Provider Information Packet

Electronic Medical Record – Data Sharing

Revision History

Version	Date	Modified By	Comment
1.0	05/22/2020	Quality Management	2020 Final Draft - Approved
2.0	10/26/2020	Quality Management	Updated HEDIS Specifications MY 2021 – Approved
3.0	04/27/2021	Quality Management	Updated for MY 2021 Goals – Approved
4.0	2/10/2022	Quality Management	Updated for MY 2022 Goals – Approved

Provider Information Packet

Electronic Medical Record Data Sharing

Healthcare Effectiveness Data and Information Set® / Quality Assurance Reporting Requirements Measure Year 2022

Contents

Executive Summary

VNSNY CHOICE would like to establish an automated, quarterly EMR file feed between our organizations to reduce administrative burden for our partnering providers. Among other items, this will:

- Position your practice to take advantage of value-based purchasing arrangements
- Reduce requests of your office during HEDIS® audit season
- Improve patient adherence to evidence-based practices
- Allow VNSNY CHOICE to obtain needed medical record data year-round

Information on technical file specifications and VNSNY CHOICE target measures is available within this packet. We will follow a 5-step process to work with your organization to initiate routine file sharing.

1. **Kick-Off with CHOICE EMR Team**: Our Quality and technical team will provide an overview of the benefits associated with sharing EMR data with CHOICE. This will include a review of current performance that outlines strengths and opportunities for improvement.
2. **Assign an IT Contact:** We'll ask that your practice assign a point of contact to align file formatting with CHOICE specifications. This person will work with the CHOICE technical team to align specifications and set up a secure transfer portal. This standard network protocol is used for the secure file access, transfer, and management of any data stream.
3. **Conduct File Testing:** The practice will send a test file to CHOICE through the secure arrangement. CHOICE will review the file and provide any feedback on necessary updates. File testing includes chart submission for primary source verification.
4. **Finalize File and Routine Sharing Schedule:** The practice will incorporate requests by CHOICE and establish timeline for routine data sharing.
5. **Establish Response File:** CHOICE will provide feedback on the data shared, including the gaps closed by measure as a result of the file.

We believe bi-directional data sharing is essential to improving health care quality for our shared populations and are confident this initiative will greatly benefit both our organizations and patients moving forward.

We look forward to our continued partnership.

Provider Welcome Letter

Dear Partnering Provider:

First and foremost, thank you for the care that you provide to our members on a daily basis - the high-quality services provided are essential to our members' health and happiness. In an effort to make your experience with VNSNY CHOICE as efficient and rewarding as possible, we would like to request your collaboration in automating data sharing for Healthcare Effectiveness Data and Information Set (HEDIS®) and Quality Assurance Reporting Requirements (QARR) supplemental data collection. These quality improvement tools, largely designed by the National Committee for Quality Assurance (NCQA), measure quality by examining medical records to determine whether certain care has been rendered to patients. It's important to note – HEDIS® and QARR monitor managed care organization performance and are not evaluations of independent physicians.

VNSNY CHOICE has an opportunity to reduce your office staff's administrative burden if you use a secure Electronic Medical Record (EMR). We would like to establish an automated quarterly EMR file feed to allow VNSNY staff to securely access needed medical record data during the audit reporting season and beyond. This process may also prove beneficial financially to your practice; establishing SFTPs and robust quality reporting will position you well to take advantage of value-based purchasing agreements (VBP) and other quality incentives. You'll find data sharing file format details and the requested measures in this packet.

To accomplish this goal, VNSNY CHOICE will ask for an IT contact to assist in setting up a Secure File Transfer Protocol (SFTP). This standard network protocol is used for the secure file access, transfer, and management of any data stream. We will also request assistance on your end in establishing and sending a quarterly report. Certain providers will receive a more frequent Gaps in Care report, but we'll only ask that you reconcile on a quarterly basis. For the first initial two files submitted to CHOICE, and subsequently once per annum, CHOICE will request a medical chart sample in order to conduct primary source verification.

