HEDIS®

Commercial Quality Improvement Training

of Tennessee

Commercial Quality and Performance Improvement | Q1 2024

AGENDA

Commercial Quality Improvement Training

- CAHPS Overview
- HEDIS® Focus Measures
  - Wellness and Preventive Care
  - Immunization Care
  - Diabetes Care
  - Cardiac/Respiratory Care
  - Overuse/Appropriateness Care
- Tips and Best Practices for Attestation
- Contacts

CAHPS Overview

What is CAHPS?

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** family of surveys measures topics that are important to patients, such as communication skills of providers and the accessibility of services. CAHPS is considered the national standard for measuring and reporting on consumers' experiences with health plans and their services.

What does CAHPS measure?

The CAHPS surveys ask, “Are consumers satisfied with the quality of care and customer services provided by their health plan (such as BlueCross), and their providers?”

The purpose of the surveys is to determine if consumers are satisfied with the quality of care and customer services given by their health plan and providers. They provide a measurement of how patients perceive the care they receive from the doctors and providers we’re contracted with.

Best Practice Tip

Patient experience surveys can be mistaken for customer satisfaction surveys. Patient experience surveys focus on how patients experienced or perceived key aspects of their care, not how satisfied they were with their care.

These surveys focus on asking patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions, and the coordination of their health care needs.

Tips for Improving Patient Experience

Incorporating simple techniques into your daily interactions with patients will provide them with a better experience, help them achieve better health outcomes and can lead to better patient retention. Tips to consider include:

- Coordinate patient's care by using information and reports from other provider visits
- Provide timely appointments
- Discuss care received from the ER and other providers
- Follow-up to communicate test results
- Offer help scheduling appointments with specialists
- Discuss current medications and addressing any barriers
- Review current medications from all providers
- Submit claims timely and accurately

Tips for Interacting with Patients

How you interact with your patients has a direct impact on their response to the survey.

- Communicate information at the patient's level
- Coordinate patient care by:
  - Asking about care received in the ER
  - Asking about physical therapy, home health or other specialist visits
  - Reviewing current medications from all providers

Tips for Interacting with Patients (cont.)

- Ensure patient's their care plan by using phrases like:
  - "Do you have any questions about your treatment plan?"
  - "Is there anything you'd like to discuss further?"
  - "Do you feel confident with the plan we discussed?"

Healthcare Effectiveness Data and Information Set (HEDIS) Focus Measures

What is HEDIS?

Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans those areas where a stronger focus could lead to improvements in patient health. HEDIS reporting is mandated by NCQA for compliance and accreditation.

Wellness and Preventive Care

Breast Cancer Screening (BCS-E)

Goal of the Measure

Patients, 50-74 years of age, who are recommended for a mammogram, should have this to screen for breast cancer every two years.

Patients who are recommended for routine mammogram screening as those who have:

- Administrative Gender of Female (Administrative Gender code F) any time in the member's history.
- Sex Assigned at Birth (LOINC code 76689-9)
- Sex Assigned of Female (LOINC code LA3-6) any time in the member's history.

Helpful Tips

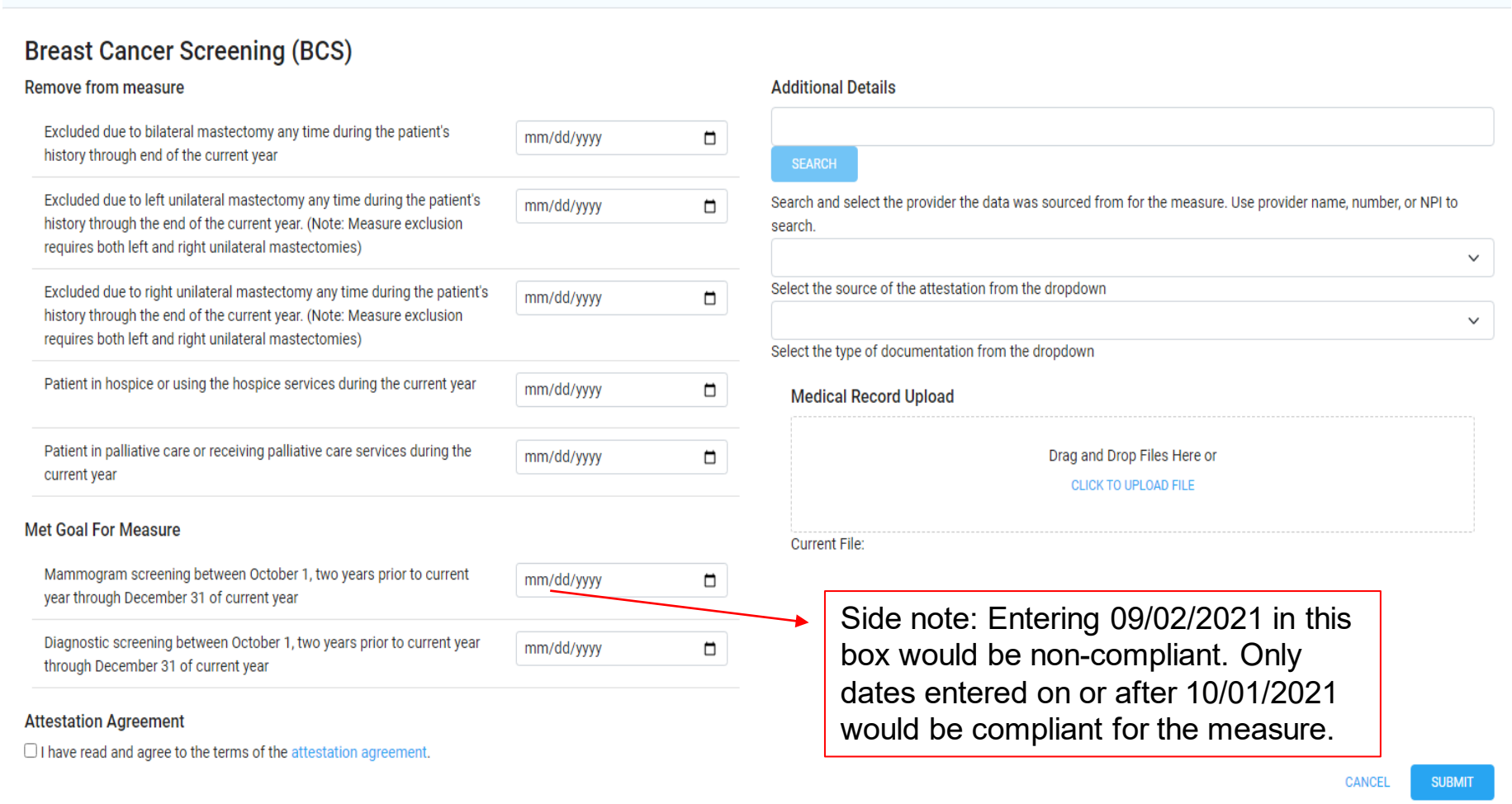
- An order alone isn't acceptable to close the gap in care. There must be documentation that a procedure was done (date and result).
- A patient's refusal doesn't exclude them from the measure.
- All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance.
- Breast MRI, ultrasounds and biopsies don't count for numerator compliance of the measure.
- If a patient only had a unilateral mastectomy, they aren't exempt them from the measure. Documentation must show "bilateral" mastectomy to be excluded from the measure.

Unacceptable Documentation

- Date ranges, i.e., "mammogram 1-2 years ago"
- Documentation of date due, ordered, scheduled, etc. without documentation of completion
- Documentation alone that screening is "up to date"
- Documentation of "patient reported"
- Documentation of only "mastectomy" for exclusion

BREAST CANCER SCREENING (BCS-E)

Exclusions



Side note: Entering 09/02/2021 in this box would be non-compliant. Only dates entered on or after 10/01/2021 would be compliant for the measure.

Cervical Cancer Screening (CCS, CCS-E)

Goal of the Measure

Patients, 21-64 years of age, who are recommended for a routine cervical cancer screening, should be as: screened for cervical cancer using either of the following criteria:

- Ages 21-64 years of age who had cervical cytology performed every three years
- Ages 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed every five years
- Ages 30-64 years of age who had cervical cytology/ (hrHPV) co-testing performed every five years

Helpful Tips

- Documentation of hysterectomy alone doesn't exclude a patient from this measure.
- The documentation must show total hysterectomy, complete hysterectomy, vaginal hysterectomy, or that the cervix is surgically absent to show evidence that the cervix was removed, and screening isn't needed.
- Documentation of the pap test result and date in the chart is needed to close this gap through medical record review. However, the gap will close through claims with the correct coding for cervical cancer screenings.
- Biopsies don't count because they're diagnostic and not valid for primary cervical cancer screening.
- An order alone isn't acceptable to close the gap in care. There must be documentation that the procedure was performed (date and result).
- A patient's refusal doesn't exclude them from the measure.

CERVICAL CANCER SCREENING (CCS, CCS-E)

Exclusions

Cervical Cancer Screening (CCS)*

Remove from measure

Excluded due to hysterectomy with no residual cervix any time during the patient's history through end of the current year	mm/dd/yyyy
Excluded due to Cervical Agenesis any time during the patient's history through end of the current year	mm/dd/yyyy
Excluded due to acquired absence of cervix any time during the patient's history through end of the current year	mm/dd/yyyy
Patient in hospice or using the hospice services during the current year	mm/dd/yyyy
Patient in palliative care or receiving palliative care services during the current year	mm/dd/yyyy

Met Goal For Measure

Cervical cytology performed by the end of the current year or 2 previous years	mm/dd/yyyy
Age 30 to 64 years of age as of December 31 of the current year who had cervical high-risk human papillomavirus (hrHPV) testing during the current year or the previous 4 years and who were 30 years or older on the date of the test	mm/dd/yyyy

Attestation Agreement

☐ I have read and agree to the terms of the attestation agreement.

Additional Details

SEARCH

Search and select the provider the data was sourced from for the measure. Use provider name, number, or NPI to search.

Select the source of the attestation from the dropdown

Select the type of documentation from the dropdown

Medical Record Upload

Drag and Drop Files Here or

CLICK TO UPLOAD FILE

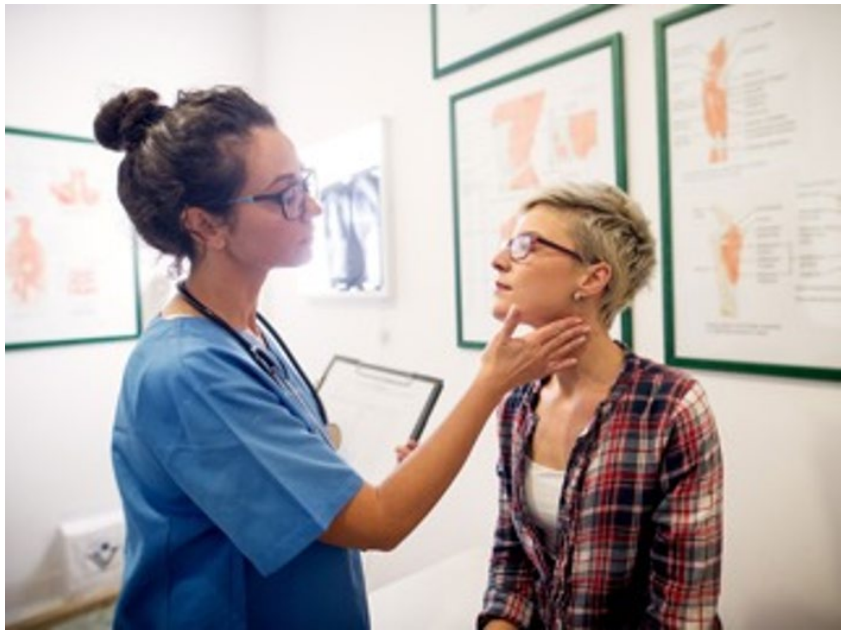
Current File:

CANCEL SUBMIT

Chlamydia Screening in Women (CHL)

Goal of the Measure

Females ages 16-24, with continuous enrollment, who were identified as sexually active during the measurement year should have at least one test for chlamydia during the measurement year, Jan. 1-Dec. 31 (each year).

