HEDIS
Healthcare Effectiveness Data & Information Set
Provider Guide
ARE YOU PREPARED?

We are your partners in care and would like to assist you in improving your HEDIS scores.
HIPAA

Under the Health Information Portability and Accountability Act:

• Personal Health Information (PHI) can be shared with health plans for quality purposes
• Data collection by health plans is permitted
• No further authorization needed from the patient
HEDIS DATA

We collect two types of data:

• **Administrative Data:** Data captured from claims, encounters, pharmacy, lab

• **Hybrid Data:** A combination of administrative data and medical record review
Medical Record Review Measures

• Controlling high blood pressure
• Comprehensive diabetes care
• Cervical cancer screening
• Childhood immunizations
• Adolescent immunizations
• Weight assessment & counseling for children and adolescents
• Well child visits in the first 15 months
• Well child visits for 3, 4, 5, and 6 year olds
• Frequency of prenatal care
• Post-partum care
Making HEDIS Easier for You

• Complete preventive health screenings on schedule and document them in the medical record
• Avoid missed opportunities - take advantage of every office visit to do as much care as possible
• Remember to accurately and completely document all care
Controlling High Blood Pressure

Ages 18--85
Diagnosis of hypertension
Blood pressure controlled
18--59 <140/90
60--85 with diabetes <140/90
60--85 without diabetes <150/90

Documentation must include:
- HTN diagnosis on or before June 30
- Last blood pressure reading

We need:
- Progress notes
- Problem list
- Consult notes

Common Chart Deficiencies:
- Date of hypertension diagnosis is not clearly documented

Use Correct Billing Codes

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>I10,401.0,401.1</td>
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</table>
Tips to Improve Your Scores for Controlling High Blood Pressure

• Check and calibrate the sphygmomanometer annually
• Select appropriate size blood pressure cuff
• If you get a high BP reading, repeat the reading after a few minutes. We use the lowest systolic and lowest diastolic readings in the same day, and often times the second reading is lower
• Record exact values when using an automated cuff
Comprehensive Diabetes Care

Age 18 – 75
- HbA1c testing
- HbA1c results
- Nephrology Exam
- Retinal eye exam
- Blood pressure reading

Documentation must include:
- Hemoglobin A1c
- Blood pressure recording
- Nephropathy: urine tests (+) or visit notes from nephrologists
- Retinal eye exam – Measurement year or previous year

We need:
- Most recent HbA1c
- Most recent blood pressure recording

Common Chart Deficiencies:
- Tests ordered but not done
- Lab results not documented
- Specialist referrals/consultation reports are not documented
## Use Correct Billing Codes

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Diabetes codes</td>
<td>E10, E11, E13, O24</td>
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<tr>
<td>HBA1c</td>
<td><strong>CPT:</strong> 83036,83037</td>
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<tr>
<td></td>
<td><strong>CPT II:</strong> HbA1c &lt; 7% 3044F</td>
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<tr>
<td></td>
<td>HbA1c 7-9% 3045F</td>
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<tr>
<td></td>
<td>HbA1c &gt; 9% 3046F</td>
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<tr>
<td>Nephropathy Screening</td>
<td><strong>CPT:</strong> 81000-81003,81005,82042,82043,82044</td>
</tr>
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<td><strong>CPT II:</strong> 3060F,3061F,3062F</td>
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<tr>
<td>Eye Exam (must be performed by Optometrist/Ophthalmologist)</td>
<td><strong>CPT:</strong> 92002,92004,92012,92014,92018,92019,92134,92225,92226,92227,92228,92230,92235,92240,92250,92260,99203-99205,99213-99215,99242-99245</td>
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<tr>
<td>Potential diabetic retinopathy procedures</td>
<td>67028,67030,67031,67036,67039-67043,67101,67105,67107,67108,67110,67112,67113,67121,67141,67145,67208,67210,67218,67220,67221,67227,67228</td>
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<tr>
<td>Codes to identify diabetic retinal screening</td>
<td><strong>CPT II:</strong> 2022F,2024F,2026F,3072F</td>
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Tips to Improve Diabetes Care Scores