There is a lag of a month or more for the Gaps in Care Report, so your quarterly update will include the below dates of service and return requested by dates.

Quarter	Dates of Service Covered	Return Requested By
Quarter 1	January 1 – March 31	May 15th
Quarter 2	April 1 – June 30	August 15th
Quarter 3	July 1 – September 30	November 15th
Quarter 4	October 1 – December 31	January 15th (of next measurement year)

The collection of this data will help VNSNY CHOICE reduce patient data gaps and in turn, minimize the records we request of your office during the HEDIS®/QARR season. This data will assist VNSNY CHOICE identify patients with true gaps in care and allow us to implement interventions where they will be most impactful. It is our belief that working together on this effort

will result in improved patient health. Practices with familiarity and experience in data sharing will be able to take advantage of additional funding available.

As you know, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits sharing of medical record information needed for quality assessment and improvement activities, without the need for specific patient consent. (See 45 CFR 164.501 and 164.506.1). Your provider participation agreement with VNSNY CHOICE requires that you supply VNSNY CHOICE with medical records needed for various purposes, including HEDIS®/QARR quality assessments. VNSNY CHOICE will make every effort to minimize disruption to your practice and to patient care.

Your assistance in the HEDIS®/QARR supplemental data collection process is extremely important to health plan success. As always, thank you for your continued partnership and please don't hesitate to email Choice.ProviderRelations@vnsny.org with any questions.

Sincerely,

John Caralyus,
Director, Network Contracting & Provider Relations

Proposed Workflow

EMR Data-Sharing Initial Set-Up Workflow

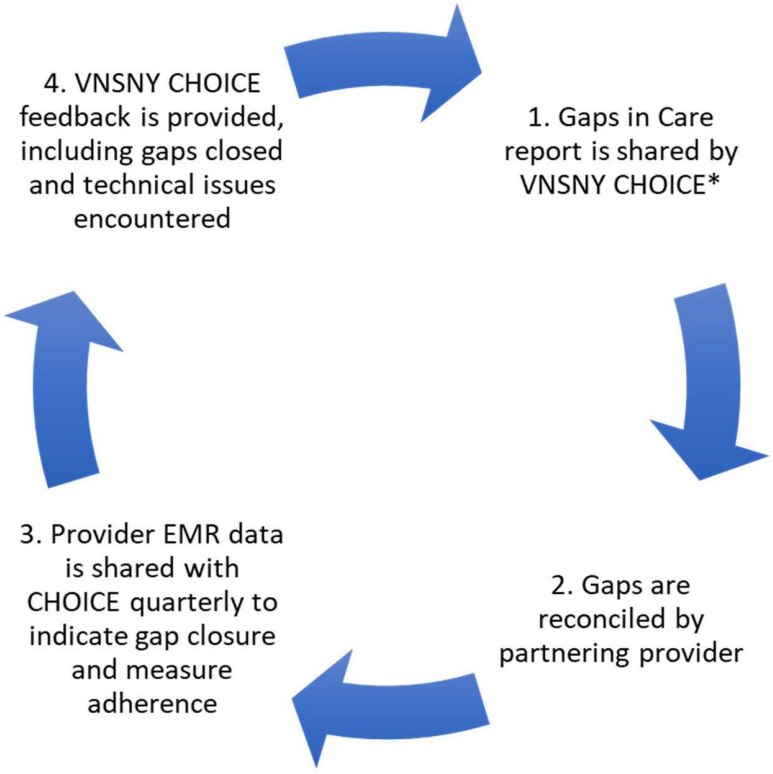
- Provide data-sharing benefits overview
- Review current performance
- Outline strengths and opportunities

- Align file sharing format and specifications
- Set up secure file transfer portal

- Test file sharing using sample data file
- Review and provide feedback

- Submit initial member results file to help close data gaps

Ongoing Bi-Directional Data-Sharing Workflow



**Generally monthly, the frequency of the Gaps in Care report will differ by provider.*

File Format – Field Names and Definitions

Please ensure to send your quarterly data file to VNSNY CHOICE in a delimited (.csv) format. A sample is embedded below. This will assist our efforts to process the data. Please note that most measures will only require one entry row. The CBP measure requires three.

