HEDIS 2012
Compliance Audit Kickoff
HEDIS 2012 Kick-off Meeting Agenda

- Introductions
- Audit Process Details and Changes
- Baseline Schedule
- Technical Specification Changes
Team Introductions and Contacts
# DTS Group HEDIS Audit Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Phone</th>
<th>Cell/Alternate Phone</th>
<th>E-Mail</th>
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</tbody>
</table>

Address: DTS Group  
3208 E. Colonial Drive  
Suite #450  
Orlando, FL 32803  
Phone: 407-444-2770  
Fax: 407-444-2770
Your Plan

- Organizational changes?
- System changes?
- Personnel changes?
- Auditor feedback/suggestions?
Audit Process Details and Changes
CAHPS

- Commercial and Medicaid Plans
  - Health Plans can produce either entire sample frame or reduced sample frame (30,000 members randomly selected from the entire eligible population for each CAHPS submission)
  - MCO request a CAHPS submission in NCQA’s HOQ (opens 1/10/12)
  - MCO ensures auditor on the list of authorized users. Add auditor e-mail if required

- Medicare Plans
  - Health plans select and pay for a survey vendor
  - CMS sends the survey sample frame/membership file to the survey vendor via RAND
  - Health plan coordinates information with the survey vendor
  - DTS Group does **not** audit the Medicare CAHPS submission
CAHPS - Commercial and Medicaid

• MCO posts the following to the DTS website:
  • a completed CAHPS survey form from DTS. This CAHPS background info to help the
    auditor assess your survey sample frame. Here is the website address to a survey
    sample form: <https://dtsg.webexone.com/r.asp?a=12&id=37547>
  • The entire sample frame or the reduced sample frame (include method for reducing
    sample frame)
  • Program code used to generate sample frame (if you program source code internally)
• Auditor validates CAHPS program code and sample frame as usual
• Auditor provides plan with CAHPS approval letter indicating the survey sample frame
  supports reporting
• Auditor indicates approval of the sample frame in the Healthcare Organization
  Questionnaire (by end of January. HOQ closes 2/29/12)
• Plan submits CAHPS approval letter and approved sample frame to survey vendor to begin
  survey administration
Roadmap

- Almost identical to last year. Link to blank Roadmap is <https://dtsg.webexone.com/r.asp?a=12&id=34000>
- New attachment GI.3 requests documentation of all measures with incentives (bonuses, Medicare Star measures, internal P4P initiatives and all others) ... NCQA will look for this
- Auditor will read Roadmap and create Issue Log of questions and clarifications.
- Post responses to issues in folder #02 – All Issues and Follow-Up Information
- Put the Issue # in the Title of the Document - see example
- (new) preferred due date 1/27/12 – NCQA deadline 2/10/12
- All Issues to be closed by June 1, 2012
Program Code Review

- Plans using certified software - Auditor reviews CAT, CAB, and BCR only
- Plans programming measures internally
  - Core set minimum number equal to 15 measures plus the survey sample frames, focusing on new measures, changed measures, and challenging measures.
  - **Provide list of programmers by measure will significantly speed up core set selections**
  - Post code as soon as available. All code due by March 31\(^{th}\) for first review
  - Always post Data Control Sheet so we have the right contact info. Here is the website address to the form <https://dtsg.webexone.com/r.asp?a=5&id=112000>
  - Send e-mail notification when code is posted
Medical Record Review – Convenience Sample

- The plan will be exempt from the convenience sample if:
  - The plan received a “Pass” on the MRR validation for the prior year HEDIS audit
  - The current MRR process has not changed significantly
  - The plan does not report hybrid measures the auditor determines to be at risk of inaccurate reporting

- If a convenience sample is required:
  - DTS Group will request a small number of medical records (at least 10) once abstraction fieldwork begins
  - The plan will select the records to be sent to DTS Group
  - DTS Group will communicate any errors to the plan so systematic problems can be corrected before proceeding with additional reviews
Medical Record Review – Final Statistical Validation

