HEDIS® 101 for Providers
2018
Improving Quality of Care
<table>
<thead>
<tr>
<th>Outline</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIPAA</td>
<td>3</td>
</tr>
<tr>
<td>What is HEDIS?</td>
<td>4</td>
</tr>
<tr>
<td>What is your role in HEDIS?</td>
<td>6</td>
</tr>
<tr>
<td>Annual HEDIS Calendar</td>
<td>7</td>
</tr>
<tr>
<td>Types of Reviews</td>
<td>8</td>
</tr>
<tr>
<td>Medical Record Request</td>
<td>9</td>
</tr>
<tr>
<td>Hybrid &amp; Administrative HEDIS Measures</td>
<td>10-11</td>
</tr>
<tr>
<td>Questions &amp; Answers</td>
<td>12</td>
</tr>
<tr>
<td>Appendix 1 - Hybrid &amp; Administrative HEDIS Measures &amp; Required</td>
<td>13-44</td>
</tr>
<tr>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td>Appendix 2 – HEDIS Physician Documentation Guidelines &amp; Administrative Codes</td>
<td>45-46</td>
</tr>
<tr>
<td>Appendix 3 – Survey Data</td>
<td>47-52</td>
</tr>
</tbody>
</table>
**HIPAA**

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted and does not require patient consent or authorization. Please be assured our members’ personal health information is maintained in accordance with all federal and state laws. Data is reported collectively without individual identifiers. All of the health plans’ providers’ records are protected by this.

HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities.
What is HEDIS?

HEDIS (HĒ · DIS)

Healthcare

Effectiveness

Data and

Information

Set

- HEDIS is the measurement tool used by the nation’s health plans to evaluate their performance in terms of clinical quality and customer service.

- HEDIS is coordinated and administered by NCQA (National Committee for Quality Assurance) and used by Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations.

- All managed care companies which are NCQA accredited perform HEDIS reviews the same time each year.

- A subset of HEDIS measures will be collected and reported for the Marketplace (healthcare exchanges) product lines.

- HEDIS is a retrospective review of services and performance of care.
Receiving all requested medical records helps ensure that our results are an accurate reflection of care provided.

HEDIS results are audited by an independent, NCQA–certified auditor prior to being reported.

Results are used to measure performance, identify quality initiatives, and provide educational programs for providers and members.

Results are reported as part of Medicare Stars, NCQA Health Plan Ratings, and State and Marketplace Report Cards.
• You play a central role in promoting the health of our members
• You and your office staff can help facilitate the HEDIS process improvement by:
  • Providing the appropriate care within the designated timeframes
  • Documenting all care in the patient’s medical record
  • Accurately coding all claims. Providing accurate information on a claim may reduce the number of records requested
  • Responding to our requests for medical records within 5-7 business days

The records you provide during this process help us validate the quality of care provided to our members.
Annual HEDIS Calendar

Jan – May

• Clinical Quality Staff initiates Medical Record requests and collection from our Providers.

June

• Results are reported to NCQA

July - Oct

• NCQA releases Quality Compass® results nationwide
  • July – Commercial Edition
  • Sep/Oct – Medicaid and Medicare Editions

Each year NCQA sets a hard deadline in May for health plans to complete HEDIS data collection

“Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).”
Types of Reviews

HEDIS data is collected three ways:

• **Administrative Data**: Obtained from our claims database
• **Hybrid Data**: Obtained from our claims database and medical record reviews
• **Survey Data**: Obtained from member and provider surveys
Medical Record Requests

- Medical Record Requests are sent to providers
- The request includes a member list identifying their assigned measures and the minimum necessary information needed
- Data collection methods include: fax, mail, onsite visits for larger requests, remote electronic medical record (EMR) system access, and electronic data interchange via a secure site
- Due to the shortened data collection timeframe, a 5- to 7- business day turnaround is appreciated.