Field Name	Field Definition	Max Character Length	Data Type	Acceptable Values (Examples)	Field Required Status
Measure (Line 1)	HEDIS measure corresponding to data provided	50	Char	CBP Systolic	Required
Measure (Line 2)	HEDIS measure corresponding to data provided	50	Char	CBP Diastolic	Required
Measure (Line 3)	HEDIS measure corresponding to data provided	50	Char	CBP Outpatient	Required
Subscriber ID	VNSNY subscriber ID	9	Char	V80041957	Required
Member Name	VNSNY member name (First Last)	50	Char	John Smith	Required
Member_DOB	VNSNY member date of birth	8	DateTime	01/01/1900	Required
Event_Date	Date of Service	8	DateTime	01/01/1900	Required
Event_Department	Place of Service Name	50	Char	220 E 42ND CLINIC	*Optional*
Event_Provider	Rendering Provider	100	Char	LEE, DOMINIC	Required
Event_Provider_NPI	Rendering Provider NPI	9	Char	1883985462	Required
CODE (CPT/CPTII/ ICD/HCPCS) – Line 3 only	Service CPT, CPT II or ICD 10 code (if available)	25	Char	99214	Required
Procedure_Name_1 (Line 1)	Procedure or Test Name	50	Char	Systolic	Required
Procedure_Name_1 (Line 2)	Procedure or Test Name	50	Char	Diastolic	Required
Procedure_Name_1 (Line 3)	Procedure or Test Name	50	Char	OP Visit	Required
Procedure_Value_1 (Line 1)	Procedure or Test Value	25	Char	120	Required
Procedure_Value_1 (Line 2)	Procedure or Test Value	25	Char	80	Required
Procedure_Units_1 (Lines 1 & 2)	Procedure or Test Units	25	Char	mm Hg	*Optional*

The example illustrated in the file format table is only for Controlling Blood Pressure. Most measures will only require one Procedure Name entry, code, and value.

Measure Definitions

The codes provided in the table below are listed as samples that may satisfy the accompanying measure. The list is not comprehensive and does not represent an endorsement of various coding practices.

Measure Name	Measure Definition	MAP	SH	Sample Codes
Breast Cancer Screening (BCS)	Number of women 50–74 years of age who had at least one mammogram any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	X	X	*CPT Codes:* 77061-77063; 77065 -77067 *Exclusion Codes:* 19180; 19200
Advance Care Planning (ACP)	The number of adults 66+ who had advance care planning during the measurement year.	X		*CPT Codes:* *99483; 99497* *CPT II Codes:* *1123F -1124F* *1157F - 1158F*
Care for Older Adults – Functional Status Assessment (COA)*	The number of adults 66 years and older who had a functional status assessment during the measurement year.	X		*HCPCS:* G0438 – G0439 *CPT II Code:* 1170F
Care for Older Adults – Medication Review (COA)	The number of adults 66 years and older who had a medication review during the measurement year. **Update**: Medication review does not require the member to be present. Telephone visit, e-visit, or virtual check-ins meet the criteria.*	X		*CPT Codes:* 1160F with 1159F; *OR* 99495; 99496
Care for Older Adults –Pain Assessment (COA)*	The number of adults 66 years and older who had a pain assessment during the measurement year.	X		*CPT II Codes:* 1125F; 1126F

Cervical Cancer Screening (CCS)	Number of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Cervical cytology performed every3 years for women aged 21–64. • Cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years for women 30–64 years of age. • Cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years for women aged 30–64. **Update**: Documentation of “vaginal hysterectomy” meets criteria for hysterectomy with no residual cervix.		X	Cervical Cytology *CPT Codes:* 88141-88143 *High Risk HPV Lab Test* *CPT Codes* 87624-87625; *Exclusion codes*: 51925; 56308; 57540