• Review diabetes services needed at each visit
• Order labs prior to the appointment
• Document the A1c date and test result in the chart especially if completed in-office
• Digital eye exams, remote imaging, and fundus photography results must be read by Optometrist/Ophthalmologist
• Members with chronic conditions such as diabetes may qualify for care management. Please refer them to University of Utah Health Plans Care Management Program for evaluation: 801-587-6480 opt 2
Cervical Cancer Screening

**PAP**
- Females 21-64
  - Cervical cytology in the measurement year or the 2 years prior
- PAP with HPV
  - Females 30-64
  - Cervical Cytology and/ HPV testing in the measurement year or 4 years prior

**Documentation must include:**
- Date and result of cervical cancer screening (PAP) OR
- Date and result of cervical cancer screening (PAP) and HPV on the same date of service

**We need:**
- Laboratory reports
- PAP test results
- HPV test results
- Consult Note
- Operative notes

**Common Chart Deficiencies:**
- PAP test results not documented
- Evidence of hysterectomy not documented
- Reflex HPV does not count as co-testing
## Use Correct Billing Codes

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Cervical cytology</td>
<td>CPT: 88141-88143, 88147,88148,88150, 88152-88154, 88164-88167, 88174,88175</td>
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<tr>
<td>HPV Test</td>
<td>CPT: 87620-87622 87624,87625</td>
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<table>
<thead>
<tr>
<th>Description of cervical cancer screening exclusions</th>
<th>ICD -10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired absence of both cervix and uterus</td>
<td>Z90.710</td>
</tr>
<tr>
<td>Acquired absence of cervix with remaining uterus</td>
<td>Z90.712</td>
</tr>
<tr>
<td>Agenesis and aplasia of cervix</td>
<td>Q51.5</td>
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</tbody>
</table>
Tips to Improve Scores for Cervical Cancer Screening

• Identify and remind women who need screening
• Emphasize preventive care visits and screenings at your facility
• Document in the medical record results of Pap tests done at OB/GYN visits or outside labs
• Complete Pap tests during regularly scheduled well woman visits, sick visits, urine pregnancy tests, or screenings for UTI or chlamydia/STIs
• Document evidence of hysterectomy correctly. Use “total”, “complete”, radical” or hysterectomy with no residual cervix
Frequency of Ongoing Prenatal Care

Live births delivered on or between November 6 of previous year to November 5 of the current year

We need:
• Prenatal flow sheet
• OB/GYN visits
• Labs and Ultrasound reports

Documentation must include:
• Pregnancy diagnosis
• Documented LMP or EDD with either a completed obstetric history or prenatal risk assessment and counseling/education
• Basic obstetrical exam that includes auscultation for fetal heart tone, OR pelvic exam with obstetric observations, OR measurement of fundus height
• TORCH antibody panel (toxoplasma, rubella, cytomegalovirus and herpes simplex testing)
• Prenatal visit with rubella and ABO, rubella and Rh, or rubella and ABO/Rh

Common Chart Deficiencies:
• Duplicated prenatal visits
• Ultrasound and Lab visits counted as prenatal visit
Prenatal and Postpartum Care

**Live Births delivered on or between November 6 of previous year to November 5 of the measurement year**

**We need:**
- Prenatal flow sheet
- OB/GYN visits
- Labs and Ultrasound reports

**Common Chart Deficiencies:**
- Duplicated prenatal visits
- Postpartum visit not done within 21-56 days after delivery
- Visit for incision check post C-section counted as postpartum visit

**Required prenatal care documentation:**
- LMP or EDD with either a completed obstetric history or prenatal risk assessment and counseling/education OR
- Basic obstetrical exam that includes auscultation for fetal heart tone, OR pelvic exam with obstetric observations, OR measurement of fundus height OR
- Prenatal visit with TORCH antibody panel (Toxoplasma, Rubella, Cytomegalovirus and Herpes simplex testing) -OR
- A prenatal visit with rubella and ABO/Rh

