US FAMILY HEALTH PLAN

Care Gap Reporting & Closure

Spring 2024

USFHP Care Gaps

- Focus on DHA's priority measures
- Determined by available claims data and supplemental data submitted to USFHP
- Identified based on HEDIS measure criteria without continuous enrollment using HEDIS certified software
- Monthly data refresh

- Breast Cancer Screening (BCS-E)
- Controlling High Blood Pressure (CBP)
- Cervical Cancer Screening (CCS-E)
- Colorectal Cancer Screening (COL-E)
- Eye Exam for Patients with Diabetes (EED)
- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Well Child Visits (W30 and WCV)
- Social Needs Screening and Intervention (SNS-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Closing Care Gaps

In order for a care gap to be closed, one of the following must occur:

- ❑ a claim for the service must be received; or
- ❑ a claim for exclusion must be received; or
- ❑ HEDIS team must receive documentation of service or exclusion that meets HEDIS criteria to use as supplemental data

Ordering the test or making a referral does not meet criteria; the member must actually complete it!

Breast Cancer Screening (BCS-E)

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Measure	Exclusions	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
Women, people with female sex assigned at birth, or female gender at any time in the member's history 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years	• Bilateral mastectomy • Unilateral mastectomy with bilateral modifier • History of gender-affirming chest surgery (CPT 19318) with diagnosis of gender dysphoria	• Document date and result last mammogram • HEDIS-acceptable mammography: diagnostic, film, digital, or digital tomosynthesis • MRIs, ultrasounds, and biopsies **DO NOT** count toward HEDIS compliance. • Document and code exclusions found in the member's history or on exam	• Date and result of last mammogram • Mammography result report • Patient mammogram result letter • Document history or exam finding of bilateral mastectomy	***Screening:*** CPT: 77061-77067 ***Exclusion:*** ICD10CM: 0HTV0ZZ

Note: *TRICARE covers screening beginning at age 40.*

Controlling High Blood Pressure (CBP)

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Measure	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
Adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/ <90 mm Hg)	• Document the patient's blood pressure at each visit • If patient's blood pressure is uncontrolled upon arrival, recheck the blood pressure before the patient leaves the clinic • Document all blood pressure readings if taken multiple times during a visit • Adequately treat uncontrolled blood pressure • Schedule follow-up appointments for BP check if reading remains uncontrolled while at the clinic	• BP values coded in EMR • CPTII codes submitted on claims	3074F: Systolic <130 mm Hg 3075F: Systolic 130-139 mm Hg 3077F: Systolic ≥140 mm Hg 3078F: Diastolic <80 mm Hg 3079F: Diastolic 80-89 mm Hg 3080F: Diastolic ≥90 mm Hg

Note: *HEDIS looks at the latest blood pressure of the year, regardless of control throughout the year.*

Cervical Cancer Screening (CCS-E)

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Measure	Exclusions	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
Women or individuals with a cervix 21–64 years of age who were recommended for routine cervical cancer screening and were who were screened for cervical cancer using any of the following criteria: • Cervical cytology performed within the last 3 years (ages 21-64) • Cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years (ages 30-64) • Cervical cytology with hrHPV co-testing within the last 5 years (ages 30-64)	• Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix • Male sex assigned at birth	• Document date and result of patient's last cervical screening • Complete screening if PCP provides GYN services • Refer to GYN and ensure screening completion • Document and code exclusions found in the member's history or on exam using terms "Complete," "total," or "radical" hysterectomy • **Must explicitly indicate cervix is surgically absent**	• Date and result of last pap smear and hrHPV • Lab report • Clear and correct documentation of exclusions – complete, radical or total hysterectomy	***Screening:*** CPT: 88141-88143, 88147-88148, 88150, 88152-88153, 88164-88167, 88174-88175 HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001 Q0091 ***Exclusion:*** ICD10CM: Z90.710

Colorectal Cancer Screening (COL-E)

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Measure	Exclusions	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
Members 45–75 years of age who had appropriate screening for colorectal cancer	• History of colorectal cancer • History of total colectomy	Order one of the following as part of preventative care visit or when care gap identified: ○ Annually: Fecal Immunochemical Test (FIT) or guaiac (gFOBT) ○ Every 3 years: Stool FIT-DNA test (Cologuard) ○ Every 5 years: Flexible sigmoidoscopy ○ Every 5 years: CT colonography ○ Every 10 years: Colonoscopy	Date and result of last colorectal cancer screening, including location/provider and recommendations for next screening	**FIT/gFOBT** – ▪ CPT: 82270, 82274 ▪ HCPCS: G0328 **sFIT-DNA Cologuard** – ▪ CPT: 81528 ▪ LOINC: 77353-1, 77354-9 **Flex Sig** – ▪ CPT: 45330-45335, 45337-45338, 45340-45342, 45346-45347, 45349-45350 ▪ HCPCS: G0104 **CT Colonography** – ▪ CPT: 74621-74623 **Colonoscopy** – ▪ CPT: 44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393,45398 ▪ HCPCS: G0105 (high risk), G0121 (normal risk) **Exclusions:** ICD10CM: Z85.038, Z85.048, C18-C21

Eye Exam for Patients with Diabetes (EED)