Colorectal Screening	Number of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests completed within the timeframes listed: • Fecal Occult Blood Test: Measurement Year • FIT/Stool DNA Test: Measurement Year and 2 years prior. • Flexible Sigmoidoscopy: Measurement Year and 4 years prior. • Computed Tomography Colonography: Measurement Year and 4 years prior. • Colonoscopy: Measurement Year and 9 years prior. **Update**: Telephone visit, e-visit, or virtual check-ins acceptable for advanced illness exclusion.*	X	X	*Colonoscopy CPT Codes:* 44388-44394 *CT Colonography CPT Codes:* 74261-74263 *Flexible Sigmoidoscopy CPT Codes:* 45330-45335; *FIT/Stool DNA Test CPT Codes:* 81528 *Fecal Occult Blood Test CPT Codes*: 82270; 82274 *Exclusion Codes:* 44150-44153
Eye Exam for Patients with Diabetes (EED)	Number of adults 18–75 years of agewith diabetes who had an eye exam performed. • Retinal or dilated eye exam: Measurement year • Negative retinal or dilated exam (negative for retinopathy): Measurement year or 1 year prior • Bilateral eye enucleation any time during the member's history	X	X	*CPT II Codes:* 3072F; 2022 -2026F
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Number of adults 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c control (<8.0%). • HbA1c poor control (>9.0%).	X	X	*CPT II Codes:* 3044F; 3046F; 3051F; 3052F
Kidney Health Evaluation for Patients with Diabetes (KED)	Number of members 18–85 years of age with diabetes who received an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).	X	X	*LOINC Codes:* 50044-7; 50210-4 13705-9; 14958-3

Controlling High Blood Pressure < 140/90 (CBP)	Number of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was controlled. **Update**: Blood Pressure values can be captured via telehealth. Member self-reported BP reading exclusion removed, member reported BP readings taken by any digital device are acceptable.	X	X	*Office/Home/Telehealth Visit Codes:* 99345; 99201; 99441 *BP Values CPT II Codes:* ***Diastolic Codes*** 3078F; 3079F; 3080F ***Systolic Codes*** 3074F; 3075F; 3077F
Osteoporosis Management in Women Who Had a Fracture (OMW)	Number of women 65-75 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	X		*CPT Codes:* 76977; 77078; 77080; 77085
Osteoporosis Screening in Older Women (OSW)	Number of women 65-75 years of age who received an osteoporosis screening.	X		*CPT Codes:* 76977; 77078; 77080; 77085
Transitions of Care (TRC): Notification of Inpatient Admission	The percentage of discharges for members 18+ years of age for whom documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days) is noted in the medical record.	X		*Imputed Codes:* TRC01 For any evidence on admit date through 2 days after TRC11 For evidence of PCP ordering tests and treatments anytime during the inpatient stay
Transitions of Care (TRC): Receipt of Discharge Information	The percentage of discharges for members 18+ years of age for whom documentation of receipt of discharge information on the day of discharge through 2 days after the discharge) is noted in the *medical* record.	X		*Imputed Codes:* TRC02

Transitions of Care (TRC): Patient Engagement After Inpatient Discharge	The percentage of discharges for members 18+ years of age for whom documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge	X		*CPT Codes:* *99495; 99496* *98966 -98968* *99201- 99205*
Transitions of Care (TRC): Medication Reconciliation Post Discharge	The percentage of discharges for members 18+ years of age for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).	X		*CPT Codes:* 99483; 99495; 99496 *CPT II Codes*:1111F
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	The number of emergency department (ED) visits for members 18+ years old who have multiple high-risk chronic conditions and who had a follow-up service within 7 days of the ED visit	X		*CPT Codes:* *99495; 99496* *98966 – 98968* *99201 - 99205*

* *Codes added for telehealth visit, include place of service '02'; or provider may add '95' modifier to the CPT® code*

Appendix 1 – FAQs and Helpful Tips

Frequently Asked Questions:

What is the timeline for returning chart requests to VNSNY CHOICE?

- The chart submission deadline is within 10 business days from when CHOICE requests charts. This will allow the Quality Management team time to conduct primary source verification and process the EMR data received.

When will the data submitted be reflected on my quality performance report?

