

HEDIS®

Documentation and Reporting

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Topics to be Covered Today

- **Introduction to HEDIS**
- **Data Collection, Methodology and Obstacles**
- **PQRS Measures and Relationship to HEDIS**
- **Documentation Tips, CDI and ICD-10**
- **Analysis of Key Measures Requirements for PCP and OB/GYN Practices**
- **Summary Tips to Improve HEDIS Reporting**
- **Examples for Preventive Medicine and Chronic Conditions**

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.
- Kohler HealthCare has no relevant financial or commercial relationship with NCQA, HEDIS , Johns Hopkins entities or their associated payers.

Healthcare Effectiveness Data and Information Set (HEDIS®)



- **National Committee of Quality Assurance (23 years) 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 for Patient Centered Medical Home.**
 - **the most used performance measure in the managed care industry.**
 - **used by NCQA for Commercial, Medicare and Medicaid.**

What is HEDIS?

- **The majority of HEDIS are measurements derived from administrative [claims] results, 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 processes 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 the 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 **80 measures across 5 domains** of care that address important health issues in 2014 and beyond.

HEDIS Five Domains

● HEDIS Five Domains of Data Collected for 2014 and 2015:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care (Patient Satisfaction)
4. Utilization and Relative Resource Use
5. Health Plan Descriptive Information

RED = those areas you have the most control over outcomes!

HEDIS Physician's Domains

- 2014 HEDIS has Five Domains of Data (48 total measures) on Care Specific to Physicians:
 1. **Effectiveness of Preventive Care**
 2. **Effectiveness of Acute Care**
 3. **Effectiveness of Chronic Care**
 4. Access/Availability of Care
 5. Utilization

RED = those areas you have the most control over patient care outcomes!

- **Cost vs. Quality-: As of 11/2013: CMS + NCQA report “Increasing value-based payment and accountable care models and now moving the needle on some national metrics, e.g.,**
 - Readmissions
 - Line Infections
- **Cost trends are down, outcomes are improving & adverse events are falling**
 - **Example: Medicaid spending per beneficiary has decreased over last two years - .9% and .6% in 2011 and 2010”**
- **See www.jhhc.com Priority Partners Performance Measures for “VBP 2014 Tip Sheet” (in packet)**

HEDIS Reporting Cycle



- **Data is reported to NCQA in June of the reporting year**
 - Data reflects events that occurred during the measurement year (prior calendar year)
 - HEDIS 2014 data is reported in June 2014; however, it reflects data from January 2013 to December 2013
 - “HEDIS 2014” = 2013 data



The Language of HEDIS



◆ Key Terms to Know

- **Denominator** = eligible members of the population
- **Numerator** = members that met the criteria of a measure
 - Example: 100 members of which 20 met criteria = $20/100 = 20\%$
- **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

HEDIS- What Obstacles are Commonly Encountered?

● 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**
- **Certain measures did not meet date parameters, such as completion of child immunizations on/before 2nd birthday or post-partum visit by 21-56 days after delivery**
- **All components of the required measure were not met**
- Appointment availability to members and provider's open hours

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 ICD-9 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?

- In order to comply with CMS requirements, providers will be required to switch to ICD-10 Diagnosis and Procedure codes effective some time on or after October 1, 2015.
- NCQA has created a plan to identify a valid and appropriate set of ICD-10 codes for each HEDIS measure in time for inclusion in the HEDIS 2015 publications.

What Are Measures?

- **The Hybrid method of data collection consists of the selection of a random sample of the population and allows for supplementation of Administrative data with data collected during the medical record reviews.**
 - **MCOs commonly use this method**
 - **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) 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 5.0 survey must be conducted by an NCQA-approved external survey organization

Where Can I Find HEDIS Measures?

● For All NCQA HEDIS Measures:

- ❖ HEDIS 2014 SUMMARY TABLE OF MEASURES, PRODUCT LINES AND CHANGES:
http://www.ncqa.org/Portals/o/HEDISQM/HEDIS2014/List_of_HEDIS_2014_Measures.pdf
- ❖ HEDIS 2014 SUMMARY TABLE OF PHYSICIAN MEASURE CHANGES:
http://www.ncqa.org/Portals/o/HEDISQM/HEDIS2014/HEDIS_2014%20List_of_Physician_Measures.pdf

● For JHHC HEDIS Measures:

- ❖ “2014 Provider Tips for Optimizing HEDIS® Results” which includes HEDIS Measures, Required Documentation, Provider Specialty and Billing Tips, see: www.jhhc.com “HEDIS® Tip Sheet” (*in packet*)

Moving Towards Clinical Documentation Improvement

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.**

Why Is Documentation Important?

