### Quality Management Report Case Clarification for 2013 Measurement Year

**Reporting to NCQA:** HPHC follows published NQCA technical specifications ([www.ncqa.org](http://www.ncqa.org)) for HEDIS Reporting and data submission. Patients cannot be removed from the HEDIS denominator based on LCU information because NCQA specifies that if claims data indicates the patient was eligible for the measure, they must remain in the denominator. However, if the LCU supplemental information indicates the measure was met, CPQM will determine if it can be used to supplement (improve) the numerator.

**HPHC Operations** (Member mailings, Physician case list mailings, Recognition (Honor Roll) and Pay for Performance Programs): Based on the review of clinical data supplied by the LCUs during the Case Clarification process, HPHC maintains a database of patients who should be suppressed from use in these internal business processes. This suppression classification lasts for a limited period of time, based on measure specification.

<table>
<thead>
<tr>
<th>When do I submit the info? When do I hear back?</th>
<th>How do I submit the info securely?</th>
<th>Where do I go with questions?</th>
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</table>
| LCUs may submit clarification documentation to HPHC at any time. Prior to creating any postings or mailings, HPHC will ensure that valid exclusions are removed from the data stream. HPHC will review the clinical documentation (typically aligned with other operational processes described above). If HPHC determines that suppression from HPHC internal operational use of this case is appropriate, HPHC will record the patient as flagged for suppression and will notify the LCU. | **HPHC is committed to the secure sharing of PHI in order to support local efforts to improve care to our members.**  
Use the QMR report itself to submit requests for Case Clarifications:  
1. Flag patients using a Y in the “Clarify_Flag” column, provide a short description how the exclusion criteria apply to the patient in the “Clarify_Reason” column.  
2. Repost the file saved with the flagged cases to the sftp server using the naming convention as on the original file posted by HPHC, with the term HEDIS CLARIFICATION at the beginning of the file name.  
3. Scan appropriate clinical documentation and post to sftp server, using the term HEDIS CLARIFICATION DOCUMENTATION  
4. Send email to [HPHC_HEDISClarif@hphc.org](mailto:HPHC_HEDISClarif@hphc.org) to alert us to a posting; HPHC will respond with a “receipt of file” acknowledgement.  

For paper documentation that cannot be scanned, please submit to:  
Secure Fax: 617-509-4251  
or  
Mail: HEDIS Clarifications  
c/o Clinical Programs & Quality Measurement  
93 Worcester Street  
Wellesley, MA 02481-9181  

For questions about this process, contact the Network Medical Management mailbox at [HPHC_NMM@HPHC.org](mailto:HPHC_NMM@HPHC.org) or the CPQM mailbox [HPHC_HEDISClarif@hphc.org](mailto:HPHC_HEDISClarif@hphc.org)  

Version Date: March 2013
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<tr>
<th>QMR report</th>
<th>Data Distribution Process</th>
<th>Methodology Overview 2013</th>
<th>Case Clarification process</th>
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<tr>
<td>Asthma (ASM)</td>
<td>QMR postings: March posting summarizes asthma-related utilization for the previous year September posting summarizes asthma-related utilization for 12 months ending June 30th of the current year November posting is the most accurate estimate of members (including their claim history) who will be included in the HEDIS/QAP calculations Paper Mailings Please see our website for timing of mailings <a href="http://www.HarvardPilgrim.org/MedDir">www.HarvardPilgrim.org/MedDir</a> See Quicklinks for Clinical Programs and Quality Measurement Communications Schedule</td>
<td>Denominator: Met at least one of the following criteria during both the measurement year (2013) and the year prior to the measurement year (2012). Criteria need not be the same across both years. - At least one ED visit with asthma as the principal diagnosis - At least one acute inpatient claim/encounter with asthma as the principal diagnosis - At least four outpatient asthma visits with asthma as one of the listed diagnoses and at least two asthma medication dispensing events - At least four asthma medication dispensing events</td>
<td>Denominator: Provider supplies clinical documentation indicating the conditions allowable for exclusion exists for the patient (and had not been previously picked up via claims coding).</td>
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<td></td>
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<td>Allowable Exclusions Members diagnosed with emphysema, COPD, cystic fibrosis or acute respiratory failure.</td>
<td>Numerator: Provider supplies documentation that medications were provided (e.g. sample closet stock).</td>
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<td>Numerator: Dispensed at least one prescription for a preferred therapy during the measurement year (2013).</td>
<td>Clinical Documentation Examples: Problem list, clinical notes</td>
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<td></td>
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<td>Reminder: Clinical data must be on dates of service allowable in the measurement year [2013].</td>
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<td>Diabetes (CDC)</td>
<td>QMR postings:</td>
<td>Denominator:</td>
<td>Denominator:</td>
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<td>Monthly denominator file based on rolling 24 month time period.</td>
<td>Pharmacy data. Members who were dispensed insulin or an oral hypoglycemic/anti-hyperglycemic agent during the measurement year [2013] or year before the measurement year [2012] on an ambulatory basis.</td>
<td></td>
<td>Provider supplies clinical documentation indicating the conditions allowable for exclusion exist for the patient.</td>
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<td>Numerator data included quarterly.</td>
<td>Claim/encounter data: During the measurement year [2013] or the year prior to the measurement year [2012], members who: a. two face-to-face encounters, in an outpatient setting or non-acute inpatient setting, on different dates of service, with a diagnosis of diabetes, or b. one face-to-face encounter in an acute inpatient or ED setting.</td>
<td>Numerator:</td>
<td>Provider supplies documentation that care events occurred and those clinical values were within target range.</td>
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<td>HPHC’s HEDIS rates submitted to NCQA are based on a random sample of eligible diabetics. Each case not meeting numerator criteria (“defect”) is chart-reviewed. If a member in the sample is not diabetic, chart review will confirm this and the member will be dropped from the measure.</td>
<td>Allowable Exclusions</td>
<td>Clinical Documentation Examples:</td>
<td>Clinical Documentation Examples:</td>
</tr>
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<td>Paper Mailings Please see our website for timing of mailings <a href="http://www.HarvardPilgrim.org/MedDir">www.HarvardPilgrim.org/MedDir</a></td>
<td>Polycystic ovaries</td>
<td>Problem list, clinical notes, lab results</td>
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<td>See Quicklinks for Clinical Programs and Quality Measurement Communications Schedule</td>
<td>Gestational diabetes</td>
<td>Reminder: Clinical data must be on dates of service allowable in the measurement year [2013] or the year prior to the measurement year [2012].</td>
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<td>Steroid-induced diabetes</td>
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<td>Numerator:</td>
<td>Evidence that the required tests and exams have occurred during the measurement year [2013] or that clinical outcomes on tests performed within the measurement year [2013] are within clinical target ranges.</td>
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| Breast CA Screen (BCS) | Postings: Quarterly lists are posted on the SFTP server for LCU leadership review         | Denominator:  
  - Women 42-69 in measurement year  
  