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Measure	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
Members 18–75 years of age with diabetes (types 1 and 2) who received a diabetic retinal eye evaluation by an ophthalmologist or optometrist	• Complete retinal imaging in primary care setting with images sent to eye specialist for interpretation. Maintain documentation in chart. • Refer member to Ophthalmologist or Optometrist and follow up to ensure completion	• Diabetic eye exam report letter from eye care provider to PCP • Retinal imaging report reviewed by eye specialist • CPTII codes indicating presence or absence of retinopathy submitted on claims	Eye Exam <u>With</u> Evidence of Retinopathy: 2022F, 2024F, 2026F Eye Exam <u>Without</u> Evidence of Retinopathy: 2023F, 2025F 2033F

Glycemic Status Assessment for Patients with Diabetes (GSD)

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Measure	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
Members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (A1c) or glucose management indicator (GMI) is at the following levels: • Glycemic Status Controlled <8.0% • Glycemic Status Poorly Controlled >9%	• Document date and result of patient's last HbA1c test • Document date ranges of continuous glucose monitoring used to derive the value • If test was completed with a different provider, note date and test results in chart • Order HbA1c lab test as part of diabetic care visit. Results required for HEDIS compliance.	• Lab report • Date and result of A1c test • CPTII codes indicating results submitted on claims	3044F: HbA1c <7.0 3051F: HbA1c ≥7.0 & <8.0 3052F: HbA1c ≥8.0 & ≤9.0 3046F: HbA1c >9.0

Notes:

Measure name changed, formerly Hemoglobin A1c Control for Patients with Diabetes.
HEDIS looks at the latest A1c result of the year, regardless of control throughout the year.

Well Child Visits (W30 and WCV)

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Measure	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
Well Child Visits in the First 15 Months (W30) The percentage of children who: • turn 15 months old during the year who have six or more well child visits with a PCP by 15 months of age • turn 30 months during the year and have 2 or more well child visits with a PCP between 15 and 30 months of age **Child and Adolescent Well Care Visits (WCV)** Members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the year	• Follow AAP's Schedule of Well-Child Visits • Create appointment reminders for subsequent well child visits at the time of the current visit	• Coding for all visits • Progress notes	ICD10CM: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, or Z76.2 CPT: 99381-99385, 99391-99395, 99461

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

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Measure	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
The percentage of members 12 years of age and older who were screened for clinical depression using a standardized screening instrument, and if screened positive, received follow up care.	• Screen patients at least annually for depression using a standardized tool: PHQ-2, PHQ-9, BDI-FS, BDI-II, EPDS, PROMIS, CESD-R, DUKE-AD, GDS long or short form, M-3, or CUDOS. • Maintain depression screening documentation and build LOINC codes into the EMR • Provide follow up care on or within 30 days of the positive screen	• Coding for all visits • Progress notes	***Key LOINC Codes:*** PHQ-2: 55758-7 PHQ-9: 44261-6 PHQ-9M: 89204-2 BDI-FS: 89208-3 BDI-II: 89209-1 EPDS: 71354-5 PROMIS:71965-8 CESD-R: 89205-9 DUKE-AD:90853-3 GDS Long: 48544-1 GDS Short: 48545-8 M-3: 71777-7 CUDOS: 90221-3 ***Note: CPT 96127 does not meet HEDIS screening criteria***

Social Needs Screening and Intervention (SNE-E)

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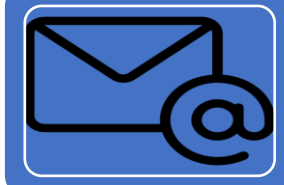
Measure	PCP Responsibilities	Most Common Documentation to Close Care Gap	Key Codes
The percentage of members who were screened, using prespecified instruments, at least once during the year for unmet food, housing, and transportation needs, and received a corresponding intervention within 1 month if they screened positive.	• Screen patients at least annually for food, housing, and transportation needs using a standardized tool (i.e., AAFP Social Needs Screens Screening Tool) • Maintain SDoH screening documentation and build LOINC codes into the EMR. • Provide intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening.	• Coding for all visits • Progress notes	**AAFP SNS: 88122-7, 88123-5, 99550-6, 71802-3, 96778-6, 99594-4** ACH HRSN: 88122-7, 88123-5, 71802-3, 96778-6, 93030-5 Health Leads Screening Panel: 95251-5, 99550-6, 99553-0 HVS: 88124-3 PRAPARE: 93031-3, 93033-9, 71802-3, 93030-5 SEEK: 95400-8, 95399-2 U.S. FSS: 95264-8 We Care Survey: 96434-6, 96441-1 WellRx: 93668-2, 93669-0, 93671-6 Children's Health Watch Housing Stability Vital Signs: 98976-4, 98977-2, 98978-0 CUBS: 89569-8 PROMIS 92358-1 NCHC:99134-9, 99135-6 IRF-PIA: 93030-5 OASIS: 93030-5

How to Submit Medical Records

US FAMILY HEALTH PLAN

Fax

646-989-3319



eMail

hedis@svcmcny.org

Ciox E-Delivery

ID# 1863669

MRO E-Delivery

MRO# 354963

No Time? No Staff? We can help!

Remote EMR Access	We have clinical staff who can pull the data from your EMR for you.
Data Sharing Agreements	USFHP accepts data files to close care gaps.
Contact us!	Please contact us to discuss options.

Questions about HEDIS or Care Gaps?

US FAMILY HEALTH PLAN

Sherry Rumbaugh HEDIS Director	Magan West HEDIS Manager
• srumbaugh@svcmcny.org • 212-356-4891	• mwest@svcmcny.org • 212-356-4905