



HEDIS[®] Tip Sheet 2020

Medicaid Women’s Health Measures

The National Committee for Quality Assurance (NCQA) has developed Healthcare Effectiveness Data and Information Set (HEDIS) measures as a tool for performance improvement. We collect HEDIS data from our providers to measure and improve the quality of care our members receive. The NCQA recommends tracking the following HEDIS measures for our members.

HEDIS Measures

- BCS:** Breast Cancer Screening
- CCS:** Cervical Cancer Screening
- CHL:** Chlamydia Screening in Women
- PPC:** Prenatal and Postpartum Care



How to improve HEDIS scores

On the following page are measure definitions, documentation requirements and helpful tips you may choose to follow to improve HEDIS scores. Compliance with HEDIS measures reduces the need for you to send additional medical records later for review. You may also refer to the **HEDIS Quick Reference Guide**, can be found in the Clinical Resources/HEDIS section of our Provider website at https://www.bcbstx.com/provider/medicaid/education_reference.html.

Breast Cancer Screening (BCS)

Measure definition for BCS: Women 50 to 74 years of age who had a mammogram to screen for breast cancer.

Documentation Requirements

- Document screenings in the medical record. The medical record must indicate the specific date and result of the screening
- Document a bilateral mastectomy in the medical record
- This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, MRIs or tomosynthesis (3D mammography)

Helpful Tips

- Discuss the importance of early detection and encourage testing
- Discuss possible fears the patient may have about mammograms and inform them that currently available testing methods are less uncomfortable and require less radiation
- Have a list of mammogram facilities available to share with the patient

Cervical Cancer Screening (CCS)

Measure definition for CCS: Women 21 to 64 years of age who were screened for cervical cancer using any of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed within the last 3 years
- Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years
- Women 30 to 64 years of age who had cervical cytology/ high-risk human papillomavirus (hrHPV) co-testing within the last 5 years

Documentation Requirements

- A note indicating the date when the cervical cytology was performed and the result or finding
- A note indicating the date when the hrHPV test was performed and the result or finding
- Generic documentation of "HPV test" can be counted as evidence of hrHPV test
- Document in the medical record if the patient has had a hysterectomy with no residual cervix and include terms like total, complete or radical hysterectomy
- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening

Helpful Tips

- Complete Pap tests during regularly-scheduled well woman visits, sick visits, urine pregnancy tests, urinary tract infection (UTI) and chlamydia/ sexually transmitted infection screenings
- Request to have results of Pap tests sent to you if done at OB/GYN visits



Prenatal and Postpartum Care (PPC)

Measure definition for PPC: Deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- Timeliness of Prenatal Care: Deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization
- Postpartum Care: Deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Documentation Requirements

- Prenatal care visit to an OB/GYN or other prenatal care practitioner, or primary care physician (PCP). For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:
- Basic physical obstetrical exam that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used)
- Obstetric panel
- Ultrasound of pregnant uterus
- Pregnancy-related diagnosis code
- TORCH antibody panel (Toxoplasma, Rubella, Cytomegalovirus, and Herpes simplex testing)
- Rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing (e.g., a prenatal visit with rubella and ABO, a prenatal visit with rubella and Rh, or a prenatal visit with rubella and ABO/Rh)
- Documented last menstrual period (LMP) or estimated date of delivery (EDD) with either a completed obstetric history or prenatal risk assessment and counseling/education

Postpartum Care: Had a postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 7 and 84 days following delivery of live birth.

Helpful Tips

- Schedule prenatal care visits starting in the first trimester or within 42 days of enrollment
- Have a direct referral process to obstetrician-gynecologist (OB/GYN) in place
- Refer patients to our Special Beginnings Program : 1-888-421-7781
- Schedule your patient for a postpartum visit within 7 to 84 days from delivery (please note that staple removal following a cesarean section does not count as a postpartum visit for HEDIS)
- Educate the patient on the leading causes of postpartum complications and mortality



Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam
- Evaluation of weight, BP, breasts and abdomen. Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component
- Notation of postpartum care (PP), PP check, PP care, six-week check, or pre-printed “Postpartum Care” form in which information was documented during the visit
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders
- Glucose screening for women with gestational diabetes
- Documentation of any of the following: infant care or breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity and attainment of healthy weight

Addition of Telephone Visits, E-visits and Virtual Check-ins

NCQA has made changes to its HEDIS measures. Telephone visits, e-visits and virtual check-ins have been added as eligible methods for use in reporting both rates.

Chlamydia Screening in Women (CHL)

Measure definition for CHL: Women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Documentation Requirements

- Date test was performed and the result

Helpful Tips

- Perform chlamydia screening every year on every 16 to 24-year-old female identified as being sexually active
- Inform patient that chlamydia screening can be performed through a urine test. Offer this as an option for patients
- Place chlamydia swab next to Pap test or pregnancy detection materials



Clinical Practice Guidelines

can be found in the Clinical Resources/Clinical Practice Guidelines section of our Provider website at <https://www.bcbstx.com/provider/medicaid/clinical.html>.

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