We recommend uploading records to our secure site to allow for better tracking of information submitted.
# Hybrid HEDIS Measures

<table>
<thead>
<tr>
<th>ABA</th>
<th>Adult Body Mass Index</th>
<th>IMA</th>
<th>Immunizations for Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC</td>
<td>Adolescent Preventive Care</td>
<td>LSC</td>
<td>Lead Screening in Children</td>
</tr>
<tr>
<td>AWC</td>
<td>Adolescent Well Care Visits</td>
<td>MRP</td>
<td>Medication Reconciliation Post-discharge (Medicare only)</td>
</tr>
<tr>
<td>CBP</td>
<td>Controlling High Blood Pressure</td>
<td>PPC</td>
<td>Prenatal and Postpartum Care</td>
</tr>
<tr>
<td>CCS</td>
<td>Cervical Cancer Screening</td>
<td>TRC</td>
<td>Transitions of Care (Medicare only)</td>
</tr>
<tr>
<td>CDC</td>
<td>Comprehensive Diabetes Care</td>
<td>WCC</td>
<td>Weight Assessment/Counseling for Nutrition &amp; Physical Activity for Children/Adolescents</td>
</tr>
<tr>
<td>CIS</td>
<td>Childhood Immunization Status</td>
<td>W15</td>
<td>Well Child Visits in the First 15 Months of Life</td>
</tr>
<tr>
<td>COA</td>
<td>Care of Older Adults (Medicare <em>SNP and MMP</em>*)</td>
<td>W34</td>
<td>Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life</td>
</tr>
<tr>
<td>COL</td>
<td>Colorectal Cancer Screening</td>
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</tbody>
</table>

*SNP = Special Needs Population  
** MMP = Medicare-Medicaid Programs
# Administrative HEDIS Measures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAB</td>
<td>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</td>
<td>IET</td>
<td>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment</td>
</tr>
<tr>
<td>ADD</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication</td>
<td>LBP</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td>AMM</td>
<td>Antidepressant Medication Management</td>
<td>MMA</td>
<td>Medication Management for People with Asthma</td>
</tr>
<tr>
<td>BCS</td>
<td>Breast Cancer Screening</td>
<td>SSD</td>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications</td>
</tr>
<tr>
<td>FUH</td>
<td>Follow-Up after Hospitalization for Mental Illness</td>
<td></td>
<td></td>
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<tr>
<td>Questions &amp; Answers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---------------------</td>
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</tr>
</tbody>
</table>
| **Should you send the entire record?**  
No, we ask that you only provide the minimum necessary to meet our request. |
| **Who do I contact if I have questions about HEDIS requests?**  
Each medical record request includes contact information for a HEDIS Lead in Clinical Quality who is assigned to your office. |
| **How to improve scores for HEDIS measures?**  
Use of correct diagnosis and procedure codes, timely submission of claims and encounter data, ensure presence of **ALL** components required in the medical record documentation. |
| **How are HEDIS rates communicated to physicians?**  
Educational articles are included in provider newsletters, which can be found on the health plan’s website. |
| **Where can I get more information about NCQA and HEDIS?**  
More information can be found at [www.ncqa.org](http://www.ncqa.org) |
Appendix 1

HEDIS Hybrid and Administrative Measures and Required Documentation
HEDIS Hybrid Measures & Required Documentation
ABA – Adult BMI Assessment*

Members age 18-74 who had an outpatient visit with a BMI documented during the measurement year or the year prior

*Medicare
Medicaid
Commercial

Documentation needed:
1. **BMI (body mass index):** Date and Value
2. **Weight:** Date and Value
   - A height, weight & BMI percentile must be recorded for patients who are age 18-19 on the date of visit

Common Chart Deficiencies:
- Height and/or weight are documented but there is no calculation of the BMI
- Ranges and thresholds are not acceptable for this measure. A distinct BMI value or percentile is required
APC – Adolescent Preventive Care*

Adolescents ages 12 to 17 who had at least one outpatient visit with a PCP or OB/GYN practitioner & required documentation during the measurement year.

