

HEALTHSCRIPT

April 2006

A publication for HNE providers and their staff

It's HEDIS®* Time Again

From March through mid-May 2006, HNE once again will request copies of medical records in order to conduct data abstraction. We will use this data to measure health care outcomes and to perform medical record documentation review.

HNE strives to ensure that it has a rich administrative database from which to perform the annual HEDIS measurement project. However, where practitioner offices do not supply properly coded claim/encounter data, or where the data can be obtained only from medical record review, such as blood pressure monitoring, HNE must obtain vital information from the actual medical record. As always, HNE appreciates practitioner office cooperation for this project.

A HEDIS Fact Sheet, which explains HEDIS measures, is available on the HNE website. Questions about HEDIS or the collection process should be directed to Pat Scheer, HNE's Quality Operations Manager at 1-413-233-3435 or pscheer@hne.com

HEDIS®* Monitors Minimum Standards of Care

All Health Plan Employer Data and Information Set (HEDIS) measures monitor minimum standards of care. For instance, they measure for the rate of poor A1c control in diabetics by seeking evidence of levels greater than 9.0%

The current adopted American Diabetes Association clinical practice guidelines for diabetes care recommend that (in most circumstances) optimal A1c control be considered to be less than 7.0%. So, although we measure for minimum standards with HEDIS, the HNE Clinical Care Assessment Committee urges its providers to continue to strive to meet the most current evidence-based standards of care.

* HEDIS is a registered trademark of NCQA



Change in Prior Approval Requirement

As of April 1, 2006, HNE no longer requires prior approval for in-plan non-obstetrical elective inpatient admissions. Prior approval is still required for any procedure that requires pre-certification for clinical criteria (examples include but are not limited to bariatric surgery, human organ transplant and bone marrow transplant, and Rhinoplasty). Inpatient admissions are still subject to utilization management (UM) review. HNE's utilization management program is designed to provide access to the care our members need by assuring appropriate use of health care services. Through this program, we review certain claims and medical records to determine if services are covered benefits and are medically necessary and appropriate. Our medical director oversees the UM process and supervises all activities. Medical Record Documentation

Medical Record Documentation

IF IT'S NOT WRITTEN, IT'S NOT DONE

Well-documented medical records accurately and completely reflect the care provided to a patient and facilitate the retrieval, continuity and sharing of clinical information. Medical records that are poorly maintained, incomplete and/or illegible can impede the level of communication between healthcare providers; negatively impact member care and treatment planning; and leave openings for legal problems should a question of negligence arise in the future. Each year, HNE conducts medical record documentation audits. During these audits, random sample of medical records are analyzed for clinical quality and coordination of care. Based on this year's medical record audit results, HNE has selected the following area for performance improvement activity: documentation of follow-up and coordination of care between PCPs and specialists (especially behavioral health practitioners).

The importance of the PCP's role as coordinator of care and custodian of his or her patient's complete medical profile cannot be overstated. The responsibility of managing relationships between treating physicians is equally important as that of diagnosis, treatment and referral. Without it, the contemporary viewpoint of treating the whole person may be lost. The PCPs have the role of team coordinator and, as such, have the rare opportunity to establish expectations pertaining to the exchange of clinical information between themselves and the specialist. Additionally, the PCP relays the standard that all physicians treating a member share relevant information regarding the member's diagnosis and treatment to assure true coordination of care.

As collaborators in care, HNE solicits provider suggestions and comments helpful to improving medical record documentation in general and/or specific processes or policies providers may have found particularly helpful in assuring the quality of medical record documentation or overcoming barriers to patient follow-up.

Please fax such suggestions or comments to Pat Scheer, Quality Operations Manager at 413-233-2607 or email at pscheer@hne.com

Clarification about Members Enrolled in PPO Plan: Care from In-Network and Out-of Network Providers

At times, members may receive care from both an In-Network Provider and an Out-of- Network Provider for the same medical condition. The Plan will pay for the services that the member receives based on each provider's status. Here are some examples:

A member is admitted to an In-Network participating hospital. While there the member receives services from an ancillary provider working in that facility, such as an anesthesiologist, radiologist, or pathologist. These ancillary providers may not be participating providers. The Plan will pay the In-Network Hospital at the In-Network level, and the Out-Of-Network ancillary provider at the Out-Of-Network level.

