

Key Indicators for Select HEDIS Measures

Here are some key indicators for select Healthcare Effectiveness Data and Information Set (HEDIS^{®1}) measures. These measures need additional information from the medical chart to complement claims data for a full picture of the care or services provided. Compliance can be reported via claims (administrative specification) or through medical record documentation (hybrid specification).

Documentation that meets the hybrid specifications for these HEDIS measures is shown below.

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The medical record, lab reports, progress notes and documents must have the following information:

- Member's name and date of birth on each page
- Physician's name and signature
- The provider office or facility

Care of Older Adults (COA)	<ol style="list-style-type: none"> 1. Medication list and medication review during the current measurement year 2. Functional status assessment during the current measurement year 3. Pain assessment during the current measurement year 4. Hospice care during the current measurement year
Controlling Blood Pressure (CBP)	<ol style="list-style-type: none"> 1. Documentation from the treating provider: <ul style="list-style-type: none"> • Last office visit, telehealth visit, encounter or vital sign flow sheet in 2022 documenting the most recent blood pressure (BP) • Evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant • Pregnancy during the measurement year • Hospice or palliative care during the measurement year
Hemoglobin A1c Control for Patients with Diabetes (HBD)	<ol style="list-style-type: none"> 1. Most recent HbA1c, glycohemoglobin or glycated hemoglobin test date in 2022 with result <ul style="list-style-type: none"> • Progress Note with test date and result • Lab Report 2. Documentation of treatment in 2021 or 2022 for any of the following: <ul style="list-style-type: none"> • Polycystic ovarian syndrome

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	<ul style="list-style-type: none"> • Gestational Diabetes • Drug or chemical induced diabetes <p>3. Hospice or palliative care during the measurement year</p>									
Blood Pressure Control for Patients with Diabetes (BPD)	<ol style="list-style-type: none"> 1. 2022 office visit, telehealth visit, encounter or vital sign flowsheet documenting the most recent BP reading during the measurement year 2. Documentation of treatment in 2021 or 2022 for any of the following: <ul style="list-style-type: none"> • Polycystic ovarian syndrome • Gestational Diabetes • Drug or chemical induced diabetes 3. Hospice or palliative care during the measurement year 									
Eye Exam for Patients with Diabetes (EED)	<ol style="list-style-type: none"> 1. Diabetic eye exam in 2021 or 2022: <ul style="list-style-type: none"> • Copy of the dilated eye exam read by an eyecare professional or artificial intelligence • Progress note indicating the date it was completed, with the results and the name of eye care professional • Consultation note/letter from eye care professional indicating that an ophthalmic exam was completed, including date and results of the exam • Documentation indicating bilateral eye enucleation anytime during the member's life or acquired absence of both eyes 2. Documentation of treatment in 2021 or 2022 for any of the following: <ul style="list-style-type: none"> • Polycystic ovarian syndrome • Gestational Diabetes • Drug or chemical induced diabetes 3. Hospice or palliative care during the measurement year 									
Colorectal Cancer Screening (COL)	<ol style="list-style-type: none"> 1. Documentation of colorectal cancer or a total colectomy 2. Documentation of one of the following screenings and the date it was performed: <ul style="list-style-type: none"> • Colonoscopy between 2013 and 2022 • Stool-DNA (Cologuard®) between 2020 and 2022 • Fecal occult blood test (FOBT) in 2022 • Flexible sigmoidoscopy between 2018 and 2022 • Computerized tomography (CT) colonography between 2018 and 2022 3. Gastrointestinal consult Hospice or palliative care during the measurement year 									
Childhood Immunization Status (CIS)	<ol style="list-style-type: none"> 1. Documentation of all immunizations administered by the second birthday: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">• DTAP: 4 doses</td> <td style="width: 33%;">• HIB: 3 doses</td> <td style="width: 33%;">• HEP A: 1 dose</td> </tr> <tr> <td>• IPV: 3 doses</td> <td>• HEP B: 3 doses</td> <td>• Pneumococcal: 4 doses</td> </tr> <tr> <td>• MMR: 1 dose</td> <td>• Varicella: 1 dose</td> <td></td> </tr> </table> <ul style="list-style-type: none"> • Rotarix: 2 doses or Rotateq: 3 doses (Rotavirus vaccine) • Influenza: 2 doses with two different dates of service; LAIV administered on the second birthday meets criteria 2. Immunization record 	• DTAP: 4 doses	• HIB: 3 doses	• HEP A: 1 dose	• IPV: 3 doses	• HEP B: 3 doses	• Pneumococcal: 4 doses	• MMR: 1 dose	• Varicella: 1 dose	
• DTAP: 4 doses	• HIB: 3 doses	• HEP A: 1 dose								
• IPV: 3 doses	• HEP B: 3 doses	• Pneumococcal: 4 doses								
• MMR: 1 dose	• Varicella: 1 dose									