- Plan completes a template of MRR abstraction status
- Auditor selects 2 measures for validation and notifies plan
- Plan posts a list of positive hits for selected measures to the DTS website
- Auditor selects random sample of 30 plus 2 oversamples
- Plan forward the corresponding hard copy documentation to DTS
  - If scanned, send 1 .pdf file for all 30 records (recommend 150 x 150 4-bit grayscale)
  - If hardcopy, please label with sample # and order from 1-30
    Please do not staple the hard copies.
- DTS will validate records and provide results to plan
- DTS will conduct t-test on any measure with less than 100% agreement
On-Site Review

- DTS has sent our preferred onsite date and are finalizing the entire schedule
- DTS will send agenda requirements and advance queries to help the plan prepare
- Follow-up interviews may be conducted for special circumstances, e.g., with medical record review staff or outside vendors
- All issues from the onsite will be documented on the Issue Log
- Please post follow-up items in the “02 – All Issues and Follow-Up Information” folder on the website.
Supplemental Data

• Supplemental data is information used for HEDIS reporting that is not part of a transactional, adjudicated claims or encounter.

• Plan provides
  • Documentation
  • File layouts
  • Provider forms
  • Policies and procedures

• If the supplemental data is non-standard, auditors are required to perform primary source verification. The sample size can vary.
  • Primary source verification is copy of the medical record or screenshot of the original EMR verifying the information
  • A spreadsheet or provider signature alone is not sufficient evidence.
  • If the database did not change from the prior year, the auditor has the discretion to perform primary source verification.
Data Submission

- NCQA increasing emphasis on preliminary rate review
- Preliminary rate review now formal part of the audit guidelines
- Already part of DTS queries and onsite review
  - Plans with certified software – notify vendor you need a .csv of preliminary rates by May 1 (new)
  - Plans with internally-developed software – Provide admin rates in an easy-to-read format for review
- IDSS has 2 submission files
  - 1 for RRUs (new)
  - 1 for all other measures
- Medicare has 2 Patient Level Detail Files
  - 1 for PCR measure that accommodates multiple admits per member (new)
  - 1 for all other measures
Data Submission

- Data submitted via web-based interactive data submission system (IDSS)
- Plan loads data onto IDSS and runs through NCQA’s Tier I and Tier II validations
- Plan applies Plan Lock to data submission and notifies DTS it is ready for review by:
  - May 25th for Commercial, Medicaid, and Medicare data (including patient-level detail file)
- All Attestations are electronic only
  - Cannot be submitted until plan lock is applied
  - Must be re-submitted if plan lock is removed for changes
- DTS runs benchmark and year-over-year analysis and provides Benchmark Report to plan
- Plan responds to Benchmark Report
- Iterations continue until issues are resolved and results are satisfactory. DTS applies Auditor Lock to dataset
- Plan “Marks Final” and submission cannot be changed by:
  - June 15th for Commercial, Medicaid and Medicare data
Report

- Final Report documents plan’s conformance to specifications
- IS Standards Compliance Tool
  - Provides more detail
  - Filed in workpapers only
- DTS will provide draft of Report and IS Tool to plan
- Plan has opportunity to review/make corrections
- DTS provides final copy with signatures to plan and NCQA
Baseline Schedule
## Baseline Schedule