A member is admitted to an In-Network Hospital by an Out-of-Network Doctor. The Plan will pay the In-Network Hospital at the In-Network level and the Out-of-Network Doctor at the Out-of-Network level.

A member has chosen to receive all of his/her primary care from an In-Network participating doctor. The doctor orders lab tests and sends the tests to an Out-of-Network lab. HNE will pay the In-Network doctor at the In-Network level and the Out-of-Network lab at the Out-of-Network level.

Unless being treated for an Emergency, members should verify that the providers who are treating them are In-Network Providers.

HNE Will Require Proper HCPCS or CPT Coding to Accompany Pharmacy Revenue Codes Accompany Pharmacy Revenue Codes

At HNE, one of our goals is to provide our members with access to high quality, affordable health care. By monitoring the use of high cost medications, our quality program is designed to support prescribing practices that are appropriate to the patient's situation – so that the right patient has access to the right drug at the right time.

In keeping with our efforts to monitor the escalating costs of our prescription drug benefit, we are requesting that all pharmacy revenue codes (for example 250, 630, and 636) be accompanied by the appropriate HCPCS or CPT code to define the drug associated with the claim. In the future HNE will require the correct HCPCS or CPT code for payment of pharmacy revenue codes.

If you have any questions about these changes, please contact Donna O'Shea, MD, HNE Associate Medical Director at 413-233-3445 or by e-mail at doshea@hne.com.

Blue text indicates new or changes to HEDIS 2007 measures (measures PY 2006)

TO MEET THIS MEASURE:	WE LOOK FOR THIS DESIRED CARE (the “measurement year” refers to prior year care):
Childhood Immunizations	<p>Children with a completed series of the following vaccinations <u>by 2nd birthday</u>.</p> <ul style="list-style-type: none"> ⊙ 4 - DtaP/DT (none prior to 42 days of age) ⊙ 3 -IPV (none prior to 42 days of age) ⊙ 1 - MMR ⊙ 3 - HiB (none prior to 42 days of age) ⊙ 3 - Hepatitis B ⊙ 1 - Varicella immunization or documented history of chickenpox disease having occurred prior to 2nd birthday ⊙ 4 - Pneumococcal conjugate <p><i>Medical records may be reviewed if claims/encounter data not sufficient</i></p>
Adolescent Immunizations	<p>Adolescents with a completed series of the following vaccinations <u>by 13th birthday</u>.</p> <ul style="list-style-type: none"> ⊙ 1 - MMR (between 4th and 13th birthdays) <i>or</i> 2 - MMR (on or between the 1st and 4th birthdays) ⊙ 3 - Hepatitis B vaccines (3 HepB by the 13th birthday or evidence of 2-dose regime having been completed) ⊙ 1 - Varicella or documented history of chickenpox disease having occurred prior to the 13th birthday <p><i>Medical records may be reviewed if claims/encounter data not sufficient</i></p>
Well-Child Exams (First 15 Months of Life)	<p>Looks for 6 well child exams (at least 2 weeks apart) having occurred <u>by 15th month birthday</u>; that must have evidence of <i>all</i> of the following components of care:</p> <ul style="list-style-type: none"> ⊙ A health and developmental history (physical and mental) ⊙ A physical exam ⊙ Health education/anticipatory guidance (problem focused guidance alone does not meet standard of care) <p><i>Medical records may be reviewed if claims/encounter data not sufficient</i></p>
Well-Child Exams (Ages 3, 4, 5, and 6 years)	<p>An annual well child exam during the measurement year; that must have evidence of all of the following components of care:</p> <ul style="list-style-type: none"> ⊙ A health and developmental history (physical and mental) ⊙ A physical exam ⊙ Health education/anticipatory guidance (problem focused guidance alone does not meet standard of care) <p><i>Medical records may be reviewed if provider claims/encounter data not sufficient</i></p>