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	<ol style="list-style-type: none"> 3. Immunization registry (Florida SHOTS) 4. History of encephalopathy on or before the 2nd birthday 5. History of Immunodeficiency on or before the 2nd birthday 6. History of the illness or Seropositive test for MMR, Hep B, Hep A, VZV on or before the 2nd birthday 7. History of anaphylactic reaction on or before the 2nd birthday 8. Hospice care during the measurement year
Cervical Cancer Screening (CCS)	<ol style="list-style-type: none"> 1. Pap smear with results and findings between 2020 and 2022 2. Pap smear with HPV co-testing performed between 2018 and 2022 3. Evidence of cervical high-risk HPV between 2018 and 2022 4. History of total hysterectomy (no cervix) or vaginal hysterectomy 5. Hospice or palliative care during the measurement year
Immunizations for Adolescents (IMA)	<ol style="list-style-type: none"> 1. Documentation of the following immunizations by the 13th birthday: <ul style="list-style-type: none"> • 1 dose of Tdap • 2 doses (at least 146 days apart) or 3 doses (with different dates of service) of HPV • 1 dose of meningococcal 2. Immunization record (flow sheet) 3. Immunization registry (Florida SHOTS) 4. History of encephalopathy on or before member's 13th birthday 5. History of anaphylactic reaction on or before member's 13th birthday 6. Hospice care during the measurement year
Prenatal and Postpartum Care (PPC) <u>Do not submit hospital or delivery records</u>	<ol style="list-style-type: none"> 1. Documentation of the initial prenatal visit: <ul style="list-style-type: none"> • Documentation of the physical prenatal exam that includes one of the following: <ul style="list-style-type: none"> ○ Auscultation for fetal heart tone ○ Pelvic exam with obstetrics (OB) observations ○ Measurement of the fundus height (in the first trimester) • Evidence of prenatal care procedure: <ul style="list-style-type: none"> ○ Lab – OB panel ○ TORCH testing (toxoplasma, rubella, cytomegalovirus, herpes simplex) ○ Ultrasound of a pregnant uterus • Documentation of first day of last menstrual period (LMP) or estimated due date (EDD) in conjunction with either a prenatal risk assessment and counseling and education or complete OB history 2. Documentation of postpartum visit: <ul style="list-style-type: none"> • Pelvic exam • Evaluation of blood pressure, weight, breasts and abdomen • Perineal or cesarean incision/wound check • Glucose screening for women with gestational diabetes 3. Documentation of any of the following:

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	<ul style="list-style-type: none"> • Infant care or breastfeeding • Resumption of intercourse • Sleep/fatigue • Resumption of physical activity or healthy weight • Birth spacing or family planning <p>4. Documentation of non-live birth (fetal demise)</p> <p>5. Telephone, telehealth/virtual and office visits meet the criteria to report prenatal/postpartum care</p> <p>6. Hospice care during the measurement year</p>
Transition of Care (TRC)	<p>1. Documentation of each of the following:</p> <ul style="list-style-type: none"> • Receipt of notification of the inpatient admission on the day of admission through two days after the admission with a date and time stamp <ul style="list-style-type: none"> ○ Communication between inpatient providers or the emergency room department and the primary care providers (faxes, emails, phone calls) • Receipt of the discharge information on the day of discharge through two days after the discharge <ul style="list-style-type: none"> ○ Discharge summary/summary of care record • Patient engagement within 30 days of discharge • Clear documentation of member being seen for a post hospital follow up • Documentation of medication reconciliation completed post-discharge including the date it was performed <ul style="list-style-type: none"> ○ Documentation can be from an outpatient, office, home or telehealth/virtual visit record and must include the date it was performed ○ Documentation that no meds were prescribed at time of discharge <p>2. Hospice care during the measurement year</p>
Weight Assessment Counseling for Children/ Adolescents (WCC)	<p>1. Weight assessment (documented in 2022)</p> <ul style="list-style-type: none"> • Documentation of BMI percentile as a value or BMI percentile plotted on age-growth chart (must include height, weight, and BMI percentile) • Office visit, telephone visit, e-visits or virtual check-in, or encounter documentation anytime in the measurement year <p>2. Nutrition counseling (documented in 2022)</p> <ul style="list-style-type: none"> • Office visit, telephone visit, e-visits or virtual check-in, or encounter documentation anytime in the measurement year • Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors) • Checklist indicating nutrition was addressed • Counseling or referral for nutrition education • Member received educational materials about nutrition during a face-to-face visit • Anticipatory guidance for nutrition • Weight or obesity counseling • Referral to Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

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3. Counseling for physical activity (documented in 2022)

- Office visit, telephone visit, e-visits or virtual check-in, or encounter documentation anytime in the measurement year
- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating physical activity was addressed
- Counseling or referral for physical activity
- Received educational materials about physical activity during a face-to-face visit
- Anticipatory guidance specific to the child's physical activity
- Weight or obesity counseling

4. Hospice care during the measurement year

5. Diagnosis of Pregnancy during the measurement year

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