



# HEDIS<sup>®</sup> Pediatric Resource Guide



# What's Inside

## Pediatric Resource Guide

Pediatric and Behavioral Health Measures

- 1 | What is HEDIS®?
- 2 | HEDIS Reference Guide for Pediatrics

# What Is HEDIS®?

The Healthcare Effectiveness Data and Information Set (HEDIS) of performance measures is utilized by more than 90 percent of America's health plans. The performance measure rates generated, using the HEDIS measures' specifications, allow health plans to compare how well they perform to other health plans in the following areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

## Why HEDIS Is Important

HEDIS is a tool used by health plans to measure performance of health plans by consumers and employers.

## Value of HEDIS to You, Our Providers

HEDIS can help save you time while also potentially reducing healthcare costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care.

HEDIS can also help you:

- Identify noncompliant members to ensure they receive appropriate treatment and follow-up care
- Understand how you compare with other Missouri Care providers as well as with the national average

## Value of HEDIS to Your Patients, Our Members

HEDIS gives members the ability to review and compare plans' scores, helping them to make informed healthcare choices.

## What You Can Do

- Encourage your patients to schedule healthcare visits and required metabolic testing
- Remind your patients to follow up with ordered tests
- Complete outreach calls to noncompliant members

If you have questions about **HEDIS** or need more information, please contact your local Provider Relations representative or Quality Practice Advisor (QPA).

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*

Source: [www.ncqa.org](http://www.ncqa.org)

# HEDIS® Reference Guide for Pediatrics

The following measures in the HEDIS Quick Reference Guide are in compliance with the HEDIS® 2019 Volume 2 Technical Specifications. **Reimbursement for these services will be in accordance with the terms and conditions of your provider agreement.**

## Prevention and Screening

**Lead Screening in Children (LSC):** *Percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.*

Required Documentation	Key Notes
A note indicating the date the test was performed, and the result or finding.	A submitted lab slip with results will meet criteria.

**Childhood Immunizations by their 2<sup>nd</sup> Birthday (CIS):** *Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three H influenza type B (HiB), three hepatitis B (HepB), one chicken pox vaccine (VZV), four pneumococcal conjugate (PCV), one hepatitis A (HepA), two or three rotavirus (RV), and two influenza vaccines (flu) on or before their second birthday.*

Required Documentation	Key Notes										
<p>A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by a healthcare provider and contains the dates and types of immunizations given.</p> <p>Children 2 years of age who had the following vaccines by their second birthday:</p> <table border="0"> <tr> <td>4 DTaP</td> <td>1 VZV 1</td> </tr> <tr> <td>3 IPV</td> <td>Hepatitis A</td> </tr> <tr> <td>1 MMR</td> <td>2 Influenza</td> </tr> <tr> <td>3 HiB</td> <td>4 Pneumococcal conjugate</td> </tr> <tr> <td>3 Hepatitis B</td> <td>2 or 3 Rotavirus</td> </tr> </table> <p>*For MMR, VZV, and Hep A, the vaccinations must be administered on or between the child's first and second birthdays.</p> <ul style="list-style-type: none"> <li>For rotavirus, vaccine must be on different dates of service. The rotavirus vaccine maybe given as follows; 2 doses of the 2 dose vaccine, or 1 dose of the 2 dose vaccine and 2 doses of the 3 dose vaccine, or 3 doses of the 3 dose vaccine.</li> <li>Document history of specific disease, anaphylactic reactions, or contraindications for a specific vaccine.</li> </ul>	4 DTaP	1 VZV 1	3 IPV	Hepatitis A	1 MMR	2 Influenza	3 HiB	4 Pneumococcal conjugate	3 Hepatitis B	2 or 3 Rotavirus	<p>A note that says, "immunizations are up to date" does not count.</p> <p>This measure follows CDC and ACIP guidelines for immunizations.</p>
4 DTaP	1 VZV 1										
3 IPV	Hepatitis A										
1 MMR	2 Influenza										
3 HiB	4 Pneumococcal conjugate										
3 Hepatitis B	2 or 3 Rotavirus										

