HEDIS RY2016: Integrated Care Program: ICP 2015

Required Documentation for Medical Record Abstraction

Prevention/Screening Services

BCS – Breast Cancer Screening

Women 52-74 years of age who had one (1) or more mammograms any time on or between October 1 two (2) years prior to the measurement year and December 31 of the measurement year.

Exclusions: require thorough documentation of any of the following:

- Bilateral mastectomy.
- Unilateral mastectomy with bilateral modifier.
- Two (2) unilateral mastectomies with service dates fourteen (14) days or more apart.
- Both of the following (on the same or different date of service):
  - Unilateral mastectomy with either right or left side modifier.
- Absence of the left and right breast on the same or different dates of service.

Left and right unilateral mastectomy on the same or different date of service

CCS – Cervical Cancer Screening

Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology and/or cervical cytology and human papillomavirus (HPV) were performed.
  - Cervical Cytology (PAP) performed every three (3) years.
  - Cervical Cytology (PAP)/Human papillomavirus (HPV) co-testing every 5 years.
- The result or finding.

Exclusions should be clearly and distinctly noted in the medical record and must indicate presence or lack of cervix. Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member’s history through December 31 of the measurement year should be noted in order to meet the exclusionary requirements.
ABA – Adult BMI (Body Mass Index) assessment

For members 21 years and older on the date of service, documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI value must be from the same data source.

For members younger than 21 years on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The height, weight and BMI percentile must be from the same data source.

For BMI percentile, the following documentation meets criteria:

- BMI percentile documented as a value (e.g. 85th percentile).
- BMI percentile plotted on an age-growth chart.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for measure compliance.

SCOL – State Modified Colorectal Screening

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the “medical history” section of the record; if this is not clear, the result or finding must also be present.

FOBT performed during the measurement year. Flexible sigmoidoscopy performed during the measurement year or the four (4) years prior to the measurement year. Colonoscopy performed during the measurement year or the nine (9) years prior to the measurement year.

There are two (2) types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of the FOBT test, a certain number of samples are required for compliance:

- If the medical record does not indicate the type of test and there is indication of how many samples were returned, assume the required number was returned. The member meets the screening.
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- If the medical record does not indicate the type of test and the number of returned samples is specified, the members meets the screening criteria only if the number of samples specified is greater than or equal to three (3) samples. If there are fewer than three (3) samples, the member does not meet the screening.
- iFOBT tests may require fewer than three (3) samples. If the medical record indicates that an iFOBT was done, the member meets the screening.
- If the medical record indicates that a gFOBT was done:
  - No indication of number of samples returned – member meets screening.
  - Three (3) of more samples returned – member meets screening.
  - Fewer than three (3) samples returned – member does not meet screening

Appropriate Care

MCDC – State Modified Comprehensive Diabetes Care

HbA1c, Eye exam and Nephropathy testing should be performed and documented for the measurement year.

HbA1c:

An HbA1c test performed during the measurement year. At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notations of the following: A1c, HbA1c, Hemoglobin A1c, Glycohemoglobin A1c, HgbA1c.

- Poor Control >9% - most recent documented HbA1c distinct result. Ranges and thresholds do not meet criteria and member is not compliant.
- HbA1c Control <8% - most recent documented HbA1c distinct result. Ranges and thresholds do not meet criteria and member is not compliance.
- HbA1c Control <7% for a Selected Population – most recent documented HbA1c distinct result. Rangers and thresholds do not meet criteria and member is not compliance.
- REQUIRED EXCLUSIONS for HbA1C Control <7% for a Selected Population. Provide documentation supporting any of the following exclusions through December 31 of the measurement year.
  - 65 years of age and older as of December 31 of the measurement year.
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- CABG. Dated documentation of CABG in the measurement year or the year before the measurement year.
- PCI. Dated documentation of PCI in the measurement year or the year before the measurement year.
- IVD. Documentation of an IVD diagnosis:
  - IVD.
  - Ischemic heart disease.
  - Angina.
  - Coronary atherosclerosis.
  - Coronary artery occlusion.
  - Cardiovascular disease.
  - Occlusion or stenosis or pre-cerebral arteries (including basilar, carotid and vertebral arteries).
  - Atherosclerosis of renal artery.
  - Atherosclerosis of native arteries of the extremities.
  - Chronic total occlusion of artery of the extremities.
  - Arterial embolism and thrombosis.
  - Atheroembolism.
  - Thoracoabdominal or thoracic aortic aneurysm.
  - CHF or cardiomyopathy.
  - Prior MI.
  - ESRD.
  - Chronic Kidney Disease (stage 4).
  - Dementia.
  - Blindness – in one or both eyes.
  - Amputation (lower extremity).

**Eye Exam:**

At a minimum, documentation in the medical records must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye
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professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.

- A chart of photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operated under the direction of a medical director who is a retinal specialist.

- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was present (e.g. documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional (optometrist or ophthalmologist) meets criteria).

Medical Attention for Nephropathy:

Documentation required with any of the following and will meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy:

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet this criteria:
  o 24-hour urine for albumin or protein.
  o Timed urine for albumin or protein.
  o Spot urine for albumin or protein.
  o Urine for albumin/creatinine ratio.
  o Random urine for protein/creatinine ratio.

- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type):
  o Diabetic nephropathy.
  o ESRD.
  o Chronic renal failure (CRF).
  o Chronic kidney disease (CKD).
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- Renal insufficiency.
- Proteinuria.
- Albuminuria.
- Renal dysfunction.
- Acute renal failure (ARF).
- Dialysis, hemodialysis or peritoneal dialysis.

- Evidence of ACE/ARB therapy. Documentation in the medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

BP Control <140/90 mmHg:

Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g. sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g. EKG/ECG, stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the member.

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading when multiple readings are recorded for a single date.