- If the file is submitted by the 15th of the month as detailed on Page 4, then the data will be reflected the following month. For example, if CHOICE receives the EMR submission by May 15th, the gaps closed will be reflected in the June rate report. This assumes no issues within the file or with chart requests.

What should the submission file be named?

- Please follow the following naming convention: *EMR_Provider Name_mmddyyyy*. For example, a file submitted by a provider named "CHOICE" on 1/1/2022 would be: *EMR_CHOICE_01012022.*

Are the CPT and other codes listed in the Measure Definitions comprehensive?

- Starting on Page 8, the codes listed are **not comprehensive**. These codes are applicable to the listed measure, but do not represent a full set of codes that may be used. A full list of applicable codes may be obtained via NCQA.

Are the codes listed specific to CHOICE?

- The codes listed are applicable to other payors.

Can the EMR file template be altered?

- No. Please **do not** change the field names or add/delete columns. This will impact our ability to process the file and provide your organization with an impact and quality report timely.

Should I populate all fields in the EMR template?

- Note that all fields in the EMR template are **not mandatory**. The Event Department and Procedure Units fields are optional, while certain measures will only require an entry in the CODE field or the Procedure_Value_1 field, not both. Again, please do not delete columns or change field names, even if unused.

Where can I find the VNSNY CHOICE SelectHealth formulary?

- The formulary can be accessed here.

Helpful Tips:

- *CSV File Submission*: In order to assist our IT team with file processing, please submit the Excel file in .csv format.
- *Coding*: Please ensure that all codes used are the HEDIS® codes applicable to the measure. Please refrain from using internal codes.
- *SelectHealth Providers*: Please submit STI measures in the separate template shared by CHOICE.
- *Dates of Service (DOS)*: Please ensure that HEDIS specifications are followed when capturing dates of service. Measures have differing requirements regarding date of service. Select examples are listed below.
- *Specific Measure Guidelines*:
    - HBD *A1c*:
        - In addition to the procedure value, an accompanying CPT code is required for the A1c test. This may also be closed via CPT II code.
        - Date of service should be the result or recorded date, as per HEDIS specifications. The test date should not be listed as DOS.
    - *Controlling Blood Pressure (CBP)*: Please include three (3) rows for each CBP entry. Each entry should contain the following rows:
        - Systolic (no code required, procedure value only)
        - Diastolic (no code required, procedure value only)
        - OP Visit (office/telehealth visit required, no procedure value necessary)
    - *Colorectal Cancer Screening:*
        - The date of service should list the test date, not the chart date.

Appendix 2 – Measure Dictionary (Technical Specifications)

Breast Cancer Screening

Administrative Specification Only: Numerator-compliant patients will have had one or more mammograms.

Key Elements:

- Admin-only – Mammogram coding

Time Frame:

- For Measurement Year 2022: 10/1/2020-12/31/2022

Advance Care Planning

Administrative Specification Only: Evidence of advance care planning must include either:

Key Elements:

- Admin-only – A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care.

Time Frame:

- Measurement Year (January – December)

***Note**: Medication review does not require the member to be present. Telephone visits, e-visits, or virtual check-ins meet the criteria.*

Care for Older Adults - Functional Status Assessment

Medical Record Hybrid Specification: Medical record documentation must include evidence of a complete functional status assessment and the assessment date. Note that a functional status assessment will not be deemed comprehensive if it is limited to an acute or single condition, event, or body system.

Key Elements (non-comprehensive):

- Functional status assessment
    - Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet, walking
    - Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances

Time Frame:

- Measurement Year (January – December)

Care for Older Adults - Medication Review

Medical Record Hybrid Specification: Documentation must include one of the following, from the same medical record. A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Do not include medication lists or medication reviews performed in an acute inpatient setting.