*NY Quality Assurance Reporting Requirements (QARR)

Documentation needed:

Documentation in 2017 for the assessment or counseling or education on:

1. Risk behaviors associated with sexual activity and preventative actions
2. Assessment for depression
3. Risks of tobacco use
4. Risk of substance abuse (including alcohol)

Common Chart Deficiencies:

- No documentation in chart
- Not all items addressed during office visit
Members 12-21 years old in the measurement year who have had at least ONE “Well Care” visit with a PCP or OB/GYN (school physical, pap, post partum visit) during the measurement year

*Medicaid & Commercial

Services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure

Documented needed:
- Health history
- Physical developmental history
- Mental developmental history
- Physical exam
- Health education/anticipatory guidance

Preventive services may be rendered on visits other than well-child visits.

Common Chart Deficiencies:
- Lack of documentation of education and anticipatory guidance
- Adolescents being seen for sick visits only and no documentation related to well-child visits
CBP – Controlling High Blood Pressure*

Members 18-85 years old with diagnosis of Hypertension before July 1st of the measurement year

*Medicare Medicaid Commercial

Documentation needed:
1. Date of Hypertension diagnosis before July 1st of the measurement year
2. Last BP Reading (date and result) in the measurement year

Diagnosis can be from progress note, problem list, consult note, hospital admission or discharge

Common Chart Deficiencies:
- Rechecked elevated pressures during the same visit not documented
- Diagnosis date of Hypertension is not clearly documented
CCS – Cervical Cancer Screening*

Female members 24-64 who had cervical cancer screening during the measurement timeframe –or–

Female members ages 30-64 during the measurement timeframe who had cervical cancer screening and HPV test

*Commercial & Medicaid

Documentation needed:
• Date and result of cervical cancer screening test –or–
• Date and result of cervical cancer screening test and date of HPV test on the same date of service –or–
• Evidence of hysterectomy with no residual cervix

Common Chart Deficiencies:
• Lack of documentation related to women’s health in PCP charts
• Incomplete documentation related to hysterectomy
• HPV’s ordered due to positive PAP’s do not count

*Commercial & Medicaid
**Documentation needed:**

1. Hemoglobin A1C*
2. Blood Pressure*
3. Nephropathy: Urine Tests, ACE/ARB prescription, or visits to nephrologists during the measurement year
4. Retinal Eye Exam (during the measurement year or year prior)

**Common Chart Deficiencies:**

- Incomplete information from consultants in the PCP charts
- Incomplete information related to yearly lab testing and results

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**CDC – Comprehensive Diabetes Care**

Members 18-75 with Type I and II Diabetes who received proper testing and care for diabetes during the measurement year

*Medicare
Medicaid
Commercial
CIS – Childhood Immunization Status*

Percentage of children 2 years of age who had all of the required immunizations

*Medicaid & Commercial

**Documentation needed:**

<table>
<thead>
<tr>
<th>4 each:</th>
<th>DTaP, PCV (Pneumococcal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 each:</td>
<td>Hep B, HIB, IPV</td>
</tr>
<tr>
<td>2 or 3</td>
<td>Rotarix = 2 dose</td>
</tr>
<tr>
<td>Rotavirus/RV</td>
<td>Rota Teq = 3 dose</td>
</tr>
<tr>
<td>2 each:</td>
<td>Influenza</td>
</tr>
<tr>
<td>1 each:</td>
<td>Hep A, MMR, VZV or had chickenpox</td>
</tr>
</tbody>
</table>

**Please include this documentation if any immunizations are missing:**

- Parental refusal
- Request for delayed immunization schedules
- Immunizations given at health departments
- Immunizations given in the hospital at birth
- Contraindications or allergies
CIS – Childhood Immunization Status

Percentage of children 2 years of age who had all of the required immunizations

Common Chart Deficiencies:
• Immunizations received after the 2\textsuperscript{nd} birthday
• Incomplete number of vaccines administered according to the recommended vaccine series
• PCP charts do not contain immunization records if received elsewhere
  • Health Departments
  • Immunizations that are given in the hospital at birth
• No documentation of contraindications/allergies
COA –  
Care of Older Adults*

The percentage of adults 66+ years who had each of the following during the measurement year.

