Coding Seminar: Tips to Improve HEDIS® Measures

Charlotte Kohler, CPA, CVA, CPAM, CPC, CHBC
Disclaimer

- HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

This presentation was current at the time it was published. NCQA and payers’ policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a tool to assist providers, coders, and billing staff. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice is the provider of services.

This publication is a general summary that explains certain aspects of the NCQA HEDIS® Program, but is not a legal document. The official Program provisions are contained in the relevant laws, regulations, and rulings.
Healthcare Effectiveness Data and Information Set (HEDIS)

- National Committee of Quality Assurance (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 one component of NCQA's accreditation
- HEDIS is the most used performance measure in the managed care industry
- NCQA uses these measures for commercial, Medicare and Medicaid
What is HEDIS?

The majority of HEDIS is measurements from administrative result claims, but some are pulled from hybrid results medical record review

- Administrative data is calculated from a claim or an encounter submitted to a health plan
- Hybrid reviews are a random sample of a members medical record (may also include administrative data)

Retroactive reviews of the medical record and data submitted may occur for data submitted in the prior year
What is HEDIS?

- Results from HEDIS data collection serve as measurements for quality improvement process and preventive care programs.
- HEDIS rates are designed to evaluate the effectiveness of a health plan’s ability to demonstrate an improvement in its preventive care and quality measures to plan’s members.
- HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.
- HEDIS consists of 75 measures across 8 domains of care that address important health issues.
What is HEDIS?

HEDIS Eight Domains of Care

1. Effectiveness of Care
2. Access/availability of Care
3. Satisfaction with the Experience of Care Provided
4. Health Plan Stability
5. Use of Service
6. Cost of Care
7. Informed Health Care Choices
8. Health Plan Information is Clear and Descriptive
What is HEDIS?

Data is reported to NCQA in June of the reporting year

- Data reflects events that occurred during the measurement year (calendar year)
- HEDIS 2011 data is reported in June 2011; however, it reflects data from January to December 2010
- HEDIS 2011 = 2010 data
What is HEDIS?

Key Terms to Know

– Denominator = eligible members of the population
– Numerator = members that met the criteria of a measure
– Anchor date = the specific date the member is required to be enrolled to be eligible for the measure
– Provider specialty = certain measures must be provided by a specific provider specialty
What is HEDIS?

HEDIS Obstacles

- Members are assigned to the wrong PCP provider or information is not properly transferred to new PCP
- **Claims are submitted without the proper ICD-9 or CPT codes that count toward the measure**
- The provider specialty does not count for the measure
- The member is not continuously enrolled
- The services are not documented properly in the member’s medical record
- **All components of the required measure where not met**
- Appointment availability to members and provider’s opening
HEDIS Measures
What Are Measures?

HEDIS measures are specified for one or more of three data collection methods:

1. Administrative
2. Hybrid and
3. Survey

Clinical measures use the Administrative and/or Hybrid data collection methodology as specified by NCQA
What Are Measures?

Administrative methodology requires that the health plan:
- identify the eligible population for the specific HEDIS measure through use of electronic records of service to include insurance claims and registration systems from hospitals, clinics, medical offices, pharmacies and labs; and,
- determine the number of that population who are found to have received the service required for that measure.

Measures that are captured through administrative data include Breast Cancer Screening and Antidepressant Medication Management.

It is critical that ICD9 codes and/or CPT codes approved by NCQA be submitted to ensure the member receives the necessary screening and the provider receives credit for performing the screening.
What Are Measures?

The Hybrid method of data collection consists of selection of random sample of the population and allows for supplementation of Administrative data with data collected during medical record reviews.

– Johns Hopkins Health Care (JHHC) uses this method for 14 measures

– A few examples are Prenatal and Postpartum Care, Comprehensive Diabetes Care and Childhood Immunizations
What Are Measures?

Consumer Assessment of Healthcare Providers and Systems (CAHPS®2) is a survey which measures members' satisfaction with their care in areas such as claims processing, customer service and getting needed care quickly.

– Data collection relating to the CAHPS 4.0 survey must be conducted by an NCQA-approved external survey organization.
What Are Measures?

- HEDIS 2012 SUMMARY TABLE OF MEASURES, PRODUCT LINES AND CHANGES (Attachment 1)
  http://www.ncqa.org/LinkClick.aspx?fileticket=O-31v4G27sU%3d&tabid=1415

- HEDIS 2012 SUMMARY TABLE OF PHYSICIAN MEASURE CHANGES (See Website)
  http://www.ncqa.org/LinkClick.aspx?fileticket=K4wzHTiYHug%3d&tabid=1415
General Documentation Tips
Why Is Documentation Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and,
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.
General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings.