**Immunizations for Adolescents (IMA):** *The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13<sup>th</sup> birthday.*

Required Documentation	Key Notes
A note indicating the name of the specific antigen and the date of the immunization, or a certificate of immunization prepared by a healthcare provider and contains the dates and types of immunizations given.	<p>A note that says "immunizations are up to date" does not count.</p> <p>This measure follows CDC and ACIP guidelines for immunizations.</p>

**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):** Percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

*\*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Required Documentation	Key Notes
<ul style="list-style-type: none"> <li>BMI percentile documentation</li> <li>Counseling for nutrition</li> <li>Counseling for physical activity</li> </ul> <p><i>BMI Percentile:</i></p> <ul style="list-style-type: none"> <li>A documented BMI percentile or BMI percentile plotted on an age-growth chart for members 3-17 years old.</li> <li>Documentation of &gt;99% or &lt;1 % meets criteria because a distinct BMI percentile is evident (i.e., 100% or 0%)</li> <li>Documentation must also include the height and weight and must be from the same data source.</li> </ul> <p><i>Counseling for 'Nutrition' and 'Physical Activity':</i></p> <ul style="list-style-type: none"> <li>Discussion of current nutrition and physical activity behaviors (eating habits, dieting behaviors, exercise routine, participation in sports, exam for sports participation), or</li> <li>A checklist indicating nutrition and physical activity was addressed, or</li> <li>Counseling or referral for nutrition education and physical activity, or</li> <li>A note stating the member received educational materials on nutrition and physical activity during a face to face visit, or</li> <li>An anticipatory guidance for nutrition and physical activity, or</li> <li>Weight or obesity counseling.               <ul style="list-style-type: none"> <li>Service rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specific documentation is present.</li> </ul> </li> </ul>	<p>The following <b>do not</b> count:</p> <ul style="list-style-type: none"> <li>A BMI value only</li> <li>A height and weight without the BMI percentile</li> <li>No BMI percentile on the record</li> <li>Ranges and thresholds</li> </ul> <p>Documented services that <b>do not</b> count for Nutritional counseling:</p> <ul style="list-style-type: none"> <li>Notes of “health education,” or “anticipatory guidance” without specific mention of nutrition,</li> <li>Counseling/education before or after the measurement year,</li> <li>No notes for counseling/education on nutrition,</li> <li>Notation related to appetite and diet,</li> <li>A physical exam finding alone (e.g., well-nourished) because it doesn't indicate counseling for nutrition.</li> </ul> <p>Documentations that <b>do not</b> count for physical activity counseling:</p> <ul style="list-style-type: none"> <li>Notes of “cleared for gym class,” “health education,”</li> <li>Anticipatory guidance related to “computer or TV time”,</li> <li>Anticipatory guidance related solely to safety without specific mention of physical activity,</li> <li>Counseling/education before or after the measurement year, and</li> <li>No notes for counseling/education on physical activity.</li> </ul> <p>For both nutritional and physical activity counseling: Services may be rendered during a visit other than a well-child visit but services specific to the assessment or treatment of an acute or chronic condition do not count toward the “Counseling for Nutrition” and “Counseling for Physical Activity” indicators. For example, notation that a member has decreased appetite as a result of an acute or chronic condition or notation that a member has exercise-induced asthma.</p> <p>Females who have a diagnosis of pregnancy are excluded.</p>

**Chlamydia Screening in Women (CHL):** Percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Required Documentation	Key Notes
<p>A note indicating the date the test was performed, and the result or finding.</p>	<p>Test with either a urine analysis or vaginal ThinPrep used for the Pap smear. Samples must be sent to a lab vendor for analysis.</p>

## Utilization

**Well-Child Visits in the First 15 Months of Life (W15):** *Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 month of life:*

- No well-child visits.
- One well-child visit.
- Two well-child visits.
- Three well-child visits.
- Four well-child visits.
- Five well-child visits.
- Six or more well-child visits.