<table>
<thead>
<tr>
<th>ID</th>
<th>Task Name</th>
<th>Start</th>
<th>Finish</th>
<th>Resource Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HEDIS 2012 Audit</td>
<td>Mon 11/7/11</td>
<td>Wed 8/1/12</td>
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<tr>
<td>2</td>
<td>Kickoff Conference Call</td>
<td>Mon 11/7/11</td>
<td>Fri 12/16/11</td>
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<td>3</td>
<td>Conduct kickoff meeting</td>
<td>Mon 11/7/11</td>
<td>Fri 12/16/11</td>
<td>DTS Group, Plan Lead</td>
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<tr>
<td>4</td>
<td>Kick off complete</td>
<td>Fri 12/16/11</td>
<td>Fri 12/16/11</td>
<td>DTS Group, Plan Lead</td>
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<tr>
<td>5</td>
<td>CAHPS Code Review (Commercial and Medicaid)</td>
<td>Mon 1/2/12</td>
<td>Tue 1/31/12</td>
<td>Plan Lead</td>
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<tr>
<td>6</td>
<td>Submit CAHPS sample frame code to DTS Group</td>
<td>Mon 1/2/12</td>
<td>Fri 1/13/12</td>
<td>Plan Lead</td>
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<tr>
<td>7</td>
<td>Review sample frame and output file for compliance</td>
<td>Wed 1/18/12</td>
<td>Mon 1/30/12</td>
<td>DTS Group</td>
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<td>8</td>
<td>Submit approved survey sample frame to survey vendor</td>
<td>Tue 1/31/12</td>
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<td>CAHPS complete</td>
<td>Tue 1/31/12</td>
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<td>DTS Group, Plan Lead</td>
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<td>Roadmap Process</td>
<td>Mon 11/21/11</td>
<td>Tue 2/14/12</td>
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<td>11</td>
<td>Complete Roadmap and submit to DTS Group</td>
<td>Mon 11/21/11</td>
<td>Fri 1/27/12</td>
<td>Plan Lead</td>
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<td>12</td>
<td>Review and complete Roadmap Issue Log</td>
<td>Mon 2/13/12</td>
<td>Tue 2/14/12</td>
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<td>Initial Roadmap process complete</td>
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<td>DTS Group, Plan Lead</td>
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<td>Program Code Review</td>
<td>Mon 2/13/12</td>
<td>Mon 4/16/12</td>
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<td>15</td>
<td>Select core measures (if measures programmed internally)</td>
<td>Mon 2/13/12</td>
<td>Mon 2/27/12</td>
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<td>Submit any required program code</td>
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<td>Tue 2/27/12</td>
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<td>Review measures for compliance</td>
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<td>Iterations and re-work</td>
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<td>Mon 4/16/12</td>
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<td>Program code review complete</td>
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<td>Medical Record Review</td>
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<td>Convenience sample</td>
<td>Mon 4/2/12</td>
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<td>If required, submit samples of DTS’s choice</td>
<td>Mon 4/2/12</td>
<td>Mon 4/9/12</td>
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<td>Review samples for compliance and provide feedback</td>
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<td>If not required, document convenience sample exemption</td>
<td>Mon 4/2/12</td>
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<td>Convenience sample complete</td>
<td>Fri 4/13/12</td>
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<td>Final statistical validation</td>
<td>Mon 4/16/12</td>
<td>Fri 5/18/12</td>
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<td>Submit form with status of medical record abstraction</td>
<td>Mon 4/16/12</td>
<td>Fri 4/27/12</td>
<td>Plan Lead</td>
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<td>Select measures for MRR</td>
<td>Mon 4/16/12</td>
<td>Mon 4/30/12</td>
<td>DTS Group</td>
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<td>29</td>
<td>Send list of positive hits to DTS Group</td>
<td>Mon 4/16/12</td>
<td>Fri 5/4/12</td>
<td>Plan Lead</td>
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<td>30</td>
<td>Select samples</td>
<td>Mon 4/16/12</td>
<td>Fri 5/11/12</td>
<td>DTS Group</td>
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<td>Send requested medical record samples to DTS Group</td>
<td>Mon 4/16/12</td>
<td>Fri 5/11/12</td>
<td>Plan Lead</td>
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<td>32</td>
<td>Perform re-abstraction and determine agreement rate</td>
<td>Mon 4/16/12</td>
<td>Fri 5/18/12</td>
<td>DTS Group</td>
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<td>33</td>
<td>Notify plan of MRR results</td>
<td>Mon 4/16/12</td>
<td>Fri 5/18/12</td>
<td>DTS Group</td>
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<td>If agreement rate &lt;100%, perform T-test</td>
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<td>Fri 5/18/12</td>
<td>DTS Group, Plan Lead</td>
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<td>Provide final MRR results</td>
<td>Mon 4/16/12</td>
<td>Fri 5/18/12</td>
<td>DTS Group</td>
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<td>Fri 5/18/12</td>
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## Baseline Schedule - cont.

