

HEDIS Hybrid Measure Issues

Measure	Issues Impacting Compliance	Actions to Take
All Measures	<ul style="list-style-type: none"> Medical records do not have a name and DOB or MRN on every page, so oftentimes unable to verify that the medical record belongs to the same member Handwritten documentation in medical records is often difficult to interpret 	<ul style="list-style-type: none"> Need name and DOB or MRN clearly documented on every page Switch from hand-written documentation to an electronic (typed) version
BPD/CBP <ul style="list-style-type: none"> Blood Pressure- Diabetes Controlling High BP 	<ul style="list-style-type: none"> Lack of documentation for BP retakes when BP elevated Lack of documentation of BP value or "average" value during a telehealth or telephone visit 	<ul style="list-style-type: none"> Recheck BP if > 140 and/or >90, document original and retake During telehealth visits document BP taken by member with a digital device or average BP (no ranges)
COA <ul style="list-style-type: none"> Care of Older Adults 	<ul style="list-style-type: none"> Functional status assessment not including enough ADLs/IADLs Medication Review – Only including the code for the presence of a medication list 	<ul style="list-style-type: none"> Need to document at least 5 ADLs and/or 4 IADLs Need to include the second code that indicates a medication review took place
EED <ul style="list-style-type: none"> Eye Exam - Diabetes 	<ul style="list-style-type: none"> No documentation of details on last diabetic eye exam 	<ul style="list-style-type: none"> Need documentation of retinal/dilated eye exam by an eye care professional (who the professional was), the date and the results
PPC	<ul style="list-style-type: none"> Lack of pregnancy diagnosis for confirmation of pregnancy visit with PCP 	<ul style="list-style-type: none"> Need positive pregnancy test, as well as diagnosis of pregnancy
TRC <ul style="list-style-type: none"> Transitions of Care 	<ul style="list-style-type: none"> No documentation of when provider is notified of member's hospital admission and/or when provider receives member's DC summary Follow up after inpatient admission - lack of documentation stating admission or inpatient stay along with hospitalization dates 	<ul style="list-style-type: none"> Need documentation of the date when provider is notified of member's inpatient admission and when DC summary is received along with provider signature or initials Include documentation that references visit for "hospital follow-up," "admission," "inpatient stay" along with dates of admission

Childhood Measures - Issues and Actions for Compliancy

Measure	Issues Impacting Compliance	Actions to Take
CIS-E - Childhood Immunization Status	<ul style="list-style-type: none"> ▪ Immunizations given after 2nd birthday ▪ Missing documentation of complete series of immunizations given 	<ul style="list-style-type: none"> ▪ Monitor for when the 2nd birthday will occur and coordinate visits so that all vaccines will occur by 2 years of age ▪ Inquire where immunization occurred if not within your records
WCV - Child and Adolescent Well-Care Visits	<ul style="list-style-type: none"> ▪ Use of appropriate codes ▪ Appropriate provider/visit type 	<ul style="list-style-type: none"> ▪ Recommended CPT Codes: 99381–99385, 99391–99395, 99461 ▪ Recommended ICD-10 Codes: Z00.00–Z00.01, Z00.110–Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z02.84, Z76.1–Z76.2 ▪ PCP or OBGYN ▪ Telehealth visits no longer allowed