*Please note: Need to have at least six or more well child visits before the first 15 months of life.*

Required Documentation	Key Notes
<p>Documentation of a visit to a PCP, the date of the visit and all of the following:</p> <ul style="list-style-type: none"> <li>• A health history</li> <li>• Two developmental histories (physical and mental)</li> <li>• A physical exam</li> <li>• Health education/anticipatory guidance</li> </ul>	<p>The following do not count:</p> <ul style="list-style-type: none"> <li>• Allergies, medications, or immunizations alone (but if all three are present, it will count)</li> <li>• Tanner stage/scale</li> <li>• “Appropriate for age” without mentioning the type of physical and mental development.</li> <li>• “Well-developed/nourished/appearing”</li> <li>• “Neurological exam”</li> <li>• Vital signs alone for the physical exam</li> <li>• Health education/anticipatory guidance related to medications or immunizations or the side effect</li> </ul> <p>Services specific to the assessment or treatment of an acute or chronic condition do not count toward this measure.</p> <p>Services rendered during an inpatient or ED visit does not count.</p>

**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34):** *Percentage of members who were 3, 4, 5 or 6 years of age who received one or more well-child visits with a primary care provider during the measurement year.*

Required Documentation	Key Notes
<p>Documentation of a visit to a PCP or OBGYN, the date of the visit and all of the following:</p> <ul style="list-style-type: none"> <li>• A health history</li> <li>• Two developmental histories (physical and mental)</li> <li>• A physical exam</li> <li>• Health education/anticipatory guidance</li> </ul>	<p>Documentation that does not count:</p> <ul style="list-style-type: none"> <li>• Allergies, medications, or immunizations alone (but if all three are present, it will count)</li> <li>• Tanner stage/scale</li> <li>• “Appropriate for age” without mentioning the type of physical and mental development</li> <li>• “Well-developed/nourished/appearing”</li> <li>• “Neurological exam”</li> <li>• Vital signs alone for the physical exam</li> <li>• Health education/anticipatory guidance related to medications or immunizations or the side effect</li> </ul> <p>Services specific to the assessment or treatment of an acute or chronic condition do not count toward this measure.</p> <p>Services rendered during an inpatient or ED visit does not count.</p>

**Adolescent Well Visits (AWC):** *Percentage of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.*

Required Documentation	Key Notes
<p>Documentation of a visit to a PCP or OBGYN, the date of the visit and all of the following:</p> <ul style="list-style-type: none"> <li>• A health history</li> <li>• Two developmental histories (physical and mental)</li> <li>• A physical exam</li> <li>• Health education/anticipatory guidance</li> </ul> <p>The Tanner stage/scale will count for Physical Development History.</p>	<p>Documentation that does not count:</p> <ul style="list-style-type: none"> <li>• Allergies, medications, or immunizations alone (but If all three are present, it will count)</li> <li>• “Appropriate for age” without mentioning the type of physical and mental development</li> <li>• “Well-developed/nourished/appearing”</li> <li>• “Neurological exam” or “Appropriately responsive” for development</li> <li>• Vital signs alone for the physical exam</li> <li>• Health education/anticipatory guidance related to medications or immunizations or the side effect</li> <li>• Notations of prenatal and postpartum topics only</li> </ul> <p>Services specific to the assessment or treatment of an acute or chronic condition do not count toward this measure.</p> <p>Services rendered during an inpatient or ED visit does not count.</p>

## Risk Adjusted Utilization

### FIRST-YEAR MEASURE

**Hospitalization Following Discharge From a Skilled Nursing Facility (HFS):** For members 18 years of age and older, the percentage of skilled nursing facility discharges to the community that were followed by an unplanned acute hospitalization for any diagnosis within 30 and 60 days. Data are reported in the following categories:

- Count of skilled nursing facility discharges to the community (SND).
- Count of observed 30-day hospitalizations.
- Count of expected 30-day hospitalizations.
- Count of observed 60-day hospitalizations.
- Count of expected 60-day hospitalizations.

Required Documentation	Key Notes
Intentionally left blank	Exclude members living long-term in an institution.

## Access/Availability of Care

**Children & Adolescents Access to Primary Care Practitioners (CAP):** Percentage of members 12 months–19 years of age who had a visit with a PCP.