● 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.

Why Is Documentation Important?

- 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.
- EMR data can be collected proactively to improve provider reporting.

Now... A Word About ICD-10

**** Implementation Delayed Until at Least
October 1, 2015***

● **ICD-10-CM -Diagnostics classification system**

- Allows level of detail needed for morbidity classification and diagnostics specificity
- Allows for better ability to measure quality outcomes.

● **ICD-10-PCS- Developed to capture CPTcodes**

- Substantially more complex, precise and specific than ICD-9
- Additional codes in ICD-10 represent laterality (right vs. left side), while others are more precise codes to represent specific anatomy and physiology.
- Coding a diagnosis in ICD-10 is likely to require more codes to accurately represent the condition.

ICD-10 and Clinical Documentation

- **ICD-10 has impact on Medical Necessity justification**
- Assigning the proper diagnosis codes to comply with medical necessity requirements is largely dependent on having proper clinical documentation. Increased details within documentation will enable maximum reimbursement for all care and services provided, while complying with medical necessity requirements.
- The greater specificity of ICD-10-CM will drive improvements in clinical documentation and what must be clearly recorded, such as:
 - Impact of the patient's complications and comorbidities
 - Reasons why diagnostic tests were ordered
 - Severity of the patient's condition

Clinical Documentation Improvement- Immediate returns. Lasting improvement.

- Accurate documentation of patient encounters is the foundation for appropriate reimbursement and quality reporting.
- As healthcare reform moves toward quality-driven reimbursement, hospitals and physicians have to justify treatments and demonstrate satisfactory quality outcomes.
- Consistent, complete and accurate clinical documentation is the key to economic health.

The Benefits of Clinical Documentation Improvement Programs

- Better communication with providers
- Decrease in claim denials/rejections
- Increase in QI program-based reimbursements
- Improved continuity of care and quality measures
- Decrease in health plan information requests
- Increase in coder productivity
- Improved documentation

Clinical Documentation- Important in Outpatient Settings

CDI Medical Necessity is of Central Importance!

Promote CDI on behalf of Providers by:

- Retrospective audits-Random sampling of problematic documentation areas for high-volume diagnoses and/or top service charges
- Establish process for communicating deficiencies/results
- Devise action plan for education and training, such as pain scores for EHR meaningful use, EKG interpretation for PQRS or specificity in documenting chronic conditions
- Track provider improvements

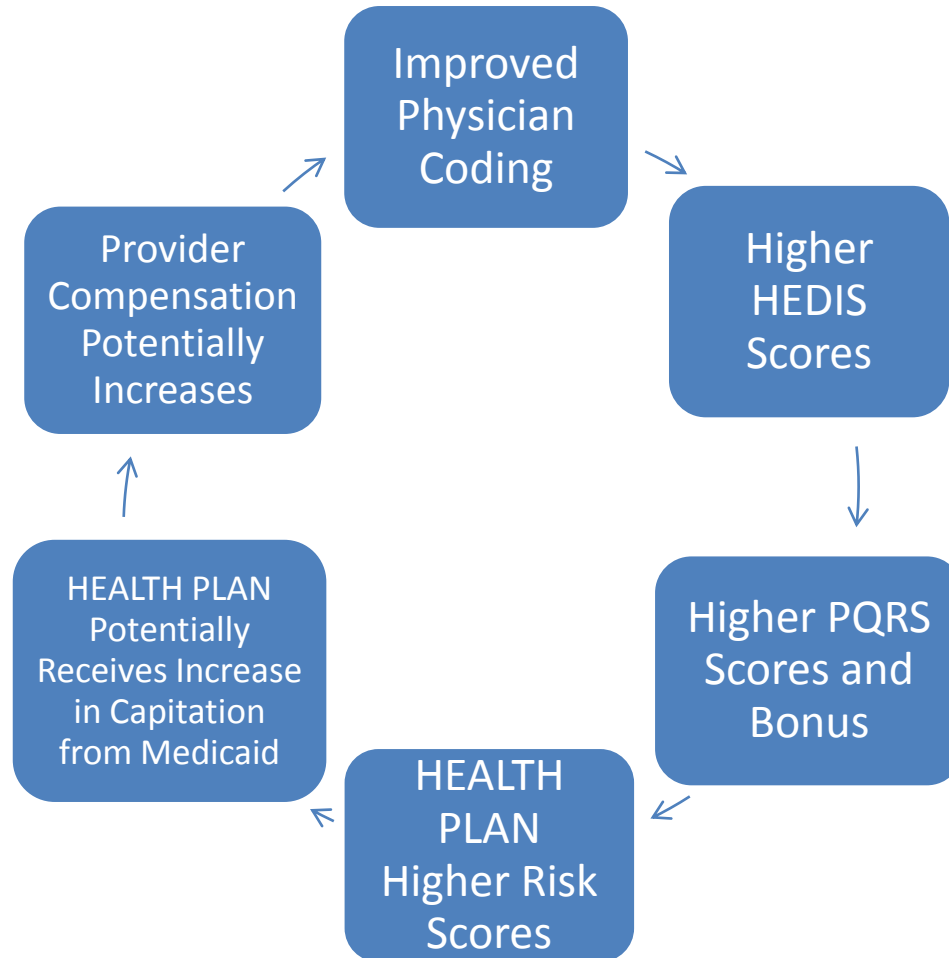
General Principles of Medical Record Documentation

