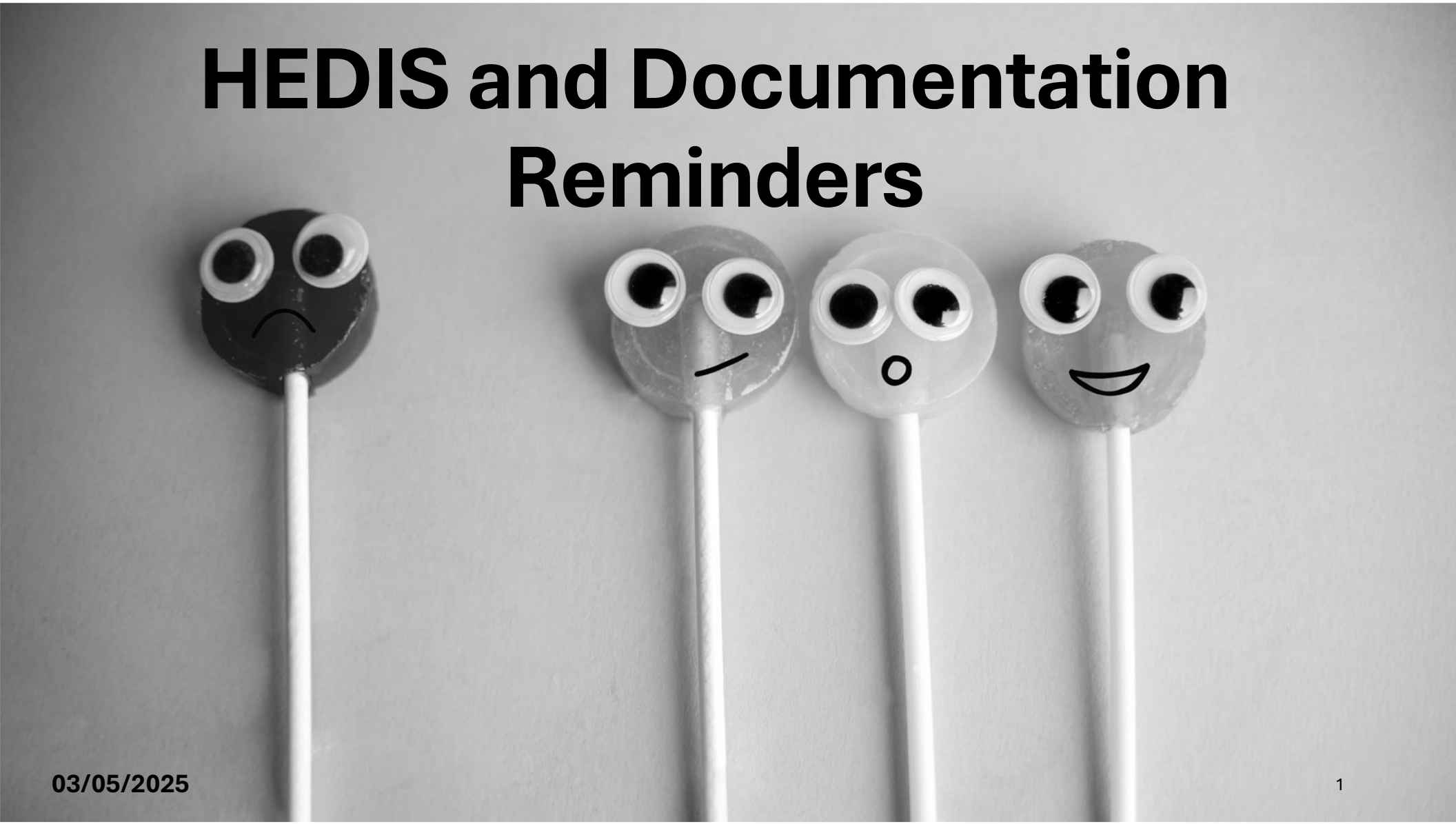
HEDIS and Documentation Reminders



The Importance of Careful EMR Documentation

- Increasing number of ECDS quality measures
- Effective capture and upload of EMR data to Health Focus
- Transmission of accurate EMR data, by Health Focus, to insurers for gap closure
- Improved audit performance rates

Know Compliance Criteria

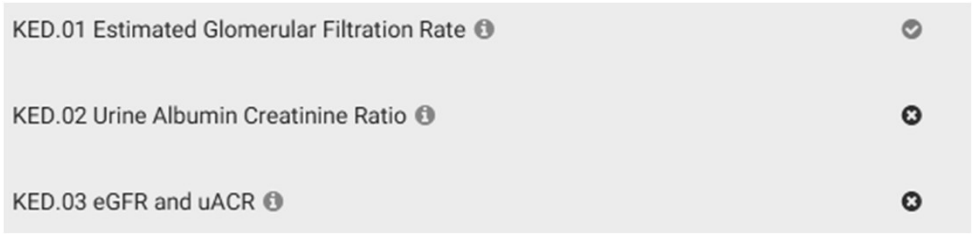
Labs/Tests

- **Thermal imaging, ultrasounds, and biopisies don't close Breast Cancer Screening gaps**
- **HPV test/co-test only closes Cervical Cancer Screening gap for women age 30+ years**
- **KED measure requires BOTH blood and urine tests**