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TO MEET THIS MEASURE:	WE LOOK FOR THIS DESIRED CARE (the “measurement year” refers to prior year care):
Adolescent Well-Care Exam (Ages 12 through 21 years)	An annual well child exam during the measurement year; that must have evidence of all of the following: <ul style="list-style-type: none"> ⊙ A health and developmental history (physical and mental) ⊙ A physical exam ⊙ Health education/anticipatory guidance (problem focused guidance alone does not meet standard of care) <i>Medical records may be reviewed if provider claims/encounter data not sufficient</i>
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD) (Ages 6 through 12 years)	Children who received an initial prescription dispensed for ADD/ADHD medication, and <ul style="list-style-type: none"> ⊙ Who had one follow-up visit with practitioner with prescriptive authority during the 30-day after meds initiated (Initiation Phase); and ⊙ Who remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within 9 months after the Initiation Phase ends. (This Continuous Medication Treatment phase spans a total of 9 months after the prescription start date.) <i>This is an administrative measure based on provider claim coding only</i>
Appropriate Treatment for Children With Upper Respiratory Infection (URI) (Ages 3 months to 18 years)	Children diagnosed with an upper respiratory infection (URI) that were not dispensed an antibiotic prescription on or three days after the Episode Date. <ul style="list-style-type: none"> ⊙ EXCLUDES: members with history of antibiotic within last 30 days ⊙ EXCLUDES: all encounters with more than one claim diagnosis <i>This is an administrative measure based on provider claim coding only</i>
Appropriate Treatment for Children With Pharyngitis (Ages 2 to 18 years)	Children diagnosed with pharyngitis, prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode. <ul style="list-style-type: none"> ⊙ EXCLUDES: members with a history of antibiotic Rx within last 30 days ⊙ EXCLUDES: all encounters with more than one claim diagnosis <i>This is an administrative measure based on provider claim coding only</i>
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis (Ages 18 to 64 years)	Healthy adults with a diagnosis of acute bronchitis who were dispensed an antibiotic prescription on or within three days after the diagnosis date. (A history negative for: significant co-morbid conditions for 12 months prior to/on the ‘episode date’, and, previous antibiotic Rx for 30 days prior, are both required for the individual to fall into the review population.) <u>A lower rate represents better performance</u> <i>This is an administrative measure based on provider claim coding only</i>
Chlamydia Screening in Women (Ages 16 to 25 years)	Women who are identified as presumed sexually active (by pharmacy, i.e. contraceptive Rx data, or claims data indicating potential sexual activity). Looks for evidence of annual Chlamydia testing. <ul style="list-style-type: none"> ⊙ EXCLUDES: women who had a pregnancy test and within 7 days had a Rx for Acutane or an X-ray. <i>This is an administrative measure based on provider claim coding only</i>

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TO MEET THIS MEASURE:	WE LOOK FOR THIS DESIRED CARE (the “measurement year” refers to prior year care):
Cervical Cancer Screening	<p>Looks at women 21 to 64 years of age as of the measurement year. Looks for evidence of a Pap test during the measurement year or within the prior 2 years.</p> <ul style="list-style-type: none"> ⊙ EXCLUDES: women who have had a complete hysterectomy with no residual cervix <p><i>Medical records may be reviewed if provider claims/encounter data not sufficient</i></p> <p><i>NOTE: HEDIS 2007 – NCQA is considering change to increase lower age limit from 21 to 24.</i></p>
Breast Cancer Screening	<p>Looks at women 52 to 69 years of age. Looks for evidence of a mammogram in the measurement year or a year prior to the measurement year.</p> <ul style="list-style-type: none"> ⊙ EXCLUDES: women who have had bilateral (occurring on same or separate dates) mastectomy <p><i>This is an administrative measure based on provider claim coding only</i></p> <p><i>NOTE: HEDIS 2007 – NCQA is considering change to decrease lower age limit from 52 to 40 and increase upper age limit from 69 to 74.</i></p>
Prenatal and Postpartum Care (by event)	<p>Women who delivered a live birth between November 6 of the previous year and November 5 of the measurement year. Looks for evidence of:</p> <ul style="list-style-type: none"> ⊙ Timeliness of Prenatal Care - Prenatal care in the first trimester or within 42 days of enrollment in HNE ⊙ Postpartum Care - Postpartum visit occurring on or between 21 and 56 days after delivery <p><i>Medical records may be reviewed if provider claims/encounter data not sufficient</i></p>
Frequency of Ongoing Prenatal Care (by event)	<p>Women who delivered a live birth between November 6 of the previous year and November 5 of the measurement year. The percentages of the expected number of prenatal care visits (based on ACOG guidelines) are compared to the number of received visits adjusted for the month of pregnancy at time of enrollment and gestational age.</p> <p><i>Medical records may be reviewed if provider claims/encounter data not sufficient</i></p>
Antidepressant Medication Management (Ages 18 years and older)	<p>A new diagnosis of major depression (no claims with depression diagnosis for past 120 days). Seeking to identify the following care for these identified members:</p> <ul style="list-style-type: none"> ⊙ Optimal practitioner contacts - Member had at least 3 follow-up visits <i>within 12 weeks</i> ⊙ An effective acute phase to see whether member filled a sufficient number of Rx(s) for antidepressant medication to allow for 84 days of continuous therapy (up to 30 days of allowable gaps permitted) ⊙ An effective continuation phase of 180-day treatment of antidepressant medication (a total of 51 days of allowable gaps are permitted) <p><i>This is an administrative measure based on provider claim coding</i></p>