- **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.
- MD Healthy Kids/ EPSDT- Documentation templates and schedule reflect minimum standards required for all MD Medicaid recipients from birth to 21 years of age. Healthy Kids Program requires yearly preventive care visits between ages 2 through 20yrs. Visit: www.dhmf.maryland.gov/epsdt/
- 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.**

Why is HEDIS Important to You?



Physician Quality Reporting System (PQRS)

- **Created by CMS**
- **Reporting program that uses a combination of incentive payments and payment adjustments to promote quality.**
 - Program provides an incentive payment to Practices with eligible providers who satisfactorily report data on quality measures covered by the Medicare Physician Fee Schedule for services furnished to Medicare Part B Fee-for-Service beneficiaries.
 - Commencing in 2015, the program also applies a payment reduction adjustment to eligible providers who do not satisfactorily report data on quality measures.

PQRS Measures?

- Eligible professionals may choose at least three individual measures or one measures group as an option to report on measures to CMS.
- If already participating in PQRS, there is no requirement to select new/different measures for the 2014 PQRS.
- For more PQRS info, visit cms.gov for “2013 PQRS Resource Guide Fact Sheet”

***NOTE:** All PQRS measure specifications are annually updated and posted prior to the beginning of each program year; therefore, eligible professionals will need to review them for any revisions or measure retirement for the current program year.*

PQRS Incentives and Penalty

- Providers may earn a 0.5% PQRS incentive (paid in 2014) based on 2013 Medicare payments.
- If a provider does not participate in the PQRS program, the provider will be subject of a 1.5% payment reduction adjustment AND a value based modifier adjustment of 1.0% in 2015.

PQRS Eligible Providers

	Eligible for Incentive	Subject to Payment Adjustment		Eligible for Incentive	Subject to Payment Adjustment
<u>Medicare Physicians</u>			<u>Practitioners</u>		
Doctor of Medicine	X	X	Physician Assistant	X	X
Doctor of Osteopathy	X	X	Nurse Practitioner	X	X
Doctor of Podiatric Medicine	X	X	Clinical Nurse Specialist	X	X
Doctor of Oral Surgery	X	X	Certified RN Anesthetist	X	X
Doctor of Dental Medicine	X	X	Certified Nurse Midwife	X	X
Doctor of Chiropractic	X	X	Clinical Social Worker	X	X
<u>Therapists</u>			Clinical Psychologist	X	X
Physical Therapist	X	X	Registered Dietician	X	X
Occupational Therapists	X	X	Nutrition Professional	X	X
Qualified Speech-Language	X	X	Audiologists	X	X

Relationship of HEDIS to PQRS

- Generally, HEDIS and PQRS measures different quality factors, but 26 of the PQRS measures “cross-walk to” (or align with) HEDIS performance measures. Visit [www.mcrh.msu.edu/documents/CrosswalkHEDIS.MU.PQRS.S.PCMH.Beacon](http://www.mcrh.msu.edu/documents/CrosswalkHEDIS.MU.PQRS.PCMH.Beacon) (last update available 4/2012)
- And providers can meet both criteria on the same visit.
- Example:
 - HEDIS Well Child 3-6 Years visit (measure #1) plus whether the child has complete immunizations on or before the child’s second birthday (measure #2) = 2 HEDIS measures for the one visit!
 - PQRS measures the percentage of patients age 6 months and older seen for a visit between October 1 and March 31 who have received an influenza immunization OR reported previous receipt of an influenza immunization.

