HEDIS® Quality Toolkit

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TABLE OF CONTENTS

Welcome 2
How to Use this Manual........ 3

Section 1: Partnering with McLaren Health Plan to Measure Quality

Pay for Transformation (P4T) Program Details........ 5
Additional PCP Incentives 8
How to Submit HEDIS Data to MHP 10
Avoid Missed Opportunities 11
How We Audit Supplemental Data 12
Glossary........ 13

Section 2: HEDIS Tips

Summary of Changes to HEDIS MY 2024........14
General HEDIS Tips to Improve Scores 16
HEDIS Tips by Measure
Avoidance of Antibiotic Treatment for Acute Bronchitis........ 17
Cardiac Rehabilitation........ 18
Antidepressant Medication Management........ 19
Appropriate Testing for Pharyngitis........ 20
Appropriate Treatment for URI........ 21
Breast Cancer Screening 22
Cervical Cancer Screening........ 23
Childhood Immunizations 24
Chlamydia Screening........ 24
Care for Older Adults........26
Colorectal Cancer Screening 25
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)........32
Glycemic Status Assessment for Patients with Diabetes (GSD)........34
Eye Exam for patients with Diabetes 35
Kidney Health Evaluation for Patients with Diabetes. 36
Blood Pressure Control for Patients with Diabetes 37
Controlling High Blood Pressure 45
Follow-up Care for Children Prescribed ADHD Medication 46
Follow-up After Hospitalization for Mental Illness 47
Immunizations for Adolescents 54
Lead Screening in Children........ 55
Low Back Pain 56
Oral Evaluation, Dental Services (OED)........ 38
Pharmacotherapy Management of COPD Exacerbation (PCE) 57
Postpartum Care 58
Prenatal Care Timeliness........ 59
Social Need Screening and Intervention (SNS-E)........
Spirometry Testing in COPD Assessment........ 40
Topical Fluoride for Children (TFC)........ 39
Transitions of Care........ 49
Weight Assessment & Counseling for Nutrition & Physical Activity........ 60
Well-Child Visits, First 30 Months of Life 61

Child and Adolescent Well-Care Visits 62
Asthma Medication Ratio 63
FAQs 64

WELCOME

Welcome to our Healthcare Effectiveness Data and Information Set (HEDIS®) provider manual. Developed by the National Committee for Quality Assurance (NCQA), HEDIS is a widely used set ofperformance measures in the managed care industry, and an essential tool in ensuring that your patients and our members are getting the best health care possible.

McLaren Health Plan, Inc. (MHP) has been operating as a Michigan-based, licensed health maintenance organization (HMO) since 1998. MHP was started to serve Michigan's Medicaid population. Through the years, we've added a second HMO, McLaren Health Plan Community (MHP Community) that offers commercial coverage to groups and individuals, as well as a Medicare Supplement plan and most recently, McLaren Medicare. Our third-party administrator, McLaren Health Advantage, offers administrative services for self-funded employer groups. Together, the three companies deliverhealth care benefits to more than 300,000 members. This manual applies to McLaren Health Plan, Inc. and MHP Community, and McLaren Medicare we will sometimes refer to the three companies collectively as "MHP."

Our mission is to provide quality health services to all families and individuals covered by McLaren Health Plan. In 2015, McLaren Health Plan, Inc. was awarded the right to operate in and service every county in the lower peninsula in the State of Michigan-the only provider-owned health plan to achieve this designation by the Michigan Department of Health and Human Services (MDHHS). In 2017, MHP Community was awarded the right to offer small groupand individual commercial plans in 64 counties and offer large group commercial plans in 63 counties. MHP has earned 15 Pinnacle Awards since 2013 from the Michigan Association of Health Plans, and both HMOs are accredited by the National Committee for Quality Assurance (NCQA).

We've designed this manual to clearly define MHP criteria for meeting HEDIS guidelines. We welcome your feedback and look forward to supporting your efforts to provide quality health care to your patients and our members. Please call Customer Service at 888-327-0671 (TTY: 711) if you have questions or if we can be of assistance.

HOW TO USE THIS MANUAL

This manual is comprised of two sections:

- Section 1: **Partnering with MHP to Measure Quality.** This section provides useful information on MHP's Primary Care Physician (PCP) Pay for Transformation (P4T) program, McLaren Health Plans Primary Care Incentive Program, and how to submit HEDIS data to MHP. We provide you with as much information as possible to understand MHP's guidelines on providing quality health care.

- Section 2: **Tips to Improve HEDIS Scores.** This section includes the description of eachHEDIS measure, the correct billing codes and tips to help you improve your HEDIS scores.The measures are in alphabetical order.

- Section 3: **CAHPS Tips**. This section includes useful information on the McLaren Health Plan's Consumer Assessment of Healthcare Providers and Systems (CAHPS) and accessibility standards.

- Section 4: **General Information**. This section includes helpful information such as contact information for various departments, Bright Futures schedule, Child and Adolescent Immunization Schedule, and Tobacco cessation information.

Section 1

Partnering with McLaren Health Plan, Inc. and MHP Community to Measure Quality

McLaren Health Plan
Primary Care
2024 Pay for Transformation Program

I. Introduction

McLaren Health Plan (MHP) is committed to providing high quality, cost effective health care to our membership. By establishing a Pay for Transformation (P4T) program, MHP builds a strong partnership with our contracted Primary Care Providers (PCPs) which results in improved access and care coordination of health care services for our members. The P4T program provides incentives that optimize transformation activities, care coordination and quality by recognizing the outstanding efforts of our PCPs. The ultimate goal of the program is to improve health care outcomes.

II. General Terms

A PCP can receive up to $2 per member per month (pmpm). This is awarded based on HMO membership as of the end of the calendar year. The actual award is subject to the following conditions for the measurement year:

A. The PCP must be contracted with MHP for at least six months of the measurement year <u>and</u> be contracted at the time of the payment.
B. The PCP must have an annual average of 50 members per month.
C. The PCP must be in an open acceptance status throughout the measurement year to be included in the P4T program.
D. To be eligible, members must be assigned with the PCP for six months of the year.
E. The PCP must participate in all PPO and HMO products.
F. Ninety percent of all claims during the measurement year must be submitted electronically.

III. Measures, Specifications, Performance Goals and Award

The following table describes the program's measures, specifications, goals and awards. Measures and awards are reviewed and goals are adjusted annually or sooner if warranted. Random audits of acceptance status will be performed throughout the measurement year.

A *Quick Reference Guide* is available that briefly explains the P4T program. The *Quick Reference Guide* displays the key elements of the program and is separate from this program description.

McLaren Health Plan
2024 Pay for Transformation Program
Quick Reference Guide

Measures (2022)	Specifications	2022 Goal	Award Per Member
Care Management and Care Coordination Activities	Reporting of care management and care coordination services provided through embedded care managers by submitting claims with the appropriate codes listed below: G9001; G9002; G9007; G9008; 98966; 98967; 98968; 98961; 98962; 99495; 99496; S0257; G0511; G0512; 99497; 99498; 99487; 99490 Services must be billed in accordance with CPT guidelines and limitations. This component has a two-part scoring system. Each measure will be scored and awarded separately. You do not need to achieve both components to receive an award for this measure.	PCP Office with embedded Care Managers provide services for: 1.At a minimum, 2% of assigned membership receive care management and care coordination services **AND/OR** 2. At a minimum, 3 codes per 100 member months	$.25 = Achieving or exceeding the 2% of membership receiving care management and care coordination services **AND/OR** $.25 = Achieving or exceeding the 3 codes submitted per 100 member months
Health Information Exchange/Health Information Technology Participation	Evidence of active participation in an HIE QO and provider's capability to receive admission, discharge and transfer (ADT) messages; Active Care Relationship Service (ACRS) enabling access to the Common Key Service; MiHIN Medication Reconciliation for the purpose of sharing patient medication information at multiple points of care; Quality Measure Information (QMI); and Health Provider Directory (HPD)	Documentation of the 5 key components of Statewide use cases	$.25
Achieved Primary Care Medical Home (PCMH) recognition	Through Physician Group Incentive Program (PGIP) or the National Committee for Quality Assurance (NCQA) or a like industry standard activity defined as extended hours and patient disease registry	Provide evidence of recognition and program/activity details if appropriate	$0.25
HEDIS Measure: Asthma Medication Ratio (AMR)	Achieve NCQA 75th percentile for assigned membership in the measure	69.67%	$0.50
HEDIS Measure: Adult Access to Preventive Care (AAP)	Achieve NCQA 75th percentile for assigned membership in the measure	80.86%	$0.50
Total Award Possible	Award based on pmpm at the end of calendar year membership, if all qualifying requirements per program detail are met by PCP		**$2**

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IV. Program Payment and Distribution

The program calculation and payments will be made as follows:

- Determine the score for each measure based on MHP specifications
- Compare against set goal for measurement year
- Calculate award pmpm for membership (Medicaid and Community) as of Dec. 31 of the measurement year

The payment schedule will be within six months of the end of the next measurement year. Payments will be made to the individual primary care provider, or as the physician group directs.

V. Contact Information

Please contact your Provider Relations Representative at **888-327-0671 (TTY: 711)** for full program details, including qualifying requirements and payment distribution.

Primary Care Physician Incentive Program 2024

McLaren Health Plan (MHP) is committed to providing high quality, cost-effective health care to our membership. By establishing a Primary Care Physician (PCP) Incentive Program, MHP builds a strong partnership with our contracted PCPs, resulting in improved access to health care services for our members.

The PCP Incentive Program, outlined below, provides incentives that optimize transformation activities, care coordination and quality by recognizing the outstanding efforts of our PCPS while improving health care outcomes.

