HEDIS Quick Reference Guide - Adult

What is HEDIS (Healthcare Effectiveness Data and Information Set)?

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of many State contracts. Through HEDIS, NCQA holds Home State Health Plan accountable for the timeliness and quality of health care services (acute, preventive, mental health, etc) delivered to its diverse membership.

HEDIS consists of over 20 Effectiveness of Care type measures as well as Access to Care and Use of Services measures. These rates are calculated based on claims/encounter data and/or medical record review data. The rates are reported to NCQA and to the State if required by contract.

What are the scores used for?

As both State and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. State purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Physician-specific scores are being used as evidence of preventive care from primary care office practices. These rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on their individual scoring of quality indicators such as those used in HEDIS.

How are the rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual Chlamydia screening, annual Pap test, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include: comprehensive diabetes care, control of high-blood pressure, immunizations, and prenatal care.

Who should I contact at Home State Health Plan for Assistance?

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement Department at 855-694-4663.

How can I improve my HEDIS scores?

- Submit claim/encounter data for each and every service rendered.
- Chart documentation must reflect services billed.
- All providers must bill (or report by encounter submission) for services delivered, regardless of contract status.
- Claim/encounter data is the most clean and efficient way to report HEDIS.
- If services are not billed or not billed accurately they are not included in the calculation.
- Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.

Adult BMI Assessment

Measure demonstrates the percentage of members ages 18 to 74 who had their BMI documented during any outpatient visit in the past two years. Recommendation is for adults to have BMI assessed at least every 2 years. Adults 19 and older must have a BMI value. Adults younger than 19 can also have a BMI percentile and/or BMI percentile plotted on an age-growth chart.

ICD-9-CM Diagnosis	V85.0-V85.5

Breast Cancer Screening

Measure evaluates the percentage of women ages 42 to 69 who had a mammogram *at least once* in the past two years.

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue
77055-77057	G0202, G0204, G0206	87.36, 87.37	0401, 0403

Women who have had a bilateral mastectomy are exempt from this measure.

Cervical Cancer Screening

Measure evaluates the percentage of women ages 24 to 64 who had *one or more* Pap tests to screen for cervical cancer in the past 3 years.

CPT	HCPCS	ICD-9-CM Procedure	UB Rev
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	91.46	0923

Women who have had a total hysterectomy with no residual cervix are exempt from this measure.

ICD-9-CM Diagnosis	V88.01, V88.03

Chlamydia Screening in Women

Measure evaluates the percentage of women ages 16 to 24 who are sexually active who had at least one test for Chlamydia per year. Chlamydia tests can be completed using any method, including a urine test.

CPT	87110, 87270, 87320, 87490-87492, 87810

Colorectal Cancer Screening

Measure evaluates the percentage of members ages 50-75 who had at least one appropriate screening for Colorectal Cancer in the past year.

Description	CPT	HCPCS	ICD-9-CM Procedure
FOBT	82270, 82274	G0328	
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104	45.24
Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121	45.22, 45.23, 45.25, 45.42, 45.43

Patients who have a history of colon cancer or who have had a colectomy are exempt from this measure.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Measure evaluates the percentage of adults aged 18-64 with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. *Include any secondary diagnoses to the bronchitis diagnosis as applicable.*

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Measure evaluates the percentage of members age 40 and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

CPT	94010, 94014-94016, 94060, 94070, 94375, 94620

Pharmacotherapy Management of COPD Exacerbation

Measure evaluates the percentage of COPD exacerbations for members age 40 and older and were dispensed appropriate medications. Intent is to measure compliance with recommended pharmacotherapy management for those with COPD exacerbations. Two rates are reported:

1. Systemic Corticosteroid - Dispensed prescription for systemic corticosteroid on or 14 days after the episode.

Description	Prescription
Glucocorticoids	Betamethasone, Hydrocortisone, Prednisolone, Triamcinolone, Dexamethasone, Methylprednisolone, Prednisone

2. Bronchodilator – Dispensed prescription for a bronchodilator on or 30 days after the episode date.

Description	Prescription
Anticholinergic agents	Albuterol-ipratropium, Ipratropium, Tiotropium
Beta 2-agonists	Albuterol, Arformoterol, Budesonide-formoterol, Fluticasone-salmeterol, Formoterol, Indacaterol, Levalbuterol, Mometasone-formoterol, Metaproterenol, Pirbuterol, Salmeterol
Methylxanthines	Aminophylline, Dyphylline-guaifenesin, Guaifenesin-theophylline, Dyphylline, Theophylline

Use of Appropriate Medications for People with Asthma

Measure evaluates the percentage of members age 5-64 who were identified as having persistent asthma and who were appropriately prescribed medication.