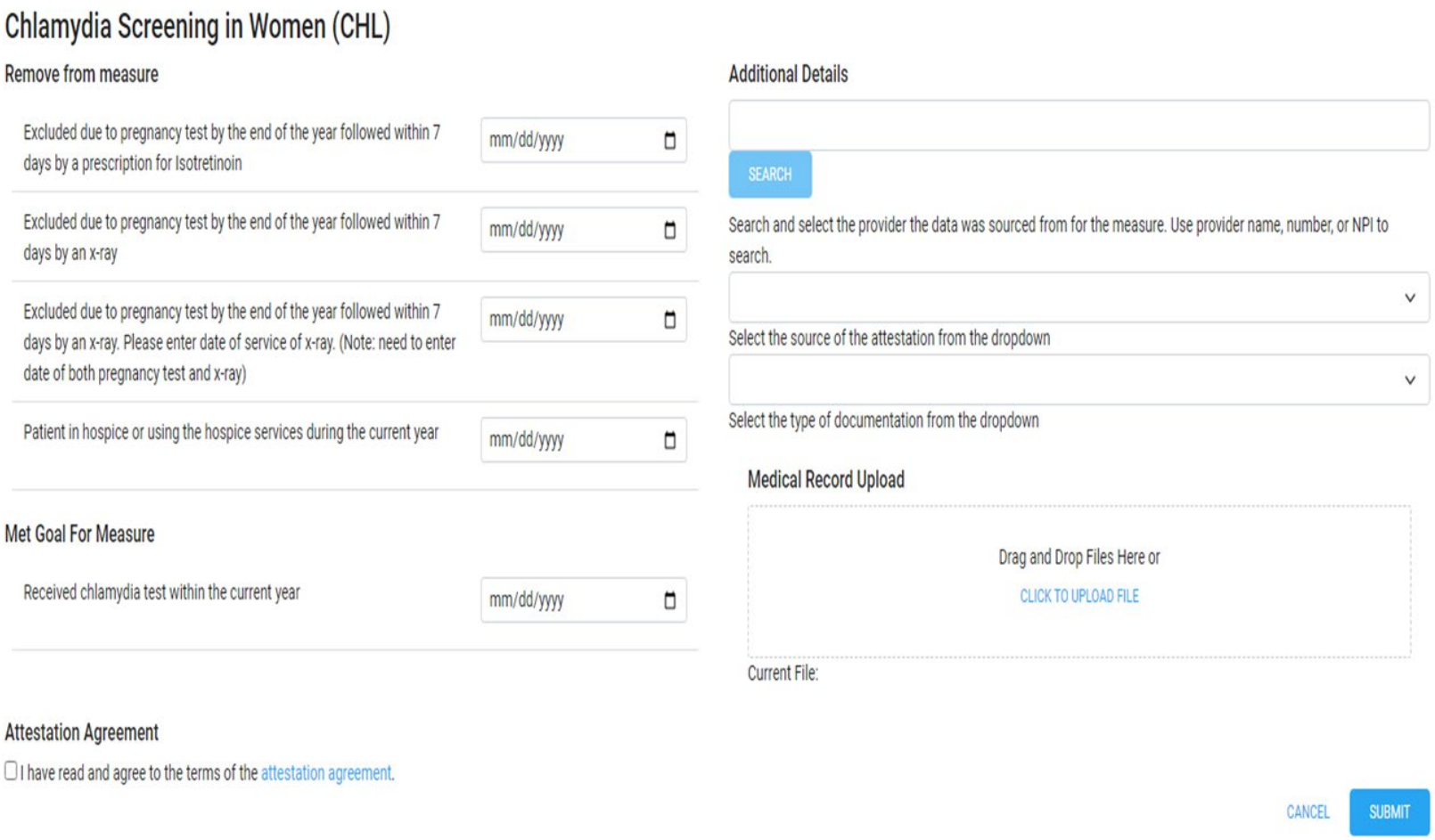


Helpful Tips

- A gap in care will still open for CHL even if a patient is taking contraceptives for a reason other than birth control, such as acne.
- "Sexually active" for this HEDIS measure is defined by:
  - Pharmacy data (contraceptives, diaphragm, spermicide)

    OR
  - Claims data
- A code that indicates any of the following:
  - Pregnancy
  - Pregnancy tests
  - Sexual activity
- An order alone isn't acceptable to close the gap in care. There must be documentation that the procedure was done (date and result).
- A patient's refusal doesn't exclude them from the measure.

Exclusions


Chlamydia Screening in Women (CHL)
Remove from measure
Excluded due to pregnancy test by the end of the year followed within 7 days by a prescription for Isotretinoin
mm/dd/yyyy
Excluded due to pregnancy test by the end of the year followed within 7 days by an x-ray
mm/dd/yyyy
Excluded due to pregnancy test by the end of the year followed within 7 days by an x-ray. Please enter date of service of x-ray. (Note: need to enter date of both pregnancy test and x-ray)
mm/dd/yyyy
Patient in hospice or using the hospice services during the current year
mm/dd/yyyy
Met Goal For Measure
Received chlamydia test within the current year
mm/dd/yyyy
Attestation Agreement
I have read and agree to the terms of the attestation agreement.
Additional Details
SEARCH
Search and select the provider the data was sourced from for the measure. Use provider name, number, or NPI to search.
Select the source of the attestation from the dropdown
Select the type of documentation from the dropdown
Medical Record Upload
Drag and Drop Files Here or
CLICK TO UPLOAD FILE
Current File:
CANCEL
SUBMIT

Colorectal Screenings (COL-E)

Goal of the Measure

Patients 45-75 years should have appropriate screening for colorectal cancer.

Helpful Tips

Any **one** of these will meet the criteria of the measure:

- Fecal occult blood test (FOBT) yearly
  - gFOBT=(guaiac) requires three samples yearly if number of samples is documented
  - iFOBT=(immunochemical) can meet criteria with one sample yearly
  - Sample tests performed in an office setting **don't count**
  - Samples obtained via a digital rectal exam (DRE) **don't count**
  - DRE exams **don't count**
- FIT-DNA test every three years
- CT colonography every five years
- Flexible sigmoidoscopy every five years
- Colonoscopy every 10 years (Gold Standard)

Remember, the screening frequency depends on the method of testing the patient had in the past. (Colonoscopy screening is only every 10 years).

Helpful Tips

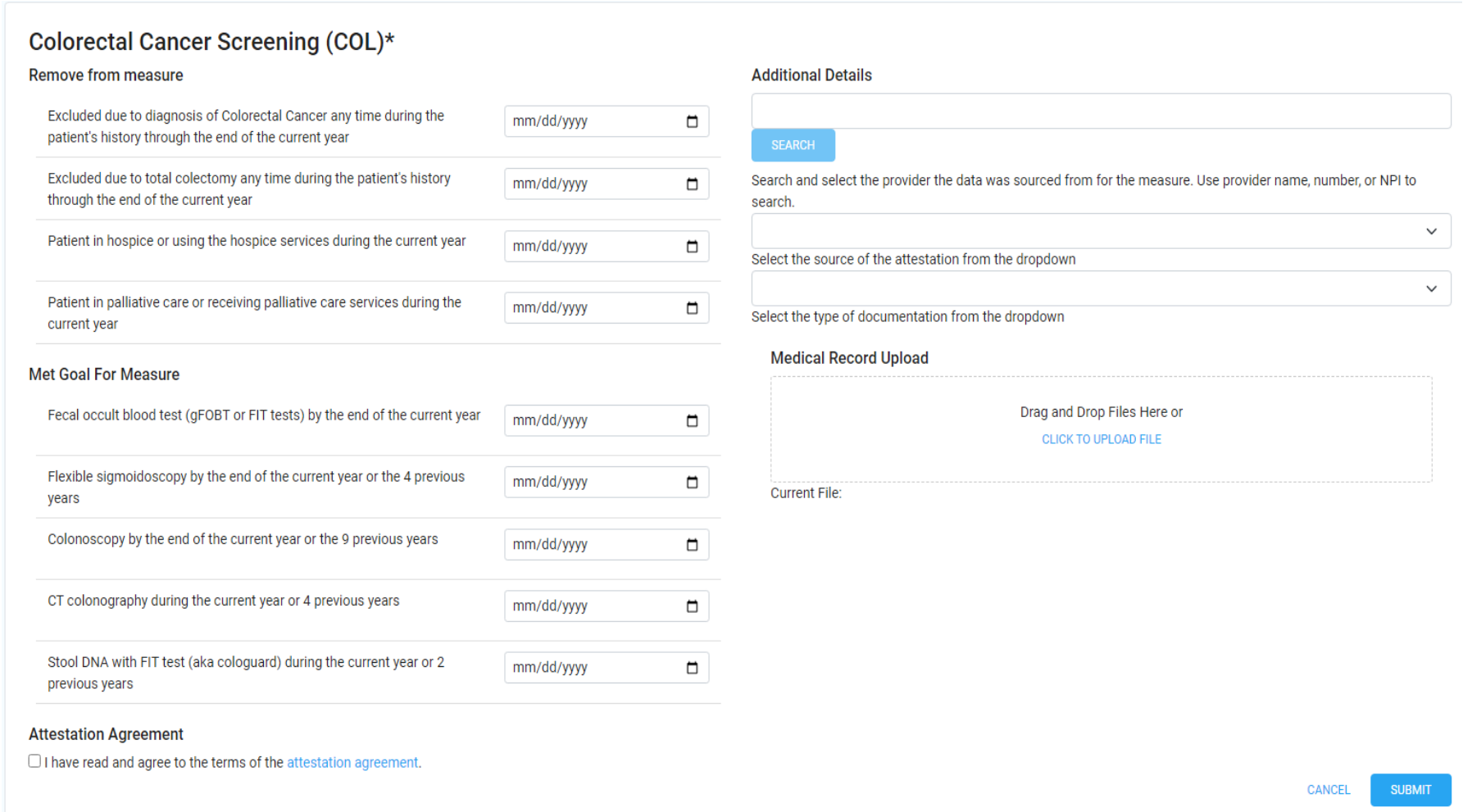
- NCQA **doesn't allow** the following to close this measure:
- Digital rectal exam as evidence of colorectal screening
  - Not specific
  - Not comprehensive
- FOBT documented as being performed in an office setting or on a sample collected via digital rectal exam (Same date of service as the office visit)
- Documentation that says "reported by patient" or "per patient"
- ColoCARE (throw in the bowl pads) or ColoVantage (blood test) aren't approved for this measure
- Partial colectomy exclusions **aren't acceptable;** Colectomy must be total and documented as such
- An order alone **isn't acceptable** to close the gap in care, there must be documentation that the procedure was done (date and result)
- A patient's refusal **doesn't exclude** them from the measure

Unacceptable Documentation

- Date ranges, i.e., "colonoscopy about nine years ago"
- Documentation of date due, ordered, scheduled, etc. without documentation of completion
- Documentation alone that screening is "up to date"
- Documentation of "patient reported"

COLORECTAL SCREENING (COL-E)

Exclusions



Well-Child Visits in the First 30 Months of Life (W30)

Goal of the Measure

- Patients 0-30 months of age must complete six or more visits with a Primary Care Provider (PCP) on different dates of service on or before the child turns 15 months;
- and
- Patients must complete two or more visits with a PCP, on different dates of service, after the child turns 15 months and before they turn 30 months.

Exclusions

- Patients in hospice and patients who die during the measurement year

Child and Adolescent Well-Care Visits (WCV)

Goal of the Measure

- Patients 3 to 21 years old should have one or more comprehensive well-visits with a PCP or obstetrician-gynecologist (OB/GYN) every year.
- **Exclusions:** Patients in hospice and patients who die during the measurement year.

Helpful Tips

- The well-child forms available on the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) website (tnaap.org) address all components of the well-child measures, if properly and fully completed. We highly encourage using those forms.
- The gaps for well visits should be closed through claims submissions.

Don’t forget!

Services specific to the assessment or treatment of an acute or chronic condition don’t count toward the measure.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BMI)

Goal of the Measure

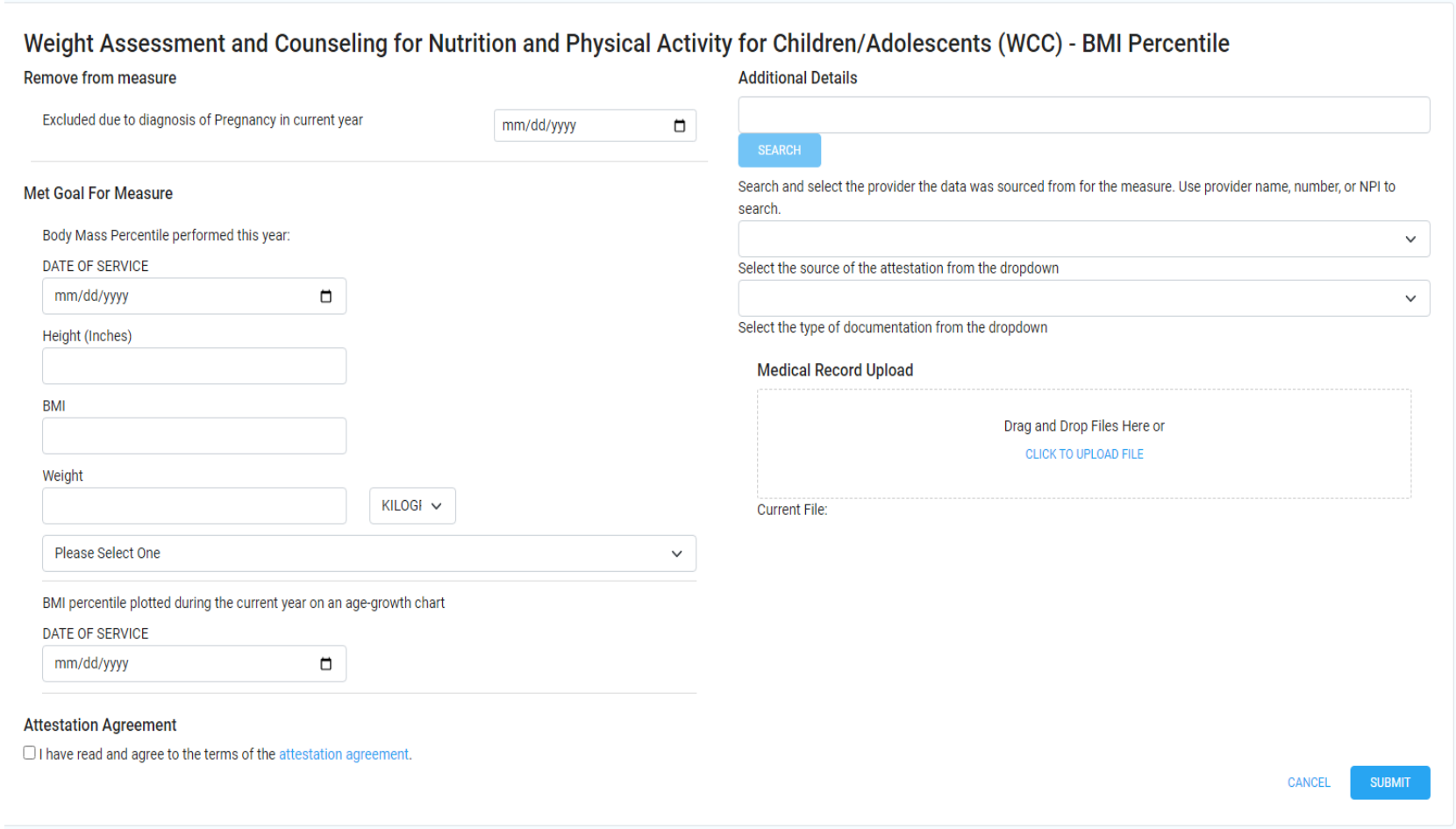
- Patients must complete at least one outpatient visit with a PCP or an OB/GYN during the measurement year and have documentation of Body Mass Index (BMI) percentile.
- Ages: Children turning 3-17 years of age as of Dec. 31 of the measurement year
- **Exclusions:**
  - Patients in hospice and patients who die during the measurement year
  - Patients with a diagnosis of pregnancy during the same measurement year

Helpful Tips

- This is a yearly measure (Jan. 1 to Dec. 31).
- Height, weight, and BMI are used to calculate a BMI percentile
- The information must be recorded, dated and maintained in the patient's legal health record.
- A specific BMI percentile can be documented on an age-growth chart.

