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# HEDIS Guidelines for Health Care Providers

## Adult BMI Assessment (ABA)

Members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

Medical record documentation must include:

- For members 21 years and older on the date of service, include documentation of weight and BMI value.
- For members younger than 21 years on the date of service, include height, weight, and BMI percentile.

Tips for Success:

- Height and weight are usually documented but calculation of the BMI is often missing. Work with your EMR vendor to update your system with the calculation.
- Code appropriately.
- Members who have a diagnosis of pregnancy during the measurement year or the year prior to the measurement year can be **excluded** from the measure.

ABA Codes

BMI:ICD-10: Z68.1, Z68.20, Z68.21, Z68.22, Z68.23, Z68.24, Z68.25, Z68.2,Z68.2, Z68.28, Z68.2, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35,Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45

BMI Percentile: ICD-10: Z68.51, Z68.52, Z68.53, Z68.54

# Controlling High Blood Pressure (CBP)

Members 18-85 years of age with diagnosis of Hypertension (HTN) prior to June 30 of the measurement year and whose B P was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/mm Hg.

Medical record documentation must include:

- The most recent BP reading (date and result) in the measurement year AFTER the diagnosis of HTN is made.

Tips for Success: when the member's BP is elevated at the visit, be sure to repeat the measurement AND document the new result. The repeat BP is often lower!

CBP Codes Essential Hypertension: ICD-10: I10

**Exclusions:** Members with evident ESRD; Diagnosis of pregnancy during the year prior to the measurement year; Members who had an admission to a non-acute inpatient setting in the year prior to the measurement year;

# Comprehensive Diabetes Care (CDC)

Members 18-75 with diabetes (Type I and Type 2) who had each of the following:

- Hemoglobin A1c testing
  - HbA1c control (<8.0%)
  - HbA1c poor control (>9.0%)
- Eye exam (retinal)
- Medical attention for nephropathy
- BP control <140/90 mm Hg

## Medical record documentation must include:

• Most recent blood pressure readings.
• Most recent lab test for HbA1c with date of test and result.
• A nephropathy screening or monitoring test (urine protein) during the measurement year or evidence of nephropathy during the measurement year.
• A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

## Tips for Success:

• Labs indicating “poor” control should be repeated again later in the calendar year. Bring the member back in for testing!
• The intent of the eye exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually.
• Communicate the importance of this exam and help coordinate the scheduling if Indicated:

□Hemoglobin A1c (HbA1c) testing.
□Eye exam (retinal) performed.
□Medical attention for nephropathy.
□BP control (<140/90 mm Hg).

# CDC Codes

**Exclusions:** Gestational diabetes, steroid induced diabetes

## Diabetic Retinal Screening:

CPT: 67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043,67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002,92004, 92012, 92014, 92018, 92019, 92134, 92225,92226, 92227,92228, 92230, 92235, 92240, 92250, 92260
HCPCS: S0620, S0621, S3000

### Diabetic Retinal Screening Negative:
3072F

### Diabetic Retinal Screening with Eye Care Professional
CPT II: 2022F, 2024F, 2026F, S0625

## HbA1c

### HbA1c Test:
CPT: 83036, 83037

### HbA1c Level Less the 7.0:
CPT II: 3044F

### HbA1c Level 7.0-9.0:
CPT II: 3045F

### HbA1c Level Greater Than 9.0:
CPT II 3046F

## Blood Pressure

Diastolic 80-89:
CPT II: 3079F

Diastolic Greater than/Equal to 90:
CPT II: 3080F

Diastolic Less than 80:
CPT II: 3078F

Systolic Greater than/Equal to 140:
CPT II: 3077F

Systolic Less than 140:
CPT II: 3074F, 3075F

## Nephropathy

Nephropathy Treatment:
CPT II: 3066F, 4010F

Urine Protein Tests:
CPT: 81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156
CPT II: 3060F, 3061F, 3062F

Dialysis
HCPCS: G0257, S2065, S9339

# Colorectal Cancer Screening (COL)

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

## Medical record documentation must include evidence of one of the following:

- Colonoscopy (within last 10 years).
- FOBT (gFOBT or iFOBT in the measurement year).
- Flexible Sigmoidoscopy (within last 5 years).
- FIT-DNA test during the measurement year or the two years prior to the measurement year.
- CT Colonography during the measurement year or the four years prior to the measurement year.