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<td>Onsite Visit</td>
<td>Thu 12/1/11</td>
<td>Mon 5/14/12</td>
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<td>38</td>
<td>Set onsite date</td>
<td>Thu 12/1/11</td>
<td>Mon 1/2/12</td>
<td>DTS Group, Plan Lead</td>
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<td>39</td>
<td>Develop agenda requirements</td>
<td>Tue 1/3/12</td>
<td>Mon 1/30/12</td>
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<td>40</td>
<td>Create agenda</td>
<td>Mon 1/16/12</td>
<td>Tue 2/20/12</td>
<td>Plan Lead</td>
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<td>41</td>
<td>Conduct pre-onsite conf. call</td>
<td>Mon 1/16/12</td>
<td>Tue 2/20/12</td>
<td>DTS Group, Plan Lead</td>
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<td>Conduct onsite visit</td>
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<td>Fri 4/6/12</td>
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<td>43</td>
<td>Complete follow-up letter with open items</td>
<td>Tue 1/24/12</td>
<td>Wed 4/11/12</td>
<td>DTS Group</td>
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<td>44</td>
<td>Resolve all open items</td>
<td>Thu 4/12/12</td>
<td>Mon 5/14/12</td>
<td>DTS Group, Plan Lead</td>
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<td>Onsite visits and open items complete</td>
<td>Mon 5/14/12</td>
<td>Mon 5/14/12</td>
<td>DTS Group, Plan Lead</td>
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<td>46</td>
<td>Medicare/Commercial/Medicaid Data Submission</td>
<td>Fri 5/25/12</td>
<td>Fri 6/15/12</td>
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<td>47</td>
<td>Apply plan-lockto Dataset in IDSS and notify DTS Group</td>
<td>Fri 5/25/12</td>
<td>Fri 5/25/12</td>
<td>Plan Lead</td>
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<tr>
<td>48</td>
<td>Perform benchmark and year over year comparison</td>
<td>Mon 5/28/12</td>
<td>Mon 6/4/12</td>
<td>DTS Group</td>
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<tr>
<td>49</td>
<td>Provide feedback to plan on validity of results</td>
<td>Mon 5/28/12</td>
<td>Mon 6/4/12</td>
<td>DTS Group</td>
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<tr>
<td>50</td>
<td>Respond to feedback</td>
<td>Tue 6/5/12</td>
<td>Tue 6/12/12</td>
<td>Plan Lead</td>
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<tr>
<td>51</td>
<td>Iterations / rework</td>
<td>Tue 6/5/12</td>
<td>Tue 6/12/12</td>
<td>DTS Group, Plan Lead</td>
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<tr>
<td>52</td>
<td>Complete audit designation table/apply auditor lock</td>
<td>Tue 6/5/12</td>
<td>Fri 6/15/12</td>
<td>DTS Group</td>
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<tr>
<td>53</td>
<td>Mark final and send attestations to NCQA</td>
<td>Fri 6/15/12</td>
<td>Fri 6/15/12</td>
<td>Plan Lead</td>
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<td>54</td>
<td>Data Submission complete</td>
<td>Fri 6/15/12</td>
<td>Fri 6/15/12</td>
<td>DTS Group, Plan Lead</td>
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<td>Medicare Patient-level detail file</td>
<td>Fri 5/25/12</td>
<td>Fri 6/15/12</td>
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<td>56</td>
<td>Submit file to DTS for review</td>
<td>Fri 5/25/12</td>
<td>Mon 6/4/12</td>
<td>Plan Lead</td>
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<tr>
<td>57</td>
<td>Provide feedback on file mismatches / correctness</td>
<td>Mon 6/4/12</td>
<td>Mon 6/4/12</td>
<td>DTS Group</td>
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<td>Iterations / rework</td>
<td>Mon 6/4/12</td>
<td>Mon 6/11/12</td>
<td>Plan Lead</td>
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<tr>
<td>59</td>
<td>Confirm patient file matches IDSS submission</td>
<td>Mon 6/11/12</td>
<td>Mon 6/11/12</td>
<td>DTS Group</td>
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<tr>
<td>60</td>
<td>Submit patient file to CMS via separate process</td>
<td>Mon 6/11/12</td>
<td>Fri 6/15/12</td>
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<td>61</td>
<td>Final Audit Reports</td>
<td>Mon 7/2/12</td>
<td>Mon 7/16/12</td>
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<tr>
<td>62</td>
<td>Submit draft report and IS standards compliance tool to plan</td>
<td>Mon 7/2/12</td>
<td>Mon 7/8/12</td>
<td>DTS Group</td>
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<td>63</td>
<td>Provide feedback on draft report</td>
<td>Tue 7/10/12</td>
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<td>Plan Lead</td>
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<td>64</td>
<td>Finalize edits</td>
<td>Wed 7/11/12</td>
<td>Fri 7/13/12</td>
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<tr>
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<td>Submit final audit report to NCQA</td>
<td>Mon 7/16/12</td>
<td>Mon 7/19/12</td>
<td>DTS Group</td>
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<tr>
<td>66</td>
<td>Provide final report and IS standards compliance tool to plan</td>
<td>Mon 7/16/12</td>
<td>Mon 7/19/12</td>
<td>DTS Group</td>
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<tr>
<td>67</td>
<td>Audit reports complete</td>
<td>Mon 7/19/12</td>
<td>Mon 7/19/12</td>
<td>DTS Group, Plan Lead</td>
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<tr>
<td>68</td>
<td>Audit Complete</td>
<td>Tue 7/17/12</td>
<td>Wed 8/1/12</td>
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<tr>
<td>69</td>
<td>Conduct wrap up call for lessons learned</td>
<td>Tue 7/17/12</td>
<td>Wed 8/1/12</td>
<td>Plan Lead, DTS Group</td>
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<tr>
<td>70</td>
<td>Audit complete</td>
<td>Wed 8/1/12</td>
<td>Wed 8/1/12</td>
<td>DTS Group, Plan Lead</td>
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</tbody>
</table>
Technical Specification Changes
What’s New for HEDIS 2012

