGR):

- 80047
- 80048
- 80050
- 80053
- 80069
- 82565

Urine Albumin-Creatinine Ratio (uACR):

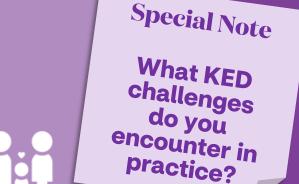
- Urine Albumin:
 - -82043
- Urine Creatinine
 - -82570



ChallengesWhy Gaps in Care?



- No kidney evaluation tests ordered/performed at all in MY
- Premature coding of Diabetes diagnosis before confirmed
- NEW 2020: No chart review allowed to capture kidney evaluation testing!





- General member noncompliance
- Lack of member understanding regarding the importance of kidney health (especially if no symptoms/ feels well)
- Transportation/access to appointments
- Potential need for member to possibly go to another facility/lab appointment
- Members who have an ER visit with Diabetes Dx that result in a diabetes medication end up in measure for 2 years



Take-Away Actions- KED

Accurate Test Coding

Increases compliance!

Bill/code for tests done in-office

Contact members on GIC report

Schedule appointments upon outreach

Educate regarding all aspects of diabetes care

Including kidney evaluation tests, even if they feel fine!

Ensure Diabetes dx coding

is current and accurate

Offer in-office testing

Eliminates need to go to another facility/ appointment

ABHWV Case Management

Utilize Diabetes CM program / refer members

Closing Thoughts and Resources

Closing Thoughts and Resources

Members trust you!

Patients consider you their most trusted source of medical information.

Your guidance and encouragement is critical in their diabetes management.

Allow time for discussion and questions. Hearing your answers can help patients feel more confident and comfortable.

ABHWV Quality Partnerships

Shelly Rouse, ABHWV Quality HEDIS Manager

ABHWVHEDIS@aetna.com

304-348-2923

- ABHWV can outreach to your members to assist in getting them into the office.
- Contact us if interested in exploring EMR data file transfer options

Diabetes Event Partnering Candace Smith

csmith19@aetna.com

304-348-2008

Other Resources

ABHWV Integrated Care Management

Refer member to Aetna Better Health of West Virginia Case Management:

- Fax to 844-330-1001
- Call 1-888-348-2922.

Diabetes links:

https://professional.diabetes.org /content-page/practiceguidelines-resources

https://www.onlinejacc.org/guide lines



Questions?



** detna**