Incentive Status	Line of Business	Program	Measure	Incentive	Reimbursement Methodology
Continued	Medicaid	Smoking Cessation	Complete smoking cessation with a member during the calendar year	99406 - $12 99407 - $20 (above Medicaid fee schedule)	At time of billed claim
Modified	Community and Medicaid	Pay for Transformation Program	Care Management/Care Coordination HIE Participation Asthma Medication Ratio and Adult Access to Preventative Care at NCQA 75th percentile PCMH recognition	$2 PMPM	Annual payout (within 6 months of the end of the measurement year)
Continued	Community and Medicaid	Diabetic Core Measures	Must complete 1 & 2 1. HbA1c test 2. eGFR & uACR Additional Opportunity 3. BP control below 140/90 4. A1c Control <8	$50 for completing test $25 for controlled BP $25 for controlled A1c	Annual payout (Within 4 months of the end of the measurement year)
Continued	Community and Medicaid	Healthy Child Immunization	Childhood Series Completion by 2nd birthday & Adolescent Immunization Series Completion by 13th Birthday	**CIS** Combo 3 $50 per child Combo 10 $100 per child **IMA** Combo 2 $50 per child	Annual payout (within 4 months of the end of the measurement year)
Continued	Medicaid	Club 101	Annual Well Child Visit up to age 14	Reimburse $101 (above Medicaid fee schedule)	At time of billed claim
Continued	Community and Medicaid	Cervical Cancer Screening	PAP & HPV test completed. Meet the NCQA 75th Percentile Standard Rate OR PAP & HPV test completed	Achiever $25 OR High Achiever $50	Within 4 months of the end of the measurement year

			Meet the NCQA 90th Percentile Standard Rate		
Continued	Medicaid	Lead Screening	Billed claim with CPT 36416 Billed claim with CPT 83655	$15 – 36416 $25 - 83655	At time of billed claim
Continued	Community and Medicaid	Chlamydia Screening	Chlamydia Screening incentive for female members ages 16-24	$25 per eligible member screened	Annual payout (within 4 months of the end of the measurement year)
Continued	Community and Medicaid	Breast Cancer Screening	Breast Cancer Screening incentive for female members ages 50-74	$50 per eligible member screened	Annual payout (within 4 months of the end of the measurement year)
Continued	Community and Medicaid	Weight Assessment and Counseling for Nutrition and Physical Activity	Claim submission of documented BMI percentile with counselingfor nutrition and physical activity	$15 ($5 for each component)	At time of billed claim
Continued	Medicaid	Developmental Screening	Members ages 0-3 with claim for developmental screening annually	$20	At time of billed claim

To assist PCPs with achieving the quality goals of the NCQA 75th and 90th percentiles, MHP will provide you with monthly *Gaps in Care* reports beginning April 2024. A Quick Reference Guide for the 2024 Pay for Transformation program and incentive flyers documenting the requirements of each quality incentive are included for your review.

Your Provider Relations Representative, Quality Outreach Representative, and our Quality Management team are here toassist you with any questions. Please call us at 888-327-0671 (TTY: 711).

Thank you for the quality care you deliver!

HOW TO SUBMIT HEDIS DATA TO MHP

Claims and Encounters

MHP prefers that you submit HEDIS information on a claim form (HCFA 1500 or UB04), an efficient and highly automated claims process that ensures prompt and appropriate payment foryour services. The *HEDIS Tips* section of this manual contains the appropriate CPT, HCPCS, LOINC, and diagnosis codes needed to bill for a particular measure.

Members with Other Primary Insurance

Many of our members have primary insurance coverage other than MHP, such as Medicare. Even though the claim is paid by the primary insurance carrier, MHP needs this secondary claimfor the P4T program and any other qualifying incentive. MHP accepts both electronic and paperclaims when a member has another primary insurance carrier.

Exclusions

Providers may submit supplemental data indicating exclusions for certain HEDIS measures. Examples include:

- Cervical cancer screening — member may have had a previous complete, radical or total hysterectomy. Please be specific in documentation about type of hysterectomy performed in order to be compliant
- Breast cancer screening — member may have had a previous bilateral mastectomy

To notify MHP of an exclusion, please fax the medical record documentation to **810-600-7985** or email records to **MHPoutreach@mclaren.org**. Identify the exclusion from a gap in care for the specific HEDIS measure. MHP will accept this information as supplemental data and buildexclusion databased for its HEDIS submission.

AVOID MISSED OPPORTUNITIES

Make Every Office Visit Count

Avoid missed opportunities by taking advantage of every MHP member office visit to provide awell-child visit, immunizations, lead testing and BMI calculations.

- A sports physical becomes a well-child visit by adding anticipatory guidance (e.g., safety,nutrition, health, social/behavior) to the sports physical's medical history and physical exam.
- A sick visit and well-child visit can be performed on the same day by adding a modifier-25 to the sick visit, and billing for the appropriate preventive visit. MHP will reimburse for bothservices.
- MHP will reimburse you for one well-child visit per calendar year for children 3 years oldand older. **You do not need to wait 12 months between the visits.**
- Remember, infants up to 15 months need at LEAST six well-child visits and by 30 monthsshould have received at least eight well-child visits.
- BMI percentiles are a calculation based on the child's height and weight and should be calculated at every office visit. Be sure to include counseling for nutrition and physical activity. All three elements are payable as a PCP incentive payment based on a billed claim.

HOW WE AUDIT SUPPLEMENTAL DATA

Auditing of Supplemental Data

Throughout the year, MHP conducts a HEDIS program audit of supplemental data provided by randomly selected network practices. To meet NCQA guidelines, MHP must ensure the supplemental data we receive reflects the highest degree of accuracy. Each audited practice is given a partial list of supplemental data provided to MHP during the year. Practices are requiredto return a copy of the medical record that documents the supplemental data. For example, if a HbA1c result has been supplied as supplemental data, the practice would submit a copy of the laboratory result as proof the service was rendered.

Procedure for the audit process:

- Audit notices are distributed either at on-site visits or by fax request.
- Providers are required to respond to the audit within two weeks of delivery date or specified timeframe. Failure to return results by the deadline may result in the plan notusing the supplemental data that was previously submitted.
- If a medical record is unavailable, audit results will be recalculated to determine a compliance score. A compliance score less than 95 percent accuracy will result in anadditional audit of medical records.
- Failure to reach a score of 95 percent or higher on the second audit will result inineligibility to submit supplemental data.

GLOSSARY

Below is a list of definitions used in this manual.

HEDIS
The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks.

Measure
A quantifiable clinical service provided to patients to assess how effectively the organization carries out specificquality functions or processes.

Administrative Data
Evidence of service taken from claims, encounters, lab or pharmacy data.

Supplemental Data
Evidence of service found from a data source other than claims, encounters, lab or pharmacy data. All supplemental data may be subject to audit.

Denominator
Entire health plan population that is eligible for the specific measure.

Numerator
Number of members compliant with the measure.

Exclusion
Member becomes ineligible and removed from the sample based on specific criteria (e.g., incorrect gender, age). Or member has received a medical procedure that removes them from the measure such as a total hysterectomy or double mastectomy.

Hybrid
Evidence of services taken from the patient's medical record.

Measurement Year (MY 24)
The year the health plan gathers data.

HEDIS Measure Key
The three letter acronym NCQA uses to identify a specific measure.

MCIR
The Michigan Care Improvement Registry is an electronic birth-to-death immunization registry available to private and public providers for the maintenance of immunization records.

NDC
The National Drug Code is a unique ten-digit number and serves as a product identifier for human drugs in commercial distribution. This number identifies the labeler, product and trade package size.

Payout
PCP Pay-for-Transformation bonus is available if you are a contracted provider with both McLaren Health Plan, Inc. and MHP Community.

Method of Measurement
Appropriate forms and methods of submitting data to MHP to get credit for a specific measure.

Summary of Changes to HEDIS MY 2024

New Measures:

- There are no new measures for HEDIS MY 2024

Retired Measures

- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- *Colorectal CA Screening (COL)
- *Follow-up Care for Children Prescribed ADHD Medication (ADD)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)*
- *Only the COL-E, ADD-E and APM-E measure will be reported

Revised Measures

- The former Hemoglobin A1c (HBA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD) to include a glucose management indicator with hemoglobin A1c.
- Glycemic Status Assessment for Patients with Diabetes, Blood Pressure Control for Patients with Diabetes, Eye Exam for Patients with Diabetes, Kidney Health Evaluation for Patients with Diabetes, Statin Therapy for Patients with Diabetes, Diabetes Monitoring for People with Diabetes and Schizophrenia, Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes now have a diabetes diagnosis requirement in the pharmacy method to differentiate inclusions of patients who take diabetes-related medications for reasons other than diabetes (e.g. weight loss).
- Race/Ethnicity Stratification expanded to include measures of: Follow-up After Emergency Department Visit for Mental Illness; Follow-up After Hospitalization for Mental Illness; Post-partum Depression Screening and Follow-up; Prenatal Depression Screening and Follow-up; Childhood Immunization Status; Cervical Cancer Screening; Prenatal Immunization Status; Kidney Health Evaluation for Patients with Diabetes; Eye Exam for Patients with Diabetes.

Section 2

HEDIS Tips

GENERAL HEDIS TIPS TO IMPROVE SCORES

Work with MHP. We are your partners in care and will assist you in improving your HEDIS scores.

Use HEDIS specific billing codes when appropriate. We have tip reference guides identifying what codes are needed for HEDIS.

Use HEDIS *Gaps in Care* list that MHP sends you to identify patients who have gaps in care. If a patient calls for a sick visit, see if there are other needed services (e.g., well-care visits, preventive care services). Keep the *Gaps in Care* list by the receptionist's phone so the appropriate amount of time can be scheduled for all gaps in care when patients call for a sick visit.

Use your MHP Outreach Representative to assist you in contacting your MHP patients to obtain these important preventive services. If you are interested in working with the Outreach team, please contact us at 888-327-0671, TTY:711.

Avoid missed opportunities. Many patients may not return to the office for preventive care, so make every visit count. Schedule follow-up visits before patients leave.

Improve office management processes and flow. Review and evaluate appointment hours, access and scheduling processes, billing, and office/patient flow. We can help streamline processes.

- Review the next day's schedule at the end of each day.
- Identify appointments where test results, equipment or specific employees are available for the visit tobe productive.
- Call patients 48 hours before their appointments to remind them about their appointment and anything they will need to bring. Ask them to make a commitment to be there. This will reduce no-showrates.
- Use non-physicians for items that can be delegated. Have staff prepare the room for items needed.
- Consider using an after visit summary to ensure patients understand what they need to do. Thisimproves the perception that there is good communication with the provider.