Required Documentation	Key Notes
Intentionally left blank	<p>Referred to as a “Preventive Visit” on the Care Gap Reports and measure is met by <b>either</b> a sick or a well visit.</p> <p>A regular source of care improves health outcomes.</p> <p>Balance supply and demand; make it easy for the members to receive the care, treatment and test needed.</p> <p>Try to schedule follow-up appointment before the member/parent leaves the office.</p> <p>Follow-up with a phone call and postcard if the member misses an appointment.</p>

**Annual Dental Visits (ADV):** Percentage of members 2–20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.

Required Documentation	Key Notes
Intentionally left blank	If applicable, please refer your patients for a dental screening annually. Services must be rendered by a dental provider.

**Prenatal and Postpartum Care (PPC):** *The percentage of deliveries of live births on or between Nov. 6 of the year prior to the measurement year and Nov. 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.*

- **Timeliness of Prenatal Care:** *The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.*
- **Postpartum Care:** *The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.*

Required Documentation	Key Notes
<p>A prenatal visit during the first trimester with an OB/GYN, midwife, family practitioner, or PCP, with a pregnancy-related diagnosis code, the date the visit occurred AND AT LEAST ONE of the following:</p> <ul style="list-style-type: none"> <li>• A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundal height (a standardized prenatal flow sheet may be used);</li> <li>• Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing);</li> <li>• An ultrasound (echocardiography) of the pregnant uterus;</li> <li>• A TORCH antibody panel alone (all on the same date):               <ul style="list-style-type: none"> <li>- Toxoplasma</li> <li>- Rubella</li> <li>- Cytomegalovirus</li> <li>- Herpes simplex</li> </ul> </li> <li>• A rubella antibody test AND an ABO test on the same or different dates of service</li> <li>• A rubella antibody test AND an Rh test on the same or different dates of service</li> <li>• A rubella antibody test AND an ABO/Rh test on the same or different dates of service</li> <li>• Documentation of LMP, EDD or gestational age with either a prenatal risk assessment and counseling/education or a complete obstetrical history.</li> </ul> <p>A postpartum visit - the medical record must include the day the visit occurred and one of the following:</p> <ul style="list-style-type: none"> <li>• Pelvic exam</li> <li>• Evaluation of weight, BP, breasts and abdomen               <ul style="list-style-type: none"> <li>- Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component</li> </ul> </li> <li>• Notation of postpartum care, including, but not limited to:               <ul style="list-style-type: none"> <li>- Notation of "postpartum care," "PP care," "PP check," "6-week check."</li> <li>- A preprinted "Postpartum Care" form in which information was documented during the visit.</li> </ul> </li> </ul>	<p>A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.</p>

**Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET):** *The percentage of adolescent and adult members 13 years of age and older with a new episode of alcohol and other drug (AOD) abuse or dependence who received the following:*

- **Initiation of AOD Treatment:** *The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.*
- **Engagement of AOD Treatment:** *The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.*

Required Documentation	Key Notes
Intentionally left blank	<p>Schedule the 14-day follow-up visit within 10 days to allow flexibility in rescheduling. Involve the member's caregiver regarding the follow-up plan, if possible.</p> <p>At the end of the initial follow-up appointment, schedule two more follow-up appointments to occur within 34 days of the initial follow-up appointment.</p> <p>When treating a member for issues related to an alcohol or other drug dependence diagnosis, code for that diagnosis on every claim.</p>

**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP):** *The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.*

Required Documentation	Key Notes
Member must have documentation of psychosocial care (with or without a telehealth modifier) as first-line treatment prior to initiation of medication therapy.	For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a>

## Respiratory Conditions

**Appropriate Testing for Children With Pharyngitis (CWP):** *Percentage of children 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).*

Required Documentation	Key Notes
Intentionally left blank	Inpatient stays do not count. Throat culture samples must be sent to the lab for analysis. A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.

**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** *Percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.*

Required Documentation	Key Notes
Intentionally left blank	Inpatient stays do not count A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.