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC-BMI)

Attestation



Immunization Care

Childhood Immunization Status (CIS)

Goal of the Measure

- Patients should complete the entire series of all immunizations before turning 2 years old:
  - Four DTaP (diphtheria, tetanus and pertussis)
  - Three IPV (polio)
  - One MMR (measles, mumps and rubella)
  - Three HiB (haemophilus influenza type B)
  - Three Hep B (hepatitis B)
  - One Hep A (hepatitis A)
  - One VZV (varicella)
  - Four PCV (pneumococcal conjugate)
  - Two or three RV (rotavirus)
  - Two Flu (influenza)

You can find an immunization schedule and information about the different vaccines at **cdc.gov/vaccines**.

Helpful Tips

- All doses of all vaccines must be completed for the gap to close.
- If a child turns 2 and hasn't had all doses, the gap for CIS will remain open and can't be closed.
- Flu vaccines and rotavirus vaccines are the ones most frequently missed.
- Exclusions:
  - Children in hospice
  - Children who had a contraindication for a specific vaccine. In this case, the exclusion must have occurred by the child's second birthday.

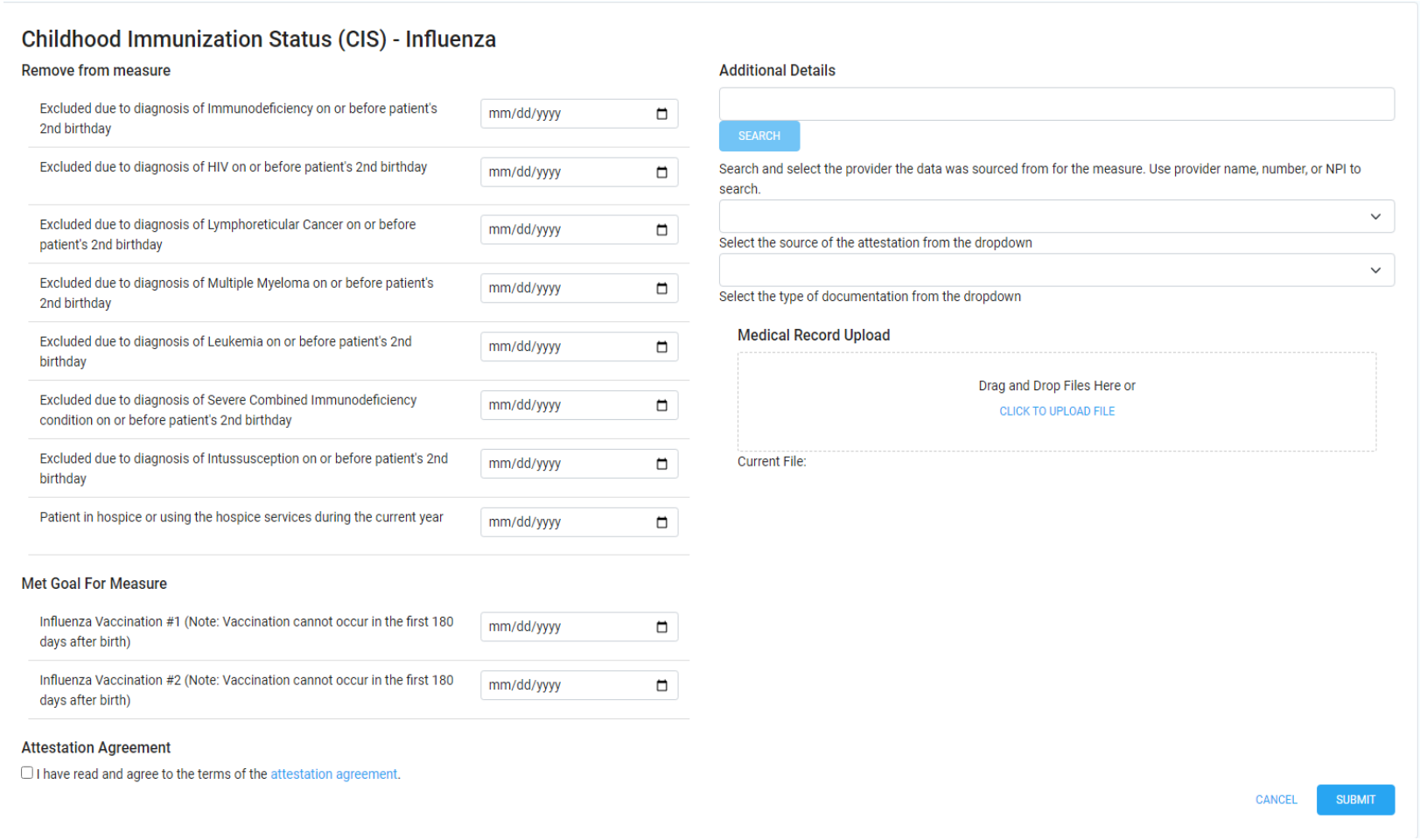
It's important to list in the record if the rotavirus vaccine is the two- or three-dose vaccine. Upon record review, if it only says "rotavirus" and doesn't specify two or three doses, we're required to assume it's the three-dose vaccine. So, if only two doses are documented, the record won't be compliant.

CHILDHOOD IMMUNIZATION STATUS (CIS)

Attestation

⌄	✗	Childhood Immunization Status (CIS) - Combo 10 (Dtap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, Influenza)*						
	✓	Childhood Immunization Status (CIS) - DTaP				✗	Add Attestation	
	✗	Childhood Immunization Status (CIS) - Influenza	12/12/2022	RECONCILED	Influenza Vaccination #1 (Note: Vaccination cannot occur in the first 180 days after birth)		Add Attestation	···
	✓	Childhood Immunization Status (CIS) - Hepatitis A				✗	Add Attestation	
	✓	Childhood Immunization Status (CIS) - Hepatitis B				✗	Add Attestation	
	✓	Childhood Immunization Status (CIS) - HiB				✗	Add Attestation	
	✓	Childhood Immunization Status (CIS) - IPV				✗	Add Attestation	
	✓	Childhood Immunization Status (CIS) - MMR				✗	Add Attestation	
	✓	Childhood Immunization Status (CIS) - Pneumococcal Conjugate				✗	Add Attestation	
	✓	Childhood Immunization Status (CIS) - Rotavirus				✗	Add Attestation	
	✓	Childhood Immunization Status (CIS) - VZV				✗	Add Attestation	

Attestation (cont.)



Immunizations for Adolescents (IMA, IMA-E)

Goal of the Measure

- Patients should complete the entire series of all immunizations before turning 13 years old:
  - One meningococcal given between 11 and 13 years old
  - One Tdap (tetanus, diphtheria toxoids and acellular pertussis) given between 10 and 13 years old
  - Completed HPV series between 9 and 13 years old

You can find an immunization schedule and information about the different vaccines at **cdc.gov/vaccines**.

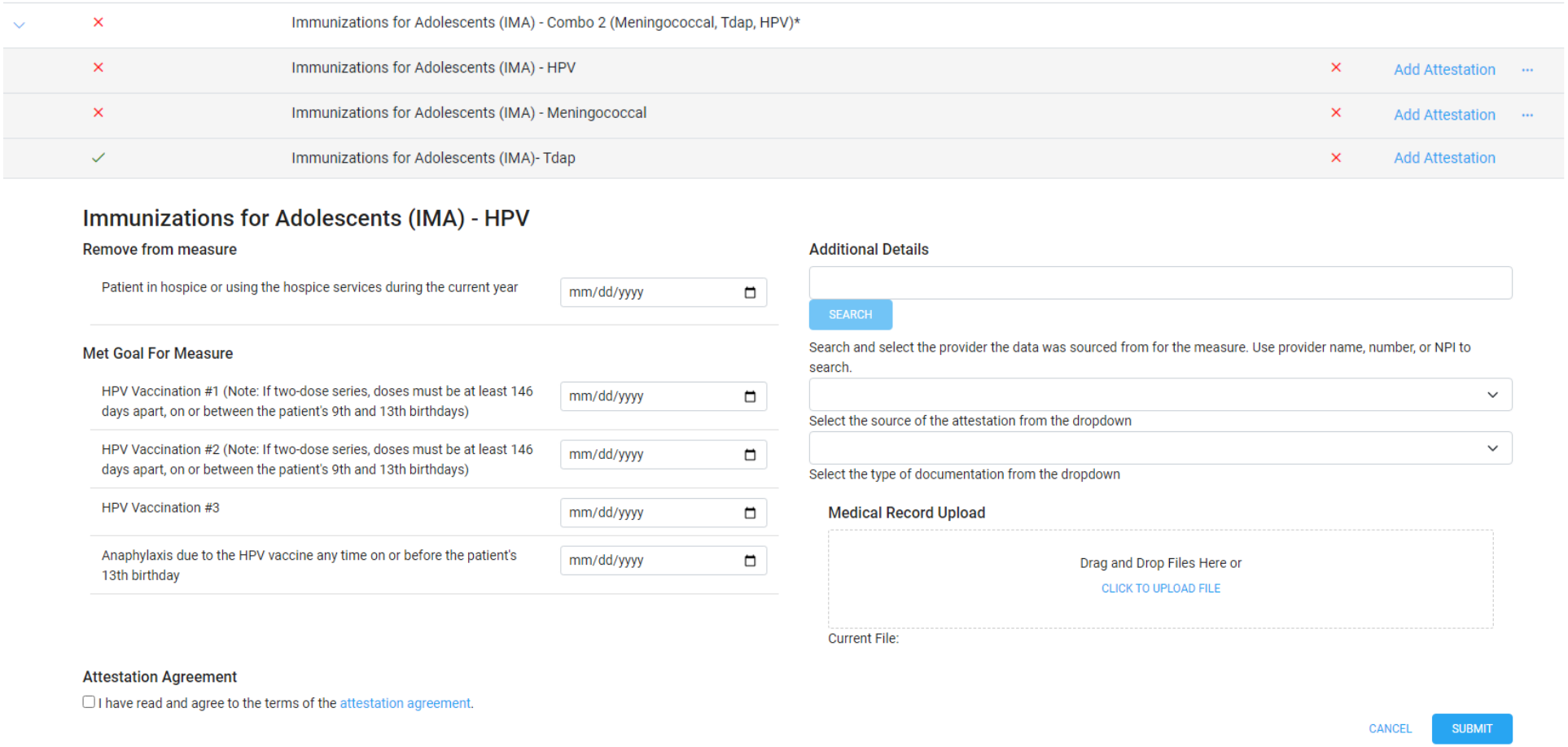
Helpful Tips

- All doses of all vaccines must be completed for the gap to close.
- If a child turns 13 and hasn't had all doses, the gap for IMA will remain open and can't be closed.
- Exclusions:
  - Adolescents in hospice
  - Adolescents who had a contraindication for a specific vaccine. In this case, the exclusion must have occurred by the child's second birthday.

Did you know?

HPV is the most missed vaccine.

Attestation



Adult Immunization Status (AIS)

Goal of the Measure

Patients 19 years and older should be up to date on recommended routine vaccines for:

- Influenza (flu)
- Tetanus and diphtheria (Td) **or**
- Tetanus, diphtheria and acellular pertussis (Tdap)
- Herpes zoster
- Pneumococcal- (not listed on the QCPI scorecard for 2024)

You can find an immunization schedule and information about the different vaccines at **cdc.gov/vaccines**.

Helpful Tips

Flu shot:

- Applies to patients 19 years and older.
- Annual vaccine.
- Must be administered on or between July 1 of the year prior and June 30 of the measurement year.
- Scores in 2024 are based on data from July 1, 2022, through June 30, 2023.