Take advantage of your Electronic Medical Records (EMR). If you have an EMR, try to build care gap alerts within the system.

HEDIS TIPS: AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS (AAB)

MEASURE DESCRIPTION

Evaluates members 3 months and older diagnosed with acute bronchitis/bronchiolitis who were **not dispensed** an antibiotic medication on or 3 days after the episode.

Note: Prescribing antibiotics for acute bronchitis is not indicated unless there is a co-morbid diagnosis or a bacterial infection (examples listed on the right).

Only about 10 percent of cases of acute bronchitis are due to a bacterial infection, so in most cases antibiotics will not help.

USING CORRECT BILLING CODES

Codes to Identify Acute Bronchitis

Description	ICD-10 Code
Acute bronchitis	J20.3 - J20.9, J21.0, J21.1, J21.8, J21.9

Codes to Identify Comorbid

Description	ICD-10 Code
Chronic bronchitis	J41.0, J41.1, J41.8, J42
Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9
Chronic airway obstruction	J44.0, J44.1, J44.9

Codes to Identify Competing

Description	ICD-10 Code
Acute sinusitis	J01.00, J01.01, J01.10, J01.11, J01.20, J01.21,J01.30, J01.31, J01.40, J01.41, J01.80, J01.81, J01.90, J01.91
Otitis media	H67.9, H67.1-H67.3, H66.10-H66.13, H66.20-H66.23, H66.40, H66.90-H66.93, H66.009, H66.019, H66.3X9, H66.3X1-H66.3X3
Acute pharyngitis or tonsillitis	J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91

How to Improve HEDIS Scores

- Educate patients on comfort measures without antibiotics (e.g., extra fluids and rest).
- Discuss realistic expectations for recovery time (e.g., cough can last for four weeks without being "abnormal").
- For patients insisting that an antibiotic be prescribed:
  - Give a brief explanation
  - Write a prescription for symptom relief instead of an antibiotic
  - Encourage follow-up in three days if symptoms do not get better
- Submit comorbid diagnosis codes if present on claim/encounter (see codes above).
- Submit competing diagnosis codes for bacterial infection if present on claim/encounter (see codes above).

HEDIS TIPS: CARDIAC REHABILIATION (CRE)

MEASURE DESCRIPTION

Members 18 years of age and older who attended cardiac rehabilitation following a qualifying cardiac event. Qualifying cardiac event could be myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/ replacement. Four rates are reported:

- Initiation: 2 or more sessions within 30 days
- Engagement 1: 12 or more sessions within 90 days
- Engagement 2: 24 or more sessions within 180 days
- Engagement 3: 36 or more sessions within 180 days

USING CORRECT BILLING

Codes to Identify Cardiac Rehabilitation

Description	CPT/HCPCS
Cardiac Rehabilitation visits	CPT: 93797, 93798 HCPCS: G0422, G0423, S9472

Make every office visit count.

How to Improve HEDIS

- Ensure timely referral and assist with setting up the initial appointment for a patient within the first 180 days from the cardiac event.
- Educate your patients on the importance of Cardiac Rehabilitation following a cardiac event
- Use Gaps in Care lists to identify patients who need visit Cardiac Rehabilitation.

HEDIS TIPS: ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM)

MEASURE DESCRIPTION

- The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.
- Effective Acute Phase Treatment.
  The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment.The percentage of newly diagnosed andtreated members who remained on an antidepressant medication for at least 180 days (six months).

USING CORRECT BILLING CODES

Codes to Identify Major Depression

Description	ICD-10 Code
Major depression	F32.0-F32.4, F32.9, F33.0-F33.3, F33.9, F33.41, F33.9

How to Improve HEDIS Scores

Educate your patients on how to take their antidepressant medications:

- How antidepressants work, benefits and how long they should be used
- Expected length of time to be on an antidepressant before starting to feel better
- Importance of continuing to take the medication even if they begin feeling better (for at least six months)
- Common side effects, how long the side effects may last and how to manage them
- What to do if there are questions or concerns

HEDIS TIPS: APPROPRIATE TESTING FOR PHARYNGITIS (CWP)

MEASURE DESCRIPTION

Members 3 years and older diagnosed with pharyngitis and dispensed an antibiotic should have received a Group A strep test.

USING CORRECT BILLING

Codes to Identify

Description	ICD-10 Code
Acute pharyngitis	J02.0, J02.8, J02.9
Acute tonsillitis	J03.00, J03.80, J03.81 J03.90, J03.91
Streptococcal sore throat	J02.0, J03.00, J03.01

Codes to Identify Strep

Description	CPT Codes
Strep test	87070, 87071, 87081, 87430, 87650-87652, 87880

How to Improve HEDIS Scores

- Perform a rapid strep test to throat culture to confirm diagnosis before prescribing antibiotics. Submit this test to MHP for payment, or as a record that you performed the test. Use the codes above.
- Clinical findings alone do not adequately distinguish strep vs. non-strep pharyngitis. Most “red throats” areviral and therefore should never treat empirically, even in people with a long history of strep. Their strep may have become resistant and needs a culture.
- Submit any co-morbid diagnosis codes that apply on claim/encounter.
- If rapid strep test and/or throat culture is negative, educate parents/caregivers that an antibiotic isnot necessary for viral infections.

HEDIS TIPS: APPROPRIATE TREATMENT FOR URI (URI)

MEASURE DESCRIPTION

Evaluates members 3 months of age and older diagnosed who were diagnosed with an URI and **were not** dispensed an antibiotic prescription.

Note: Claims/encounters with more than one diagnosis (e.g., competing diagnoses) are excluded from the measure.

USING CORRECT BILLING

Codes to Identify URI

Description	ICD-10 Code
Acute nasopharyngitis (common cold)	J00
URI	J06.0, J06.9

Codes to Identify Competing

Description	ICD-10 Code
Otitis media	H67.9, H67.1-H67.3, H66.10-H66.13, H66.20-H66.23, H66.40-H66.43, H66.90-H66.93, H66.009, H66.019, H66.3X9, H66.3X1-H66.3X3
Acute sinusitis	J01.00, J01.01, J01.10, J01.11, J01.20, J01.21, J01.30, J01.31, J01.40, J01.41, J01.80, J01.81, J01.90, J01.91
Chronic sinusitis	J32.8, J32.9
Pneumonia	J18.8, J18.9

How to Improve HEDIS Scores

- Do not prescribe an antibiotic for a URI diagnosis only.
- Submit any co-morbid/competing diagnosis codes that apply (examples listed in the “Codes to IdentifyCompeting Diagnoses” table above).
- Code and bill for all diagnoses based on patient assessment.
- Educate member on comfort measures (e.g., acetaminophen for fever, rest, extra fluids) and advise patientto call back if symptoms worsen (antibiotic can be prescribed, if necessary, after three days of initial diagnosis).
- You are encouraged to re-submit an encounter if you missed a second diagnosis code and you see a member on the Gaps in Care report published by MHP.

HEDIS TIPS: BREAST CANCER SCREENING (BCS-E)

MEASURE DESCRIPTION

Women 50-74 years of age who had one or more mammograms during the measurement year or the year prior to the measurement year.

Exclusions: Bilateral mastectomy or two unilateral mastectomies on different dates of service or members who use hospice services.

Note: Biopsies, breast ultrasounds and MRIs do not count because HEDIS does not consider them to be appropriate primary screening methods.

USING CORRECT BILLING

Codes to Identify

Description	ICD-10 Code
Breast cancer screening	**CPT:** 77061-77063, 77065-77067 **HCPCS:** G0202, G0204, G0206 **LOINC:** 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7

How to Improve HEDIS Scores

- Educate female patients about the importance of early detection and encourage testing.
- Use *Gaps in Care* list to identify patients in need of mammograms.
- Schedule a mammogram for the patient or send the patient a referral.
- Have a list of mammogram facilities available to share with the member.
- Follow-up with patients who are overdue for a mammogram and help resolve their barriers to getting screened.
- Engage members in discussion of their fears about mammograms, and let women know these tests areless uncomfortable and use less radiation than they did in the past.
- If the patient had a bilateral mastectomy or two unilateral mastectomies, document this in the medicalrecord and fax documentation of the exclusion to 810-600-7985 to close an existing gap in care.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.

HEDIS TIPS: CERVICAL CANCER SCREENING (CCS)

MEASURE DESCRIPTION

Women 21 – 64 years of age who received one or more Pap screenings to screen for cervical cancer during the measurement year or the two years prior.

Women 30 – 64 who received a Pap screening for cervical cancer and HPV screening during the measurement year or the four years prior.

Women 30-64 who received a high-risk HPV screening during the measurement year or the four years prior to the measurement year.

Exclusions: Women who had a hysterectomy with no residual cervix.

USING CORRECT BILLING CODES

Codes to Identify Cervical Cancer Screening

Description	CPT/HCPCS
Cervical Cytology	**CPT:** 88141 - 88143, 88147, 88148, 88150, 88152 - 88153, 88164 - 88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 **LOINC:** 10527-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
High Risk HPV test	**CPT:** 87624, 87625 **HCPCS:** G0476 **LOINC:** 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3

How to Improve HEDIS Scores

- Use *Gaps in Care* lists to identify women who need a Pap screening.
- Use a reminder/recall system (e.g., tickler file).
- Request results of Pap screenings be sent to you if done at OB-GYN visits.
- Document in the medical record if the patient had a hysterectomy with no residual cervix and fax documentation of the exclusion to 810-600-7985 to close an existing gap in care. Remembersynonyms- *total, complete, radical.*
- Don't miss opportunities (e.g., completing Pap tests during regularly-scheduled well-woman visits, sick visits, urine pregnancy tests, UTI and Chlamydia/STI screening).