HEDIS Documentation/Coding Tips

Analysis of Key Measures Requirements

PCP Practices

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, BMI and BMI percentile, vision, heart, lungs, GU (pap smears).
 - Health Educations/Anticipatory Guidance e.g., sex education, ETOH (short for ethanol) 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

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

– Billing Tips – Select from:

- CPT codes: 99384– 99385 and 99394– 99395
- HCPCS Codes: G0438, G0439
- ICD-9: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, and V70.9

Note: The codes do not have to be primary codes. The codes are deemed meeting the measure's assessment components.

Note: V72.3 is for a GYN Exam. It is not included in the adolescent well visit. The auditor has refused this code as a bridge to an Adolescent Well Visit.

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 hand 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.

HEDIS Documentation/Coding Tips

● 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. (CPT codes 99382-99393; ICD-9-CM Codes V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9)
- 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 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
 - – *in other words, 12-23 months (plus the number of days in that 23rd month just prior to the date of birth)*
- Complete immunizations on or before the child's second birthday:
 - 4 – DTaP/DT (CPT – 90700; ICD-9-CM V20.2)
 - 3 – IPV (90713; v04.0)
 - 3 – Hep B (90743; 90744; V05.3)
 - 3 – Hib (90647; v03.81)
 - 4 – PCV (90670; v03.82)
 - 1 – MMR (90707; v06.4)
 - 1 – VZV (90716; 90660; v05.4)
- Document all seropositives 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

- **Diabetic Eye Exam, Members 18 – 75 years of age with diabetes (CPT codes 67110-67228; 92002-92260; ICD-9-CM V72.0)**
 - Optometrist/Ophthalmologist exam every two years for patients without retinopathy and every year for diabetic retinopathy.
 - A chart or photograph of retina indicating date when photography performed with evidence that an eye professional reviewed the results and must specifically state “with” or “without” retinopathy
 - Identify diabetic exclusions requires a note indicating any of the following:
 - Polycystic ovaries
 - Steroid Induced Diabetes
 - Gestational Diabetes
 - A referral is not required for the MCO. This is a self-referred benefit and the PCP can provide a script to the member to see an eye care provider, *with clear indication that if diabetic, the question of retinopathy needs to be answered.*

HEDIS Documentation/Coding Tips

- **Disabled (SSI) Children, 0 – 20 years of age who are enrolled for 320 days or more**
 - Children that have had at least one ambulatory care visit in an office or other outpatient site.
 - All three components of a Well Child Visit must be included if a Well Child Visit is being performed
 - Health and Development History (physical and mental)
 - Physical Examination
 - Health Education/Anticipatory Guidelines
 - No provider requirements specified
 - Exclusions
 - Measure does not include mental health or chemical dependency services.
 - Send exclusions documentation to JHHC QI via confidential fax to 410-762-5941.

HEDIS Documentation/Coding Tips

- **Disabled (SSI) Adults, Age 21 – 64 years or older**
 - Adults that have had at least one ambulatory care visit in an office or other outpatient visit
 - SSI adults should receive all three components of a Well Care Visit (HCPCS codes - G0402; G0403; G0404)
 - Health and Development History (physical and mental)
 - Physical examination
 - Health Education/Anticipatory Guidance
 - No provider requirements specified
 - Exclusions
 - Measure does not include mental health or chemical dependency services.

HEDIS Documentation/Coding Tips

Analysis of Key Measures Requirements

OB/GYN Practices

HEDIS Documentation/Coding Tips

- **Hybrid Review for Cervical Cancer Screening for Women 21-64 Years of Age (HCPCS Codes - CPCS Codes G0123; G0124; G0141; G0143-G0145; G0147; G0148; P3000; P3001; Q0091; ICD-9-CM Codes - V72.32; V76.2)**
 - One screening pap test at least every three years (can be done yearly)
 - Obtain copy of results or medical record documenting the 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:
 - Documentation of Total or Partial Hysterectomy can only be used if Absence of Cervix is documented.