Key Elements (same medical record):

- Medication list
- Evidence of a medication review by a prescribing practitioner or clinical pharmacist
- Review date
- Notation that the member is not taking any medication
- Notation date

Time Frame:

- Measurement Year (January – December)

Care for Older Adults - Pain Assessment

Medical Record Hybrid Specification: Medical record documentation must include evidence of a pain assessment and assessment date. Do not include pain assessments performed in an acute inpatient setting, and please note that notation of a pain management or pain treatment plan alone will not meet criteria. Pain assessment notation must include one of the following:

Key elements (non-comprehensive):

- Documentation that the patient was assessed for pain (positive or negative findings)
- Assessment result, using a standardized pain assessment tool including, but not limited to:
    - Numeric rating scales (verbal or written)
    - Face, Legs, Activity, Cry Consolability (FLACC) scale
    - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory)
    - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale)

Time Frame:

- Measurement Year (January – December)

Cervical Cancer Screening

Medical Record Hybrid Specification: Appropriate screenings will be in the medical records of:

- Women between the ages of 24-64 (in the measurement year), who had cervical cytology during that year or the two years prior. Medical record documentation must include both the result/finding and the date. Cervical cancer screening methods including collection and microscopic analysis of cervical cells count towards the measure
- Women between the ages of 30-64 (in the measurement year) with high-risk human papillomavirus (hrHPV) testing that year or the four years prior (if over 30 at time of the test). Medical record documentation must include both the result/findings and the date

  Note: Do not count biopsies for both screening types.

Key Elements:

- Testing performed
- Results
- Date

Time Frame:

- 3 years – Cervical Cytology
- 5 years – HrHPV (high-risk human papillomavirus)

Colorectal Screening

Medical Record Hybrid Specification: Medical record documentation must include the date of the colorectal cancer screening; a result is required if the documentation is not clearly part of the member's "medical history".

Pathology reports that indicate the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the screening date meet criteria. If the report does not indicate the type of screening, or for incomplete procedures, criteria can be met either by evidence that the scope advanced beyond the splenic flexure or evidence that the scope advanced into the sigmoid colon.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting, or FOBT tests performed on a sample collected via DRE.

Key Elements:

- Date of screening
- Result (as necessary)

Time Frame:

- Fecal Occult Blood Test: Measurement Year.
- Stool DNA Test: Measurement Year and 2 years prior.
- Flexible Sigmoidoscopy: Measurement Year and 4 years prior.
- Computed Tomography Colonography: Measurement Year and 4 years prior.
- Colonoscopy: Measurement Year and 9 years prior.

Eye Exam for Patients with Diabetes

Medical Record Hybrid Specification: The following items meet medical record documentation requirements, though are not an exhaustive list:

- Indication (note, letter, etc.) from a health care provider that an ophthalmoscopic exam was completed by an optometrist or ophthalmologist (eye care professional), the date the procedure was performed, and the results
- A chart or photograph indicating the date the fundus photography was performed and evidence of review by an eye care professional
- Evidence of bilateral eye enucleation or acquired absence of both eyes

Key Elements (non-comprehensive):

- Indication of ophthalmoscopic exam/fundus photography/bilateral eye enucleation/etc.
- Date
- Evidence of review by eye care professional
- Results

Time Frame:

- 1 year – retinal or dilated eye exam
- 2 years – negative retinal or dilated exam (negative for retinopathy)
- Any time during the member's history: bilateral eye enucleation

Hemoglobin A1c Control for Patients with Diabetes: Results (Including control and poor control)

Medical Record Hybrid Specification: To satisfy the measure, medical record documentation must include the date of the HbA1c test and the result. Ranges and thresholds will not meet criteria. Control is established if the member's most recent HbA1c level during the measurement year is <8.0%. Poor control is established if the most recent HbA1c level is >9.0%.

Key Elements:

- Testing performed
- Results
- Date

Time Frame:

- Measurement Year (January – December)

Kidney Health Evaluation for Patients with Diabetes

Administrative Specification Only: This measure, new in MY 2020, aims to evaluate members between 18-85 with type 1 and type 2 diabetes who received a kidney health evaluation. An evaluation is considered obtaining two lab tests during the measurement year: an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).

The uACR is defined as both a quantitative urine albumin test and a urine creatinine test. These two tests must have service dates no more than four days apart.