HEDIS TIPS: CHILDHOOD IMMUNIZATIONS (CIS)

MEASURE DESCRIPTION

Children 2 years of age who had the following vaccines **on or before their second birthday:**

- 4 DTaP (diphtheria, tetanus and acellular pertussis)
- 3 IPV (polio)
- 1 MMR (measles, mumps, rubella)
- 3 HiB (H 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)
- 2 Flu (influenza)

USING CORRECT BILLING CODES

Codes to Identify Childhood Immunizations

Description	CPT Codes
DTaP	90697, 90698, 90700, 90723
IPV	90697, 90698, 90713, 90723
MMR	90707, 90710
Polio	90697, 90698, 90713, 90723
HiB	90644, 90647-90648, 90697, 90698, 90748
Hepatitis B	90697, 90723, 90740, 90744, 90747, 90748, G0010
VZV	90710, 90716
Pneumococcal Conjugate (PCV)	90670, G0009
Hepatitis A	90633
Rotavirus (two-dose schedule)	90681
Rotavirus (three-dose schedule)	90680
Influenza (Flu)	90655, 90657, , 90661, 90673, 90674, 90685-90689, 90756,G0008

How to Improve HEDIS Scores

- Use the Michigan Care Improvement Registry (MCIR).
- Use *Gaps in Care* lists to identify patients who need immunizations.
- Review a child's immunization record before every visit and administer needed vaccines.
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations (e.g., MMR causesautism - now completely disproven).
- Have a system for patient reminders.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- PCP Incentive available: MHP Community and McLaren Health Plan Inc. Medicaid – See page 8

HEDIS TIPS: CHLAMYDIA SCREENING (CHL)

MEASURE DESCRIPTION

Women 16 - 24 years of age who were identified as sexually active and who had at least one Chlamydia test during the measurement year.

USING CORRECT BILLING CODES

Codes to Identify Chlamydia Screening

Description	CPT Code
Chlamydia screening	87110, 87270, 87320, 87490-87492, 87810

How to Improve HEDIS Scores

- Perform Chlamydia screening every year on every 16 - 24 year old female identified as sexually active (use any visit opportunity).
- Add Chlamydia screening as a standard lab for women 16 - 24 years old. Use well-child exams and well-women exams for this purpose.
- Use *Gaps in Care* lists to identify patients who need Chlamydia screening.
- Ensure that you have an opportunity to speak with your adolescent female patients without their parent.
- Remember that Chlamydia screening can be performed through a urine test.
- Place Chlamydia swab next to Pap test or pregnancy detection materials.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- PCP Incentive available: MHP Community and McLaren Health Plan Inc. Medicaid – see page 8.

HEDIS TIPS: CARE FOR OLDER ADULTS (COA)

MEASURE DESCRIPTION

The Care for Older Adults Sub Measures evaluates adults 66 years of age and older who had each of the following during the measurement year:

- **Medication review** – Documentation of a complete medication review by a prescribing practitioner or clinical pharmacist during the measurement year.
- **Functional status assessment** – Documentation of a complete functional status assessment using a standardized functional status assessment tool and the date when the assessment was performed
- **Pain assessment –** Documentation of a complete pain assessment using a standardized pain assessment tool and the date when it was performed

Documentation in the medical record must include evidence of a medication review

Documentation in the medical record must contain evidence of a functional status assessment

Documentation in the medical record must contain evidence of a pain assessment

How to Improve HEDIS Scores

- Check your Gaps in Care Report to identify your patients with open opportunities

HEDIS TIPS: CARE FOR OLDER ADULTS (COA)
Medication Review

MEASURE DESCRIPTION

The Care for Older Adults -Medication Review measure evaluates Adults aged 66 years and older who had a medication review documented by a clinical pharmacist or a prescribing practitioner and documentation of a medication list in the medical record or transitional care management service in the measurement year.

USING CORRECT BILLING CODES

Description	Code Type	Code
Medication List	CPT II	1159* (must be billed with 1060F)
	HCPCS	G8427
Medication Review	CPT	90863, 99483, 99605, 99606
	CPT II	1160F
Transitional Care Management	CPT	99495, 99496

*CPT II code 1159F (medication documented) must be submitted with 1160F (review of all medications by a prescribing practitioner or clinical pharmacist documented) on the same date of service

How to Improve HEDIS Scores

- Check your Gaps in Care Report to identify your patients with open opportunities
- Medication lists must be included in the medical record AND the medication review must be completed by a prescribing practitioner or clinical pharmacist
- The medication list should include the medication names, dosages, and frequency/occurrence, OZTC medications and herbal and supplemental therapies
- A medication review can be completed during a office visit or telephone/e-visits if the clinician is a prescribing provider; a registered nurse can collect the list of current medications however there must be evidence that the appropriate provider reviewed the lest
- Medication review and medication list can be accepted as supplemental data.

HEDIS TIPS: CARE FOR OLDER ADULTS (COA) FUNCTIONAL STATUS ASSESSMENT

MEASURE DESCRIPTION

The Care for Older Adults- Functional Status Assessment measure evaluates older adults 66 years of age and older who had at least one documented functional status assessment (e.g. Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADLs) in the medical record in the measurement year that measures a patient's ability to perform activities of daily living and establishes a baseline in physical capacity. This assessment should be completed utilizing a standardized assessment tool.

USING CORRECT BILLING CODES

Description	Code Type	Code
Functional status assessment	CPT	99483
	CPT II	1170F
	HCPCS	G0438, G0439

Functional status assessment that takes place during a telephone visit, e-visit or virtual check-in meets compliance. Submit the appropriate CPT, CPTII or HCPCS code for the type of visit.

How to Improve HEDIS Scores

- Check your Gaps in Care Report to identify your patients with open opportunities
- A functional status assessment can be conducted in the office, telephone, e-visit or virtual check-in by a practitioner, registered nurses (RNs), licensed practical nurses (LPNs) and medical assistants for both preventative and sick visits.
- A functional status assessment done in an acute inpatient setting won't meet compliance
- A functional status assessment limited to an acute or single condition, event, or body system such as a lower leg or back won't meet compliance
- Preformatted templates containing a check box that ADLs and/or IADLs is acceptable
- Use EMR/EHR alerts for patients due for a functional status assessment. Incorporate as a standardized template within your EMR/EHR if applicable
- Functional status assessment documentation can be accepted as supplemental data, reducing the need for some chart review

Functional Status Assessment Documentation Types:

ADL: Assess at least 5 ADLs, and results documented in the patient's medical record during the measurement year:

- Dressing and undressing
- Eating
- Personal Hygiene
- Transferring (getting in and out of bed or chair)
- Using toilet
- Walking (ambulatory or functional mobility)

IADL: Assess for at least four areas with results documented in the medical record during the measurement year:

- Cooking or meal preparation
- Driving or using public transportation
- Grocery shopping
- Handling finances
- Home repair
- Laundry
- Taking medications
- Using the telephone

Functional Status Assessment: Using a standardized functional assessment tool to assess patient's ADLs with results documented in the patient's medical record during the measurement year, not limited to:

- Assessment of Living Skills and Resources (ALSAR)
- Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
- Bayer ADL (B-ADL) Scale
- Barthel Index
- Extended ADL (EADL) Scale
- Independent Living Scale (ILS)
- Katz Index of Independence in ADL
- Kenny Self-Care Evaluation
- Klein-Bell ADL Scale
- Kohlman Evaluation of Living Skills (KELS)
- Lawton & Brody's IADL scales
- Patient Reported Outcome Measurement Information System (PROMID) Global or Physical Function Scales
- SF-36

HEDIS TIPS: CARE FOR OLDER ADULTS (COA) PAIN ASSESSMENT

MEASURE DESCRIPTION

The Care for Older Adults- Pain Assessment measure evaluates older adults 66 years of age and older who had a documented pain assessment in the medical record in the measurement year that measures a patient's experience of pain.

USING CORRECT BILLING CODES

Description	Code Type	Code
Pain Assessment	CPT II	1125F, 1126F

How to Improve HEDIS Scores

- Check your Gaps in Care Report to identify your patients with open care opportunities
- Include documentation on the completion of a standardized pain assessment tool (such as 1-1- scale or faces scale) and/or documentation that the patient was assessed for pain
- As part of a service, a pain assessment can be performed telephonically by multidisciplinary care team patients such as registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, etc.
- Incorporate pain assessment as part of the standard vital sign process
- Incorporate pain assessment as a standardized template within your EMR/EHR if applicable
- Use EMR/EHR alerts for patients due for a pain assessment
- Pain assessment that takes pace during a telephone visit, e-visit or virtual check-in meets compliance. Submit the appropriate CPT or HCPCS code for the type of visit.
- Pain assessment documentation can be accepted as supplemental data

HEDIS TIPS: COLORECTAL CANCER SCREENING (COL-E)

MEASURE DESCRIPTION

Members 45 -75years of age who had one of the following screenings for colorectal cancer screening:

- FOBT with required numberof samples for each test every year; or
- Annual FIT test
- Flexible sigmoidoscopy in the past five years; or flexible sigmoidoscopy every 10 years with FIT every year; or
- Colonoscopy in the past 10 years; or
- FIT-DNA test in the past three years; or
- CT Colonography in the past five years.

USING CORRECT BILLING CODES

Codes to Identify Colorectal Cancer Screening

Description	Codes
FOBT	**CPT:** 82270, 82274 **HCPCS:** G0328
Flexible sigmoidoscopy	**CPT:** 45330 - 45335, 45337 , 45338, 45340-45342, 45346, 45347, 45349, 45350 **HCPCS:** G0104
Colonoscopy	**CPT:** 44388-44394, 44397, 45355, 44401-44408, 45378-45393, 45398 **HCPCS:** G0105, G0121
FIT DNA	**CPT:** 81528 **LOINC: 77353-1, 77354-9**
CT colonography	**CPT:** 74261-74263 **LOINC:** 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3

Codes to Identify Exclusions

Description	Codes
Colorectal cancer	**HCPCS:** G0213-G0215, G0231 **ICD-10:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total colectomy	**CPT:** 44150 - 44153, 44155 - 44158, 44210 - 44212

HEDIS TIPS: DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLECENTS AND ADULTS (DSF-E)

MEASURE DESCRIPTION

The Depression Screening and Follow-up for Adolescents and Adults measure assesses patients aged 12 years and older who were screened for clinical depression using a standardized tool and, if positive, received follow-up care within 30 days of a positive depression screen finding.