  Allowable Exclusions:  
  Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies.  
  
  Numerator:  
  One or more mammograms during the measurement year [2013] or the year prior to the measurement year [2012]. | Denominator:  
  Provider supplies clinical documentation indicating the conditions allowable for exclusion exist for the patient.  
  
  Numerator:  
  Provider supplies documentation that care events occurred.  
  
  Clinical Documentation Examples:  
  Problem list, clinical notes  
  
  Reminder: Clinical data must be on dates of service allowable in the measurement year [2013] or the year prior to the measurement year [2012]. |
|                  | Mailings: PCPs receive quarterly lists of women due for mammogram.                        |                                                                                           |                                                                                           |
|                  | Please see our website for timing of mailings  
  www.HarvardPilgrim.org/MedDir  
  See Quicklinks at right for Clinical Programs and Quality Measurement Communications Schedule |                                                                                           |                                                                                           |
| Cervical CA Screen (CCS) | Postings: Quarterly lists are posted on the SFTP server for LCU leadership review          | Denominator:  
  - Women 24–64 in measurement year  
  
  Allowable Exclusions:  
  Women who had a total hysterectomy with no residual cervix  
  
  Numerator:  
  One or more Pap tests during the measurement year [2013] or the two years prior to the measurement year [2011-2012]. | Denominator:  
  Provider supplies clinical documentation indicating the conditions allowable for exclusion exist for the patient.  
  
  Numerator:  
  Provider supplies documentation that care events occurred.  
  
  Clinical Documentation Examples:  
  Problem list, clinical notes  
  
  Reminder: Clinical data must be on dates of service allowable in the measurement year [2013] or the two years prior to the measurement year [2011-2012]. |
<p>|                  | Mailings: PCPs receive quarterly lists of women due for pap test.                         |                                                                                           |                                                                                           |</p>
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| Antidepressant Medical Management (AMM) | **Postings:** Monthly list of members with new diagnosis and new prescription. Annual server posting in February of members with diagnosis of major depression missing an antidepressant pharmacy claim. | **Denominator:**  
- At least one principal diagnosis of *major depression* in an outpatient, ED, intensive outpatient or partial hospitalization setting *or*  
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting on different dates of service with any diagnosis of *major depression* *or*  
- At least one inpatient (acute or non-acute) claim/encounter with any diagnosis of *major depression* and treated with antidepressant medication  

**Allowable Exclusions:**  
Episodic mood disorder, other than major depression  

**Numerator:**  
At least 180 days (6 months) of continuous treatment with antidepressant medication | Each February, HPHC conducts a “diagnosis clarification” outreach process. HPHC posts files to the secure server listing patients likely to be in the AMM denominator for whom there is no evidence of sustained use of antidepressants.  
The LCU is asked to clarify:  
- Did the patient have an episode of MAJOR depression, as opposed to another diagnosis? |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) | Annual server posting in February of members with an encounter during the 14-day Initiation Period, but with no AOD diagnosis submitted on the claim for that encounter | **Denominator:**  
- Members, age 13+, with at least 1 diagnosis of alcohol and other drug (AOD) dependence in an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or ED setting, during the intake period (Jan. 1 - Nov. 30).  
- Must be newly diagnosed: no AOD dependence diagnosis in previous 60 days.  

**Numerator #1:**  
- Initiation of AOD Treatment: At least 1 encounter with an AOD dependence diagnosis in an inpatient, intensive outpatient, partial hospitalization, or outpatient setting, within 14 days of index episode.  

**Numerator #2: Engagement of AOD Treatment:**  
- Initiation of treatment (numerator #1) AND 2 or more encounters in an inpatient, intensive outpatient, partial hospitalization, or outpatient setting, with any AOD dependence diagnosis.  

**Allowable Exclusions:** None. | Each February, HPHC conducts a "14-day Follow-up Clarification" outreach, identifying members in the denominator with an encounter during the 14-day Initiation Period, but with no AOD diagnosis submitted on the claim for that encounter.  
The LCU is asked to clarify 2 questions:  
- "Was the original diagnosis of AOD dependence correct at the Index Episode?"  
- If yes, "Was AOD dependence discussed at this encounter in the 14-day Initiation Period?" |