**Required postpartum care documentation:**
- Visit within 21-56 days of delivery
- Pelvic exam – OR
- Evaluation of weight, BP, breast and abdomen
- Notation of “postpartum care”
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<thead>
<tr>
<th>Description</th>
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<tr>
<td><strong>Prenatal care visits</strong></td>
<td><strong>CPT: 99201-99205</strong></td>
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<td></td>
<td>99211-99215</td>
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<td>99241-99245</td>
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<tr>
<td></td>
<td><strong>CPT II: 0500F,0501F,0502F</strong></td>
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<tr>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Postpartum visit</strong></td>
<td><strong>CPT: 57170,58300,59430,99501</strong></td>
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<tr>
<td></td>
<td><strong>CPT II: 0503F</strong></td>
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Tips to Improve Your Prenatal and Post-partum Care Scores

• Front office staff should prioritize new pregnant patients and make prompt appointments for patients requesting a pregnancy visit
• Have a direct referral process to OB/GYN practitioners in place
• Schedule your patients for a post-partum visit within 21 – 56 days of delivery
• Document “post-partum care”, “PP Check”, “PP care”, “6 week check” at the post-partum visit
• Patients diagnosed with a high-risk pregnancy, including patients with a history of previous preterm delivery may qualify for care management. Please refer them to University of Utah Health plans CM Program for evaluation: 801-587-6480 opt 2
Childhood Immunization Status

Children who had these vaccines on or before their 2\textsuperscript{nd} birthday

- 4 DTaP (diphtheria, tetanus and acellular pertussis)
- 3 IPV (polio)
- 1 MMR (measles, mumps, rubella)
- 3 HiB (Haemophilus influenza type B)
- 3 Hep B (Hepatitis B)
- 1 VZV (chicken pox)
- 4 PCV (pneumococcal conjugate)
- 1 Hep A (hepatitis A)
- 2 OR 3 RV (rotavirus)
- 1 Flu (Influenza)

Documentation must include:
- Type of vaccine
- Date administered
- Certificate of immunization
- Contraindications
- Statement of parental refusal

We need:
- Immunization records/cards
- Allergies/contraindication list
- Parental refusal document

Common Chart Deficiencies:
- Immunizations not received by the 2\textsuperscript{nd} birthday
- Charts do not contain record of immunizations received in the hospital at birth, at health departments, or at school
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<tr>
<th>Description</th>
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<tr>
<td>DTap</td>
<td>90698,90700,90721,90723</td>
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<tr>
<td>IPV</td>
<td>90698,90713,90723</td>
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<td>MMR</td>
<td>90707,90710</td>
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<tr>
<td>Rubella</td>
<td>90706</td>
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<tr>
<td>HiB</td>
<td>90644-90648,90698,90721,90748</td>
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<tr>
<td>Hepatitis A</td>
<td>90633</td>
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<td>Hepatitis B</td>
<td>90740,90744,90747,90748</td>
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<tr>
<td>VZV</td>
<td>90710,90716</td>
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<tr>
<td>Pneumococcal conjugate</td>
<td>90669,90670</td>
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<tr>
<td>Rotavirus</td>
<td>90681,90680</td>
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<tr>
<td>Influenza</td>
<td>90655,90657,90661,90662,90673,90685,90687</td>
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</table>
Children who had the following vaccines on or before their 13th birthday:

1. Meningococcal vaccine – completed on or between the 11th and 13th birthdays
2. Tdap – completed on or between the 11th and 13th birthdays
3. HPV – completed between 9th and 13th birthdays

Documentation must include:

- Date administered and type of vaccine
- Certificate of immunization
- Notation of contraindications
- Statement of parental refusal

We need:

- Immunization records/cards
- Allergies/contraindications
- Parental refusal statement

Common Chart Deficiencies:

- Immunizations not received within time frame
- Charts do not contain outside immunization records
Use Correct Billing Codes

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Meningococcal</td>
<td><strong>CPT:</strong> 90644,90734</td>
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<tr>
<td>Tdap</td>
<td><strong>CPT:</strong> 90715</td>
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<tr>
<td>Human papillomavirus (HPV)</td>
<td><strong>CPT:</strong> 90649,90650,90651</td>
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</table>
Tips to Improve Your Scores for Childhood and Adolescents Immunizations