USE CORRECT BILLING CODES

Description	**Code Type**	**Codes**
Behavioral Health Encounter	CPT	90791, 90792, 90832, 90836-90839, 90845, 90847, 90849, 90853, 90865, 90867-90870, 9875, 90876, 90880, 90887, 99484, 99492, 99493
	HCPCS	G0155, G0176, G0177, G0409, G0410, G0411, G0511, G0512, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010, H2011-H2020, S0201, S9480, S9484, S9485
	UBREV	0900-0907, 0911-0917, 0919
Depression Case Management Encounter	CPT	99366, 99492-99494
	HCPCS	G0512, T1016, T1017, T2022, T2023
Follow-up Visit	CPT	98960-98962, 98966-98972, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99421-99423, 99441-99444, 99457, 99483
	HCPCS	G0071, G0463, G2010, G2012, G2061, G2062,G2063, G2250, G2251, G2252, T1015
	UBREV	0510, 0513, 0516, 0517, 0519, 0520, 1521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

USE CORRECT BILLING CODES

Description	Code Type	Code
Patient Health Questionnaire (PHQ9) total score reported	LOINC	44261-6
Geriatric Depression Scale (GDS) total	LOINC	48544-1
Geriatric Depression Scale (GDS) short version	LOINC	48543-3
Patient Health Questionnaire (PHQ2) total score reported	LOINC	55757-9
Edinburgh Postnatal Depression Scale (EPDS)	LOINC	71354-5
Total Score (M3)	LOINC	71777-7
PROMIS-29 Depression score T-score	LOINC	71965-8
Patient Health Questionnaire (PHQ9) modified for Teens total score	LOINC	89204-2
Center for Epidemiologic Studies Depression Scale-Revised total score (CESD-R)	LOINC	89205-9
Beck Depression Inventory Fast Screen total score (BDI)	LOINC	89211-7
Beck Depression Inventory II total score (BDI)	LOINC	89201-1
Clinically Useful Depression Outcome Scale- Total Score (CUDOS)	LOINC	90222-1

How to Improve HEDIS Scores

- Please be sure to include the assessment score/result to be compliant.

HEDIS TIPS: Glycemic Status Assessment for Patients with Diabetes (GSD)

MEASURE DESCRIPTION

Adults 18 -75 years of age with diabetes (type 1 and type 2) whose Hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c Control (<8.0%)
- HbA1c poor Control (>9.0%)

If your patient is on the diabetic list in error, please submit:

1. A statement indicating the patient is "not diabetic;" and
2. At least two labs drawn in the current measurement year showing normal values for HbA1c or fasting glucose tests.

Fax the information to: 810-600-7985

USING CORRECT BILLING CODES

Description	Codes
Codes to identify diabetes	**ICD-10:** E10, E11, E13
Codes to identify HbA1c tests	**CPT:** 83036, 83037
Codes to report HbA1c Results	**CPT II: HbA1c <7% 3044F**
	CPT II: HbA1c >=7 <8 3051F
	CPT II: HbA1c >= 8 <9 3052F
	CPT II: HbA1c >=9 3046F

How to Improve HEDIS Scores

- Review diabetes services needed at each office visit.
- Order labs prior to patient appointments.
- If point-of-care HbA1c tests are completed in office, helpful to bill for this; also ensure HbA1c results and date documented in chart.
- Adjust therapy to improve HbA1c levels; follow up with patients to monitor changes.
- Member reported or member taken HbA1c results can be reported in the medical record.
- Use *Gaps in Care* lists to identify patients who need diabetic services.
- MHP has a diabetes disease management program to which you can refer patients.
- Send your completed *Gaps in Care* lists to MHP via fax, 810-600-7985; PCP incentive available, see page 8.
- Send medical records to show completed services when unable to bill via fax, 810-600-7985.

HEDIS TIPS: Eye Exam for patients with Diabetes (EED)

MEASURE DESCRIPTION

Adults 18 -75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Eye exam (retinal or dilated) performed within the measurement year
- Negative retinal or dilated eye exam (negative for retinopathy) within the measure year or the year prior

If your patient is on the diabetic list in error, please submit:

1. A statement indicating the patient is "not diabetic;" and
2. At least two labs drawn in the current measurement year showing normal valuesfor HbAlC or fasting glucose tests.

Fax the information to: 8l0-600-7985

USING CORRECT BILLING CODES

Description	Codes
Codes to identify diabetes	**ICD-10:** E10, E11, E13
Diabetic Retinal eye exam (must be performed by optometrist or ophthalmologist)	**CPT:** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201. 92202 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 **HCPCS:** S0620, S0621, S3000, **CPT Category II:** 2022F - 2026F, 2033F, 3072F

How to Improve HEDIS

- A digital eye exam, remote imaging, and fundus photography can count as long as the results areread by an eye care professional (optometrist or ophthalmologist).
- Use *Gaps in Care* lists to identify patients whoneed diabetic services.
- MHP has a diabetes disease management program to which you can refer patients.
- Send your completed *Gaps in Care* lists to MHPvia fax to 810-600-7985.
- PCP incentive available. See page 8.
- Send medical records to show completed services when unable to bill to 810-600 7985.

HEDIS TIPS: KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

MEASURE DESCRIPTION

Patients age 18-85 who have diabetes (type 1 and 2) andreceived a kidney health evaluation duringthe measurement year. **Both services are needed:**

1. Estimated Glomerular Filtration Rate (eGFR) AND
2. Urine Albumin-creatinine ratio (uACR)

which includes both a quantitative urine albumin test and a urine creatinine test within 4 days.

USING CORRECT BILLING CODES

Description	Codes
eGFR	**CPT Code:** 80047, 80048, 80050, 80053, 80069, 82565
uACR	**CPT Code:** 82043, 82570

How to Improve HEDIS Scores

- Use correct billing codes
- Submit any exclusion information to McLaren Health Plan. Exclusions include Polycystic Ovarian Syndrome, Gestational Diabetes or Steroid-induced Diabetes.
- Use *Gaps in Care* list to identify patients who need eGFR and uACR.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- **Note: A urine dipstick does not count towards the KED measure**

HEDIS TIPS: BLOOD PRESSURE CONTROL FOR PAITENTS WITH DIABETES (BPD)

MEASURE DESCRIPTION

Adults 18 -75 years of age with diabetes (type 1 and type 2) and whose blood pressure (BP) is adequately controlled (<140/90) during the measurement year.

If your patient is on the diabetic list in error, please submit:

1. A statement indicating the patient is "not diabetic;" and
2. At least two labs drawn in the current measurement year showing normal values for HbAlC or fasting glucose tests.

Fax the information to: 8l0-600-7985

USING CORRECT BILLING CODES

Description	Codes
Codes to identify diabetes	**ICD-10:** E10, E11, E13
Diastolic less than 80	CPT II 3078F
Diastolic between 80-89	CPT II 3079F
Diastolic greater than/equal to 90	CPT II 3080F
Systolic less than 130	CPT II 3074F
Systolic between 130-139	CPT Ii 3075F
Systolic greater/equal to 140	CPT II 3077F

How to Improve HEDIS

- Take and document multiple blood pressure readings.
- Member reported or member taken blood pressures can be reported.
- Order labs prior to patient appointments.
- Adjust therapy to improve BP levels; follow-up with patients to monitor changes.
- Use *Gaps in Care* lists to identify patients whoneed diabetic services.
- MHP has a diabetes disease management program to which you can refer patients.
- Send your completed *Gaps in Care* lists to MHPvia fax to 810-600-7985.
- PCP incentive available. See page 8.
- Send medical records to show completed services when unable to bill to 810-600-7985

HEDIS TIPS: ORAL EVALUATION, DENTAL SERVICES (OED)

MEASURE DESCRIPTION

The Oral Evaluation, Dental Services measure evaluates patients 21 years of age and under who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

USING CORRECT BILLING CODES

Description	**Code Type**	**Code**
Oral Evaluation (billed by dental providers only)	CDT	D0120, D0145, D0150

How to Improve HEDIS

- Check your Gaps in Care Report to identify your patients with open care opportunities
- Document history of dental evaluation
- Encourage new patients to establish a dental home to ensure good routine oral healthcare and follow ups
- Educate patient and/or family members regarding the importance of dental/oral health
- Educate the patient and/or family regarding the importance of dental/oral referral
- Utilize other members of the care team (CHW) to help connect the patient and/or family with assistance in finding a dental home and/or overcoming barriers (transportation) to obtain services.

HEDIS TIPS: TOPICAL FLUORIDE FOR CHILDREN (TFC)

MEASURE DESCRIPTION

The Topical Fluoride for Children measure evaluates patients 1-4 years of age who received at least 2 fluoride varnish applications during the measurement year.

USING CORRECT BILLING CODES

Description	**Code Type**	**Code**
Application of Fluoride Varnish	CPT	99188
Application of Fluoride Varnish	CDT	D1206

How to Improve HEDIS Scores

- Check your Gaps in Care Report to identify your patients with open care opportunities
- American Academy of Pediatrics (AAP) recommends application of fluoride varnish at least once every 6 months, and preferably every 3 months, starting at tooth eruption
- Educate patient and/or family on the care and cleaning of teeth and mouth and how to prevent dental and gum disease.
- Provide caregiver instructions on varnish application and after care
- Educate patient and/or family members regarding the importance of dental/oral health
- PCPs should ask when the last dental appointment was during every well child visit
- Educate the patient and/or family regarding the importance of dental/oral referral
- Utilize other members of the care team (CHW) to help connect the patient and/or family with assistance in finding a dental home and/or overcoming barriers (transportation) to obtain services.