**Medication Management for People with Asthma (MMA):** *Percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:*

- Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
- Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Required Documentation	Key Notes
Intentionally left blank	The Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma recommend that because asthma is a chronic inflammatory disorder of the airway, persistent asthma is most effectively controlled with daily long-term control medication directed toward suppression of airway inflammation. Additionally, the Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, recommends all asthma patients receive a written asthma action plan. FDA-Approved Asthma Medications: For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a> .

**Asthma Medication Ratio (AMR):** *The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.*

Required Documentation	Key Notes
Intentionally left blank	FDA-Approved Asthma Medications: For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a> .

## Behavioral Health

You can also find Behavioral Health measures under the following domain headings: Measures Collected Using Electronic Clinical Data Systems, Overuse/Appropriateness and Access/Availability of Care.

**Follow-up After Hospitalization for Mental Illness (FUH):** Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health practitioner. Two rates are reported:

1. The percentage of discharges with a follow-up within 30 days of discharge.
2. The percentage of discharges with a follow-up within 7 days of discharge.

Required Documentation	Key Notes
Intentionally left blank	<ul style="list-style-type: none"> <li>• Excludes discharges followed by readmission or direct transfer to non-acute inpatient setting within the 30-day follow-up period.</li> <li>• The follow-up visit must be with a mental health practitioner.</li> <li>• Member must be 6 years or older as of the date of discharge.</li> <li>• Schedule the 7-day follow-up visit within 5 days to allow flexibility in rescheduling, if necessary.</li> <li>• If follow-up visit does not occur within 7 days, schedule the appointment to occur within the 30-day timeframe.</li> <li>• Do not include visits that occur on the date of discharge.</li> </ul>

**Follow-Up After Emergency Department Visit for Mental Illness (FUM):** The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.

The follow-up visit after the ED visit can be with any practitioner. Member must be 6 years or older on the date of the ED visit.

Required Documentation	Key Notes
Intentionally left blank	<p>If the member's appointment does not occur within the first 7 days post-ED visit, please schedule the appointment to occur within 30 days post-ED visit.</p> <ul style="list-style-type: none"> <li>• Excludes ED visits that result in an admission on same day or within 30 days of ED visit.</li> <li>• The follow-up visit after the ED visit can be with any practitioner.</li> <li>• Member must be 6 years or older on the date of the ED visit.</li> <li>• Schedule the 7-day follow-up visit within 5 days to allow flexibility in rescheduling, if necessary.</li> <li>• Visit can occur on the same date of the ED visit.</li> </ul>

**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA):** The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence who had a follow-up visit for AOD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.

The follow-up visit after the ED visit can be with any practitioner. Member must be 13 years or older on the date of the visit.

Required Documentation	Key Notes
Intentionally left blank	<ul style="list-style-type: none"> <li>• Involve the member's caregiver regarding the follow-up plan after ED visit, if possible.</li> </ul> <p>If the member's appointment does not occur within the first 7 days post-ED visit, please schedule the appointment to occur within 30 days post-ED visit.</p> <p>Schedule the 7-day follow-up visit within 5 days.</p>

**Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC):** *Percentage of children and adolescents ages 1–17 who were on 2 or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. (Note: A lower rate indicates better performance.)*

Required Documentation	Key Notes
Intentionally left blank	<p>Lower rate of concurrent antipsychotics indicates better performance.</p> <ul style="list-style-type: none"> <li>• Be sure to complete the following for members: <ul style="list-style-type: none"> <li>- Blood glucose test or HbA1c annually</li> <li>- LDL-C test annually</li> </ul> </li> </ul> <p>Consider using standing orders to complete these labs.</p> <p>For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a>.</p>

**Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM):**

*Percentage of children and adolescents ages 1–17 who had 2 or more antipsychotic prescriptions and had metabolic testing.*

Required Documentation	Key Notes
A note indicating at least one test for blood glucose or HbA1c AND one test for LDL-C or cholesterol.	<ul style="list-style-type: none"> <li>• To increase compliance, consider using standing orders to get labs completed.</li> </ul> <p>For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a>.</p>