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TO MEET THIS MEASURE:	WE LOOK FOR THIS DESIRED CARE (the “measurement year” refers to prior year care):
<p>Use of Appropriate Medications for People With Asthma (Ages 5 to 56 years)</p>	<p>Children and adults who are identified as having <i>persistent</i> asthma, who were appropriately prescribed inhaled corticosteroids, cromolyn sodium, nedocromil, leukotriene modifiers, methylxanthines. Note: long acting beta-2 antagonists do not count by themselves, they are viewed as an add-on therapy ☉ EXCLUDES: individuals with diagnosis of emphysema or COPD <i>This is an administrative measure based on provider claim coding only</i></p>
<p>Use of Spirometry Testing in the Assessment and Diagnosis of COPD (Age 40 years and older)</p>	<p>Adults with a new (within the measurement year) diagnosis or newly active chronic obstructive pulmonary disease (COPD) and who received appropriate spirometry testing to confirm the diagnosis; (at least one claim/encounter for spirometry in the 720 days before or 180 days after the diagnosis event.) <i>This is an administrative measure based on provider claim coding only</i></p>
<p>Controlling High Blood Pressure</p>	<p>Adults 46 to 85 years of age as of the measurement year with a diagnosis of hypertension (HTN) on or before June 30 of the measurement year. Medical records are reviewed for diagnosis of hypertension (HTN) and for the presence of control: ☉ Review the most recent office visit blood pressure (BP) at PCP office ☉ Controlled if systolic BP is ≤ 140 and diastolic BP is ≤ 90 EXCLUDES: ☉ readings done same day as major diagnostic or surgical procedure, or an emergency room visit ☉ readings self-reported by the patient to the provider ☉ adults with End Stage Renal Disease (ESRD) ☉ (may) exclude members who had admission to a non-acute inpatient setting during the year <i>Medical records must be reviewed unless measure rotated</i></p> <p><i>NOTE: HEDIS 2007 – NCQA is considering change to decrease lower age limit from 46 to 18. AND Change adequately controlled blood pressure from $\leq 140/90$ to $< 140/90$</i></p>

