



Provider Scorecards Frequently Asked Questions

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General Information

How do you determine if a member is meeting a HEDIS measure for the Provider Scorecards?

Members are considered meeting a measure based on specific date criteria set by the National Committee for Quality Assurance (NCQA) HEDIS measurements. Data used for the determination of meeting HEDIS criteria can be received by MHS either administratively (through claims), or through a review of medical record data, in combination with claims. Several factors are reviewed to determine compliance:

Timeliness: Some measures require the service to be completed *anytime before 12/31 of the Measurement Year*. For example, breast cancer screening, cervical cancer screening, diabetic eye screening, and appropriate medications for people with asthma measures.

Some childhood measurements require the service to be completed **ON or BEFORE** the child’s birthday / age. For example, lead screening before age two, well-child visits within first 15 months.

Accuracy: Most measures must have claims coded with specific codes and diagnosis. For example, well child visit must be billed with a well visit code such as 99391 and a diagnosis of V20.2, rather than an E&M code such as 99213

I received notice that one of my patients did not receive a service and I disagree. How can I correct this issue?

First, please make sure that you submitted a claim with the correct codes. If you realize you did not bill the claim correctly, please resubmit the claim. While your claim may be denied under established MHS payment rules, a denied claim will still count toward the measures on your scorecard.

If you believe your claim was correctly submitted and is still not reflected on your scorecard, you can complete a Member Information Fax Back Form and fax it, along with a copy of the medical records that provide evidence of the service, to MHS Quality Improvement at (866) 912-4254. We will review this information and send you a letter informing you that your information has been reviewed. If it meets the necessary criteria, we will include the service on your scorecard.

Data determined to meet a measure that is received within three weeks prior to the end of a quarter will be reflected within the two next scorecards.



Measure-Specific Information

Pediatric Measures

What criteria are used to identify a compliant member for Childhood Immunization Status?

Age Group: Children who turn two years of age in the measurement year

Look Back Period: First two years of child's life. The look back period ends *on* the child's second birthday

Requirement: At least four DTap, three IPV, one MMR, two Hib, three Hepatitis B, and one VZV

Considerations that will influence rate:

- If the vaccination is given *after* a child's second birthday, the immunization will not be counted
- Any DTap, IPV, or Hib vaccination administered *prior* to 42 days after birth will not be counted
- Members must be continuously enrolled with MHS 12 months prior to the child's second birthday in order to be included in this measure

I do not bill MHS for immunization, but I report my immunization data to the Children and Hoosier Immunization Registry Program (CHIRP) system. Will this information be included in my childhood immunization measure?

Yes. MHS will attempt to identify your patient in the CHIRP system and include our findings in your end of the year pay-for-performance settlement.

We do encourage you to submit claims as evidence of services provided throughout the year. If you are unable to submit a claim, you may submit other evidence of services provided. Acceptable evidence would be in the form of a medical record or immunization record that includes the child's name, the name of the specific antigen, and the date of the immunization.

What criteria are used to identify a compliant member for the lead screening measure?

Age Group: Children who turn two years of age in the measurement year

Look Back Period: First two years of a child's life. The look back period ends *on* the child's second birthday

Requirement: At least one capillary or venous blood test *on or before* the child's second birthday



Considerations that will influence rate:

- If the two year well visit is performed after a child's second birthday, lead screening during this visit will not be counted
- Procedure code 83655 must be reflected on the claim for inclusion.
- Members must be continuously enrolled with MHS 12 months prior to the child's second birthday in order to be included in this measure

I did a lead screening on a member that was two years old this year and reported the information to CHIRP. Will this information be included in my scorecard?

Yes. MHS receives a monthly file from the state of Indiana that includes all of the lead information reported to CHIRP. The information will be included as long as the lead screening was done prior to the member's second birthday.

What criteria are used to identify a compliant member for well-child / adolescent measures (3 different measures)?

Age Group:

First 15 Months - Children who turn 15 months in the Measurement Year

Three - Six Years – Children who turn three – six years of age as of December 31

Adolescents – 12 – 21 yrs as of December 31

Look Back Period:

First 15 months - The look back period ends *on* the child's 15 month birthday

Three – Six Years - Measurement year.