Key Elements:

- Admin-only – lab test coding

Time Frame:

- Measurement year (January – December)

Controlling High Blood Pressure < 140/90

Medical Record Hybrid Specification: For the measurement year, the most recent noted blood pressure (BP) reading must occur after the second diagnosis of hypertension at an outpatient visit, telephone visit, e-visit, or virtual check-in. BP readings from remote monitoring devices are allowed if they are digitally stored and both transmitted to and interpreted by the provider. Documentation must reflect that the reading is from an electronic device.

***Note** - Blood Pressure values can be captured via telehealth. Member self-reported BP reading exclusion removed, member reported BP readings taken by any digital device are acceptable. BP readings will not count if: taken during an acute inpatient stay or an ED visit; memberself-reported; or taken on the same day, or the day before, as a medical event requiring a change in diet/medication.*

Key Elements:

- Testing performed
- Results
- Date

Time Frame:

- Measurement year (January – December)

Osteoporosis Screening in Older Women

Administrative Specification Only: This measure evaluates the percentage of women 65-75 years of age who received osteoporosis screening. Numerator-compliant members will have had one or more osteoporosis screening tests on or between the member's 65th birthday and December 31 of the measurement year.

Key Elements:

- Measurement year
- Eligible population
- Numerator events by supplemental data

Time Frame:

- Measurement year (January – December)

Osteoporosis Management in Women Who Had a Fracture

Administrative Specification Only: This measure evaluates the percentage of women 65-85 years of age who had a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Key Elements:

- Continuous enrollment
- Medical and Pharmacy Benefit
- Exclude: Fractures of finger, toe, face and skull

Time Frame:

- Fracture Intake Period: 12-month window beginning July 1st of the year prior to the measurement year through June 30th of the measurement year.
- Measurement year (January – December)

Transitions of Care: Medication Reconciliation Post Discharge

Medical Record Hybrid Specification: Outpatient medical record documentation must include evidence of medication reconciliation and the reconciliation. The following, non-exhaustive, list exhibits some of the documentation types meeting criteria:

- Documentation of current medications, with a note that the provider reconciled the current and discharge medications
- Documentation of current medications with a note referencing the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, etc.)
- Documentation of the member's current medications with notation of discharge medication review
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service

Key Elements:

- Medication documentation
- Notation of review/reconciliation

Time Frame:

January 1 through December 31 of the measurement year

Transitions of Care: Notification of Inpatient Admission

Medical Record Hybrid Specification: Outpatient medical record documentation must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).The following, non-exhaustive, list exhibits some of the documentation types meeting criteria:

- Communication between emergency department or inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and
- transfer (ADT) alert system.
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Key Elements:

- ED or Inpatient admission documentation
- Notation of receipt on the day of admission through 2 days after the admission (3 total days)

Time Frame:

January 1 through December 31 of the measurement year

Transitions of Care: Receipt of Discharge Information

Medical Record Hybrid Specification: Outpatient medical record documentation must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. At a minimum, 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.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

Key Elements:

- Discharge information documentation to the outpatient provider
- Notation of receipt on the day of discharge through 2 days after the admission (3 total days)

Time Frame:

January 1 through December 31 of the measurement year

Transitions of Care: Patient Engagement After Inpatient Discharge

Administrative Specification Only: Patient engagement (outpatient follow-up visit) provided within 30 days after discharge.

- An outpatient visit.
- A telephone visit.
- Transitional care management services.
- An e-visit or virtual check-in.

Key Elements:

- Note: Patient Engagement on the date of discharge does not meet the criteria.
- Notation of receipt on the day of discharge through 2 days after the admission (3 total days)

Time Frame: January 1 through December 31 of the measurement year

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Administrative Specification Only: This measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. The following meet criteria for follow-up:

- An outpatient visit.
- A telephone visit.
- Transitional care management services.
- An outpatient or telehealth behavioral health visit.
- An intensive outpatient encounter or partial hospitalization.
- A community mental health center visit.

Time Frame:

- Measurement Year (January – December)