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<p>Comprehensive Diabetes Care (Ages 18 to 75 years)</p>	<p>Adults with diagnosis of diabetes (Type I or II) who demonstrate annual care during the measurement year:</p> <ul style="list-style-type: none"> ⊙ A1c screening lab ⊙ Last A1c of the measurement year >9.0 (seeking evidence of poor control) ⊙ LDL screening lab - with <i>last</i> LDL of the measurement year <100 (also measures rate for <130) ⊙ Documented results of a diabetic retinal eye exam <i>by an eye care specialist</i> ⊙ Documented evidence of monitoring for nephropathy (or treatment of nephropathy) by either of the following methods: <ul style="list-style-type: none"> ⊙ Testing for urine microalbuminuria (24hr urine/timed urine/spot urine/microalbumin/creatinine ratio) ⊙ Documented treatment for nephropathy, end stage renal disease, chronic renal insufficiency, acute renal failure dialysis, or visit with nephrologist ⊙ A positive urine macroalbumin test in the measurement year (macro must be beyond trace) <p style="text-align: center;"><i>Medical records may be reviewed</i></p> <p><i>NOTE: HEDIS 2007 – NCQA is considering change to add A1c control measure of <7.0 AND add blood pressure control measure of 135/85</i></p>																
<p>Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (Ages 18 years and older)</p>	<p>Adults with a diagnosis of rheumatoid arthritis and who had at least one ambulatory prescription dispensed for a disease modifying antirheumatic drug (DMARD) during the measurement year. See table:</p> <table border="1" data-bbox="565 1129 1513 1272"> <tbody> <tr> <td>Adalimumab</td> <td>Cyclosporine</td> <td>Infliximab* J1745</td> <td>Penicillamine</td> </tr> <tr> <td>Anakinra</td> <td>Etanercept</td> <td>Leflunomide</td> <td>Staphylococcal Protein A</td> </tr> <tr> <td>Azathioprine</td> <td>Gold (oral or IM)</td> <td>Methotrexate</td> <td>Sulfasalazine</td> </tr> <tr> <td>Cyclophosphamide</td> <td>Hydroxychloroquine</td> <td>Minocycline</td> <td></td> </tr> </tbody> </table> <p style="text-align: center;"><i>This is an administrative measure based on provider claim coding only</i></p>	Adalimumab	Cyclosporine	Infliximab* J1745	Penicillamine	Anakinra	Etanercept	Leflunomide	Staphylococcal Protein A	Azathioprine	Gold (oral or IM)	Methotrexate	Sulfasalazine	Cyclophosphamide	Hydroxychloroquine	Minocycline	
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<p>Annual Monitoring for Patients on Persistent Medications (Ages 18 years and older)</p>	<p>Adults on any of the following medications for at least 180 days and for whom for at least one therapeutic monitoring event for the specific medication(s) occurred in the measurement year. The intent is to prevent potential harm associated with persistent use of these drugs.</p> <ul style="list-style-type: none"> ⊙ angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) ⊙ digoxin ⊙ diuretics ⊙ anticonvulsants (phenytoin, phenobarbital, valproic acid, carbamazepine) ⊙ statins <p>EXCLUDES: anyone with a hospitalization in the measurement year</p> <p style="text-align: center;"><i>This is an administrative measure based on provider claim coding only</i></p>																

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TO MEET THIS MEASURE:	WE LOOK FOR THIS DESIRED CARE (the “measurement year” refers to prior year care):
<p>Beta-Blocker Treatment After a Heart Attack (Ages 35 years and older)</p>	<p>Adults who were hospitalized and discharged alive from January 1–December 24 of the measurement year with a diagnosis of acute myocardial infarction and who received a prescription for beta-blockers upon discharge.</p> <ul style="list-style-type: none"> ⊙ EXCLUDES: individuals who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy. <p><i>Medical records may be reviewed if provider claims/encounter data not sufficient</i></p>
<p>Persistence of Beta-Blocker Treatment After a Heart Attack (Ages 35 years and older)</p>	<p>Adults discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.</p> <p><i>EXCLUDES: individuals who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy.</i></p> <p><i>Medical records may be reviewed if provider claims/encounter data not sufficient</i></p>
<p>Cholesterol Management for Patients With Cardiovascular Conditions (Ages 18 to 75 years)</p>	<p>Adults who the year prior to the measurement year were discharged alive for any of the following:</p> <ul style="list-style-type: none"> ⊙ acute myocardial infarction, ⊙ coronary artery bypass graft, or ⊙ percutaneous transluminal coronary angioplasty, or ⊙ who had a diagnosis of Ischemic Vascular Disease; <p>and during the measurement year had each of the following:</p> <ul style="list-style-type: none"> ⊙ LDL-C screening performed ⊙ LDL-C controlled (<130 mg/dL) ⊙ LDL-C controlled (<100 mg/dL). <p><i>Medical records may be reviewed if provider claims/encounter data not sufficient</i></p>
<p>Use of Imaging Studies for Low Back Pain (LBP) (Ages 18 to 50 years)</p>	<p>Measures overuse of imaging studies in patients ages 18 to 50 with primary diagnosis of acute LBP.</p> <ul style="list-style-type: none"> ⊙ EXCLUDES: all members with LBP diagnosis in last 6 months ⊙ EXCLUDES: members with any history of cancer ⊙ EXCLUDES: members with recent trauma, IV drug abuse, neurological impairment <p><i>This is an administrative measure based on provider claim coding only</i></p>
<p>Medical Assistance With Smoking Cessation (Ages 18 years and older)</p>	<p>Adults who are current smokers, who were seen by an HNE practitioner during the measurement year, and</p> <ul style="list-style-type: none"> ⊙ who received advice to quit smoking; ⊙ for whom smoking cessation medications were recommended or discussed; ⊙ for whom smoking cessation methods or strategies were recommended or discussed. <p><i>External CAHPS survey methodology</i></p>