HEDIS Documentation/Coding Tips

- **Breast Cancer Screening, Women age 40 – 69 years**
(HCPCS Code - G0202 CPT Code - 77055; ICD-9-CM Codes = V76.11; V76.12)
 - 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)
 - The MCO members may have a yearly mammogram. The PCP can provide a written script to the member for the service.

HEDIS Documentation/Coding Tips

- **Part of the UDS measures: Uniform Data System and is part of the Health Resources and Services Administration's (HRSA) Health Center Program.**
 - It is “[a core set of information appropriate for reviewing the operation and performance of health centers](#)”.
- **Postpartum Visit, Women who have delivered between 11/6 of the previous year and 11/5 of the measurement year.**
 - A visit that occurs on or **between 21–56 days after delivery.**
 - Components of a postpartum exam visit note (one of the following)
 - Pelvic exam or,
 - Weight, BP, breast and abdominal evaluation, breast feeding status, or
 - Notation of PP check, PP Care, six-week check notation, or pre-printed “Postpartum Care” form in which information was documented during the visit

HEDIS Documentation/Coding Tips

● Postpartum (Cont)

- 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 physician
 - General pediatrician
 - Include visits with physician assistants, nurse practitioners, midwives, and registered nurse if a physician co-signature is present; if required by State law
 - 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

- 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 frames
 - *Example: Child immunizations series should be completed on/before 2nd birthday to be counted*

Practice improvement action: look at forms and electronic health records and add guidance on requirements

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
- Lead blood testing for 1 year olds. Required for all children turning one, regardless of risk, especially for Medicaid/PPMCOs

● Service received outside timeframe

- Prenatal visit (1st trimester)
- Postpartum visit (21 - 56 days after delivery)

HEDIS Documentation/Coding Tips

• Member non-compliance

- Failure to follow physician advice
- Lack of knowledge- *It is MOST IMPORTANT for physician to recommend and explain the importance of screening tests*
- Fear of test results
- “No Shows” for scheduled appointments

• **PROOF is in the DOCUMENTATION!**

Summary Tips To Improve HEDIS Reporting

Overall

***JHHC 2014 HEDIS Tip Sheet**
“2014 Provider Tips for Optimizing HEDIS® Results”

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 tool-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 for “fail safe” process
- Appoint a staff “guru”
- Work with your IT electronic medical records vendor to all conditions and guidance based on the HEDIS measurement standards
 - *Example: Have Ht + Wt calculate BMI and BMI percentile for all visits, including GYN visits.*

Examples for Preventive Medicine and Chronic Conditions

Preventive Medicine Visit with a Problem 9939x and 9921x with Modifier -25

Child comes in for his 20 year old well child and to get his school form completed.

However, Mom is concerned about his recent cough and allergy symptoms, as well as his eczema is flaring up.

You do everything for the well child visit, but also spend a significant amount of time treating his asthma flare up and adjusting his medications.

Preventive Medicine Visit with a Problem

9939x and 9921x with Modifier -25

- **Chief Complaint**: Well child with a significant additional complaint
 - **History**: Include history.
 - 1) as for a well child visit and,
 - 2) present illness
 - **ROS, Past Family, Social History**: Combine system review and presenting problem
 - **PE**: Combine the well child exam and the presenting problem exam
 - **A/P**: A combination of screening and medical decision making
- ❖ *The most commonly missed aspect of well visits is documentation of anticipatory guidance/health education and mental & developmental status.*

Preventive Medicine Visit with a Problem

9939x and 9921x with Modifier -25

- If an additional problem is identified and treated, an additional E/M code may be warranted.
- If the encounter intent is preventive (i.e. a well child appointment), code the preventive E/M (e.g., 99384-99394-7) first
 - #1 dx is v20.2
 - Subsequent dx are related to the problem(s) addressed
 - Append modifier -25 to the problem-oriented E/M (e.g., 99212-14).