– The medical record should be complete and legible.
– The documentation of each patient encounter should include:
  • reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
  • assessment, clinical impression, or diagnosis;
  • plan for care; and,
  • date and legible identity of the observer.
– If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
General Principles of Medical Record Documentation

– Past and present diagnoses should be accessible to the treating and/or consulting physician.
– Appropriate health risk factors should be identified.
– The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
– The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
HEDIS Documentation/Coding Tips
HEDIS Documentation/Coding Tips

Hybrid Review for Well Child 3-6 Years

– One well child visit with a PCP during the measurement year.
– All three components of a well-child visit must be included:
  • Health & Development History (physical & mental) e.g. communication skills, self-care skills, disposition
  • Physical Examination e.g. height, weight, lungs, abdomen, vision, hearing, abuse/neglect, etc.
  • Health Educations/Anticipatory Guidance e.g. bed time, second hard smoke, friends, proper eating

– Sick visits are opportunities to include this information
– Visits to school based clinic practitioners whom the organization would consider PCPs may be counted if the documentation that a well exam occurred is available in the medical record or administrative system.
Hybrid Review for Well Child 3-6 Years (con’t.)

– The claim must have the proper ICD-9/CPT codes and be submitted by the correct specialty to be counted.

– PCP: A physician or non physician (e.g. nurse practitioner) who offers primary care medical services. Licensed practical nurses, registered nurses, and physician assistants are not considered PCPs because they are not licensed to practice independently.

– Primary Care Physician includes:
  • General or family practice physicians
  • General internal medicine physicians
  • General pediatricians
  • Obstetricians/gynecologists (OB/GYN)
  • Certified nurse midwives and Nurse Practitioners under the direction of an OB/GYN certified provider or PCP

– The PCP does not have to be assigned to the member.
HEDIS Documentation/Coding Tips

Hybrid Review for Adolescent Well Care Visits, Age 12 – 21 years

- One well child visit with a PCP or OB/GYN during the measurement year
- All three components of an adolescent well visit must be included:
  - Health & Development History (physical and mental) e.g. developmental questionnaires regarding school, emotional development, activities, depression, peer relations, etc.
  - Physical Examination e.g. weight, height, vision, heart, lungs, GU (pap smears)
  - Health Educations/Anticipatory Guidance e.g. sex education, ETOH avoidance, safety, etc.
HEDIS Documentation/Coding Tips

Hybrid Review for Adolescent Well Care Visits, Age 12 – 21 years (con’t.)

– Sick visits are opportunities to include this information
– Visits to school based clinic practitioners whom the organization would consider PCPs may be counted if the documentation that a well exam occurred is available in the medical record or administrative system
HEDIS Documentation/Coding Tips

Appropriate Medications for Patients with Asthma, Age 5 – 64 years

- For patients with persistent asthma at least one dispensed controller medication
- Review and assess asthma prescriptions every visit
  - Patient adherence
  - Consideration of other health conditions
  - Lifestyle issues
  - Educational material
- A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
HEDIS Documentation/Coding Tips

Hybrid Review Childhood Immunization and Lead Screenings

– The health plan is looking for all childhood immunizations and lead screenings to be completed on or before the child’s second birthday

– Complete immunizations on or before the child’s second birthday:
  • 4 – DTaP/DT
  • 3 – IPV
  • 3 – Hep B
  • 3 – Hib
  • 4 – PCV
  • 1 – MMR
  • 1 – VZV

– Document all sero positives and illness history of chicken pox, measles, mumps, and rubella

– Document the 1st Hep B vaccine given at the hospital when applicable or if unavailable name of hospital where child was born

– No provider requirements specified
HEDIS Documentation/Coding Tips

Hybrid Review of Prenatal Care

Prenatal care visits to an OB/GYN practitioner or midwife.

– Documentation in the medical record must include a note indicating the date on which the prenatal care visits occurred and evidence of one of the following.

– A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used)

– Evidence that a prenatal care procedure was performed, such as:
  • Screening test in the form of an obstetric panel (e.g., hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing), or
  • TORCH antibody panel alone or a rubella antibody test/titer with an Rh incompatibility(ABO/Rh) blood typing, or
  • Echography of a pregnant uterus

– Documentation of LMP or EDD in conjunction with either of the following.
  • Prenatal risk assessment and counseling/education, or
  • Complete obstetrical history
Hybrid Review of Prenatal Care

- Prenatal care visits to a family practitioner or other PCP.