## Tips for Success:

- Providers should review/confirm all preventive health screenings at each visit.
- Dates and results need to be consistently documented.
- When colorectal screening is reported, obtain report from specialist to ensure medical record is complete.

## COL Codes

### Colonoscopy

CPT: 44388, 44389, 44390, 44391, 44392, 44393, 44394 ,44397, 44401-44408, 45355,45378,45379, 45380, 45381, 45382, 45383, 45384,45385, 45386,45387, 45391, 45392

HCPCS: G0105, G0121, G0213, G0214, G0215

### FOBT

CPT: 82270, 82274
HCPCS: G0328

### Flexible Sigmoidoscopy

CPT: 45330-45335, 45337-45342, 45345-45347, 45349-45350
HCPCS: G0104

### CT Colonography

CPT: 74261-74263

FIT DNA
CPT: 81528,
HCPCS: G0464

## Medication Reconciliation Post-Discharge (MRP)

Members 18 years and older with discharges (acute and non-acute inpatient) from January ,1 to December ,1 of the measurement year, for whom medications were reconciled the date of discharge through 30 days after discharge (31 days total)

### Medical record documentation must include:

- Evidence of medication reconciliation AND the date when it was performed.
- Must be conducted by a prescribing practitioner, clinical pharmacist, or RN.
- Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

### Tips for Successful Hybrid Chart Review:

Any of the following meet criteria:

- Documentation that the provider reconciled the current and discharge medications.
- Documentation of the current medication with a notation that references the Discharge medications.
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service.
- Notation that no medications were prescribed or ordered upon discharge.

### Medication Reconciliation (MRP) Codes

CPT: 99495, 99496
CPT II: 1111F, 1159F, 1160F

# Transitions of Care (TRC)

Members 18 years of age and older with discharges (acute and non-acute inpatient) who had documentation by the Provider of each of the following during the measurement year.

1. Notification of Inpatient Admission

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
- Documentation in your outpatient record of any tests and treatments ordered during the member's inpatient stay.
- Documentation that the admission was elective and you had performed a preadmission exam or were notified of pre-admission testing results.

2. Receipt of Discharge Information

   Documentation of receipt of discharge information on the day of discharge or the following day.

3. Patient Engagement after Inpatient Discharge

   Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge (does not include the date of discharge).

   Codes

   CPT:

   99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455-99456

   HCPCS:

   T1015, G0402, G0438, G0439, G0463

4. Medication Reconciliation Post-Discharge

   Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). (See MRP measure)

# Care of Older Adults (COA)

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

## 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

### Codes:

CPT: 99497
CPT II: 1123F, 1124F, 1157F, 1158F
HCPCS: S0257

## 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 and the date when it was noted.

### Codes:

### Medication review Codes:

CPT: 90863, 99605, 99606
CPT II: 1160F

### Medication list Codes:

CPT II: 1159F
HCPCS: G8427

### Transitional care management services Codes:
CPT: 99495, 99496

## 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

### Functional status assessment Codes:

CPT II:1170F

## 4. Pain assessment

Includes evidence of a pain assessment using a standardized pain assessment tool and the date it was performed

### Pain assessment Codes:

CPT II: 1125F,1126F

## How to Improve your HEDIS Rates

•Timely submission of all claims and encounter data

•Complete and accurate coding of all services performed

•Document all services and care provided in the medical record

•Schedule patients for their annual screenings and check- ups

•Continually monitor patients with chronic conditions

•Continually monitor patients on persistent medications

•Understand the HEDIS measure criteria and the standard practice guidelines