Chronic Care Management - 2015

- The Centers for Medicare and Medicaid Services (CMS) emphasized High-quality care and efficiency with the release of its 2014 Medicare Physician Fee Schedule. Included in one of the provisions, primary care physicians will begin to see reimbursements for chronic care management services outside of face-to-face visits, beginning in 2015.
- Patient eligible for chronic care management are patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Chronic Care Management includes the following.
 - The provision of 24-hour- a-day, 7-day- a-week access to address a patient’s acute chronic care needs. To accomplish these tasks, CMS would expect that the patient and caregiver would be provided with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.
 - Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
 - Care management for chronic conditions including systematic assessment of patient’s medical, functional, and psychosocial needs;

Chronic Care Management - 2015

- To bill for the services, the practitioner would be required to document in the patient's medical record that all of the chronic care management services were explained and offered to the patient, noting the patient's decision to accept these services. Also, a written or electronic copy of the care plan is required to be provided to the beneficiary, and the provision of the plan to the patient must also be recorded in the beneficiary's electronic medical record.
- Chronic Care Management Services will be billed with HCPCS codes G0438 and G0439. CMS proposed that a beneficiary must have received an Annual Wellness Visit (AWV) in the past 12 months for a practitioner to be able to bill separately for chronic care management services and the Annual Wellness Visit (G0402)

Q & A

Answers to Questions Concerning Priority Partners *Raised in Prior Years*

Priority Partner Tips

- The prenatal risk assessment does not need to be completed at the initial visit.
 - The maternity enrichment HCPC's code, H1000, can be billed when the risk assessment is completed.
- PPMCO covers school and sports physicals.
 - This is an opportunity to include all of the components of an Adolescent Well Care Visit;
 - Health & Development History (physical and mental)
 - Physical Examination
 - Health Education/Anticipatory Guidance
- There is no limit for providing well child services as long as they are properly coded. This also applies to wellness exams for adolescents and adults.
 - For example, a PCP may perform a well child visit for a 3-year old, and then four months later the child turns 4. The next Well Child Visit for the change in age may be scheduled.

Priority Partner Tips

- PPMCO will not cover EPSDT services when provided by a PCP who is not the assigned PCP.
 - Strongly recommended that the PCP's office contact PPMCO customer service at 1-888-819-1043 and have the member choose a new PCP in order for the visit to be covered.
 - The provider can also complete the *PCP Change Form*, located on www.jhhc.com, under *For Providers |Resources and Guidelines|Priority Partners Forms and fax it to their Enrollment Department at 410-762-5218 in order to have the PCP visit covered.*

Priority Partner Tips

- A PCP can prescribe refills for existing medications that a patient is on for mental health services when they are unable to get an appointment with their mental health provider.
- When a provider is both a family practice physician and a psychiatrist they should follow the guidelines below when performing both services.
 - Maintain separate charts based on the type of visit for which you are seeing the patient.
 - Bill the primary care services to PPMCO.
 - Bill the mental health services to Value Options.

Priority Partner Tips

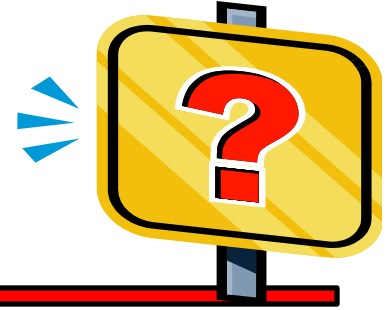
- A PPMCO member may have other insurance which is primary. Under Federal law, Medicaid, including Medicaid Managed Care, are payers of last resort.
 - The primary carrier should be billed first
 - PPMCO should be billed as a secondary insurance
 - Include a copy of the primary carrier's EOB

NOTE: If a PPMCO member is identified as having other insurance as primary, PPMCO is required to retract any payments made to PPMCO as primary.

- PPMCO is required to go back 18 months from a paid date of the claim.
- A letter is sent to each provider in which a retraction is made, identifying the primary carrier to bill.
- Once the primary carrier is billed and the claim processed, providers have 180 days from the date of the primary carrier's EOB to bill PPMCO.
- The secondary claim should be billed to PPMCO with a copy of the primary carrier's EOB.
- Please reference the *Claims Retraction Policy* under *For Providers\Resources and Guidelines* on www.jhhc.com.

Priority Partner Tips

- When another PCP is providing backup coverage for your Practice, it is important that you contact your Provider Relations Network Manager at 1-888-895-4998 to have the records updated to reflect the backup coverage, in order to ensure proper claims payment.
- Well Child Exams do not need to be 365 days apart since there is no limit for providing properly coded well child care services. **Each January 1 starts a new year.**



In Closing...

- Thank you for your valuable time and attention!
- What *QUESTIONS* do you have?
- What additional information or training do you need?