Adolescents - Measurement year

Requirement:

First 15 Months - Six or more well child visits *on or before* first 15 months of life, any of the following can be billed:

CPT - 99381, 99382, 99391, 99392, 99432, 99461

ICD-9 - V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Three – Six Years - At least one well-child visit with a Primary Medical Provider (PMP) during the measurement year. Any of the following can be billed:

CPT - 99382, 99383, 99392, 99393

ICD-9 - V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Adolescents - At least one comprehensive well-care visit with a PMP (including an OB/GYN) during the measurement year. Any of the following can be billed:

CPT - 99383-99385, 99393-99395

ICD-9 - V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

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Considerations that will influence rate:

- Visit *must occur* with a PMP (not a specialist).
- Medical records documentation must include health and developmental history, physical exam and health education / anticipatory guidance
- Child must have been continuously enrolled with MHS from 31 days to 15 months of life with no more than a 45 day gap in enrollment to be included in the well-child (age 15 month) measure
- Member must be continuously enrolled for 12 months prior to the end of the reporting quarter to be included in the well-child (age three to six) and adolescent well visit measures

I saw a member who was in for sick symptoms, but was also able to do a well visit. Will these visits count if I include the sick visit on the bill?

Yes. The well visit will count even when a sick visit is billed on your claim. But, you must bill for both the sick and the well visit and ensure that the diagnosis code used for the well visit is V20.2.

What criteria are used to identify a compliant member for the Appropriate Testing for Children with Pharyngitis measure?

Age Group: Children two years of age as of July 1 of the year *prior* to the measurement year to 18 years of age as of June 30 of the measurement year

Look Back Period: July 1 of the year prior to June 30 of the measurement year

Requirement: Children two - 18 years of age, who were diagnosed only with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. MHS will identify outpatient and ER claims for members with a primary diagnosis of acute pharyngitis (icd9: 462), acute tonsillitis (ICD9: 463), streptococcal sore throat (ICD: 034.0) to include in eligible population of this measure

What criteria are used to identify a compliant member for appropriate treatment for children with upper respiratory infection measure?

Age Group: Children three months - 18 years of age

Look Back Period: July 1 of the year prior to June 30 of the measurement year

Requirement: Children three months - 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were *not* dispensed an antibiotic prescription by *any* provider on or three days after the index episode start date



Claims billed for members with diagnosis codes 460 and 465 will be the only codes used to identify a member with URI. Members with a competing diagnosis (i.e. Otitis media, Acne, etc) will not be included on your scorecard

If I diagnose a member with URI and don't write a prescription, but my patient gets a prescription from another provider, will I still meet the measure?

No. If you diagnose your patient with an URI and they get a prescription for an antibiotic filled within three days of your diagnosis then you will *not* meet the measure.

What criteria are used to identify a compliant member for appropriate medications for people with asthma?

Age Group: Five – 56 years of age as of end of reporting period.

Look Back Period: Member must be continuously enrolled with MHS 24 months from the end of the reporting period.

Requirement:

Denominator (Eligible Population) - Members with persistent asthma are defined as having had:

- at least one (ED) visit with principal diagnosis of asthma; or
- at least one acute inpatient discharge with principal diagnosis of asthma; or
- at least four outpatient visits with asthma as one of the diagnoses and at least two asthma medication events; or
- at least four asthma medication dispensing events.

Numerator (Compliant Members) - Members who were dispensed at least one prescription for a preferred asthma therapy during the measurement year



Adult Measures

What criteria are used to identify a compliant member for Comprehensive Diabetes Care measure?

Age Group: 18 – 75 years of age as of end of reporting period

Look Back Period: Member must be continuously enrolled with MHS 24 months from the end of the reporting period with no more than a 45 month gap in coverage

HbA1c Testing

Requirement: An HbA1c test performed during the measurement year

Considerations that will influence rate: Use most recent HbA1c test during the measurement year--claims billed with CPT codes 83036 and 83037 will count toward this measure

LDL-C Screening/Control <100mg/DL

Requirement: An LDL-C test performed during the measurement year

Considerations that will influence rate: Use the most recent LDL-C test during the measurement year. Claims billed with CPT codes 80061, 83700, 83701, 83704, 83721 will count toward this measure

Medical Attention for Nephropathy

Requirement: A nephropathy screening test or evidence of nephropathy

Considerations that will influence rate:

Evidence of Nephropathy (Numerator Compliance):

- Claim / encounter with code to indicate treatment for nephropathy during the measurement year;
- Nephrologist visit during the measurement year;
- Positive urine macroalbumin test in the measurement year; and
- Evidence of ACE inhibitor/ARB therapy during the measurement year.