1. Serum Creatinine ⇒ calculated eGFR

AND

2. Quantitative Urine Albumin AND Urine Creatinine (or Urine Microalbumin/Creatinine Ratio)

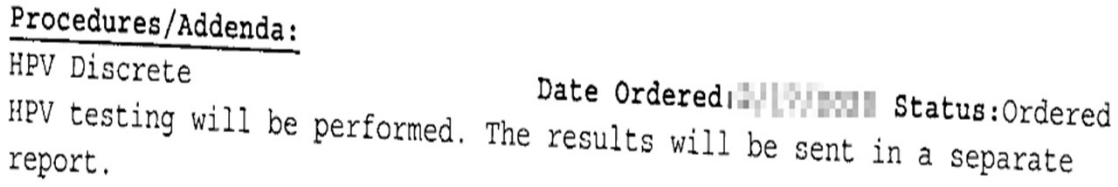


Know Compliance Criteria

Timeframes

- **E.g., Colonoscopy has a 10-year HEDIS compliance timeframe**
- **To close a 2025 Colorectal Cancer Screening care gap, a colonoscopy must have been performed within the current measurement year plus 9 years prior (2016)**
- **A patient whose last colonoscopy was in 2015 is DUE, <u>not</u> up-to-date, for colorectal cancer screening in 2025**

Missing Documentation



Procedures/Addenda:
HPV Discrete
Date Ordered: [redacted] Status:Ordered
HPV testing will be performed. The results will be sent in a separate report.

See NPO's 2025 Quality Measures Guide for more information

Correctly Identify Labs/Tests

<u>Know the Difference</u> (and Label Accordingly)

- **FIT (annual test) vs. FIT-DNA (= Cologuard, 3-year test)**

- **Endoscopy (Upper GI) vs. Colonoscopy (Lower GI)**

Support Exclusion Documentation

- **Be precise with your documentation**
  - ❖ **Hysterectomies must be "Complete", "Total", "Radical" or "Vaginal" (indicates no cervix)**
  - ❖ **Mastectomies must be bilateral (or unilateral x 2)**
- **Include exclusion diagnosis codes in the Problem List and recode annually**
  - ❖ **Z90.710 = Acquired Absence of Both Cervix and Uterus**
  - ❖ **Z90.712 = Acquired Absence of Cervix with Remaining Uterus**
  - ❖ **Z90.13 = Acquired Absence of Bilateral Breasts and Nipples**
  - ❖ **Z90.12 = Acquired Absence of Left Breast and Nipple**
  - ❖ **Z90.11 = Acquired Absence of Right Breast and Nipple**
- **When using templates, modify responses as necessary**

Treat Structured Data Fields with Care

- **Lab and DI orders are automatic structured data fields**
- **Do not include non-numeric characters (e.g., units) in numeric-only structured fields**
  - **i.e., Height, Weight, BMI, Blood Pressure, labs such as HbA1c**
  - **Non-numeric characters will invalidate the result.**
- **If a patient did not complete a lab/test, DO NOT ENTER ANYTHING in the result field**
  - **i.e., Do not type "Noncompliant" or "Patient did not complete", etc., in a result field or select it from a result drop box (Use non-structured "Note" fields)**
  - **Anything in a result field indicates a completed lab/test**
  - **Instead, leave all result-related fields blank ("Received", "Result Date" and "Result")**
- **Make sure the Order Date is earlier than, or the same as, the Result Date**

Regarding Blood Pressures…

- **To be quality measure compliant (and close care gaps), the last BP of the year must be <140 systolic AND < 90 diastolic**
- **Take another BP if a diastolic and/or systolic value is out of range**
- **If multiple blood pressures are taken during an encounter, put the lowest diastolic and lowest systolic values in the BP Vitals fields (i.e., mix and match)!**
- **Example:**

  BP #1 = 142/88
  BP #2 = 138/92

  Put 138/88 in the BP Vitals field

Use CPT II Codes Correctly

- **CPT II codes are alphanumeric non-payable, reporting codes that, when added to claims, close care gaps with insurers**

  E.g., There are CPT II codes for systolic and diastolic BP values, A1c values, and retinal eye exams/results

- **These codes can be reported by any provider, including the PCP**

- **As with any CPT code, the date of the claim is identified as the DOS for the service being reported**

- **When reporting services using CPT II codes, the date on the claim must match the date the service was performed**

- **This means the code may need to be reported on a separate zero-dollar claim**

Use CPT II Codes Correctly

Example #1

- **John Smith has an appointment for a physical exam with his PCP, Dr. Boring, on Wednesday, March 5, 2025.**
- **Dr. Boring's practice (Mind Numbing Medical) performs HbA1c tests in-house.**
- **When John arrives for his physical, he has an HbA1c test, then sees Dr. Boring for the exam.**
- **Dr. Boring adds the CPT II code for John's HbA1c result to the claim for the March 5th physical exam.**

OK!! Exam DOS = A1c test DOS

Use CPT II Codes Correctly

Example #2

- **Mary Smith, John's wife, also has an appointment for a physical exam with her PCP, Dr. Snazzy, on Wednesday, March 5, 2025.**
- **Since Dr. Snazzy's practice (Glitter Gal Women's Clinic) does not have the capability to perform HbA1c tests in-house, Mary visited a local outpatient lab on February 24th to get her labs drawn.**
- **During Mary's March 5th physical, Dr. Snazzy reviews the lab results with Mary.**
- **Dr. Snazzy then adds the CPT II code for Mary's HbA1c result to the claim for the March 5th physical exam.**

NOT OK!! Exam DOS ≠ A1c test DOS

Dr. Snazzy needs to put the A1c CPT II code on a separate (zero-dollar) claim dated February 24, 2025

Put Practice Documentation Processes in Place

- **For best results, standardize documentation processes**
  - **Decide where quality measure information is to be documented (e.g., Lab Order, DI Order, custom-built structured data fields, etc.)**
  - **Write a step-by-step procedure for each documentation type**
  - **Train staff on documentation procedures**
  - **Monitor Health Focus to verify data is displaying**
  - **If data is missing or incorrect in Health Focus, alert NPO for troubleshooting assistance (support@npoinc.org)**
- **Minimize the number of staff members doing manual data entry in the EMR**