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.

Continued >>>

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HOME STATE™ Health Plan

HEDIS Quick Reference Guide - Women

HOME STATE™ Health Plan

HEDIS QUICK REFERENCE GUIDE - Women's Health

How can I improve my HEDIS rates?

- 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 21 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 Revenue
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

Prenatal Visits – Timeliness of First Visit and Frequency of 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
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 (3 and 8 weeks).

CPT	CPT II	HCPCS	ICD-9-CM Diagnosis	ICD 9 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

Adolescent Well Care Visits

Measure evaluates the percentage of adolescents age 12 to 21 years old who had at least one comprehensive well care visit (EPSDT) per year. Visit can be provided by an OB/GYN as long as it includes 1) a health and developmental history (physical and mental), 2) a physical exam, and 3) health education/anticipatory guidance.

CPT	99383-99385, 99393-99395	ICD-9	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9