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1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
WHAT IS HEDIS?

**Healthcare Effectiveness Data and Information Set (HEDIS)**

NCQA defines HEDIS as, **“a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans.”**

- HEDIS is a performance measurement tool that is coordinated and administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations.
- Results from HEDIS data collection serve as measurements for quality improvement processes, educational initiatives, and preventive care programs.
- All managed care companies that are NCQA accredited perform HEDIS reviews at the same time each year.
- HEDIS consists of 80 measures across five domains of care that address important health issues.
- HEDIS is a retrospective review of services and performance of care from the prior calendar year.
- There are two types of HEDIS data collected:
  - Administrative data – comes from submitted claims and encounters
  - Hybrid data – comes from chart collection/review
ANNUAL HEDIS TIMELINE

February to early May
Quality department staff collect and review HEDIS data (On-site provider office chart collecting occurs)

June
HEDIS results are certified and reported to NCQA and Florida’s Agency for Health Care Administration (AHCA)

October
NCQA releases Quality Compass results nationwide for Medicaid

Remember that HEDIS is a retrospective process
HEDIS 2017 = Calendar Year 2016 Data

HEDIS MEDICAL RECORD REQUEST PROCESS:

- Data collection methods include: fax, mail, onsite visits for larger requests, and remote electronic medical record (EMR) system access if available
- Medical record fax requests will include a member list identifying their assigned measure(s) and the minimum necessary information needed by the health plan
- Due to the limited data collection timeframe, a turnaround time of 3-5 days is appreciated
- For on-site chart collections, the office will be contacted to schedule a time the abstractor can come to the office for chart review. A list of members charts being reviewed will be provided ahead of time
TIPS AND BEST PRACTICES

General tips and information that can be applied to most HEDIS measures:

- Use your member roster to contact patients who are due for an exam or are new to your practice
- Take advantage of this guide, coding information, and the on-line resources to help your practice understand HEDIS measures, compliance, and requirements
- Member rosters and members due for HEDIS services can be found on the provider portal: directprovider.com
- You can provide evidence of completed HEDIS services and upload records securely into the provider portal
- Ask your Provider Relations representative about obtaining a ‘Members Due for Service’ HEDIS report
- Schedule the members’ next well-visit/preventive care at the end of the current appointment
- Assign a Quality or HEDIS nurse to perform internal reviews and serve as a point of contact
- Most Electronic Health Records (EHRs) are able to create alerts and flags for required HEDIS services. Be sure to have all these prompts turned on or check with your software vendor to have these alerts added
- Consider extending your office hours into the evening, early morning or weekend to accommodate working parents

REGARDING HIPAA

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and the release of this information requires no special patient consent or authorization. Please be assured our members’ personal health information is maintained in accordance with all federal and state laws. Data is reported collectively without individual identifiers. All of the health plans’ contracted providers’ records are protected by these laws.

- HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities
- The records you provide during this process helps us to validate and demonstrate the quality of care you provide to our members
The Importance of Documentation

Principles of the medical record and proper documentation:

• Enable physician and other healthcare professionals to evaluate a patient’s healthcare needs and assess the efficacy of the treatment plan
• Serves as the legal document to verify the care rendered and date of service
• Ensure date of care rendered is present and all documents are legible
• Serves as communication tool among providers and other healthcare professionals involved in the patient’s care for improved continuity of care
• Facilitate timely claim adjudication and payment
• Appropriately documented clinical information can reduce many of the ‘hassles’ associated with claims processing and HEDIS chart requests
• Support the ICD-9 and CPT codes reported on billing statements

Common reasons why members with PCP visits remain ‘non-compliant’ are:

• Missing or incomplete required documentation components
• Service provided without claim/encounter data submitted
• Lack of referral to obtain the recommended service (i.e. diabetic member eye exam to check for retinopathy)
• Service provided, but outside of the required time frame or anchor date (i.e. Lead screening performed after age 2)
• Incomplete services (i.e. Tdap given but no Meningococcal vaccine for adolescent immunization measure)
• Failure to document or code exclusion criteria for a measure

Look for the “Common Chart Deficiencies and Tips” sections to help guide some of the more challenging components to HEDIS measure compliance
CHILDREN’S MEASURES

Well-Child Visits in the First 15 Months of Life (W15)

Members who turn 15 months of age in the measurement year and receive at least six well-child visits with a Primary Care Provider (PCP). The well-child visits must be received on or before the child turning 15 months old.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Age (W34)

Members who are 3 to 6 years of age and receive at least one well-child visit in the measurement year.