**Follow-Up Care for Children Prescribed ADHD Medications (ADD):** *The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:*

- **Initiation Phase:** *The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.*
- **Continuation and Maintenance (C&M) Phase:** *The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.*

Required Documentation	Key Notes
Intentionally left blank	<p>When prescribing a new medication, be sure to schedule a follow-up visit within 30 days to assess how the medication is working and to address side effect issues.</p> <ul style="list-style-type: none"> <li>• Schedule this visit (allow for time to reschedule prior to 30 days, if necessary) while your patient is still in the office.</li> <li>• Schedule two more visits in the 9 months after the 30-day Initiation Phase to continue to monitor patient's progress. (At least two follow-up visits on different dates of service. Only one of the two visits may be a telephone visit or telehealth visit.)</li> </ul> <p>For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a>.</p>

## Medication Management and Care Coordination

**Transitions of Care (TRC):** Percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- **Notification of Inpatient Admission.** Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
- **Receipt of Discharge Information.** Documentation of receipt of discharge information on the day of discharge or the following day.
- **Patient Engagement After Inpatient Discharge.** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- **Medication Reconciliation Post-Discharge.** Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

### Required Documentation

- Only one outpatient medical record can be used for all indicators.

#### Notification of inpatient documentation:

- Notification must include the date when the documentation was received.

#### Receipt of discharge information documentation:

- Discharge information may be included in, but not limited to, a discharge summary or summary of care record or an EHR. The discharge information must include all of the following:
  - The practitioner responsible for the member's care during the inpatient stay.
  - Procedures or treatment provided.
  - Diagnoses at discharge.
  - Current medication list (including medication allergies).
  - Testing results, or documentation of pending tests or no tests pending.
  - Instructions to the PCP or ongoing care provider for patient care.

#### Patient engagement after discharge documentation:

- Engagement cannot be on the date of discharge.
- Must be within 30 days after discharge.

#### Medication reconciliation post-discharge documentation:

- Documentation must be outpatient and include evidence of medication reconciliation and the date when it was performed. A current medication list must be in the record and any of the following meets criteria:
  - Notation of the current medications were reconciled with the discharged medications,
  - Notation of the current medications are the same medications at discharge or to discontinue the all discharge medications,
  - Notation of both current and discharge medications were reviewed,
  - Both medication lists (current and discharge) in the chart with a notation the lists were reviewed on the same day,
  - Notation that the member was seen post discharge and the medications were reviewed,
  - Notation that there were no medications prescribed or ordered upon discharge.
  - Notation in the discharge summary that discharge medications were reconciled with the most recent medication list. Discharge summary must be in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).

**Member or family notification of admission or discharge does not meet criteria.**

### Key Notes

Member or family notification of admission or discharge does not meet criteria.

Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.

Communication to the PCP can be done by phone, email, or fax and must be documented.

Follow-up care can include office, home, and telehealth visits.

**Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC):** Percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

**Note:** Members in hospice are excluded from the eligible population.

Required Documentation	Key Notes
Within 7 days of discharge	Schedule the 7-day follow-up visit within 5 days to allow flexibility in rescheduling, if necessary. Involve the patient's caregiver regarding the follow-up plan after discharge.

## Overuse/Appropriateness

**Use of Opioids at High Dosage (UOD):** For members 18 years and older, receiving prescription opioids for  $\geq 15$  days during the measurement year at a high dosage (average milligram morphine dose [MME]  $> 120$  mg).

Required Documentation	Key Notes
Intentionally left blank	<ul style="list-style-type: none"> <li>Guidelines on opioid prescribing for chronic, non-malignant pain recommend the use of "additional precautions" when prescribing dosages.</li> <li><math>\geq 50</math> morphine equivalent dose (MME) and recommends avoiding increasing dosages <math>\geq 90</math>mg (MME) or to "carefully justify" dosage <math>\geq 90</math>mg (MME) (CDC, 2016).</li> <li>For members who are already taking doses <math>\geq 90</math>mg (MME), the CDC recommends that providers should "explain in a nonjudgmental manner" the risks and benefits of continuing high-dose opioids, and should offer these members the opportunity to taper to a safer, lower dose.</li> <li>A lower rate indicates better performance.</li> <li>For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a>.</li> </ul>

**Use of Opioids From Multiple Providers (UOP):** For members 18 years and older, receiving prescription opioids for  $\geq 15$  days during the measurement year who received opioids from multiple providers. Three rates are reported.