HEDIS TIPS: SOCIAL NEED SCREENING AND INTERVENTION (SNS-E)

MEASURE DESCRIPTION

The goal of this measure is to identify and address members' social determinants of health needs. This measure assesses members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

Six rates are reported for the SNS-E measure:

- Food screening for food insecurity
- Food intervention: Members received a corresponding intervention within 1 month of screening positive for food insecurity
- Housing screening for housing instability, homelessness or housing inadequacy
- Housing intervention: members received a corresponding intervention within 1 month of screening positive for housing insecurity
- Transportation screening: members who were screened for transportation insecurity
- Transportation intervention: members who received a corresponding intervention within 1 month of screening positive for transportation insecurity

USING CORRECT BILLING CODES

Description	Code Type	Codes
Food Insecurities	CPT	96156, 96160, 96161, 97802, 97803, 97804
	HCPCS	S5170, S9470
Homelessness	CPT	96156, 96160, 96161,
Housing Instability	CPT	96156, 96160, 96161
Inadequate Housing	CPT	96156, 96160, 96161
Transportation Insecurity	CPT	96156, 96160, 96161
Has lack of transportation kept you from medical appt's, meetings, work, or getting things needed for daily living? (CMS Assessment)	LOINC	101351-5
Housing Status	LOINC	71802-3
Within the past 12 months we worried whether our food would run out before we got money to buy more? (US FSS)		88122-7
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more (US FSS)	LOINC	88123-5
Food Insecurity Risk (HVS)	LOINC	88124-3

USING CORRECT BILLING CODES

Description	Code Type	Codes
Access to transportation/mobility status (CUBS)	LOINC	89569-8
Current level of confidence I can use public transportation (PROMIS)	LOINC	92358-1
Has lack of transportation kept you from medical appointments, meetings, work, or things getting needed for daily living?	LOINC	93030-5
Have you or any family members you live with been unable to get any of the following when it was really needed in the past year? (PRAPARE)	LOINC	93031-3
Are you worried about losing your housing? (PRAPARE)	LOINC	93033-9
Did you or others you live with eat smaller meals or skip meals because you didn't have money for food in the past 2 months? (WELLRx)	LOINC	93668-2
Are you homeless or worried that you might be in the future? (WELLRx)	LOINC	93669-0
Do you have trouble finding or paying for transportation? (WELLRx)	LOINC	93671-6

USING CORRECT BILLING CODES

Description	Code Type	Codes
In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food? (US FSS)	LOINC	95251-5
Food security status (US FSS)	LOINC	95264-8
Within the past 12 months the food we bought just didn't last and we didn't have money to get more Caregiver (UD FSS)	LOINC	95399-2
Within the past 12 months we worried whether our food would run out before we got money to buy more Caregiver (USFSS)	LOINC	95400-8
Always has enough food for family Caregiver	LOINC	96434-6
At risk of becoming homeless Caregiver	LOINC	96441-1
Problems with place where you live	LOINC	96778-6
Behind on rent or mortgage in past 12 months	LOINC	98976-4
Number of residential moves in past 12 months	LOINC	98977-2

USING CORRECT BILLING CODES

Description	Code Type	Codes
Homeless in past 12 months	LOINC	98978-0
You or your families' health is affected by environmental conditions at home	LOINC	99134-9
Environmental conditions in the home that affect you or your families' health	LOINC	99135-6
Worried about housing stability in the next 2 months	LOINC	99550-6
Went without healthcare due to lack of transportation in the last 12 months	LOINC	99553-0
Delayed medical due to distance or lack of transportation	LOINC	99594-4
At risk	LOINC	LA19952-3
Often true	LOINC	LA28397-0
Mold	LOINC	LA28580-1
My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured	LOINC	LA29232-8

USING CORRECT BILLING CODES

Description	Code Type	Codes
My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.	LOINC	LA29233-6
I have no access to transportation, public or private; may have car that is inoperable	LOINC	LA29234-4
I am not at all confident	LOINC	LA30024-6
I am a little confident	LOINC	LA30026-1
I am somewhat confident	LOINC	LA30027-9
Food	LOINC	LA30125-1
Yes, it has kept me from medical appts or from getting my medications	LOINC	LA30133-5
Yes, it has kept me from non-medical meetings, appts, work, or from getting things I need	LOINC	LA30134-3
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car or in a park	LOINC	LA30190-5
Low food security	LOINC	LA30985-8
Very low food security	LOINC	LA30986-9
I have a place to live today, but I am worried about losing it in the future	LOINC	LA30994-9
I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a care, abandoned building, bus or train	LOINC	LA31995-6

USING CORRECT BILLING CODES

Description	Code Type	Codes
Pests such as bugs, ants or mice	LOINC	LA31996-4
Lead paint or pipes	LOINC	LA31997-2
Lack of heat	LOINC	LA31998-0
Oven or stove not working	LOINC	LA31999-8
Smoke detectors missing or not working	LOINC	LA32000-4
Water leaks	LOINC	LA32001-2
Bug infestation	LOINC	LA32691-0
Lead paint/pipes	LOINC	LA32693-6
Inadequate heat	LOINC	LA32694-4
Non-functioning oven/stove	LOINC	LA32695-1
No or non-working smoke detectors	LOINC	LA32696-9
No	LOINC	LA32-8
Yes, it has kept me from medical appointments or getting medications	LOINC	LA33093-8
Yes	LOINC	LA33-6
Sometimes true	LOINC	LA6729-3

How to Improve HEDIS Scores

- Create a culture of health equity and utilize a team-based approach to assess and address SDOH within your practice.
- Screen your patients for social needs and identify local resources to address barriers
- Engage with your community to address the underlying drivers of health equities

HEDIS TIPS: CONTROLLING HIGH BLOOD PRESSURE (CBP)

MEASURE DESCRIPTION

Members 18 - 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year (the most recent BP is used).

Note: Members are included in the measure if they had at least two visits on different dates of service with a diagnosisof HTN during the measurement year or the year prior to the measurement year.

USING CORRECT BILLING CODES

Description	ICD-10 Code
Hypertension	I10

Codes to Identify Blood Pressure

Description	CPT II Code
Diastolic = 80-89	3079F
Diastolic >= 90	3080F
Diastolic < 80	3078F
Systolic >= 140	3077F
Systolic < 130	3074F
Systolic 130-139	3075F
History of kidney transplant	ICD-10 Z94.0

How to Improve HEDIS Scores

- Calibrate the sphygmomanometer annually.
- Select appropriately sized BP cuff.
- If the BP is high at the office visit (140/90 or greater), take it again (HEDIS allows us to use the lowest systolic and lowest diastolic readings in the same day) and often the second reading is lower.
- Do not round BP values up. If using an automated machine, record exact values.
- Review hypertensive medication history and patient compliance, and consider modifying treatment plans for uncontrolled blood pressure, as needed. Have the patient return in three months.
- MHP has pharmacists available to address medication issues.
- Member taken or reported BP readings can be reported.
- Use your *Gaps in Care* list to identify patients who need a BP reading

HEDIS TIPS: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD-E)

MEASURE DESCRIPTION

Members 6-12 years old, with a new prescription for an ADHD medication who had:

- Initiation Phase: At least one follow-up visit with practitioner with prescribing authority during the first 30 days
- Continuation and maintenance phase: remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

USING CORRECT BILLING CODES

Codes to Identify Follow-up Visits

Description	Codes
Or in Follow-up visits	**CPT:** 96150-96154, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 98960-98962, 98966-98968, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412,99441-99442, 99510, 99483, 99492-99494 **HCPS:** G0155, G0176, G0177, G0409, , G0463, G0512, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, , H2010- -H2020, , T1015 **UB Revenue:** 0510,0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0907, 0911, 0914-0917, 0919, 0982, 0983

Description	Codes		
Follow-up visits	**CPT:** 90845, 90847, 90849, 90853, 90875, 90876, 90791-90792, 90832-90834, 90836-90840	WITH	POS: 02, 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	POS: 52, 53

How to Improve HEDIS Scores

- When prescribing a new medication to your patient, be sure to schedule a follow-up visit within 30 days to assess how the medication is working. Schedule this visit while your patient is still in the office.
- Schedule two more visits in the nine months after the first 30 days, to continue to monitor your patient's progress.
- Use a phone visit for one of the visits after the first 30 days. This may help you and your patients if getting to an office visit is difficult (codes: 98966-98968, 99441-99443).
- NEVER continue these controlled substances without at least two visits per year (one telephonic) to evaluate a child's progress. If nothing else, you need to monitor the child's growth to make sure he or she is on the correct dosage.

HEDIS TIPS: FOLLOW-UP AFTER HOSPITALIZATIONFOR MENTAL ILLNESS (FUH)

MEASURE DESCRIPTION

Members 6 years of age and older who were hospitalized for treatment of selected mental health disorders or intentional self-harm diagnosis who had a follow up visit with a mental health provider (2 rates are reported):
1. Patient received follow-up within 30 days after discharge with a mental health provider
2. Patient received follow-up within 7 days after discharge with a mental health provider. (Note: The Follow-up visit must be on a different date than the discharge date)

USING CORRECT BILLING CODES

Description	Codes		
Follow-up Visits	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836-90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	**POS:** 02, 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	**POS:** 52, 53

Codes to identify follow-up visits (must be with mental health practitioner)

Description	Codes		
Follow-up Visits with mental health provider-visit setting unspecified	**CPT:** 90791, 90792, 90832, 90833, 90834, 90836-90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	**POS:** 02, 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	**POS:** 52, 53

Description	Codes
Follow-up Visits with Behavioral Health Outpatient	**CPT:** 98960-98962, 98966-98968, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99394, 99401-99404, 99411, 99412, 99483, 99492-99493 , 99510 **HCPS:** G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, HO036-H0037, H0039, H0040,H2000, H2010, HO2011,H2013-H2020, T1015 **UB:** 0510, 0513, 0515, 0516, 0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983

How to Improve HEDIS Scores

- Educate inpatient and outpatient providers about the measure and the clinical practice guidelines.
- Try to schedule the follow-up appointment before the patient leaves the hospital.
- Try to use plan case managers or care coordinators to set up appointment.
- Ensure accurate discharge dates, and document not only appointments scheduled, but appointments kept. Visits must be with a mental health practitioner.