- Use the Utah State Immunization System to document immunizations: [www.usiis.org](http://www.usiis.org)
- Have a patient reminder system in place
- Review immunization records before every visit and administer needed vaccines
- Document in your record vaccines given outside your office or before they were UUHP members
- Train your office staff to identify overdue immunizations in advance of the visit
- Recommend immunizations to parents and review missing vaccines with parents
- Address common misconceptions about vaccinations
- Correctly document parental refusal, contraindications, allergies or illness
Weight Assessment and Counseling

Children 3-17 years of age who had an outpatient visit and evidence during the year of:
- BMI percentile plotted on age-growth chart
- Height, weight and BMI percentile documentation in medical record
- Counseling for nutrition or referral for nutrition education
- Counseling for physical activity or referral for physical activity

Documentation must include:
- BMI date and percentile
- Height and weight date and value
- Nutrition counseling
- Physical activity counseling

Common Chart Deficiencies:
- BMI documented as value and not as percentile
- BMI, height and weight not plotted on growth chart
- Nutrition and physical activity not addressed in anticipatory guidance

We need:
- Growth chart
- Vitals flow chart
- Most recent notes with BMI percentile, height and weight, nutrition counseling and physical activity counseling
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<table>
<thead>
<tr>
<th>Description</th>
<th>ICD -10 Codes</th>
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<tbody>
<tr>
<td>BMI Percentile</td>
<td>Z68.51–Z68.54</td>
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<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Counseling for Nutrition</td>
<td>Z71.3</td>
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<tr>
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<td><strong>CPT:</strong> 97802-97804</td>
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<thead>
<tr>
<th>Description</th>
<th>ICD -10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling for Physical activity</td>
<td>S9451,Z02.5</td>
</tr>
</tbody>
</table>
Tips to Improve Your Scores for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

• Correctly document BMI percentile, height and weight at each visit and plot on growth chart
• Nutrition counseling must document current nutrition behaviors - Meal patterns, appetite, eating and dieting habits
• Physical activity counseling must document current physical activity behaviors – Exercise patterns, routine exercise and participation in sports activities
• Developmental milestones DO NOT COUNT as physical activity counseling
• Include specific physical activity and nutrition recommendations in anticipatory guidance
Well Child Visits First 15 Months of Life

Children who have at least 6 well child visits before turning 15 months old

We need:
Well child visit records that include
• Health history
• Physical and mental developmental history
• Health education/anticipatory guidance discussion

Documentation must include:
• Health history
• Physical and developmental history
• Mental developmental history
• Complete physical exam
• Health education/anticipatory guidance discussion

Common Chart Deficiencies:
• Health history, mental and physical developmental history not documented correctly
• Anticipatory Guidance discussion not documented
Well Child Visits for 3, 4, 5, and 6 Year Olds

Children 3, 4, 5, and 6 year old who had 1 or more well child visits during the year

Documentation must include:
- Health history
- Complete physical exam
- Physical and mental developmental history
- Health education/anticipatory guidance discussion

We need:
- Health history
- Physical developmental history
- Mental developmental history
- Health education/anticipatory guidance discussion

Common Chart Deficiencies:
- Health history, mental and physical developmental history not documented correctly
- Anticipatory guidance discussion not documented

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<table>
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<tbody>
<tr>
<td>Well child visits</td>
<td>CPT: 99381-99385, 99391-99395, 99461</td>
</tr>
</tbody>
</table>
Tips to Improve Your Scores for Well Child Visits

• BMI Percentile, height and weight are documented on the growth chart at every visit
• Medical record includes the date health history and physical and mental developmental histories were taken
• Medical record includes the date of the physical exam and health education/anticipatory guidance
• Daycare physicals count as well care visits if you perform and document health history, physical exam, physical and mental developmental history, and health education/anticipatory guidance
For questions contact:

Ila Rajashekar
Ila.Rajashekar@hsc.Utah.edu
Phone: 801-587-2779
Fax: 801-281-6121