Positive Practice

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Benefits of Improving HEDIS Scores

- Functions as an early warning system to catch diseases/conditions early and while still treatable
- High scores attract more members by demonstrating the expertise of the Plan's Providers and enabling members to feel secure in selecting AHF Plans
- High scores enables AHF to acquire the resources needed to improve the health of the overall population
- Provides opportunities for improvement in Medical Record Documentation and code usage.
- Helps Providers gauge their annual performance: highlighting areas which they excel and opportunities for improvement.

AHF Hedis Measure Requirements At-A-Glance

Measure	Notes	Codes
Adult BMI Assessment (ABA)	Must include date, weight and BMI value **Exclusion:** Pregnancy	Codes the patient's BMI in Claims: ICD-10: Z68.*
Cervical Cancer Screening (CCS)	• Cervical Cytology tests every three (3) years • Cervical Cytology and HPV tests less than 4 days apart every five (5) years **Exclusion:** Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.	**CPT:** 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 **HPV Test CPT:** 87620-87625 **HCPCS:** G0476 *Use ICD10 code Q51.5 [Agenesis and aplasia of cervix] to identify patients born without cervixes, including patients who were born male and later transitioned to female.*
Care for Older Adults (COA): **Advance Care Planning**	• The presence of an advance care plan in the medical record. • Annual documentation of an advance care planning discussion with the provider including if a patient declines. • Notation that the member previously executed an advance care plan.	**CPT:** 99497 **CPT Cat. II:** 1123F, 1124F, 1157F, 1158F **ICD10:** Z66 **HCPCS:** S0257
Care for Older Adults (COA): **Medication Review**	• Both of the following on the same date of service during the measurement year: – At least one medication review conducted by a prescribing practitioner or clinical pharmacist. – The presence of a medication list in the medical record.	**CPT:** 90863, 99605, 99606 **CPT Cat. II:** 1160F
Care for Older Adults (COA): **Functional Status Assessment**	• Notation that Activities of Daily Living (ADL) were assessed: bathing, dressing, eating, using toilet, walking. **OR** Notation that Instrumental Activities of Daily Living (IADL) were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances. **OR** • Result of assessment using a standardized pain assessment tool	**CPT Cat. II:** 1170F **HCPCS:** G0438, G0439
Care for Older Adults (COA): **Pain Screening**	• Documentation that the patient was assessed for pain (which may include positive or negative findings for pain). **OR** • Result of assessment using a standardized pain assessment tool	**CPT Cat. II:** 1125F, 1126F

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continued from front

AHF Hedis Measure Requirements At-A-Glance *continued*

Measure	Notes	Codes
Colorectal Cancer Screening (COL)	Members 50–75 years of age who received one or more of the following screenings: • Do **iFOBT** annually, or • **FIT DNA** every 3 years, or • **CT Colonography** every 5 years, or • **Sigmoidoscopy** every 5 years, or • **Colonoscopy** every 10 years **Exclusion from measure:** Documented colon cancer or history of colon cancer or a total colectomy,	• ***Fecal Occult Blood Test Codes:*** **CPT:** 82270, 82274 **(iFOBT)** **HCPCS: G0328 (iFOBT)** • ***FIT-DNA Codes:*** **CPT:** 81528 **HCPCS:** G0464 • ***CT Colonography Codes:*** **CPT:** 74261, 74262, 74263 • **Flexible Sigmoidoscopy Codes: CPT:** 45330-45335, 45337-45342, 45345-45350; **HCPCS:** G0104 • ***Colonoscopy Codes:*** **CPT:** 44388-44394, 44397, 44401-44408. 45355, 45378-45393, 45398 **HCPCS:** G0105, G0121 **Exclusion from COL Measure codes:** • ***Colorectal Cancer:*** **ICD-10**: C18.*, C19.*, C20.*, C21.*, C78.* AND Z85.*
Comprehensive Diabetes Care (CDC): HbA1C Test	Obtain a HgA1C test result at least once per year documented in the medical record.	**CPT II Codes:** 3045F, HbA1c Level 7.0-9.0 3046F, HbA1c Level Greater Than 9.0 3044F, HbA1c Level Less Than 7.0 **CPT:** 83036,83037
Comprehensive Diabetes Care (CDC): Eye Exams	Document date and result of all **retinal** eye exams. Example: "Retinal eye exam 6/23/2016 WNL" (With Normal Results)	• ***Diabetic Retinal Screening:*** **CPT:** 67028, 67030, 67031, 67036, 67039 TO 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 TO 92228, 92230, 92235, 92240, 92250, 92260, 99203 TO 99205, 99213 TO 99215, 99242 TO 99245, **HCPCS:** S0620, S0621, S3000 • ***Diabetic Retinal Screening With Eye Care Professional:*** **CPT II:** 3072F, 2022F, 2024F, 2026F
Comprehensive Diabetes Care (CDC): Nephropathy	Document Nephropathy screening each year, preferably on flowchart. **Exclusion:** On Acel or ARB, nephrologist visit, and kidney disease, dialysis for transplant.	***Urine protein tests:*** **CPT:** 81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156 **CPT2:** 3060F, 3061F, 3062F
Controlling High Blood Pressure (CBP) **To be compliant with the blood pressure measure – last reading of the year must be recorded as 139/89 or less. Multiple bp's can be taken during the same visit. hedis abstractors use the lowest systolic and the lowest diastolic of the visit.**	The goal is to control patients' BP as follows: •BP <140/90 ***Hypertension is chronic. If the patient's BP is normal, still note the hypertension in the record.*** **Exclusion:** Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.	***Hypertension Diagnosis:*** **ICD-10:** I10.*, I11.*, I12.*, I13.*, I16.* ***Blood Pressure Codes:*** 3079F, Diastolic 80-89 3080F, Diastolic Greater Than/Equal To 90 3078F, Diastolic Less Than 80 3077F, Systolic Greater Than/Equal To 140 3074F or 3075F, Systolic Less Than 140
Medication Reconciliation Post-Discharge (MRP)	Document: "Medications prescribed upon discharge were reconciled with the current medication in the outpatient record" (Evidence of Reconciliation) **OR** Documentation that "no medications were prescribed upon discharge."	**CPT:** 99495, 99496 **CPT2:** 1111F
Transition of Care (TRC): **Patient Engagement After Discharge**	Patient Engagement After Inpatient Discharge Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.	**CPT:** 992*, 993*, 994* **HCPCS:** G0402, G0438-9, G0463, T1015 TCM 14-Day CPT: 99495 TCM 7-Day CPT: 99496 Telephone Visits CPT: 98966-68, 99441-3 *TCM=Transitional Care Management