HEDIS TIPS: TRANSITIONS OF CARE (TRC)

MEASURE DESCRIPTION

The **Transitions of Care measure** evaluates patients age 18 years of age and older with an acute and nonacute hospital discharge in the measurement year, who had the following:

- Notification of inpatient admission- Documentation of receipt notification of inpatient admission on the day of admission through 2 days after the admission (3 total days)
- Receipt of discharge information- Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days)
- Patient engagement after inpatient discharge- Documentation of the patient engagement (office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication reconciliation post-discharge-Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Note: Supplemental data is accepted for this measure.

How to Improve HEDIS Scores

- Review the MiHIN admission, discharge or transfer service report to identify all acute and nonacute inpatient admissions.
- Review the Daily Inpatient/Discharge Report from the hospitals, request a copy of the discharge summary and have staff schedule office follow-up visits or telehealth visits within one week to check progress and address any barriers to the discharge plan (i.e. prescriptions filled, DME delivered, etc.)

HEDIS TIPS: TRANSITIONS OF CARE (TRC)
Notification of Inpatient Admission

MEASURE DESCRIPTION

The **Transitions of Care Inpatient Notification** measure evaluates patients age 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Note: Administrative reporting is not available for this indicator- Medical record review only.

How to Improve HEDIS Scores

- Review the MiHIN admission, discharge or transfer service report to identify all acute and nonacute inpatient admissions.
- Review the Daily Inpatient/Discharge Report from the hospitals, request a copy of the discharge summary and have staff schedule office follow-up visits or telehealth visits within one week to check progress and address any barriers to the discharge plan (i.e. prescriptions filled, DME delivered, etc.)

HEDIS TIPS: TRANSITIONS OF CARE (TRC) Receipt of Discharge Information

MEASURE DESCRIPTION

The **Transitions of Care Receipt of Discharge Notification** measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a notification of inpatient admission documented the day of or 2 days after the admission (3 days total).

Note: Administrative reporting is not available for this indicator- Medical record review only.

How to Improve HEDIS Scores

- Review the MiHIN admission, discharge or transfer service report to identify all acute and nonacute inpatient admissions.
- Note: When using a shared EMR/EHR system, documentation of the "received date" in the EMR/EHR isn't required to meet criteria. Evidence that the information was filed in the EMR/EHR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 days total) meets criteria.

HEDIS TIPS: TRANSITIONS OF CARE (TRC) Patient Engagement After Inpatient Discharge

MEASURE DESCRIPTION

The **Transitions of Care Patient Engagement After Discharge** measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with documentation of patient engagement completed within 30 days of the inpatient discharge.

USING CORRECT BILLING CODES

Description	Code Type	Code
Outpatient Visits	CPT	99201-99205,99211-99215, 99241-99245,99341-99345,99347-99350,99385-99387,99395-99397,99401-99404,99411-99412,99429,99455,99456.99483
	HCPCS	G0402, G0438,G0439,G0463,T1015
	UBREV	0510-0517,0519-0523,0526-0529,0982,0983
E-Visit or Virtual Check-in	CPT	98969-98972,99421-99423,99444,99457,99458
	HCPCS	G0071,G2010,G2012,G2061-G2063,G2250-G2252
Telephone Visits	CPT	98966-98968,99441-99443
Transitional Care Management	CPT	99495,99496

How to Improve HEDIS Scores

- Review the MiHIN admission, discharge or transfer service report to identify all inpatient discharges.
- Use EMR/EHR alert reminders for follow-up appointments post discharge
- Patient engagement After Inpatient Discharge services provided during a telehealth visit meet the criteria.
- Progress notes for office visits within 30 days of an inpatient discharge can be accepted as supplemental data.

HEDIS TIPS: TRANSITIONS OF CARE (TRC)

Medication Reconciliation Post-Discharge

MEASURE DESCRIPTION

The **Transitions of Care Inpatient Notification** measure evaluates patients 18 years of age and older with an acute and nonacute inpatient hospital discharge in the measurement year with a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse on the date of discharge through 30 days after discharge (31 total days).

USING CORRECT BILLING CODES

Description	Code Type	Code
Medication Reconciliation Encounter	CPT	99483,99495,99496
Medication Reconciliation Intervention	CPT II	1111F

How to Improve HEDIS Scores

- Document evidence of medication reconciliation of discharge and current medications
- Discharge medication post-discharge does not require that the patient be present
- Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse
- Medication reconciliation must be completed within 30 days of discharge
- A medication list must be present in the medical record to fully comply with this measure
- Submit the appropriate CPT II codes for post-discharge medication reconciliation
- Medication reconciliation does not require the member to be present
- Progress notes for medication reconciliation can be accepted as supplemental data

HEDIS TIPS: IMMUNIZATIONS FOR ADOLESCENTS (IMA)

MEASURE DESCRIPTION

Children 13 years of age who received the following vaccines on or before turning 13 years old:

- one meningococcal vaccine
- one Tdap or one Td vaccine
- two or three Human Papillomavirus (HPV)

Note: HPV vaccination should be discussedas early as 9 years of age. For two dose vaccine, there must be at least 146 days between the first and second dose of the HPV vaccine.

USING CORRECT BILLING CODES

Codes to Identify Adolescent Immunizations

USING CORRECT BILLING CODES

Codes to Identify Adolescent Immunizations

Description	Codes
Meningococcal	**CPT:** 90619, 90733, 90734
Tdap	**CPT:** 90715
Human Papillomavirus (HPV)	**CPT:** 90649, 90650, 90651

How to Improve HEDIS Scores

- Use the Michigan Care Improvement Registry (MCIR).
- Use *Gaps in Care* lists to identify patients who need immunizations.
- Review missing vaccines with parents.
- Recommend immunizations to parents. Parents are more likely to agree with vaccinations when supported by the provider. Address common misconceptions about vaccinations.
- Train office staff to prep the chart in advance of the visit and identify overdue immunizations.
- Make every office visit count - take advantage of sick visits for catching up on needed vaccines. Institute a system for patient reminders.
- Ensure patient leaves office with a set appointment for the second and third dose of the HPV vaccine series.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- PCP Incentive available: MHP Community and McLaren Health Plan, Inc. Medicaid see page 8.

HEDIS TIPS: LEAD SCREENING IN CHILDREN (LSC)

MEASURE DESCRIPTION

Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

USING CORRECT BILLING

Codes to Identify Lead

Description	CPT Code
Lead tests	83655

How to Improve HEDIS Scores

- Make every visit count.
- Use *Gaps in Care* lists to identify patients who need lead screening.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to performlead testing.
- Consider a standing order for in-office lead testing.
- Educate parents about the dangers of lead poisoning and the importance of testing.
- Provide in-office testing (capillary). Contact MDHHS at 517-335-9639 for a CLINIC CODE and freetesting supplies. There is no charge for specimens submitted for Medicaid clients.
- Bill in-office testing where permitted by the State fee schedule and MHP policy.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- PCP Incentive available: McLaren Health Plan, Inc. Medicaid see page 8.

HEDIS TIPS: LOW BACK PAIN (LBP)

MEASURE DESCRIPTION

Members 18 - 75 years of age as of December 31 of the measurement year with a new primary diagnosis of low back pain in an outpatient or ED visit who did NOT have an x-ray, CT or MRI within 28 days of the primary diagnosis. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

USING CORRECT BILLING CODES

Codes to Identify Uncomplicated Low Back Pain

Description	ICD-10 Codes
Low back pain uncomplicated	M47.26,-M47.28, M47.816-M47.818, M47.896-M47.898, M48.06-M48.08, M51.16, M51.17, M51.26, M51.27,M51.36, M51.37, M51.86, M51.87, M53.2X6-M53.2X8, M53.3, M53.86-M53.88, M54.16- M54.18, M54.30-M54.32, M54.40-M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S133.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.92XS , S39.92XA, S39.92XD, S39.92XS

How to Improve HEDIS Scores

- Avoid ordering diagnostic studies within 30 days of a diagnosis of new-onset back pain in the absence of red flags (e.g., cancer, recent trauma, neurologic impairment or IV drug abuse).
- Provide patient education regarding comfort measures (e.g., pain relief, stretching exercisesand activity level).
- Use correct exclusion codes if applicable (e.g., cancer).
- Look for other reasons for visits for low back pain (e.g., depression, anxiety, narcotic dependency, psychosocial stressors.)

HEDIS TIPS: PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION (PCE)

MEASURE DESCRIPTION

Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between Jan. 1 through Nov. 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:

- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
- Dispensed a bronchodilator (or there was evidence of an active prescription)within 30 days of the event.

Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

USING CORRECT BILLING

Codes to Identify COPD

Description	ICD-10-CM Diagnosis
COPD	J41.0, J41.1, J41.8, J42, J43.0-J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9

How to Improve HEDIS Scores

- For patients who were hospitalized, schedule an office visit within seven days of discharge.
- Review medications prescribed upon discharge and prescribe appropriate medications.

HEDIS TIPS: POSTPARTUM CARE (PPC2)

MEASURE DESCRIPTION

Postpartum (PP) care visit to a PCP and OB-GYN and other prenatal care practitioners between 7 and 84 days after delivery.

A postpartum exam note should include the date and one of the following:

- Pelvic exam; or
- Weight, BP, breast and abdominal evaluation, incision check, screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders, breast feeding status incompatibility (ABO/Rh blood typing); or
- PP check, PP care, six-week check notation or pre-printed *Postpartum Care* form in which information was documented during the visit.

USING CORRECT BILLING

Codes to Identify Postpartum

Description	Codes
Postpartum visit	**CPT:** 57170, 58300, 59430, 99501 **CPT II:** 0503F **HCPCS:** G0101 **ICD-10-CM Diagnosis:** Z01.42, Z01.411, Z01.419, Z30.430, Z39.1, Z39.2
Postpartum bundled visits	**CPT:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

How to Improve HEDIS Scores

- Schedule your patient for a postpartum visit within 7 to 84 days from delivery.
- Provider incentive available - MHP Community and McLaren Health Plan, Inc. Medicaid, see page 8.

HEDIS TIPS: PRENATAL CARE - TIMELINESS (PPC1)

MEASURE DESCRIPTION

Prenatal care visit in the first trimester or within 42 days of enrollment.