Claims billed with CPT 82042, 82043, 82044, 84156 will count toward this measure.

Diabetic Eye Screening

Requirement: Diabetics who had a retinal or dilated eye exam by an Optometrist or Ophthalmologist in the measurement year *or* who had a *negative* retinal exam in the measurement year or year prior



Considerations that will influence rate: The medical record should include a note or letter from the Provider or PMP indicating that the exam was completed, the date on which the procedure was performed and the results or a chart or photograph of retinal abnormalities indicating the date on which the exam was performed and evidence that an eye care professional reviewed the results

Claims billed with 67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 by an eye care provider will count toward this measure.

What criteria are used to identify a compliant member for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measure?

Age Group: 18 - 64 years of age

Requirement: Members with a diagnosis of acute bronchitis who were ***NOT*** dispensed an antibiotic prescription

Considerations that will influence rate: Member must be continuously enrolled with MHS one year prior to the episode date through seven days after the episode date to be included in this measure

What criteria are used to identify compliant members for Use of Spirometry Testing in the Assessment and Diagnosis of COPD measure?

Age Group: 40 years of age or older

Requirement: Members with a ***NEW*** diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis

Considerations that will influence rate: Must have at least one claim / encounter with a code for spirometry in the 730 days (2 years) before the index episode start date to 180 days after the index episode start date



OB/GYN Measures

What criteria are used to identify a compliant member for Chlamydia Screening measure?

Age Group: Women 16 - 24 years of age as of December 31

Look Back Period: Measurement year

Requirement: Women who were identified as sexually active and had at least one test for Chlamydia during the measurement year--sexually active women are identified through evidence of a pregnancy test or a prescription for a contraceptive

What criteria are used to identify a compliant member for Breast Cancer Screening measure?

Age Group: Women 42 - 69 years of age as of December 31

Look Back Period: Measurement year and year prior

Requirement: Women who had at least one mammogram during the measurement year *or* year prior

What criteria are used to identify a compliant member for Cervical Cancer Screening measure?

Age Group: Women 21 – 54 years of age as of December 31

Look Back Period: Measurement year and two years prior

Requirement: At least one Pap test during the measurement year or within two years prior

What criteria is used to identify a compliant member for Prenatal / Postpartum Care measure?

Age Group: None

Requirement: Percentage of deliveries of live births between November 6 of the year prior and November 5 of the measurement year. The measure assesses the following:

Timeliness of Prenatal Care – The percentage of deliveries that received a prenatal care visit as a member in the first trimester or within 42 days of enrollment

Postpartum Care – The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery



What criteria are used to identify a compliant member for Frequency of Ongoing Prenatal Care measure?

Age Group: None

Requirement: Percentage of deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the expected (recommended) number of prenatal visits

Considerations that will influence rate: The recommended number of prenatal visits (see table) is determined by the gestational age and state of pregnancy at time of enrollment per ACOG

Month of Pregnancy Member Enrolled in the Organization								
Gestational age in weeks	0-1 st month	2 nd month	3 rd month	4 th month	5 th month	6 th month	7 th month	8 th month
28	6	5	4	3	1	1	-	-
29	6	5	4	3	1	1	-	-
30	7	6	5	4	2	1	1	-
31	7	6	5	4	2	1	1	-
32	8	7	6	5	3	2	1	-
33	8	7	6	5	3	2	1	-
34	9	8	7	6	4	3	2	1
35	9	8	7	6	4	3	2	1
36	10	9	8	7	5	4	3	1
37	11	10	9	8	6	5	4	2
38	12	11	10	9	7	6	5	3
39	13	12	11	10	8	7	6	4
40	14	13	12	11	9	8	7	5
41	15	14	13	12	10	9	8	6
42	16	15	14	13	11	10	9	7