Tdap/Td Vaccine:

- Applies to patients 19 years and older.
- Patients should receive at least one vaccine within the end of the measurement year or the nine years prior (given every 10 years).
- Patients can also meet the measure if they have a documented history of at least one of the following contraindications:
  - Anaphylaxis due to diphtheria, tetanus or pertussis vaccines
  - Encephalitis due to diphtheria, tetanus or pertussis vaccines

Helpful Tips (cont.)

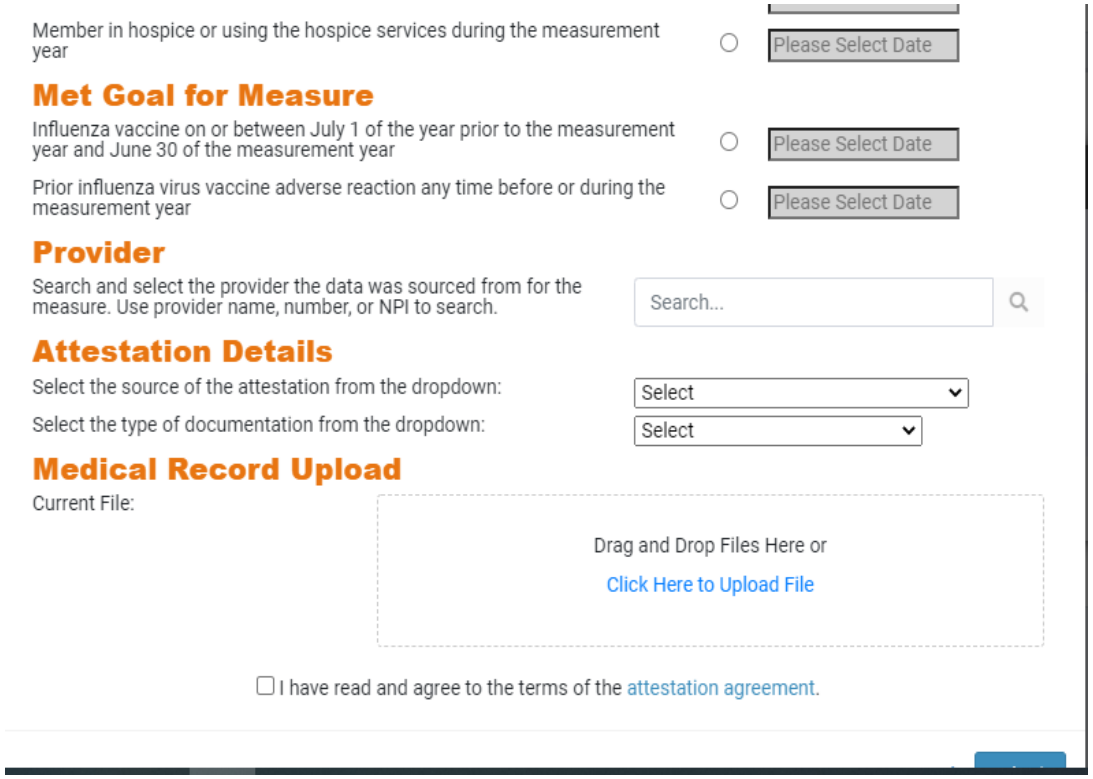
Herpes Zoster Vaccine

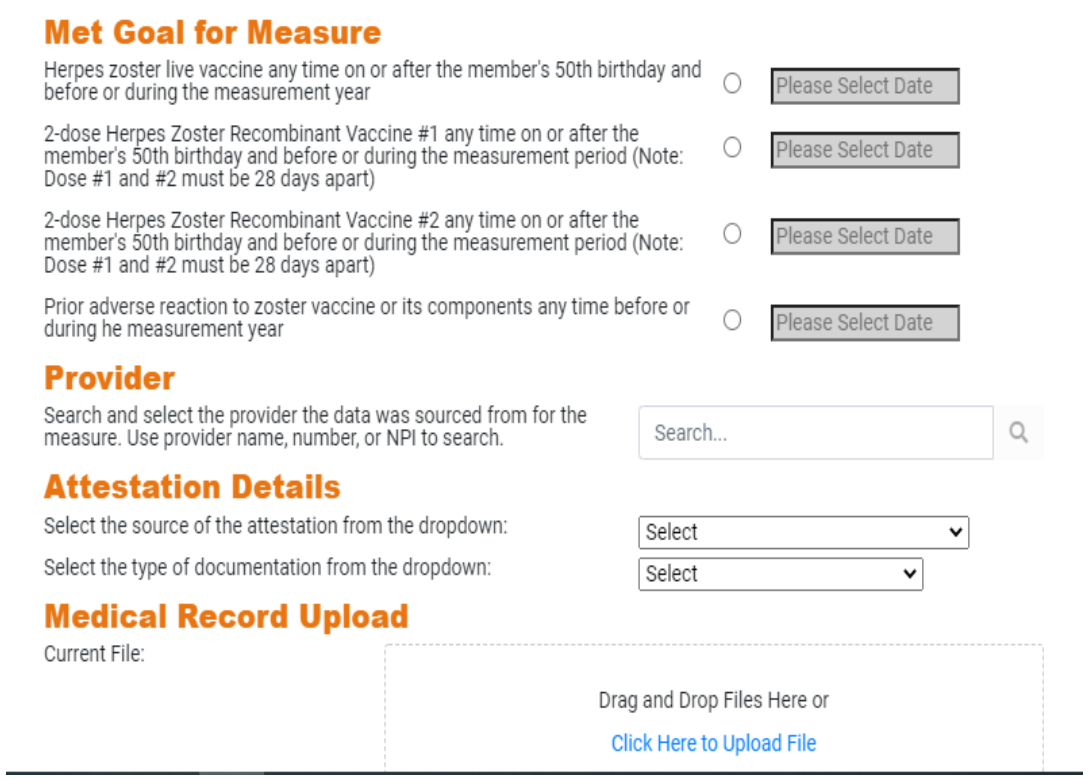
- Applies to patients 50 years and older.
- Patients should receive the vaccine on or after their 50th birthday and either before or during the measurement period.
- Patients can receive either:
  - One dose of the herpes zoster live vaccine **or**
  - Two doses of the herpes zoster recombinant vaccine at least 28 days apart.

Pneumococcal Vaccine

- Applies to patients 66 years and older.
- Patients should get the 23-valent pneumococcal polysaccharide vaccine (PPSV23).

Attestation





Diabetes Care

Diabetes Care

DIABETES CARE

Eligibility

- Patients 18-75 years old diagnosed with diabetes (Type 1 and Type 2)
- Patients should be identified by:
  - **Claims/encounter data**: Patients who had at **least two diagnoses of diabetes** on different dates of service during the measurement year or the year prior to the measurement year.
  - **Pharmacy data:** Patients who were dispensed insulin or hypoglycemic/ antihyperglycemics during the measurement year or the year prior to the measurement year **and have at least one diagnosis of diabetes** during the measurement year or the year prior to the measurement year.
- Exclusions
  - Patients in hospice or palliative care
  - Patients 66 years and older with both advanced illness and frailty (At least two indications of frailty diagnoses with different dates of service during the measurement year)
  - Patients who died any time during the measurement year

Blood Pressure Control for Patients With Diabetes (BPD)

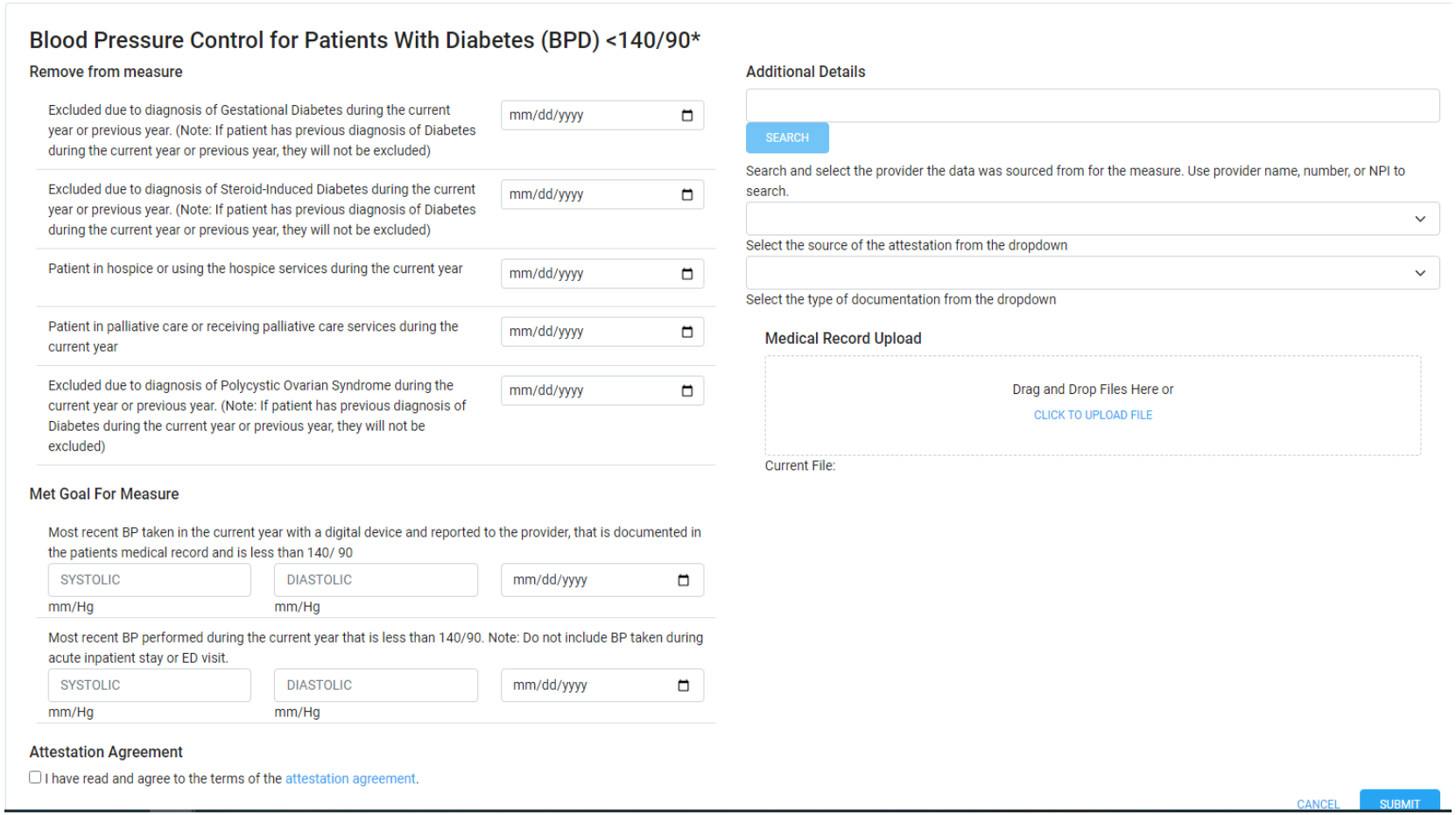
Goal of the Measure

Patients 18-75 years diagnosed with diabetes should have a controlled blood pressure (B/P) of <140/90 during the measurement year.

Helpful Tips

- Patients can only enter the denominator once a year.
- Identify the most recent B/P reading during an outpatient visit, telephone visit, a nonacute inpatient encounter or remote monitoring event.
- The gaps for B/P can reopen during the year based on results and the last result documented will stand as the representative level for the year for that patient.
- Patients can now self-report B/P levels during telehealth or telephone visits if the B/P level was taken on a digital device.
- You can retake a B/P for a patient on the same visit if the first one is out of the acceptable range. If multiple readings were recorded for the same date, same visit, use the lowest systolic and lowest diastolic B/P on that date as the representative B/P.
  - Example: 1st reading – 130/95; 2nd reading – 156/80
  - The gap can be closed with the reading of 130/80

Attestation



Eye Exam For Patients with Diabetes (EED)