- Multiple Prescribers:** The proportion of members receiving prescriptions for opioids from four or more different prescribers during measurement year.
- Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
- Multiple Prescribers and Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year.

Required Documentation	Key Notes
Intentionally left blank	<ul style="list-style-type: none"> <li>Guidelines for prescribing opioids for chronic, non-malignant pain recommends the use of "additional precautions".</li> <li><math>\geq 50</math> morphine equivalent dose (MME) and recommends avoiding increasing dosages <math>\geq 90</math>mg (MME) or to "carefully justify" dosage <math>\geq 90</math>mg (MME) (CDC, 2016).</li> <li>For members who are already taking doses <math>\geq 90</math>mg (MME), the CDC recommends that providers should "explain in a nonjudgmental manner" the risks and benefits of continuing high-dose opioids, and should offer these members the opportunity to taper to a safer, lower dose.</li> <li>A lower rate indicates better performance.</li> <li>For a complete list of medications and NDC codes, please visit <a href="http://www.ncqa.org">www.ncqa.org</a>.</li> </ul>

### FIRST-YEAR MEASURE

**Risk of Continued Opioid Use (COU):** The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

- The percentage of members whose new episode of opioid use lasts at least 15 days in a 30-day period.
- The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period.

Required Documentation	Key Notes
Intentionally left blank	<p>A lower rate indicates better performance.</p> <p>Exclusions: members in hospice</p>

## Measures Collected Using Electronic Clinical Data Systems

**Depression Screening and Follow-Up for Adolescents and Adults (DSF):** *The percentage of members 12 years of age and older who were screened for clinical depression using an age-appropriate standardized tool and, if screened positive, who received follow-up care.*

- **Depression Screening:** *The percentage of members who were screened for clinical depression using a standardized tool.*
- **Follow-Up on Positive Screen:** *The percentage of members who received follow-up care within 30 days of screening positive for depression.*

Required Documentation	Key Notes
<p>Documentation of depression screening performed using an age-appropriate standardized instrument.</p> <ul style="list-style-type: none"> <li>• PHQ-9: For 12 years of age and above</li> <li>• PHQ-9: Modified for Teens ages 12-18</li> </ul>	<ul style="list-style-type: none"> <li>• Selection of the appropriate assessment should be based on the age of the member.</li> <li>• Follow-up care on or 30 days after the date of the first positive screen (31 days total).</li> </ul>

**Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS):** *Percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.*

Required Documentation	Key Notes
<p>Use PHQ-9 assessments based on the member's age:</p> <ul style="list-style-type: none"> <li>• PHQ-9: 12 years of age and older.</li> <li>• PHQ-9: Modified for Teens: 12–18 years of age.</li> </ul>	<p>The PHQ-9 assessment does not need to occur during a face-to-face encounter; for example, it can be completed over the telephone or through a Web-based portal.</p> <p><b>Clinical Recommendation Statement</b></p> <p>“Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms.”<sup>9</sup></p> <p>“For adolescents, guidelines recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms.”<sup>10</sup> The PHQ-9 tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IV-TR) criteria symptoms and effects on functioning, and has been shown to be highly accurate in discriminating patients with persistent major depression, partial remission and full remission.</p> <p><sup>9</sup> Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. <i>Adult Depression in Primary Care</i>. Updated March 2016.</p> <p><sup>10</sup> Cheung, A.H., R.A. Zuckerbrot, P.S. Jensen, K. Ghalib, D. Laraque, R.E.K. Stein. 2007. GLAD-PC Steering Group. “Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing management.” <i>Pediatrics</i> 120(5):e1313–26.</p>

**Depression Remission or Response for Adolescents and Adults (DRR):** *The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4 to 8 months of the elevated score.*