New measure – HPV

New Measure – MMA

Other Measure-Specific changes

Other Changes – v Code Removal

Other Changes – General Guidelines

Rotation
2012 New Measures - HPV

- Eligible Population (Commercial and Medicaid)
  - Females who turned 13 during the measurement year
  - Continuous enrollment period of 12 months prior to the 13\textsuperscript{th} birthday

- Optional exclusions
  - Contraindication for the HPV vaccine. ICD-9 Diagnosis code 999.4 – Anaphylactic shock due to serum

- Admin - Numerator
  - At least 3 HPV vaccinations on different dates of service on or between member’s 9\textsuperscript{th} and 13\textsuperscript{th} birthday

- Hybrid specifications – systematic sample
  - Can start with female members of the IMA measure, and draw additional female members from the remaining eligible population until the full sample size and oversample is reached
HPV and IMA Sampling Example

- Select the IMA sample, use the females to start the HPV sample. Draw the rest of the HPV sample from the remaining females in the IMA eligible population.

IMA Eligible Population = 5,000
- 2500 Girls
- 2500 Boys

Draw IMA Sample of 411
- 261 Girls
- 150 Boys

HPV Sample (MRSS)
- 150 Girls from IMA Sample
- 261 Girls drawn from remaining IMA elig pop

Remaining IMA Eligible Population = 4,589
- 2239 Girls
- 2350 Boys
2012 New Measures - MMA

- Eligible Population
  - Commercial and Medicaid product lines. Members 5-64 during the measurement year
  - Continuous enrollment period measurement year and year prior
  - Same denominator as ASM measure except also excludes members with no medications dispensed in the MY

- Numerator
  - Number of members with a proportion of days covered (PDC) of at least 50% or 75% during the MY
  - Differentiate between types of asthma medications. MMA includes only controller medications
    - Controller medications – long-term medications used to achieve and maintain control of persistent asthma
    - Quick reliever medications for acute symptoms and exacerbations are not included (long and short-acting, inhaled beta-2 agonists)
2012 Other measure-specific changes

- ABA and WCC
  - Weight must be documented in MY or PY
  - Weight and BMI must be from same source
- WCC
  - Pregnancy exclusion must be applied across all indicators
  - Documentation solely on screen time not compliant for Counseling for Physical Activity indicator
- ASM
  - Increase upper age limit to 64 and added new age stratifications
  - Added required exclusions
2012 Other measure-specific changes

• COA
  – Clarified when results of a pain screening tool are acceptable
  – Can count Activities of Daily Living (ADL) assessment for the Functional Status Assessment

• CDC
  – Optional exclusion criteria must be applies to all CDC denominators
  – Documentation of a renal transplant meets criteria for the nephropathy indicator
  – Added an exclusion list to the BP Control criteria for the Administrative Specification
  – Only count BP readings in conjunction with an outpatient visit code or a nonacute inpatient visit code in Table CDC-C
2012 Other measure-specific changes