Goal of the Measure

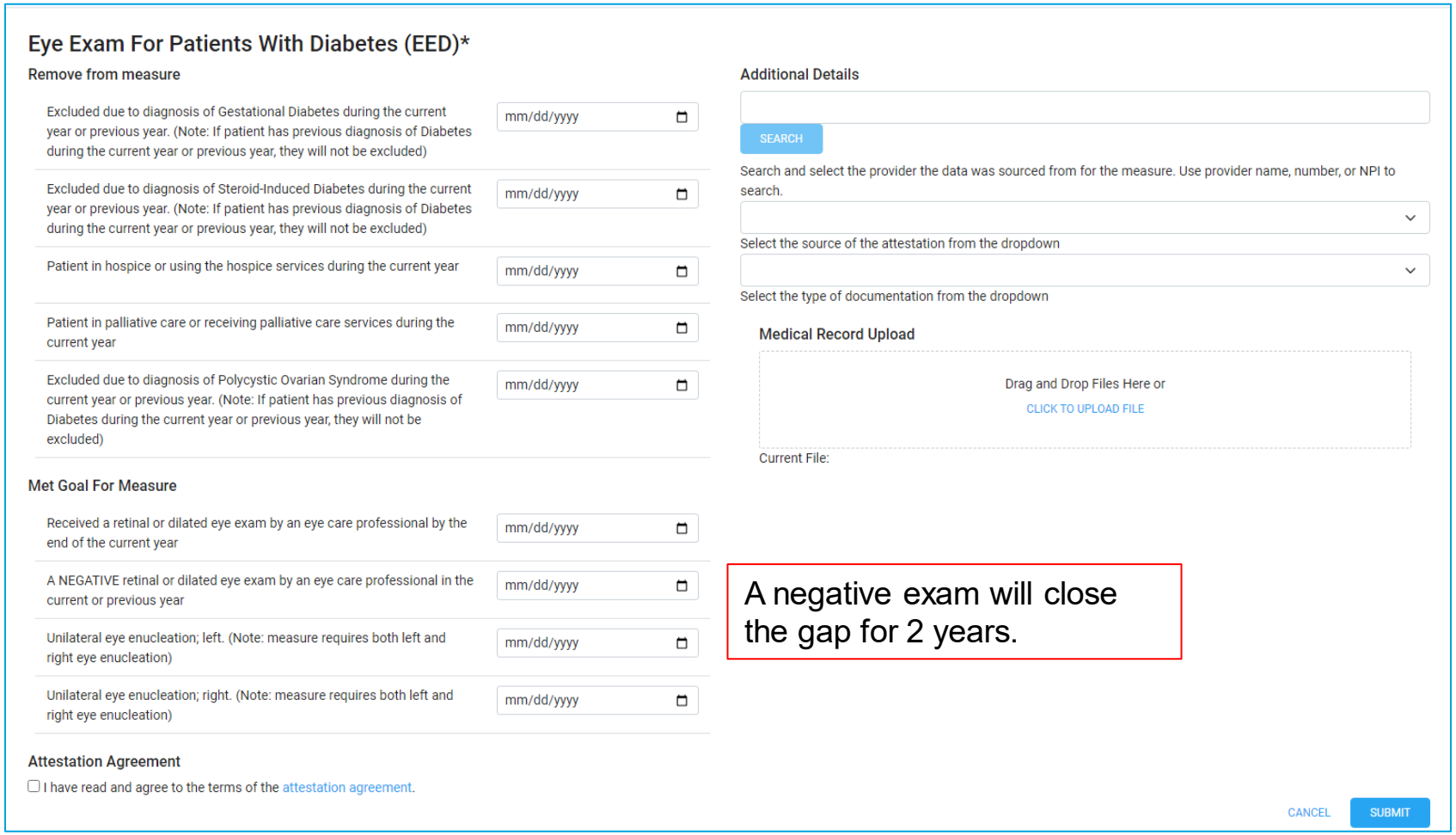
Patients 18-75 years diagnosed with diabetes should have a retinal or dilated eye exam by an eye care professional or interpreted by an eye care professional during the measurement year

Helpful Tips

- Any retinal or dilated eye exam from an eye care provider is acceptable in the measurement year, but an exam from the previous year must have a negative result for retinopathy to be compliant.
- Documentation of a negative retinopathy exam can close the gap for two years, but it must be coded as such.
- Blindness isn't an exclusion for a diabetic eye exam because it's difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore don't require an exam.
- Bilateral eye enucleation will close the gap in care if there's documentation that the patient has had bilateral enucleation or acquired absence of both eyes.
- The statement "diabetes without complications" doesn't meet criteria and won't close the gap.

EYE EXAM FOR PATIENTS WITH DIABETES (EED)

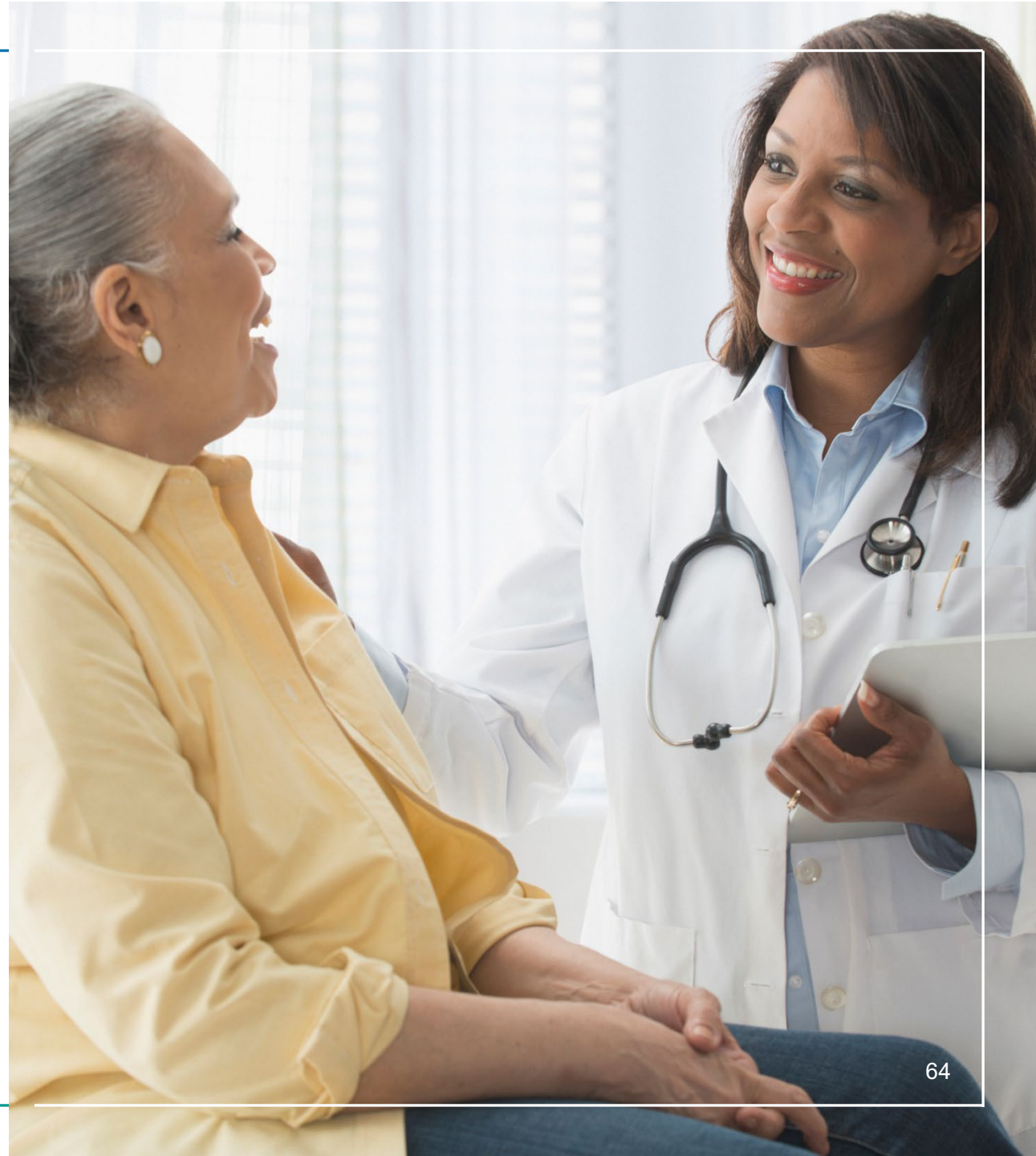
Attestation



A negative exam will close the gap for 2 years.

Glycemic Status Assessment for Patients with Diabetes (GSD)

Formally known as (HBD) HbA1c Control <8



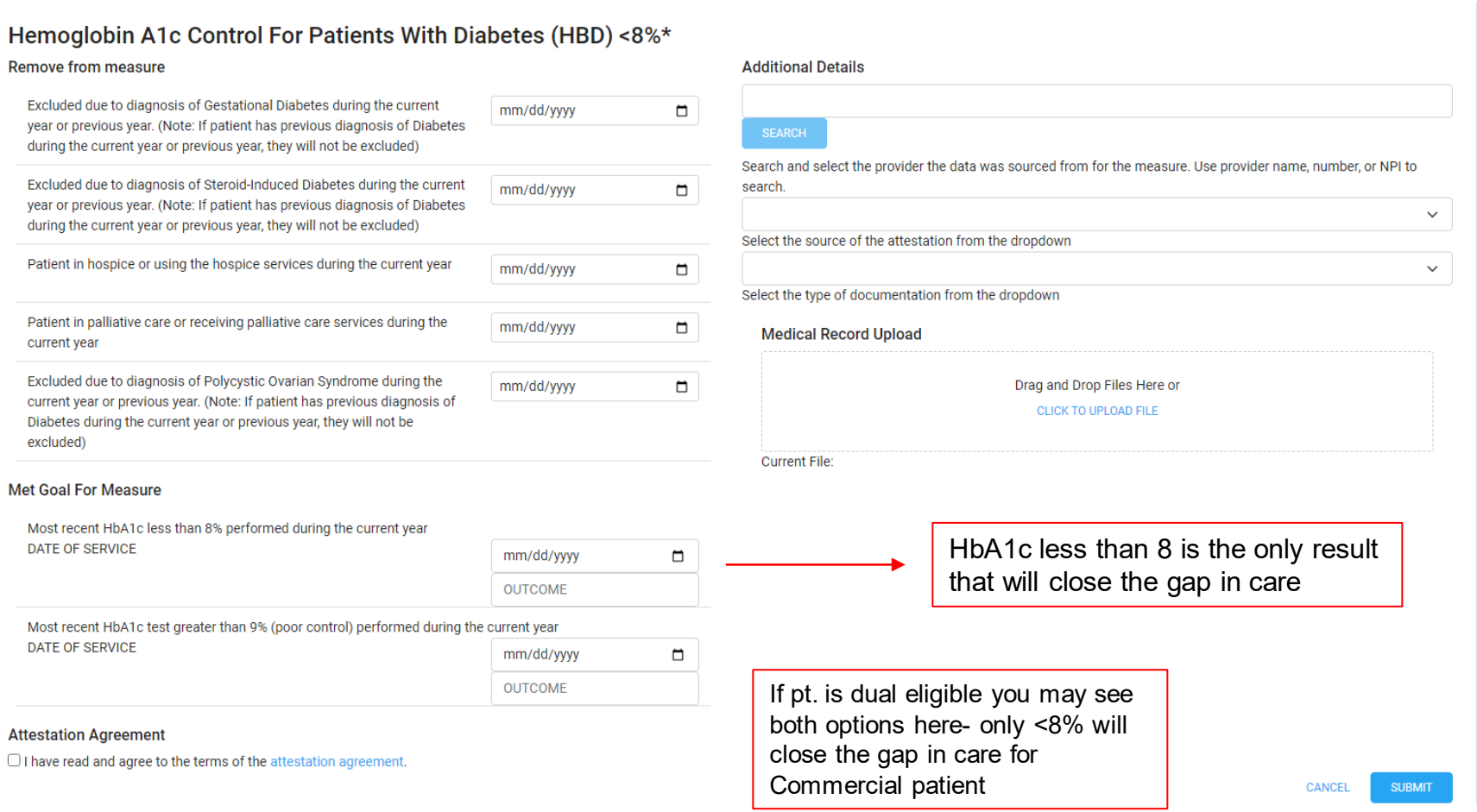
Goal of the Measure

Patients 18-75 years diagnosed with diabetes whose most recent glycemic status (HbA1c) or glucose management indicator (GMI) was <8 during the measurement year.

Helpful Tips

- The gaps for HbA1c/GMI can reopen during the year based on results and the last result documented will stand as the representative level for the year.
- HbA1c/GMI results must be on a specific date. Documentation stating “recent or last A1C” doesn’t meet the measure for gap closure; it must have a date.
- At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c/GMI test was performed and the result.