- **Follow-Up PHQ-9.** *The percentage of members who have a follow-up PHQ-9 score documented within the 4 to 8 months after the initial elevated PHQ-9 score.*
- **Depression Remission.** *The percentage of members who achieved remission within 4 to 8 months after the initial elevated PHQ-9 score.*
- **Depression Response.** *The percentage of members who showed response within 4 to 8 months after the initial elevated PHQ-9 score.*

Required Documentation	Key Notes
<p>Selection of the appropriate assessment should be based on the age of the member.</p> <ul style="list-style-type: none"> <li>• PHQ-9: For 12 years of age and above.</li> <li>• PHQ-9 Modified for Teens: For ages 12–18.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Follow-Up PHQ-9:</b> The PHQ-9 assessment does not need to occur during a face-to-face encounter; for example, it can be completed over the telephone or through a web-based portal.</li> <li>• <b>Depression Remission:</b> Must be the most recent score recorded.</li> <li>• <b>Depression Response:</b> The score must be the most recent noted in the member's record during the depression follow-up period. Members who indicate a response to depression treatment as noted by a PHQ-9 depression response score at least 50% lower than the PHQ-9 score associated with the Index Episode Start Date (IESD), recorded in the ECDS during the depression follow-up period.</li> </ul>

**Unhealthy Alcohol Use Screening and Follow Up (ASF):** *The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized tool and, if screened positive, received appropriate follow-up care.*

- **Unhealthy Alcohol Use Screening:** *The percentage of members who had a systematic screening for unhealthy alcohol use.*
- **Alcohol Counseling or Other Follow-Up Care:** *The percentage of members who screened positive for unhealthy alcohol use and received brief counseling or other follow-up care within 2 months of a positive screening.*

Required Documentation	Key Notes
<p><i>Unhealthy Alcohol Use Screening:</i> An adult standard assessment tool: Audit, Audit-C and single question screenings.</p> <ul style="list-style-type: none"> <li>• Must have documented results of the screening performed between Jan. 1 and Nov. 1 of the measurement year.</li> </ul> <p><i>Counseling or follow-up on Positive Screen:</i> Counseling or follow-up care on or 60 days after the first positive screening.</p>	<p>The assessment does not need to occur during a face-to-face encounter; for example, it can be completed over the telephone or through a Web-based portal.</p> <p>Schedule follow-up appointment, on or 60 days after the first positive screening, for members with positive screen to receive appropriate care.</p>

**FIRST-YEAR MEASURE**

**Adult Immunization Status (AIS):** *The percentage of members 19 years of age and older who are up-to-date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.*

Required Documentation	Key Notes
<p>A note indicating the specific antigen name and the immunization date, or an immunization certificate prepared by a healthcare provider that has the dates of administration.</p> <p>Document history of specific disease, anaphylactic reactions or contraindications for a specific vaccine.</p>	<p>Encourage members to receive their vaccinations.</p>

**FIRST-YEAR MEASURE**

**Prenatal Immunizations Status (PRS):** *The percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.*

Required Documentation	Key Notes
<p>A note indicating the specific antigen name and the immunization date, or an immunization certificate prepared by a healthcare provider that has the dates of administration.</p> <p>Document history of specific disease, anaphylactic reactions or contraindications for a specific vaccine.</p>	<p>Encourage members to receive their vaccinations.</p>

Source: HEDIS® 2019 Volume 2 Technical Specifications

This document is an informational resource designed to assist licensed healthcare practitioners in caring for their patients. Healthcare practitioners should use their professional judgment in using the information provided. HEDIS measures are not a substitute for the care provided by licensed healthcare practitioners and patients are urged to consult with their healthcare practitioner for appropriate treatment.







[www.wellcare.com/Missouri](http://www.wellcare.com/Missouri)

PRO\_20613E Internal Approved 08202018  
©WellCare 2018

MO9PROGDE20613E\_0000

**Quality care is a team effort.  
Thank you for playing a starring role!**

**missouricare**  <sup>SM</sup>  
A WellCare Company