Adolescent Well-Care Visits (AWC)

Members who are 12 to 21 years of age in the measurement year and receive at least one comprehensive well-child visit with a PCP or an OB/GYN provider in the measurement year.

All Well-Child exams MUST include documentation of three criteria:
- Physical Exam
- Health and Developmental History
- Health Education/Anticipatory Guidance

Common Chart Deficiencies & Tips:
- Missing or undocumented anticipatory guidance
- Documenting “Patient Education Given” is not sufficient
- Sick visits in calendar year without well-visit(s)
- Schedule next well visit at end of each appointment
- Sick visits present an opportunity to complete a well visit as long as all the required documentation is met
- Bill for both well and sick exams using modifier code (25)
Lead Screening in Children (LSC)

Children who turn 2 years of age in the measurement year and receive one or more capillary or venous lead blood tests on or before their second birthday.

Lead poisoning information and the complete testing guidelines for children are available from the Florida Department of Health:


Weight Assessment and Counseling for Nutrition and Physical Activity for Children (WCC)

Members who turn 3-17 years of age in the measurement year.

Ages 3-17 years on the date of service, documentation of:
- BMI percentile or BMI percentile plotted on growth chart
- (A BMI value alone is not acceptable for this age rage)
- Counseling for nutrition
- Counseling for physical activity

There are diagnostic codes that can be used which will drive administrative compliance for these measure components.
Children who turn 2 years of age in the measurement year and receive the following vaccinations on or by their second birthday:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>4</td>
</tr>
<tr>
<td>IPV</td>
<td>3</td>
</tr>
<tr>
<td>MMR</td>
<td>1</td>
</tr>
<tr>
<td>Hib</td>
<td>3</td>
</tr>
<tr>
<td>Hep B</td>
<td>3</td>
</tr>
<tr>
<td>VZV</td>
<td>1</td>
</tr>
<tr>
<td>PCV</td>
<td>4</td>
</tr>
<tr>
<td>Hep A</td>
<td>1</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>*2 or 3</td>
</tr>
<tr>
<td>Influenza</td>
<td>2</td>
</tr>
</tbody>
</table>

**Common Chart Deficiencies & Tips:**

- Vaccines for DTaP, IPV, HiB, or PCV, given before 42 days after birth do not count as compliant for HEDIS
- Record the immunizations in the state registry – Florida Shots
- Use each visit to review vaccine schedule and opportunity to catch-up on missing immunizations
- Document parent refusal and place a signed copy in the medical record
- Document the date of the first hepatitis B vaccine given at the hospital and name of the hospital, if available
- Record date and immunization(s) provided at health department in the patient’s medical record
- Document and code any contraindications or allergies
- Finding IMA vaccines given prior to the specified age ranges

*Be sure to give the correct number of doses based on manufacturer and code Rotavirus correctly.

- Rotarix® from GlaxoSmithKline is a two-dose formula and the CPT code is 90881
- RotaTeq® from Merck is a three dose formula and the CPT code is 90680
**Immunization for Adolescents (IMA)**

Changes made to this measure by NCQA for HEDIS 2017!

Adolescents who turn 13 years of age in the measurement year and receive the following vaccinations by their 13th birthday:

- Meningococcal vaccine given between 11th and 13th birthdays
- Tdap/Td vaccine given between 10th and 13th birthdays
- HPV vaccine given at least three times between 9th and 13th birthdays

The HPV vaccine measure is retired by NCQA and vaccine is now part of the IMA measure. HPV measure update includes **Male and Female** population to receive the HPV vaccine.