Attestation



HbA1c less than 8 is the only result that will close the gap in care

If pt. is dual eligible you may see both options here- only <8% will close the gap in care for Commercial patient

Kidney Health Evaluation for Patients with Diabetes (KED)

Goal of the Measure

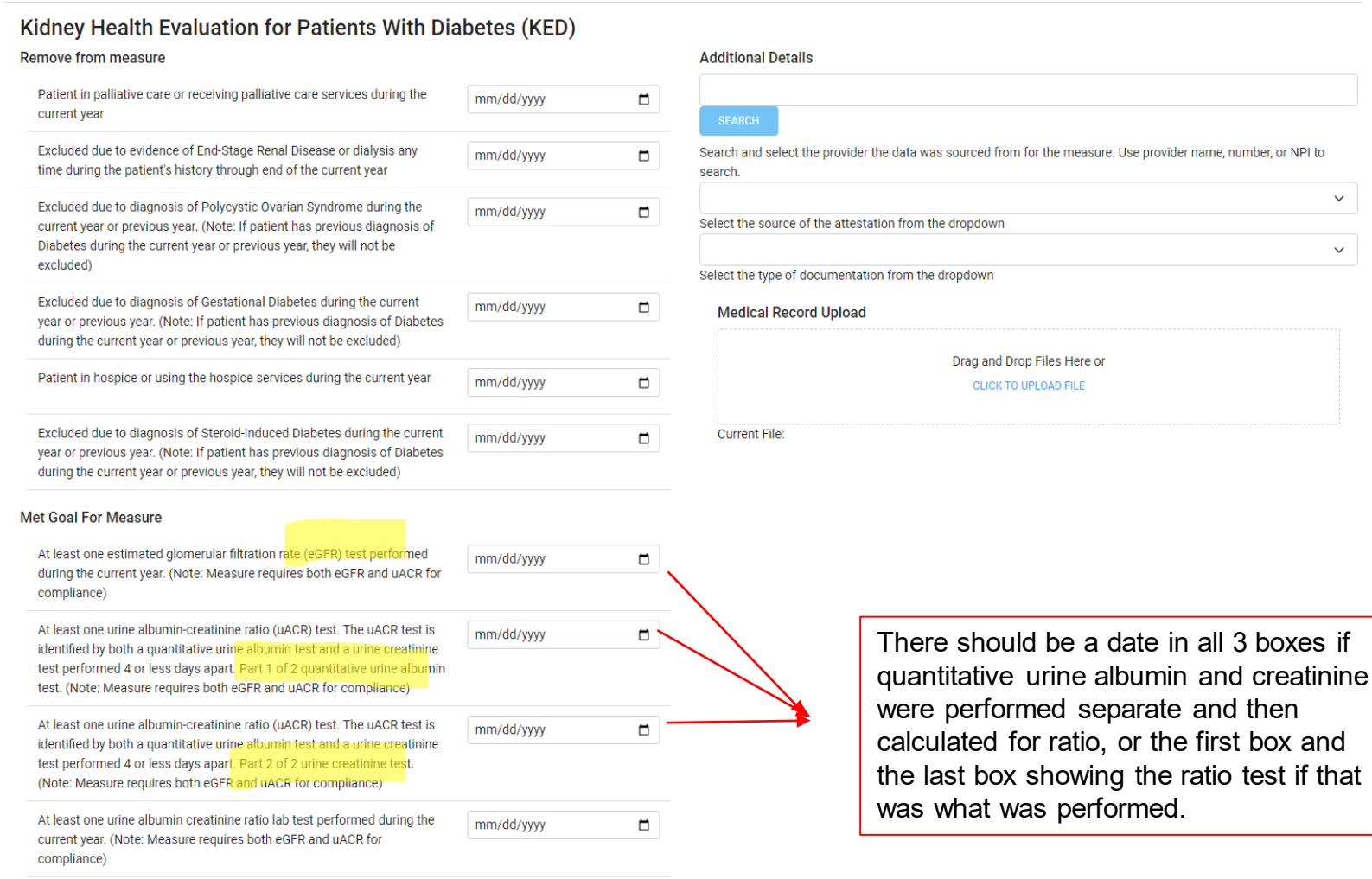
Patients 18-85 years diagnosed with diabetes (type 1 and type 2) should receive a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Helpful Tips

- The specifications are looking for the quantitative number to provide an accurate ratio calculation. Code 82043 is for Albumin, urine (e.g., microalbumin) quantitative.
- The evaluation should include at least one eGFR lab test **and** at least one uACR identified by either of the following:
  - Both a quantitative urine albumin test and a urine creatinine test with service dates **four days or less** apart.
- For example, if the service date for the quantitative urine albumin test was Feb. 1 of the measurement year, then the urine creatinine test must have a service date on or between Jan. 28 and Feb. 5 of the measurement year.

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

Attestation



There should be a date in all 3 boxes if quantitative urine albumin and creatinine were performed separate and then calculated for ratio, or the first box and the last box showing the ratio test if that was what was performed.

Received Statin Therapy for Patients with Diabetes(SPD)

Goal of the Measure

Statin Therapy for Patients with Diabetes (SPD) – Received Statin Therapy

Statin Therapy for Patients with Diabetes (SPD) – Statin and Adherence 80%

Patients 18-75 years diagnosed with diabetes should be given a low-to-moderate-intensity statin medication and remain on this for 80% of their treatment period. (Any intensity statin will meet the intent of this measure)

Helpful Tips

- The data to close these measures comes from claims as patients fill prescriptions and they're processed through their insurance.
- Any intensity of statin will meet the measure.
- You can view the patient's pharmacy information by accessing the clinical tab in the QCR application.

STATIN THERAPY FOR PATIENTS WITH DIABETES (SPD)- RECEIVED

Attestation

Statin Therapy for Patients with Diabetes (SPD)- Received Statin Therapy

Remove from measure

Patient discharged from inpatient setting with MI during the previous year; date of discharge required	mm/dd/yyyy
Patient had a CABG during the previous year; procedure date requested	mm/dd/yyyy
Patient had a PCI during the previous year; procedure date requested	mm/dd/yyyy
Excluded due to diagnosis of Pregnancy in the current or previous year; applies to female patients only	mm/dd/yyyy
Excluded due to In-Vitro Fertilization in the current or previous year	mm/dd/yyyy
Excluded due to End-Stage Renal Disease or dialysis in the current or previous year	mm/dd/yyyy
Excluded due to diagnosis of Cirrhosis during the current or previous year	mm/dd/yyyy
Excluded due to muscle pain or muscular disease (Myalgia, Myositis, Myopathy or Rhabdomyolysis) during the current year	mm/dd/yyyy
Patient in hospice or using the hospice services during the current year	mm/dd/yyyy
Patient in palliative care or receiving palliative care services during the current year	mm/dd/yyyy
Excluded due to diagnosis of Polycystic Ovarian Syndrome during the current year or previous year. (Note: If patient has previous diagnosis of Diabetes during the current year or previous year, they will not be	mm/dd/yyyy

Additional Details

SEARCH

Search and select the provider the data was sourced from for the measure. Use provider name, number, or NPI to search.

Select the source of the attestation from the dropdown

Select the type of documentation from the dropdown

Medical Record Upload

Drag and Drop Files Here or

CLICK TO UPLOAD FILE

Current File:

STATIN THERAPY FOR PATIENTS WITH DIABETES (SPD)- ADHERENCE

Attestation

Statin Therapy for Patients with Diabetes (SPD) - Statin Adherence 80%

Remove from measure

Patient discharged from inpatient setting with MI during the previous year; date of discharge required	mm/dd/yyyy
Patient had a CABG during the previous year; procedure date requested	mm/dd/yyyy
Patient had a PCI during the previous year; procedure date requested	mm/dd/yyyy
Excluded due to diagnosis of Pregnancy in the current or previous year; applies to female patients only	mm/dd/yyyy
Excluded due to In-Vitro Fertilization in the current or previous year	mm/dd/yyyy
Excluded due to End-Stage Renal Disease or dialysis in the current or previous year	mm/dd/yyyy
Excluded due to diagnosis of Cirrhosis during the current or previous year	mm/dd/yyyy
Excluded due to muscle pain or muscular disease (Myalgia, Myositis, Myopathy or Rhabdomyolysis) during the current year	mm/dd/yyyy
Patient in hospice or using the hospice services during the current year	mm/dd/yyyy
Patient in palliative care or receiving palliative care services during the current year	mm/dd/yyyy
Excluded due to diagnosis of Polycystic Ovarian Syndrome during the current year or previous year. (Note: If patient has previous diagnosis of Diabetes during the current year or previous year, they will not be excluded)	mm/dd/yyyy

Additional Details

SEARCH

Search and select the provider the data was sourced from for the measure. Use provider name, number, or NPI to search.

Select the source of the attestation from the dropdown

Select the type of documentation from the dropdown

Medical Record Upload

Drag and Drop Files Here or

CLICK TO UPLOAD FILE

Current File:

Cardiac/Respiratory Care

Controlling High Blood Pressure (CBP)

Goal of the Measure

Patients 18-85 years with a diagnosis of hypertension should have a controlled B/P level of <140/90 during the measurement year.

Patients are enter into the measure when they've had at least two visits on different dates of service with a diagnosis of hypertension on or between Jan. 1, 2023, and June 30, 2024.

(That is January 1 of the year prior to the measurement year and June 30 of the measurement year)

Helpful Tips

- Patients can only enter the denominator once a year.
- Identify the most recent B/P reading during an outpatient visit, telephone visit, a nonacute inpatient encounter, or remote monitoring event.
- The gaps for B/P can reopen during the year based on results, and the last result documented will stand as the representative level for the year for that patient.
- Patients can now self-report B/P levels during telehealth or telephone visits if the B/P level was taken on a digital device.
- You can retake a B/P for a patient on the same visit if the first one is out of the acceptable range. If multiple readings were recorded for the same date, same visit, use the lowest systolic and lowest diastolic B/P on that date as the representative B/P.
  - Example: 1st reading – 130/95; 2nd reading – 156/80.
  - The gap can be closed with the reading of 130/80.
- B/P control is a three-weight measure.

CONTROLLING HIGH BLOOD PRESSURE (CBP)

Attestation

Controlling High Blood Pressure (CBP)*

Remove from measure

Excluded due to diagnosis of End-Stage Renal Disease any time during the patient's history through end of the current year	mm/dd/yyyy
Excluded due to history of kidney transplant any time during the patient's history through end of the current year	mm/dd/yyyy
Excluded due to dialysis any time during the patient's history through end of the current year	mm/dd/yyyy
Excluded due to diagnosis of Pregnancy by the end of the current year; applies to female patients only	mm/dd/yyyy
Patient in hospice or using the hospice services during the current year	mm/dd/yyyy
Patient in palliative care or receiving palliative care services during the current year	mm/dd/yyyy
Excluded due to history of nephrectomy any time during the patient's history through end of the current year	mm/dd/yyyy

Met Goal For Measure

Most recent BP taken in the current year with a digital device and reported to the provider, that is documented in the patients medical record and is less than 140/ 90

SYSTOLIC mm/Hg | DIASTOLIC mm/Hg | mm/dd/yyyy

Most recent BP performed during the current year that is less than 140/90. Note: Do not include BP taken during acute inpatient stay or ED visit.

SYSTOLIC mm/Hg | DIASTOLIC mm/Hg | mm/dd/yyyy

Attestation Agreement

☐ I have read and agree to the terms of the attestation agreement.

Additional Details

SEARCH

Search and select the provider the data was sourced from for the measure. Use provider name, number, or NPI to search.

Select the source of the attestation from the dropdown

Select the type of documentation from the dropdown

Medical Record Upload

Drag and Drop Files Here or

CLICK TO UPLOAD FILE

Current File:

CANCEL SUBMIT

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Goal of the Measure

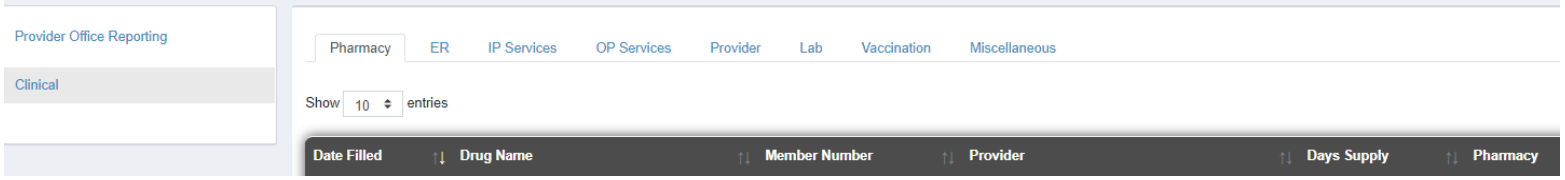
Statin Therapy for Patients with Cardiovascular Disease (SPC) – Received Statin Therapy

Statin Therapy for Patients with Cardiovascular Disease (SPC) – Statin Adherence 80%

The purpose of the SPC measure is to ensure patients diagnosed with clinical atherosclerotic cardiovascular disease (ASCVD) during the measurement year and the year prior be dispensed a **moderate- or high-intensity statin medication** and remain on that statin medication for at least 80% of their treatment period for the measurement year.

Helpful Tips

- The data to close these measures comes from claims as patients fill their prescriptions and process them through their insurance.
- Only a moderate- or high-intensity statin will satisfy the measure.
- There are two age groups:
  - Men 21-75 years
  - Women 40-75 years
- You can view the patient's pharmacy information by accessing the clinical tab in the QCR application.