- Documentation in the medical record must include a note indicating the date on which the prenatal care visits occurred, with diagnosis of pregnancy and evidence of one of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations or measurement of fundus height (a prenatal flow sheet may be used)

- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel, or
  - Rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
  - TORCH antibody panel, or
  - Echography of a pregnant uterus

- Evidence that a diagnosis of pregnancy has been established in the form of a documented LMP or EDD in conjunction with either
  - Complete obstetrical history or
  - Prenatal risk assessment and counseling/education
**Hybrid Review of Postpartum Care**

- A visit that occurs on or between 21 – 56 days after delivery
- Components of a postpartum exam visit note:
  - Pelvic exam or
  - Weight, BP, breast & abdominal evaluation, breast feeding status or
  - PP check, or PP Care, or 6 week check notation
- The claims must be submitted by the appropriate provider specialty to count towards the measure
  - OB/GYN practitioner or midwife
  - Family practitioner or other PCP
  - General or family practice physicians
  - General internal medicine physicians
  - General pediatricians
HEDIS Documentation/Coding Tips (con’t.)

- The claims must have the appropriate coding to count towards these measures
- See TIP Sheet for appropriate ICD-9 and CPT codes
- **Missed opportunity** is when the member was in the office for a postpartum visit and needs a pap smear for HEDIS measures—not provided during the visit; missed opportunity of performing two measures at the same visit.
HEDIS Documentation/Coding Tips

Hybrid Review for Cervical Cancer Screening for Woman 21-64 Years of Age

– One screening pap test every three years
– Obtain copy of results or record date of test results
– The following does not qualify:
  • Lab results that indicate inadequate sample or no cervical cells
  • Referral to OB/GYN alone does not meet the measure
  • Biopsies are considered diagnostic and do not meet the measure
– Document exclusions:
  • Record “total” or “complete” hysterectomy as applicable
Breast Cancer Screening, Women age 40 – 69 years

- One mammogram breast screening every two years
- Obtain a copy of mammogram results or record date of test and result
- The purpose of the breast cancer screening measure is to evaluate primary screening. Biopsies, breast ultrasounds and MRIs do not count because HEDIS® does not consider them to be appropriate primary screening methods
- Exclusions:
  - Women who have had bilateral mastectomy (may occur on the same or separate dates)
HEDIS Documentation/Coding Tips

Diabetic Eye Exam, Members 18 – 75 years of age with diabetes

- Percent of diabetic patients who have had a retinal eye exam by an optometrist/ophthalmologist in the measurement year or patients who have had a negative retinal exam in the year prior to the measurement year.
- A chart or photograph of retina indicating date when photography performed with evidence that an eye professional reviewed the results or
- Results can be read by a qualified reading center under the direction of a retinal specialist.
- Identify diabetic exclusions require a note indicating any of the following:
  - Polycystic ovaries
  - Steroid Induced Diabetes
  - Gestational Diabetes
HEDIS Documentation/Coding Tips

We found that the most common reasons for a negative score across all measures are due to:

- lack of documentation in the medical record
- lack of referral to obtain the recommended service
- HEDIS service received but outside of the recommended time frame.
HEDIS Documentation/Coding Tips

- Lack of documentation in medical record
  - No immunization flow sheet
  - No preventive health documentation sheet
  - No diabetes flow sheet

- Lack of referral or recommendation for services
  - Diabetic retinal exam
  - HbA1c testing
  - Cholesterol screening

- Service received outside timeframe
  - Prenatal visit (1st trimester)
  - Postpartum visit (21 - 56 days after deliver)
HEDIS Documentation/Coding Tips

Member non-compliance
  • Failure to follow physician advice
  • Lack of knowledge
  • Fear of test results
  • No shows for scheduled appointments

PROOF is in the DOCUMENTATION!
Summary Tips To Improve HEDIS Reporting
What You Can Do to Improve Reporting?

- ICD-9 Codes—multiple codes with correct decimals
- CPT Codes—check accuracy
- Complete all required fields
- Improve standardization across providers/locations
- Audit encounters submitted
- Talk to your plan about provider took-kits containing educational required materials, forms, to assist physicians and staff in utilizing best practices to improve care to members, thus improving HEDIS performance.
What You Can Do to Improve Reporting?

- Review and work reports of members with gaps in care to assist with member and provider interventions
- Develop and **USE** forms and tools to “poka-yoke” process
- Appoint a staff guru
Questions??????