*Medicare SNP
Medicare-Medicaid Programs (MMP)

Documentation needed:

1. Advance care planning
   Includes a discussion about preferences for resuscitation, life sustaining treatment and end of life care. Examples include:
   - Advance Directives
   - Actionable Medical Orders
   - Living Will

2. Medication review
   Includes at least one medication review conducted by a prescribing practitioner or clinical pharmacist in the measurement year and the presence of a medication list or includes notation that the member is not taking any medication.
3. Functional status assessment
Includes evidence of at least one functional status assessment and the date it was performed as documented by:
• Instrumental Activity of Daily Living (IADL) – or –
• Activities of Daily Living (ADL) – or –
• Results of a standardized functional status assessment tool – or –
• Notation that at least 3 of the 4 following were assessed: notation of functional independence, sensory ability, cognitive status, and ambulatory status

4. Pain assessment
Includes evidence of a pain assessment using a standardized pain assessment tool and the date it was performed
COL - Colorectal Cancer Screening*

Members age 50-75 who had appropriate screening for colorectal cancer

*Medicare Commercial

Documentation needed:
Date and result of one of these screenings:
- Colonoscopy (within last 10 years)
- FOBT (in measurement year)
  - FOBT tests performed in an office setting or on a DRE do not count
- Flexible Sigmoidoscopy (within last 5 years)
- CT Colonography (within last 5 years)
- FIT-DNA (aka Cologuard) test (within last 3 years)

Patient reported data noted on a medical record is sufficient evidence with date and results noted.

Common Chart Deficiencies:
- Colorectal screenings are not consistently documented in health histories
- Typically this information is included on health history forms; however, this information is not always provided as part of the record submissions.
IMA - Immunizations for Adolescents*

Adolescent members turning 13 in the measurement year who had these immunizations

*Medicaid & Commercial

Documentation needed:

1. **Meningococcal**: 1 dose on or between 11th & 13th birthdays
2. **Tdap**: 1 dose on or between 10th & 13th birthdays
3. **HPV**: 2-dose or 3-dose vaccine series administered between 9th & 13th birthdays

If immunizations are missing please include:
- Documentation of parental refusal
- Health Department records
- Patient Contraindications/allergies

Common Chart Deficiencies:

- Immunizations not administered during appropriate timeframes
- PCP charts do not contain immunization records if received elsewhere, i.e. Health Departments
LSC – Lead Screening in Children*

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

*Medicaid/ NY QARR

Documentation needed:

- A note indicating the date the test was performed, and
- The result or finding

Common Chart Deficiencies:

- Lead assessment does not constitute a lead screening
- Testing conducted outside of time frame
- MD assumes that there is no exposure due to environment
Documentation needed:

- Medication reconciliation completed by the prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.
- Need documentation that it was completed and the date that it was done.

Any of the following evidence meets criteria:

- Notation that the medications prescribed upon discharge were reconciled with the current medications in the outpatient record
- A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications
- Notation that no medications were prescribed or ordered upon discharge
- Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review

*Medicare

The percentage of discharges from 1/1 – 12/1 of the measurement year for members 18+ for whom medications were reconciled on or within 30 days of discharge.

MRP – Medication Reconciliation Post-Discharge*

*Medicare
PPC - Prenatal and Postpartum Care*

Female members who had a live birth between November 6 of the year prior and November 5 of the measurement year

*Medicaid & Commercial

Documentation needed:

1. **Prenatal Care:** Prenatal visit within 42 days of enrollment or during the first trimester

2. **Postpartum Care:**
   Postpartum visit within 21-56 days of delivery

Common Chart Deficiencies:
- Incision check for post C-section alone does not constitute a postpartum visit
- Office visit outside of time frame
TRC-Transitions of Care*