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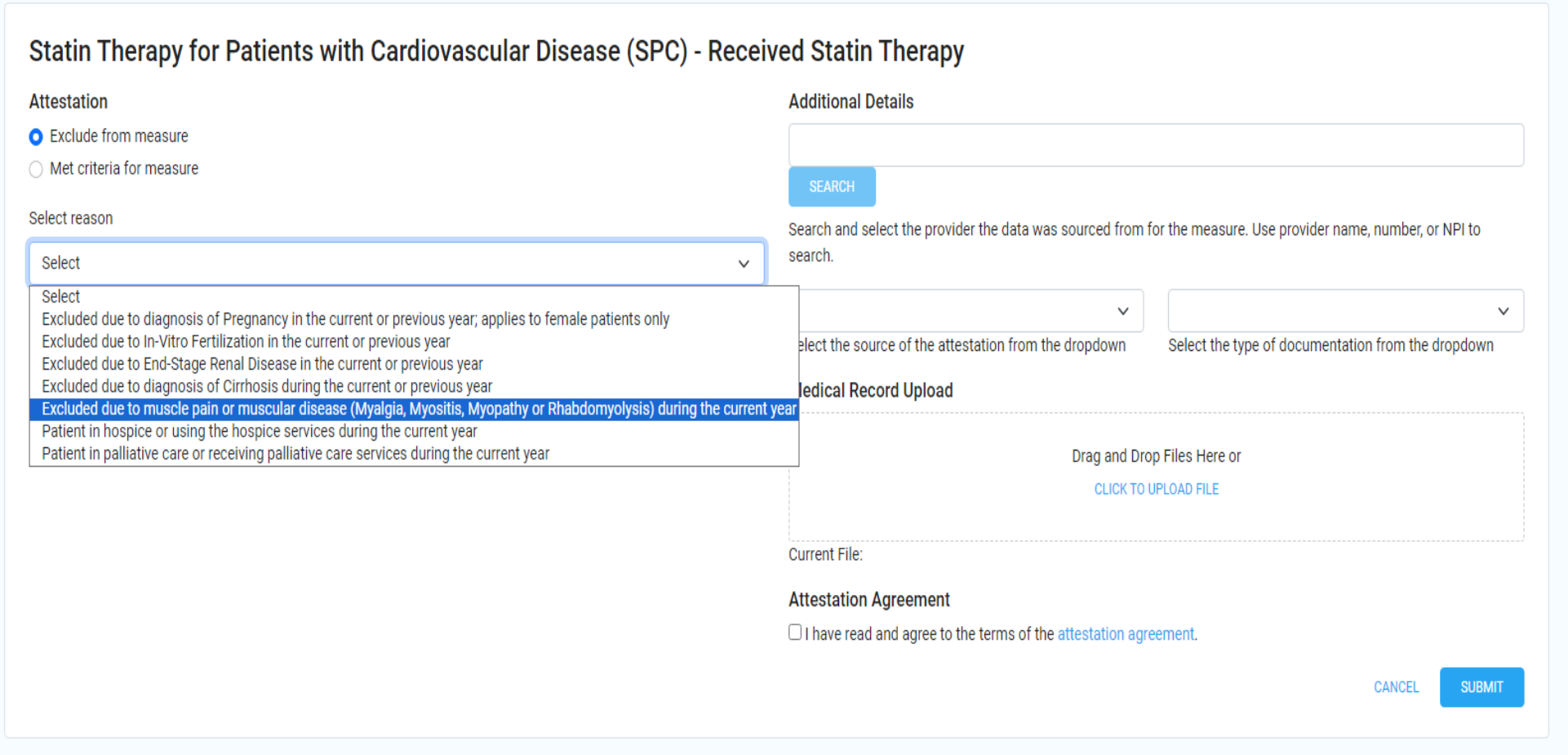
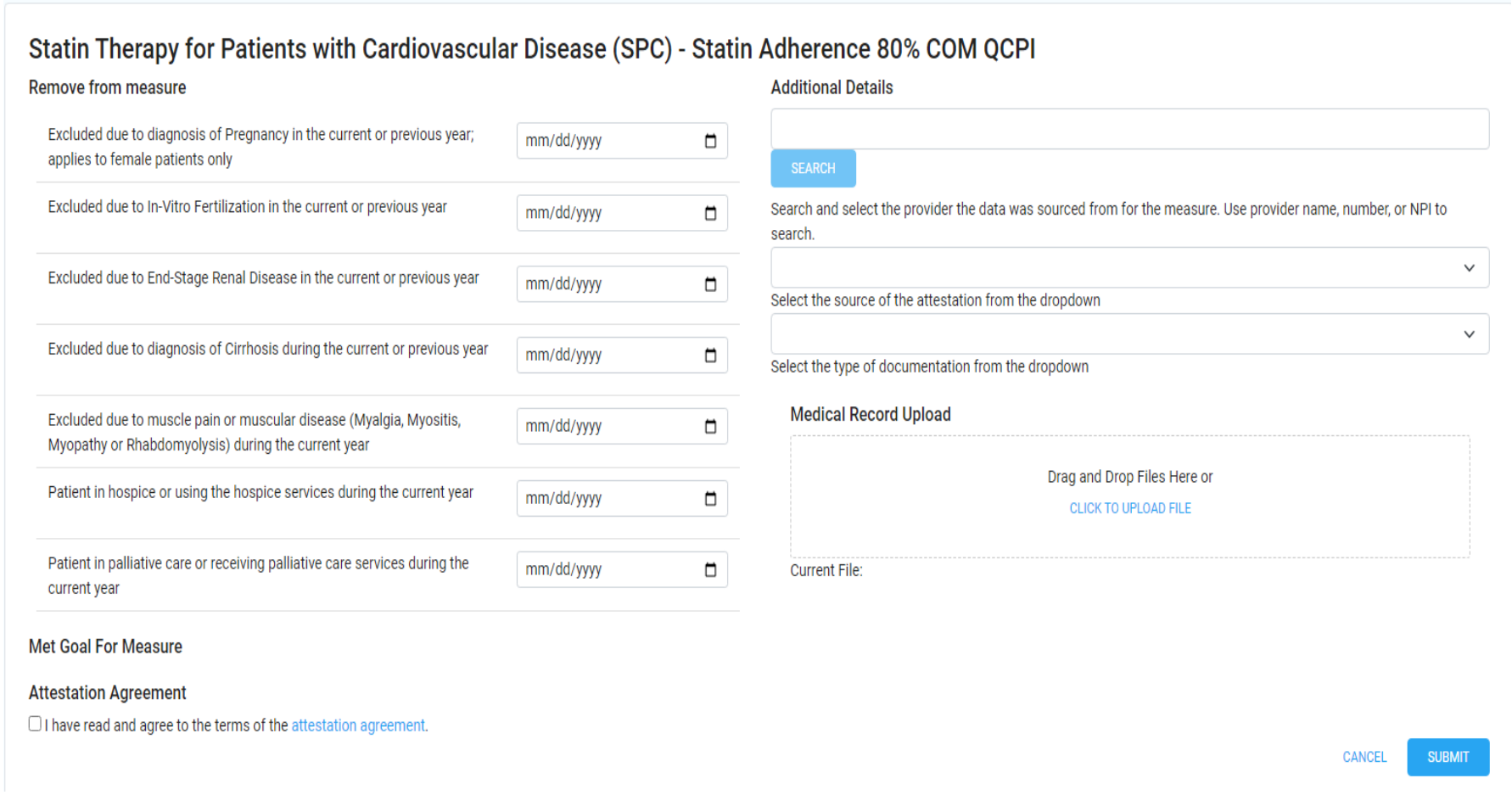


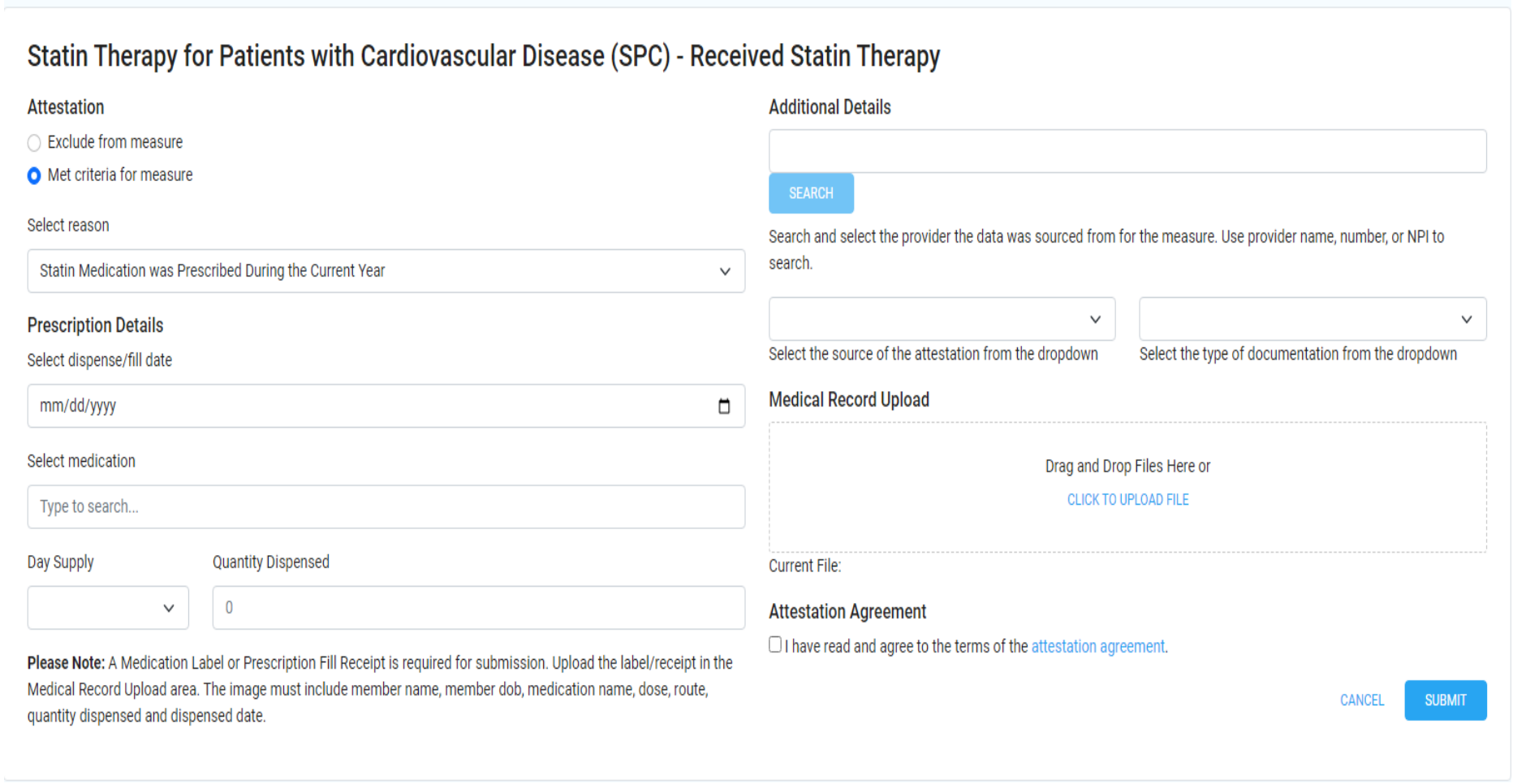
STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

Attestation



STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

Attestation



Asthma Medication Ratio (AMR)

Goal of the Measure

- Patients 5-64 years of age who were identified as having persistent asthma and who had a ratio of controller medications to total asthma medications of >=0.50 during the measurement year.
- Must meet at least one of the following criteria during **both** the measurement year and the year prior to the measurement year:
  - At least one ER visit, with a principal diagnosis of asthma
  - At least one acute inpatient encounter, with a principal diagnosis of asthma
  - At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller medication or reliever medication
  - At least four asthma medication dispensing events for any controller or reliever medication

NCQA uses administrative data to identify patients with certain conditions. Since claims data isn't meant to be diagnostic in nature, NCQA uses special rules to help eliminate false positives.

Helpful Tips

- The purpose of the AMR measure is to ensure patients are using controller medications as much as, or more than, they're using reliever medications (i.e., rescue inhalers).
- Appropriate asthma medication ratios of 0.50 or greater of long-term controller medications to quick-reliever medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, ER visits), while also lowering non-medication costs.

Exclusions

- Patients who had a diagnosis of any of the following, any time during their history through Dec. 31 of the measurement year:
  - Chronic obstructive pulmonary disease
  - Obstructive chronic bronchitis
  - Chronic respiratory conditions due to fumes/vapors
  - Cystic fibrosis
  - Acute respiratory failure
  - Emphysema
- Patients in hospice
- Patients who had no asthma controller medications dispensed during the measurement year
- Patients who died any time during the measurement year

Formula = Units of Controller Medication/Units of Total Asthma Medications
This should equate to > or = to 0.50

Overuse and Appropriateness Care

Antidepressant Medication Management (AMM)

Goal of the Measure

- Patients 18 years and older with a diagnosis of major depression should fill their prescription for antidepressant medication and remain on prescribed antidepressant medication.
- There are two components for this measure:
  - Effective Acute Phase: Patients should remain on antidepressant medication for at least 84 days *(This component is not in the QCPI measure set)*
  - **Effective Continuation Phase: Patients should remain on antidepressant medication for at least 180 days (six months)**

Measurement Period/Intake Period

May 1-April 30 (This is the data year when you're doing the work.) The measurement period is May 1, 2023-April 30, 2024.

Index Prescription Start Date (IPSD)

The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there's a Negative Medication History.

Negative Medication History

A period of 105 days prior to the IPSD when the patient had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.

ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM)

Identifying Compliance

Denominator (Eligible Population):

Meets all the following for AMM:

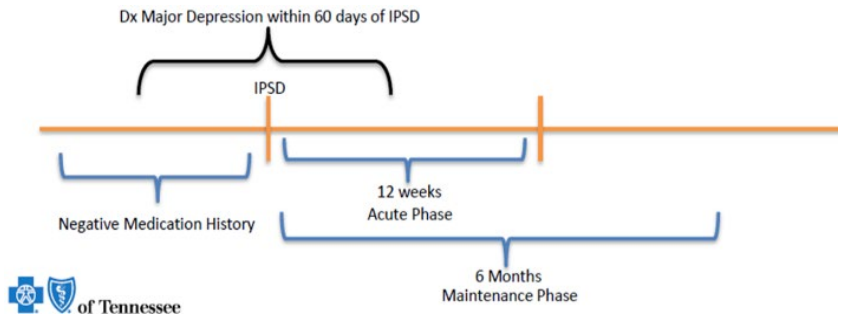
- 18 years and older as of April 30 of the measurement year
- Dispensed a prescription for antidepressant medication
- Diagnosed with major depression within 60 days prior to or after the IPSD (Can be from I/P, O/P, telehealth, ER, OBS, telephone visit, community mental health center)

Numerator for Compliance Phase:

- Patients who remained on an antidepressant medication for at least 180 days (within the 231 days following the IPSD).
- All patients who fulfill the quality criteria for the measure.