*Note that CDC recommendation has changed to 2 doses of HPV, however, the Tech Specs have not been changed yet for HEDIS 2017 by NCQA.

For more information to share with your patients regarding the importance of the HPV vaccine go to: [http://www.cdc.gov/hpv/resources.html](http://www.cdc.gov/hpv/resources.html)

**Common Chart deficiencies and Tips:**

- Less than 3 HPV vaccine doses given
- Final dose of HPV vaccine given after age 13
- First dose of MCV given before age 11

**Annual Dental Visit (ADV)**

Members 2-20 years of age in the measurement year and had at least one dental visit during the measurement year.

- Medicaid Dental vendor MCNA Provider Hotline: 1-855-698-6262
- Dental visits can start before age 2, especially for children at risk for dental problems
- Fluoride can be applied at the PCP office, but referral to dentist for appropriate care must occur to make ADV measure compliant
ADULT MEASURES

Adult BMI Assessment (ABA)

Members 21 years of age or older that have their BMI and weight documented in the measurement year or year prior.

For members younger than 21 years of age, the BMI percentile must be documented in the measurement year or year prior.

Care of Older Adults (COA)

Members 66 years of age and older in the measurement year that had each of the following:

- **Advance care planning**
  - Advance directives
  - Living will

- **Medication review**
  - At least one medication review by a prescribing practitioner in the year
  - Medication list in the medical record

- **Functional status assessment**
  - Activity of daily living (ADL) assessment
  - Functional independence
  - Sensory ability
  - Cognitive and ambulatory status

- **Pain assessment**
  - Evidence of a pain assessment using a standardized pain assessment tool and date performed

Common Chart Deficiencies & Tips:
- Height and/or weight are documented but no documentation of the BMI
- Diagnosis Codes V85.0-85.5 can be used to make this measure compliant without chart review.
WOMEN’S MEASURES

Breast Cancer Screening (BCS)

Women ages 50-74 years of age in the measurement year that had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Cervical Cancer Screenings (CCS)

Women 21-64 years of age in the measurement year that were screened for cervical cancer using either of the following criteria:

- Age 21-64 - Cervical cytology performed every three years
- Age 30-64 - Cervical cytology/human papillomavirus (HPV) co-testing performed every five years

Common Chart deficiencies and Tips:

- Documentation for members with hysterectomy, must include words such as “complete,” “total,” or “radical”
- Documentation of hysterectomy alone does not meet the NCQA guidelines because it does not indicate the cervix was removed
- Cervical cytology and HPV co-testing must occur on the same date of service and be from the same data source
- Results for both tests must be documented

Chlamydia Screening in Women (CHL)

Members 16-24 years of age in the measurement year identified as sexually active that had at least one chlamydia test during the measurement year.

- Best Practice - Make chlamydia screening via urine test as part of the annual physical exam. Parental consent is not required.
- Members are identified as sexually active through administrative claim data either through pregnancy codes or pharmacy data for prescription contraceptives
Prenatal and Postpartum Care (PPC)

Intake period for this measure is for women who delivered a live birth between November 6 of the year prior to the measurement year, and November 5 of the measurement year.

There are two components to this measure:

**Timeliness of Prenatal Care**
- Prenatal visit in the first trimester or within 42 days of enrollment into the health plan
- Refer to and use the ACOG sheets to help ensure measure compliance

**Postpartum Care**
- Postpartum visit between 21 and 56 days after delivery (excludes C-section suture/staple removal appointment)
- Educate C-Section patient upon suture/staple removal visit that she must return between 21-56 days after the delivery date for a complete and compliant HEDIS postpartum visit
- Aetna Better Health of Florida does pay for both a staple removal visit and a subsequent post-partum visit
Comprehensive Diabetes Care (CDC)

Members 18-75 years of age in the measurement year with a diagnosis of diabetes (Type 1 or Type 2) and that have each of the following performed annually:

- Hemoglobin A1c (HbA1c) testing
  - HbA1c control <8.0%
- Nephropathy Screening
- Dilated Retinal Eye Exam
- BP Control (<140/90 mm Hg)

Common Chart deficiencies and Tips:
- Failure to order lab tests or results not documented in chart
- Lab values show poor control
- No documentation or testing for Nephropathy screening
- No referral for retinal eye exam
- Incomplete or missing information from specialty or consulting providers

Controlling High Blood Pressure (CBP)

Members 18-85 years of age in the measurement year with a diagnosis of hypertension whose blood pressure is adequately controlled. The HEDIS requirement is to review the last blood pressure reading in the measurement year.

- 18-59 years of age whose Blood Pressure is <140/90
- 60-85 years of age with a diagnosis of diabetes whose Blood Pressure is <140/90
- 60-85 years of age without a diagnosis of diabetes whose Blood Pressure is <150/90

Common Chart deficiencies and Tips:
- Often times the patient’s BP is taken first thing from walking to the exam room – and just after being weighed so:
  - Retake the BP if elevated
  - Check BP in both arms – HEDIS allows lowest reading
  - Ensure the BP cuff is the correct size for the patient’s arm
  - HTN diagnosis on or before June 30 of the measurement year must be in the patient’s medical record
Medication Management for People with Asthma (MMA)

Members 5-64 years of age in the measurement year identified as having persistent asthma and were dispensed appropriate medications which they remained on during the treatment period.

Two components reported:
- Members who remained on an asthma controller medication for at least 50% of their treatment period
- Members who remained on an asthma controller medication for at least 75% of their treatment period

Antidepressant Medication Management (AMM)

Members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and that remained on an antidepressant medication treatment. This measure runs between May 1 of the year prior to the measurement year and ends on April 30 of the measurement year.

Two components reported:
- **Effective Acute Phase Treatment**: Members who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective Continuation Phase Treatment**: Members who remained on an antidepressant medication for at least 180 days (6 months)
Follow-up Care for Children Prescribed ADHD Medication (ADD)

Members 6-12 years of age in the measurement period, newly prescribed ADHD medication and had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

The measurement period for this measure is March 1 of the year prior to measurement year and ending February 28 of the measurement period.

Two components are reported:

- **Initiation Phase** – one follow-up visit by a practitioner with prescribing authority within 30 days of dispensed prescription

- **Continuation Phase** – members who remained on ADHD medication for at least 210 days who in addition to the Initiation Phase visit, had at least two more follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

**Best Practice Tips:**

- No refills until the initial follow-up visit is complete
- Conduct initial follow-up visit 2-3 weeks after member starts medication therapy
- Member needs 2 additional visits within 9 months of starting medication, schedule these appointments at initial visit
- If member cancels, reschedule appointment right away
Follow-Up after Hospitalization for Mental Illness (FUH)

Members 6 years of age and older in the measurement year discharged after hospitalization for treatment of selected mental illness diagnoses and had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

Two components reported:
- Members who received a follow-up visit within 7 days of discharge.
- Members who received a follow-up visit within 30 days of discharge.

For both indicators, any of the following meet criteria for a follow-up visit (7-Day or 30-Day):
- A Stand Alone Visit with a mental health practitioner
- A visit to a behavioral healthcare facility
- A visit to a non-behavioral healthcare facility with a mental health practitioner
- A visit to a non-behavioral healthcare facility with a diagnosis of mental illness
- Transitional care management services where the date of service on the claim is 29 days after the date the member was discharged with a principal diagnosis of mental illness.

The following meets criteria for only the 30-Day Follow-Up indicator:
- Transitional care management services where the date of service on the claim is 29 days after the date the member was discharged with a principal diagnosis of mental illness.
THANK YOU for serving our members with outstanding care!

For more HEDIS information or questions, you may send an email to: FLMedicaidQualityDept@aetna.com

For questions not pertaining to HEDIS send an email Provider Relations at: FLMedicaidProviderRelations@aetna.com