Any visit to a PCP and OB-GYN and other prenatal care practitioner with one of these:

- Obstetric panel; or
- TORCH antibody panel; or
- Rubella antibody/titer with Rh incompatibility(ABO/Rh blood typing); or
- Ultrasound of pregnant uterus; or
- Pregnancy-related diagnosis code; or
- Documented LMP or EDD with either a completed obstetric history or risk assessment and counseling/education.

USING CORRECT BILLING CODES

Codes to Identify Prenatal Care Visits

Description	Codes
Prenatal Visits	**CPT:** 59400, 59425, 59426, 59510, 59610, 59618, **CPTII:** 0500F, 0501F, 0502F **HCPCS:** H1000-H1004 Or A pregnancy related diagnosis code with: **CPT:** 99201-99205, 99211-99215, 99241-99245, 99483 **HCPCS:** T1015, G0463
Telehealth Visits	**CPT:** 98966-98968, 99441-99443, 98969-98972, 99421-994444, 99457, 99458 **HCPCS:** G0071**,** G2010, G2012,G2061-G2063, G2250-G2252

How to Improve HEDIS Scores

- Schedule prenatal care visits starting in the first trimester or within 42 days of enrollment.
- Telehealth services can be offered if in-person visits aren't necessary.
- Ask front office staff to prioritize new pregnant patients and ensure prompt appointments for any patient calling for a pregnancy visit to make sure the appointment is in the first trimester or within 42 days of enrollment.
- Have a direct referral process to OB-GYN in place.
- MHP has a McLaren MOMs program to which you can refer patients. Call Customer Service at 888-327-0671, TTY:711 for information.
- Send pregnancy notification form to MHP.
- Provider incentive available - MHP Community and McLaren Health Plan, Inc. Medicaid, see page 8.

HEDIS TIPS: WEIGHT ASSESSMENT AND COUNSELING (WCC 1,2,3)

MEASURE DESCRIPTION

Children 3-17 years of age who had an outpatient visit with a primary care physician or OB-GYN and who had evidence of the following during the measurement year:

- BMI percentile documentation or BMI plotted on age appropriate growth chart (height, weight and BMI percentmust be documented)
- Counseling for nutrition
- Counseling for physical activity

USING CORRECT BILLING CODES

Codes to Identify BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity

Description	Codes
BMI percentile	**ICD-10:** Z68.51-Z68.54
Counseling for nutrition	**CPT:** 97802-97804 **ICDI0:** Z71.3 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470
Counseling for physical activity	**HCPCS:** S9451, G0447 **ICDIO:** Z02.5, Z71.82

How to Improve HEDIS Scores

- Use *Gaps in Care* lists to identify patients who need BMI percentile and counseling for nutrition on physical activity.
- Use appropriate HEDIS codes to avoid medicalrecord review.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits and sportsphysicals) to capture BMI percent, counsel on nutrition and physical activity.
- Place BMI charts near scales.
- When documenting BMI include:
  - » Height, weight and **BMI percentile**.
- When counseling for nutrition, document:
  - » Current nutrition behaviors (e.g., during the last 15 months meal patterns, eating and dieting habits). Example: drinks two percent milk.
- When counseling for physical activity document:
  - » Current physical activity behaviors (e.g., exercise routine, participation in sports activities and exam for sports participation).Example: Plays on baseball team.
  - » Weight or obesity counseling counts for both nutritional and physical counseling.
  - » While “cleared for sports” does not count, a sports physical does count.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- PCP Incentive available: MHP Community and McLaren Health Plan Inc. Medicaid, see page 8.

HEDIS TIPS: WELL-CHILD VISITS, FIRST 30 MONTHS OF LIFE (W30)

MEASURE DESCRIPTION

The percentage of children who had the following number of well-child visits with a PCP during the last 15 months:

1. Children who turned 15 months old during the measurement year and who had at least six or more well-child visits.

2. Children for age 15 – 30 months who turned 30 months during the measurement year who had two or more well visits

Well-child visits consist of:

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

USING CORRECT BILLING CODES

Codes to Identify Well-Child Visits

Description	Codes
Well-child visits	**CPT:** 99381-99385, 99391-99395 **ICD-10:**Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76,2, Z01.411 **HCPCS:** G0438**,** G0439, S0302, S0610, S0612, S0613

How to Improve HEDIS Scores

- Use *Gaps in Care* lists to identify patients who need well visits.
- Make every office visit count.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to providea well-child visit, immunizations, lead testing, developmental screening and BMI calculations.
- Visits must be with a PCP and assessment/treatment that are specific to an acute or chronic condition do not count towards this measure.
- Make day care physicals into well-care visits by performing the required services and submitting appropriate codes.
- Medical record needs to include the date when a health and developmental history and physical exam were performed and health education/anticipatory guidance was given.
- Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- PCP Incentive available for McLaren Health Plan, Inc. Medicaid (developmental screening andwell-child, starting at age 1), see page 8.

HEDIS TIPS: CHILD AND ADOLESCENT WELL-CARE VISIT (WCV)

MEASURE DESCRIPTION

Children Patients age 3- 21 years of age who had at least one or more comprehensive well-care visits with a PCP or an OB/GYN during the measurement year.

Well-care visits consists of:

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

USING CORRECT BILLING CODES

Codes to Identify Well-Child Visits

Description	Codes
Well-care visits	**CPT:** 99381-99385, 99391-99395, 99461 **HCPCS:** G0438, G0439, S0302, S0610, S0612, S0613 **ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2

How to Improve HEDIS Scores

- Use *Gaps in Care* lists to identify patients who need well-visits.
- Make every office visit count.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a well-child visit, immunizations, lead testing and BMI percent calculations.
- A sick visit and well-child visit can be performed on the same day by adding a modifier-25 to the sick visit, and billing for the appropriate preventive visit. MHP will reimburse for both services.
- Make sports/daycare physicals into well-care visits by performing the required services and submitting appropriate codes.
- Medical record needs to include the date when a health and developmental history and physical exam were performed and health education/anticipatory guidance was given.
- Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities.
- Send your completed *Gaps in Care* lists to MHP via fax to 810-600-7985.
- PCP Incentive available: McLaren Health Plan, Inc. Medicaid (developmental screening and well-child, ages 3-14), see page 8.

HEDIS TIPS: ASTHMA MEDICATION RATIO (AMR)

MEASURE DESCRIPTION

The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

USING CORRECT BILLING CODES

Codes to Identify Asthma

Description	ICD-10 Codes
Asthma	J45.21, J45.22, J45.30 - J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.991, J45.998

Asthma

Asthma Controller Medications

Description	Prescriptions
Antibody inhibitors	Omalizumab
Anti-interleukin-4	Dupilumab
Anti-interleukin-5	Benralizumab
Anti-interleukin-5	Mepolizumab
Anti-interleukin-5	Reslizumab
Inhaled steroid combinations	Budesonide-formoterol
Inhaled steroid combinations	Fluticasone-salmeterol
Inhaled steroid combinations	Fluticasone-vilanterol
Inhaled steroid combinations	Formoterol-mometasone
Inhaled corticosteroids	Beclomethasone Propionate
Inhaled corticosteroids	Budesonide
Inhaled corticosteroids	Ciclesonide
Inhaled corticosteroids	Flunisolide
Inhaled corticosteroids	Fluticasone
Inhaled corticosteroids	Mometasone
Leukotriene modifiers	Montelukast
Leukotriene modifiers	Zafirlukast
Leukotriene modifiers	Zileuton
Methylxanthines	Theophylline

Asthma Reliever Medications

Description	Prescriptions
Short-acting, inhaled beta-2 agonists	Albuterol
Short-acting, inhaled beta-2 agonists	Levalbuterol

Q: Does MHP have another mechanism to collect HEDIS data other than the claims system? **A:** Yes, MHP has the capability to collect medical records using the following methods:

- Fax medical record to 810-600-7985
- Michigan Childhood Immunization Registry (MCIR).
- Michigan Health Information Network (MIHIN) data exchange
- MDHHS Care Connect 360 (CC360) data exchange

Q: Our practice did a well-child exam on an infant. Why does this service continue to show up on my report as non-compliant? **A:** Newborns less than 15 months old need six well-child visits before they turn 15 months to be marked compliant. Or eight visits before they turn 30 months to be fully compliant.

Q: A member has changed their PCP and no longer sees our doctor, but still shows up on our *Gaps in Care* list. **How do we get this changed?**

A: The member should notify MHP Customer Service of the change, either by phone 888-327-0671 (TTY:711), or online at **McLarenHealthPlan.org**. Once notified, the member will be removed from your HEDIS missing services report. The HEDIS missing services report displays members who are assigned to a provider office as of the run date of the report.

Q: Our office sees MHP members who are assigned to a different office. Will we receive a P4T bonus for the service we performed?

A: The member must be assigned to the PCP for the PCP to get a P4T bonus payment. The best way to ensure the member is correctly assigned to a PCP is to call MHP when the member is in the office or by using the PCP change request form. Have the member sign and fax to MHP.

Q: Can the member change his or her PCP on the MHP website? Or McLaren CONNECT portal?

A: Yes. Members can change their doctor and request an ID card on the MHP website at **McLarenHealthPlan.org** or on McLaren CONNECT portal.

Q: The *Gaps in Care* list **still lists services we performed months ago. How can we get the gaps in care corrected?**

A: Give your MHP Outreach Coordinator a specific example of the issue so the problem can be properly investigated. Factors that may influence whether a service is removed from the Gaps in Care include:

- HEDIS guidelines for meeting compliance for a specific measure. To mark a member compliant, a specific diagnosis or CPT code must be billed. Even though the service was performed, if the claim does not reflect the specific diagnosis or CPT code, the member will remain non-compliant and continue to show up on your list.
- Lack of a secondary claim. For members who have other primary insurance, MHP must receive a secondary

Q: Is there a penalty for doctors who have patients who do not cooperate?

A: HEDIS standards make no distinction between non-compliant and uncooperative members, and there is no provision to remove an uncooperative member from the targeted population. Plans and providers are encouraged to work with these members to render the recommended services.

NOTES

888-327-0671 (TTY:711)

INDIVIDUAL
MEDICAID
MEDICARE

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