Appropriate Medications

Antiasthmatic combinations, Antibody inhibitor, Inhaled steroid combinations, Inhaled corticosteroids, Leukotriene modifiers, Mast cell stabilizers, Methylxanthines

Medication Management for People With Asthma

Measure evaluates the percentage of members age 5-64 who were identified as having persistent asthma and were dispensed appropriate medications they remained on during the treatment period within the past year. Two rates:

Medication Compliance 50% - Members who were covered by one asthma control medication at least 50% of the treatment period

Medication Compliance 75% - Members who were covered by one asthma control medication at least 75% of the treatment period

Appropriate Medications

Antiasthmatic combinations, Antibody inhibitor, Inhaled steroid combinations, Inhaled corticosteroids, Leukotriene modifiers, Long-acting, inhaled beta-2 agonists, Mast cell stabilizers, Methylxanthines, Short-acting, inhaled beta-2 agonists

Cholesterol Management for Patients with Cardiovascular Disease

Measure evaluates the percentage of members age 18 to 75 who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) or had a diagnosis of ischemic vascular disease who had an LDL-C level drawn in the past year.

CPT	80061, 83700, 83701, 83704, 83721	CPT II	3048F, 3049F, 3050F

Comprehensive Diabetes Care

Measure demonstrates the percentage of members ages 18-75 with diabetes (types 1 & 2) who were compliant in the following submeasures:

Description	CPT	CPT II	HCPCS
An **HbA1C test** is completed *at least* once per year.	83036, 83037	3044F, 3045F, 3046F	
An **LDL-C test** is completed *at least* once per year.	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	
Eye Exam – a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) is completed every year **OR** a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior.	67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F*	S0620 S0621 S0625 S3000

Description	CPT	CPT II	HCPCS
A **nephropathy screening** test is performed *at least* once per year. A member who is on ACE/ARBs or has nephropathy is compliant for this submeasure.	82042, 82043, 82044, 84156	3060F, 3061F	

*CPT Category II code 3072F can only be used if the claim/encounter was during the measurement year because it indicates the member had "no evidence of retinopathy in the prior year." Additionally, because the code definition itself indicates results were negative, an automated result is not required.

Use of Imaging Studies for Low Back Pain

Measure evaluates the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. Intent is to identify compliancy to recommendation of no imaging studies for a first-time complaint of low back pain without another diagnosis. **Add other diagnoses indicating need for an imaging study for the low back pain, such as any trauma, cancer, IV drug abuse or neurological impairment.**

Adult Access to Preventive/Ambulatory Health Services

Measure evaluates the percentage of members age 20 and older who had an ambulatory or preventive care visit. Recommendation is for each adult member to have routine outpatient visits at least annually.

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Preventive medicine	99385-99387, 99395-99397, 99401-99404,	G0344, G0402,		
General medical examination	99411, 99412, 99420, 99429	G0438, G0439	V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Timeliness and Frequency of Prenatal Visits

Measure evaluates the percentage of pregnant women who had their first prenatal visit in the first trimester. Also, frequency of prenatal visits is assessed.

CPT*	CPT II	HCPCS	Applicable E&M code billed in conjunction with ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Rev Revenue
59400*, 59425*, 59426*, 59510*, 59610*, 59618*, 99201-99205, 99211-99215, 99241-99245, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 80055, 86644, 86694, 86695, 86696, 86762, 86777, 86762, 86900, 86901, 99500,	0500F, 0501F, 0502F	H1000-H1004, H1005**	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28	88.78	0514

The expected number of prenatal visits is adjusted based on the gestational age and duration of member's enrollment.

*Generally, these codes are used on the date of delivery. Code is useful only if claim form indicates when prenatal care was initiated.

**H1005 indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

Postpartum Visits

Measure evaluates the percentage of women who delivered a baby and who had their postpartum visit on or between 21 and 56 days after delivery.

CPT	CPT II	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Rev
57170, 58300, 59400*, 59410*, 59430, 59510*, 59515*, 59610*, 59614*, 59618*, 59622*, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175, 99501	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46	0923