The percentage of discharges for members 18 years of age and older who had each of the following during the measurement year. Four rates are reported:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement after Inpatient Discharge
- Medication Reconciliation Post-Discharge

*Medicare (New measure for 2018)

Documentation needed:

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day
- Documentation of receipt of discharge information on the day of discharge or the following day
- Documentation of patient engagement after inpatient discharge (e.g. office visits, home visits, telehealth) provided within 30 days after discharge
- Documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 31 days after discharge

*Medicare (New measure for 2018)
WCC — Weight Assessment & Counseling for Nutrition & Physical Activity for Children / Adolescents*

Members age 3-17 who had an outpatient visit with the following components in the measurement year

*Medicaid & Commercial

Documentation needed:

1. **BMI (body mass index) Percentile**
   - BMI Percentile and date
   - BMI values, ranges and thresholds do not meet the criteria for this measure
   - Weight and date
   - Height and date

2. **Counseling for Nutrition**
   Discussion on diet and nutrition, anticipatory guidance or counseling on nutrition

3. **Counseling for Physical Activity**
   Discussion of current physical activities, counseling for increased activity, or anticipatory guidance on physical activity
Common Chart Deficiencies:

• BMI documented as number not percentile based on height, weight, age and gender
• BMI growth chart not included in records submitted
• Anticipatory guidance does not always specify what areas were addressed and are not always age appropriate
• Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations
• Developmental milestones do not constitute anticipatory guidance or education for physical activity
• Preprinted forms do not always address nutrition and physical activity

WCC — Weight Assessment & Counseling for Nutrition & Physical Activity for Children / Adolescents

Members age 3-17 who had an outpatient visit with the following components in the measurement year
W15 – Well Child Visits in the First 15 Months of Life*

Services **specific** to the assessment or treatment of an **acute** or **chronic** condition do **not** count toward the measure

Children who turned 15 months of age during the measurement year who had 6 or more well-child visits

*Medicaid & Commercial

**Documentation needed:**
1. Health history
2. Physical developmental history
3. Mental developmental history
4. Physical exam
5. Health education/anticipatory guidance

**Preventive services may be rendered on visits other than well-child visits.**

**Common Chart Deficiencies:**
- Lack of documentation of education and anticipatory guidance
- Children being seen for sick visits only and no documentation related to well-child visits
W34 – Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life*

Services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure

Children 3-6 years old in the measurement year that have had at least ONE “Well Care” visit with a PCP during the measurement year

*Medicaid & Commercial

Documentation needed:
1. Health history
2. Physical developmental history
3. Mental developmental history
4. Physical exam
5. Health education/anticipatory guidance

Preventive services may be rendered on visits other than well-child visits.

Common Chart Deficiencies:
• Lack of documentation of education and anticipatory guidance
• Children being seen for sick visits only and no documentation related to well-child visits
HEDIS Administrative Measures
### AAB – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were *not* dispensed an antibiotic prescription

*Medicaid & Commercial

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Dispensed prescription for antibiotic medications (listed in the HEDIS 2018 Medication list) on or three days after the IESD (index episode start date).

**Intake Period:** January 1–December 24 of the measurement year. The Intake Period captures eligible episodes of treatment.

**Episode Date:** The date of service for any outpatient or ED visit during the Intake Period with a diagnosis of acute bronchitis.

- This measure is reported as an inverted rate. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were *not* prescribed).
Two rates are reported:

- **Effective Acute Phase Treatment:** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

- **Effective Continuation Phase Treatment:** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

**AMM – Antidepressant Medication Management***

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

*Medicare
Medicaid
Commercial
Two rates are reported:

**Initiation Phase**: Received at least one follow-up visit with a practitioner with prescribing authority within 30 days of RX.

**Continuation & 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 between 31 and 270 days (9 months) with a practitioner with prescribing authority.

The percentage of children ages 6 – 12 who received an initial prescription for ADHD medication and had a least three follow-up visits within a 10 month period.