Exclusions:

- Patients who are in hospice or using hospice services
- Patients who died any time during the measurement year



If a patient misses filling the prescription by enough days to meet the requirements, the gap can't be closed.

All patients with medical and pharmacy coverage who satisfy all specified criteria; no mental health benefit is required.

Use of Imaging Studies for Low Back Pain (LBP)

Goal of the Measure

- Patients ages 18-75 years old with a diagnosis of uncomplicated low back pain (LBP) should wait 28 days or more from the primary diagnosis being given, before undergoing an imaging study (plain X-Ray, MRI, CT scan).

Helpful Tips

- Include documentation and coding, along with the diagnosis of LBP on the claim, for “red-flag” conditions (exclusions) where an imaging study should be ordered. This will prevent an open gap that can’t be closed. There’s a six-month review period for any primary diagnosis of LBP during that time.
- If this gap opens, it can’t be closed.

Documentation

Principle Diagnosis Uncomplicated back pain	**No Red Flags** (e.g. cancer, recent trauma, etc.)	Imaging Performed withing 28 days of diagnosis	Non-Compliant
Principle or Secondary Diagnosis Uncomplicated back pain	Positive for red flag exclusions	Imaging Performed	OK
Secondary Diagnosis Uncomplicated back pain		Imaging Performed	OK

Exclusions

- Cancer any time during a patient's history through 28 days after IESD (malignant neoplasms, other neoplasms, history of malignant neoplasm, other malignant neoplasms of skin)
- Recent trauma within 90 days
- Intravenous drug abuse
- Neurologic impairment
- Prolonged use of corticosteroids
- HIV
- Spinal infection
- Major organ transplant
- Hospice
- Osteoporosis
- Lumbar surgery
- Spondylopathy
- Fragility fractures
- Palliative care
- Advanced illness and frailty
- Patients who die any time during the measurement year

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

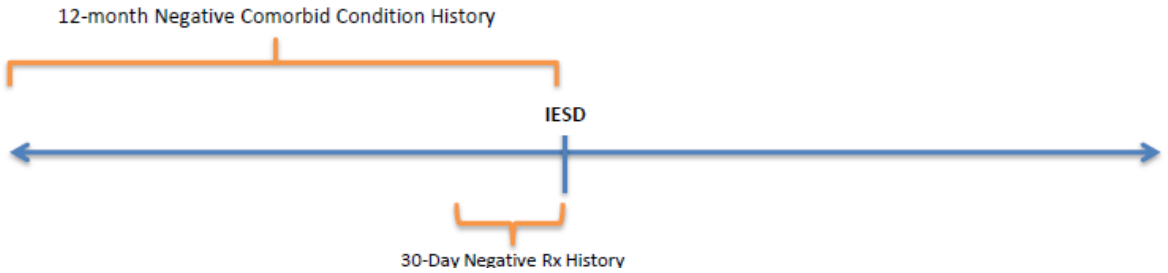
Goal of the Measure

- Patients 3 months and older with only a diagnosis of acute bronchitis/bronchiolitis shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies; or the patient continues to worsen three days after being diagnosed.
- Exclusions:
  - Patients in hospice
  - Patients with a diagnosis of comorbid conditions (claims within the past 12 months): HIV, malignant neoplasms, emphysema, chronic obstructive pulmonary disease, disorders of the immune system

Helpful Tips

- Requires negative medication history of 30 days prior to the episode date, negative comorbid condition history and negative competing condition history.
- Antibiotics may be appropriate if there's an existing comorbid condition (e.g., HIV, COPD, cancer, emphysema, etc.).
- Episodes can be through an outpatient visit, telephone visit, online assessment, OBS or ER.
- This is an off-cycle measure (July 1 to June 30).
- If the gap opens, it can't be closed.

Specifications and Compliance



Patients with a diagnosis of acute bronchitis can still be compliant when filling an antibiotic prescription if:

- The prescription is filled at day four or later **after** the date of diagnosis.
- The competing diagnosis/comorbid condition warranting antibiotic use is documented.

Important Note

Every episode counts, and patient compliance will be counted for every visit where acute bronchitis/bronchiolitis is diagnosed.

Appropriate Treatment for Upper Respiratory Infection (URI)

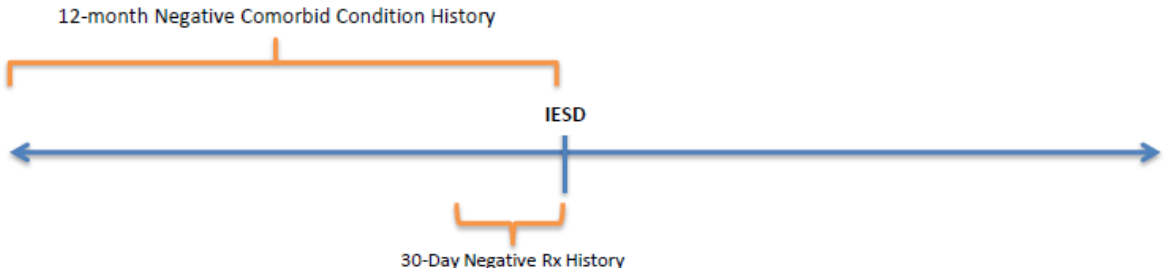
Goal of the Measure

- Patients 3 months and older with **only** an upper respiratory infection shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies, or the patient continues to worsen.
- Exclusions:
  - Patients in hospice
  - Patients with diagnosis of comorbid conditions (claims within the past 12 months): HIV, malignant neoplasms, emphysema, COPD, disorders of the immune system

Helpful Tips

- Requires negative medication history of 30 days prior to the episode date, negative comorbid condition history and negative competing condition history.
- Antibiotics may be appropriate if there's an existing comorbid condition (e.g., HIV, COPD, cancer, emphysema, etc.).
- Episodes can be through an outpatient visit, telephone visit, online assessment, OBS or ER.
- This is an off-cycle measure (July 1 to June 30).
- If the gap opens, it can't be closed.

Specifications and Compliance



Patients with a diagnosis of a URI can still be compliant when filling an antibiotic prescription if:

- The prescription is filled at day four or later **after** the date of diagnosis.
- The competing diagnosis/comorbid condition warranting antibiotic use is documented.

Important Note

Every episode counts, and patient compliance will be counted for every visit where URI is diagnosed.

Coding and documentation for either a noted bacterial infection or noted exclusion comorbidity along with the URI are important for this measure.

Appropriate Testing for Pharyngitis (CWP)

Goal of the Measure

- Patients ages 3 years and older should have a strep test completed if they're diagnosed with pharyngitis only and have received an antibiotic prescription.
- Exclusions:
  - Patients in hospice
  - Patients with a diagnosis of comorbid conditions (claims within the past 12 months): HIV, malignant neoplasms, emphysema, COPD, disorders of the immune system
  - Competing diagnosis exclusions — where patient had a claim/encounter with a competing diagnosis on or three days after the episode date

Helpful Tips

- A negative medication history of 30 days prior to the episode date, where the patient had no new or refill prescriptions for listed antibiotics or where an antibiotic was active on the episode date.
- Episodes can be through an outpatient visit, telephone visit, online assessment, OBS or ER.
- Compliance isn't based on strep test results if the test was performed.
- Documentation of the strep test is key for this measure.
- The group A strep test could be done from three days before, to three days after the episode date.
- If the gap opens, it can't be closed.
- The measurement period for this measure is July 1 of the prior year to June 30 of the current measurement year (July 1, 2023, to June 30, 2024).

Display and Bonus Only Measures

Display Only Measures

The following HEDIS Measures will be in Display Only Status in 2024:

- Custom Appropriate Testing for Pharyngitis (CWP-C)
- Custom Appropriate Treatment for Upper Respiratory Infection (URI-C)
- Custom Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-C)

These measures have been added into Display Only Status to give “real time” data to providers. The HEDIS measures have an “off-cycle” reporting date (July 1-June 30). This allows providers to have a more accurate reflection on the status of the measure throughout the year.

RACE/ETHNICITY DIVERSITY OF MEMBERSHIP (RDM)

Bonus only

An unduplicated count and percentage of patients enrolled any time during the measurement year, by race and ethnicity.

Reporting Categories for Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Some Other Race
- Two or More Races
- Asked But No Answer
- Unknown

Reporting Categories for Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Asked But No Answer

This will likely be captured through Clinical Data Exchange (CDE).

It's considered best practice to collect data directly from patients because this method reflects patients' self-identification

Tips and Best Practices

Tips and Best Practices

1. Closing measures with coding through claims or data exchange feeds, if applicable, is best.
2. Accurate coding is key to ensuring providers get credit for their quality work and patient gaps are closed.
3. It's important to make sure all diagnosis codes, procedure codes and applicable modifiers have been listed on the claim form.
4. You can find a list of the most common sample codes for gap closure in our 2024 Commercial Measures Guide.

Keys for Attestation

Submitting attestations within our Quality Care Rewards (QCR) application is another great option to close gaps in care. Please make sure to follow these guidelines when using the QCR:

- Never attest to a screening, visit or gap closure that hasn't occurred yet.
- Attestations should only be done after completing the care/screening or if an exclusion is met based on the patient's medical documentation.
- Include (upload) documented proof from the chart that what you're attesting to has already taken place.

TIPS AND BEST PRACTICES

General documentation errors that won't close gaps in care include:

1. Documentation of a patient's refusal of a test or screening
2. Documentation of "ordered" or "scheduled" test/screening
3. Documentation of patient "up-to-date" or "current"
4. Documentation that the patient was asked about immunizations
5. Documentation of where the test was done but no date or result
6. Documentation of results out of range for the measure
7. Re-entering the same attestation repeatedly

TIPS AND BEST PRACTICES

Attestation Dates

If you know the exact date of a screening or procedure, this date should be used:

- Example: Cervical cancer screening (CCS) performed on Jan. 4, 2024, showing negative result.
- Input the attestation for CCS with a date of service of Jan. 4, 2024.

If you don't know the exact date of the screening or procedure, but have physician-documented information/evidence it was done:

- Example 1: Physician documentation says, "Last colonoscopy was done in 2023." You could use Jan. 1, 2023.
- Example 2: Physician documentation says, "Mammogram done in October 2023." You could use the date Oct. 1, 2023.

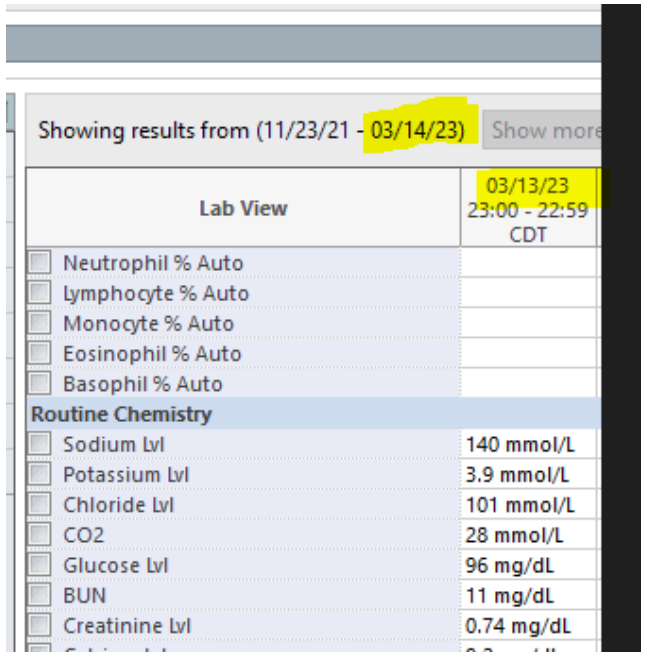
This **does not** apply to blood pressure readings or HbA1c levels.

There must be an exact date for these measures.

TIPS AND BEST PRACTICES

Example: The provider attested to a measure with a DOS of 3/14/23; however, the actual DOS is 3/13/2023. Was the provider correct?

- We should be using the Lab Reported date for attestations. If documentation is present in the medical record for both the “Lab Collected” and “Lab Reported” dates, use the “Lab Reported” date.



The only exception is if something was collected on one of the last days of the calendar year and not reported until January.

In that case, it would be a different measurement year so we would use the collected date.

FAQS

Q. Can I submit an attestation to close a gap in care if there's a doctor's order on file for the test without documentation of the result?
A. No, a documented date and result from when the test was completed is required to submit an attestation.

Q. Are charts audited by BlueCross to validate attestations made?
A. Yes, especially during our annual primary source verification audit.

Q. What should I do if I submit an attestation in error?
A. Notify us as soon as possible.

Q. Does a patient's refusal to get a screening or test exclude them from the HEDIS measure?
A. No. Refusal doesn't exclude a patient and the gap will remain open.

Q. How do I find out what exclusions are acceptable for certain measures?
A. Exclusions are very specific, and they're listed in the Commercial Measures Guide and in the QCR application for applicable measures. If you have questions, please contact one of our team patients to discuss.

Q. Do I need to submit documented proof of the exclusion I am attesting too?
A. Yes. It's always best to submit documented proof of anything that's submitted in the QCR application for closing a gap in care or excluding a patient from the attributed measure.

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Thank You