- **OMW**
  - Do not use ambulance or durable medical equipment (DME) claim/encounter data to identify members who had a fracture

- **ADD**
  - Members with a diagnosis of narcolepsy must be excluded from the denominator for both rates

- **MPM**
  - Medications dispense in the PY must be counted in the 180 treatment day time frame

- **PPC**
  - Deleted codes
2012 Other measure-specific changes

- **IPU**
  - Maternity category is not based on deliveries
  - Clarified when MS-DRG 789-795 should be reported
  - Clarified categorization of discharges based on coding and hierarchy method

- **RDM**
  - Revised reporting tables

- **LDM**
  - Indirect data not reported
  - Include members who decline to provide language in LDM-A
2012 Other measure-specific changes

• PCR
  – A principal diagnosis is required for the pregnancy exclusion in the denominator and numerator criteria
  – Clarified the steps to identify risk adjustment determination and weighting
  – Split risk adjustment for Commercial and Medicare
  – Added variance calculation to Risk Adjustment Weighting

• RRUs – Too many changes to mention
  – Added cost and service frequency categories
  – Subclassified inpatient stays and generic vs. brand Rxs
  – Increased variables from 11,000 to 48,000 !!
  – Report only via separate .xml file in IDSS
2012 Other changes – Removal of V codes

• **Measure impacted**
  
  • **ABA** – V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 (identifies OP visits)
  
  • **WCC** – V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 (identifies OP visits)
  
  • **BCS** – V76.11, V76.12 (identifies screenings)
  
  • **CCS** – V72.32, V76.2 (identifies screenings)
  
  • **COL** – V76.51 (identifies FOBT screenings)
  
  • **CHL** – V26.52 (identifies sexually active women)
  
  • **GSO** – V80.1 (identifies glaucoma screening examinations)
  
  • **CBP** – V56 (identifies dialysis exclusion)
  
  • **CDC** – V72.0 (identifies eye exam)
  
  • **OMW** – V82.81 (identifies Bone Mineral Density Test)
  
  • **DDE** – V56 (identifies Chronic Renal Failure)
2012 Other changes – Removal of V codes

• Why should you care?

  • Removal of codes is retrospective – Impacts measurement years 2011, 2010, 2009, 2008, etc.

  • Members numerator compliant by V code in prior years are no longer compliant

  • Supplemental databases using V codes are no longer compliant

  • Impact on measures vs. prior years may be hard to assess, but feasible

  • Provider education may be necessary – coding required

  • Any nonstandard encounter forms using V codes must be revised

  • Need to determine if any gaps exist in receipt of lab data
2012 Other changes – Removal of V codes

• Other Actions required
  • Examine all supplemental databases and convert all V codes used to compliant CPT codes (get auditor approval)
  • Revise any non-standard data collection forms (encounter records)
  • Initiate provider education (coding of outpatient visits – use CPT not V codes)
  • Do analysis to compare lab results received vs. lab tests paid

Note: It is not permissible to map a valid code to another valid code. You may not map a V code to a CPT code if present in your measurement year or prior year claims files.
2012 Other changes – General Guidelines

• General Guideline 46 – Identifying events/diagnoses using data from ancillary services
  – GG 46 – Data obtained from ancillary services (lab m rad. Home health, and DME) may not be used to identify an event, disease or condition unless the measure specifies otherwise
  – NCQA FAQ – “There does not seem to be a standardized definition for identifying ancillary services among organizations. NCQA is reverting back to the HEDIS 2011 text; the guideline title and text will change so the guideline will only apply to the use of lab data.” This will be put in the October update.
Measures Eligible for Rotation

- Measures Eligible for Rotation
  - Cervical Cancer Screening (Medicaid only)
  - Controlling High Blood Pressures
  - Frequency of Ongoing Prenatal Care
  - Prenatal and Postpartum Care
  - Weeks of Pregnancy at Time of Enrollment

- Other Criteria for Rotation
  - MCO had an audited, reportable, *hybrid* rate from HEDIS 2011
  - MCO reporting entity has remained constant from HEDIS 2010
  - Small denominator (NA in HEDIS 2011 is ok if NA in HEDIS 2012)
Thank You