*Medicaid & Commercial*
**BCS – Breast Cancer Screening**

The percentage of women 50-74 years of age who had one or more mammograms any time on or between October 1, 2015 and December 31, 2017.

* *Medicare
Medicaid
Commercial*
Two rates are reported:

1 - The percentage of discharges for which the member received follow-up within 30 days of discharge

2 - The percentage of discharges for which the member received follow-up within 7 days of discharge

Do not include visits that occur on the date of discharge.

*Medicare
Medicaid
Commercial
IET – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*

Members 13 years and older as of December 31 of the measurement year.

*Medicare Medicaid Commercial

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- **Initiation of AOD Treatment** - the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.

- **Engagement of AOD Treatment** - the percentage of members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.
LBP – Use of Imaging Studies for Low Back Pain*

The percentage of members 18 – 50 years old with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Intake Period: January 1–December 3 of the measurement year. The Intake Period is used to identify the first outpatient or ED encounter with a primary diagnosis of low back pain.

IESD: Index Episode Start Date. The earliest date of service for an outpatient or ED encounter during the Intake Period with a principal diagnosis of low back pain.

This measure is reported as an inverted rate. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

*Medicaid & Commercial
Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.

2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

MMA – Medication Management for People with Asthma*

The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period

*Medicaid & Commercial
SSD – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

The percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a glucose or HbA1c test performed during the measurement year.

*Medicaid

Documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following:

- A1c
- HbA1c
- HgbA1c
- Hemoglobin A1c
- Glycohemoglobin A1c
- Glycohemoglogin
- Glycoated hemoglobin
- Glycosylated hemoglobin
Appendix 2

HEDIS® 2018 Physician Documentation Guidelines & Administrative Codes
HEDIS® Measure 2018
Physician Documentation Guidelines and Administrative Codes

This document is located on our Provider Portal:

www.anthem.com > Providers > (select state) > Health and Wellness tab > Quality Improvement and Standards

This reference document includes HEDIS measures and the criteria (including ICD-10, CPT, and HCPCS codes) required for your patient’s chart or claims review to be considered valid towards HEDIS measurements.
Appendix 3

Survey Data
Survey Data

There are measures that are collected using survey methodology.

CAHPS® Health Plan Survey 5.0H, Adult Version

- This measure provides information on the experiences of our members and indicates how well the organization meets their expectations for our commercial and Medicaid populations

- **NOTE:** Medicare Advantage members are surveyed by each health plan using the Medicare Advantage CAHPS survey developed by CMS.

- Medicare Health Outcomes Survey

- This measure provides a general indication of how well an organization manages the physical and mental health of its Medicare members by measuring their status at the beginning and the end of a two-year period

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
CAHPS Surveys

CAHPS surveys represent an effort to accurately and reliably capture information from consumers about their experiences with health plans:

The surveys assess our members’ experience with our health plan over the past 12 months for Commercial plans and the past six months for Medicaid & Medicare plans.

Health plans report survey results to NCQA which uses the results to:

- make accreditation decisions,
- “rate” health plans, and
- create national benchmarks for care and service

Health plans also use CAHPS survey data for internal quality improvement purposes.
CAHPS Health Plan Survey

5.0 H – Adult Version

Results reflect members rating the plan 8, 9 or 10 on a scale of 0 to 10 in the following areas:

1. Rating of All Health Care
2. Rating of Health Plan Overall
3. Rating of Personal Doctor
4. Rating of Specialist Seen Most Often
There are two areas that are reported individually:

1. Health Promotion and Education
2. Coordination of Care

Composite scores also summarize responses for these key areas:

1. Claims Processing (Commercial only)
2. Customer Service
3. Getting Care Quickly
4. Getting Needed Care
5. How Well Doctors Communicate
6. Shared Decision Making
7. Plan Information on Costs (Commercial Only)
Provides a general indication of how well a Medicare organization manages the physical and mental health of its members at the beginning and the end of a two-year period. Scores are categorized and percentages reported as:

- Better
- Same
- Worse than expected