

February 15, 2010

Dear Doctor,

As you know, each year Florida Health Care Plans selects and examines a sample of medical records to measure quality. These quality studies, called HEDIS[®], are part of a nationally recognized quality improvement initiative. HEDIS is used by the Center for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the State of Florida (AHCA) to monitor the performance of managed care organizations. Florida Health Care Plans is pleased to participate in these studies and appreciates the support from our provider community in continuously improving our scores.

NOTE: Our reviewers will be using laptops during their on-site visit and will need access to an electrical outlet.

We anticipate that you may have questions about whether these studies are permissible under the privacy regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In particular, you may question whether a specific authorization is required from your patient (our member) prior to releasing a copy of the medical record to us.

We want to assure you that a special authorization is NOT needed.

Section § 164.504 of HIPAA defines *Health care operations* to include quality assessment and improvement activities.

Florida Health Care Plans is a covered entity under HIPAA and we are continuing to implement procedures to constantly improve our level of privacy protection for health information we receive.

The following is a list of the data elements our medical record reviewers will be abstracting from the member's chart during their on-site visit beginning in March.

Measure	Required HEDIS Information
Adult BMI Assessment	Documentation of a Body Mass Index (BMI) (V85.0x – V85.5x) in 2008 or 2009 (Strongly recommend the use of the applicable ICD-9 DX codes on claims)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Documentation of all three of the following elements in 2009: <ul style="list-style-type: none"> • BMI <u>Percentile</u> (V85.5x) or BMI <u>Percentile</u> plotted on a growth chart • And Counseling for Nutrition (V65.3) • And Counseling for Physical Activity (V65.41) (Strongly recommend the use of the applicable ICD-9 DX codes on claims)
UPDATED - Childhood Immunization Status	Evidence of immunizations documented by the child's second birthday: <ul style="list-style-type: none"> • 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hepatitis B, 1 VZV, 4 pneumococcal conjugate, 2 Hepatitis A, 2 two-dose or 3 three-dose Rotavirus, and 2 Influenza* (*administered at least 6 months after birth) • Or documentation of illness and date - valid for MMR, HepB, varicella, HepA • Or a seropositive test date and result - valid for MMR, HepB, varicella, HepA
NEW – Immunizations for Adolescents	Evidence of immunizations documented by the child's 13 th birthday: <ul style="list-style-type: none"> • 1 Meningococcal (administered on or between 11th and 13th birthdays) • 1 Tdap/Td (administered on or between 10th and 13th birthdays)
Colorectal Cancer Screening	<ul style="list-style-type: none"> • Fecal Occult Blood Test (gFOBT or iFOBT) in 2009 (NOTE: digital rectal exam specimen must be submitted to LabCorp to meet criteria) • Or Flexible sigmoidoscopy in 2005 – 2009

	<ul style="list-style-type: none"> • Or Colonoscopy in 2000 – 2009
Well Visits in the first 15 Months of Life	<p>Documentation from the medical record <u>must</u> include a note indicating a visit with a primary care practitioner (PCP, ARNP or PA), the <u>date</u> the well-child visit occurred <u>and</u> evidence of <u>all</u> of the following.</p> <ul style="list-style-type: none"> • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	<p>Documentation from the medical record <u>must</u> include a note indicating a visit with a primary care practitioner (PCP, ARNP or PA), the <u>date</u> the well-child visit occurred <u>and</u> evidence of <u>all</u> of the following.</p> <ul style="list-style-type: none"> • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance
Adolescent Well-Care Visits	<p>Documentation from the medical record <u>must</u> include a note indicating a visit with a primary care practitioner (PCP, ARNP or PA), the <u>date</u> the well-child visit occurred <u>and</u> evidence of <u>all</u> of the following.</p> <ul style="list-style-type: none"> • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance
Appropriate Testing for Pharyngitis	Children 2–18 years of age with a diagnosis of pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
Appropriate Treatment for Upper Respiratory Infection	Children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and <u>were not</u> dispensed an antibiotic prescription.
Chlamydia Screening in Women	Women 15–24 years of age who were identified as sexually active and who had at least one test for chlamydia in 2009.
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.
Cervical Cancer Screening	<ul style="list-style-type: none"> • Pap test in 2007, 2008, or 2009 • Or documentation of the history of a hysterectomy (only those <u>with no residual cervix</u> are considered an exclusion)
Controlling High Blood Pressure	<ul style="list-style-type: none"> • Documentation of confirmed diagnosis of HTN on or before June 30, 2009 • Last recorded BP during 2009 where the member was not undergoing a surgical procedure (e.g. removal of mole, sigmoidoscopy), or major diagnostic or surgical procedure (e.g. stress test, admin of IV contrast for a radiology procedure, endoscopy). Member reported blood pressure readings are NOT valid towards this measure.
Cholesterol Management for Patients with Cardiovascular Conditions	<ul style="list-style-type: none"> • Documentation that confirms a cardiovascular event (AMI, PTCA, CABG) occurred on or between 01/01/08 to 11/01/09 OR a documented diagnosis of Ischemic Vascular Disease in 2008 <u>and</u> 2009 • Most recent LDL-C screening date and result performed in 2009 (Optimal result: < 100 mg/dL)
Comprehensive Diabetic Care	<ul style="list-style-type: none"> • Most recent HbA1c or glycohemoglobin A1c test date and result performed in 2009 (Optimal result: < 8.0%) • Most recent LDL-C screening date and result performed in 2009 (Optimal result: < 100mg/dL) • Documentation of a retinal eye exam performed by an eye care professional in 2009 or 2008. The 2008 exam <u>must</u> include documentation to prove negative retinopathy in order to meet criteria. • Documentation of any of the following in 2009: documentation of a visit to a nephrologist; documentation of medical attention for any of the following: diabetic nephropathy, ESRD, CRF, CKD, ARF, renal insufficiency or dialysis; documentation of a microalbuminuria screening test; documentation of a <u>positive</u> macroalbuminuria test; or documentation of ACE/ARB therapy • Valid exclusions: gestational diabetes in 2009, steroid induced diabetes in 2009, or polycystic ovary disease diagnosis without the diagnosis of diabetes in 2008 or 2009
Prenatal / Post Partum Care	<ul style="list-style-type: none"> • Documentation that confirms member delivered a live birth on or between 11/06/08 and 11/05/09 <p><u>Prenatal Care:</u></p> <ul style="list-style-type: none"> • Documentation that confirms member received a basic physical exam that includes auscultation for fetal heart tones or pelvic exam with OB observations or measurement of fundus height (include documentation of EDC, LMP and Date of delivery) by an OB practitioner, Family Practitioner or midwife within their first trimester or within 42 days of enrollment with MCO. • Or documentation that prenatal care procedure was performed: uterine ultrasound, prenatal labs (Prenatal labs, Torch, rubella titer, ABO/Rh incompatibility) within their first trimester or within 42 days of enrollment with MCO. • Or documentation of LMP or EDD with evidence of prenatal care with an OB history, risk assessment, counseling or education within first trimester or within 42 days of enrollment with MCO. <p><u>Post Partum Care:</u></p> <ul style="list-style-type: none"> • Documentation of a visit on or between 21-56 days after delivery which includes any of the following: pelvic exam, a notation of post partum care, or an evaluation of weight, BP, breasts and abdomen

If your member(s) are selected for audit, you will be contacted to schedule an onsite visit. Most onsite visits will occur between March and April.

Again, we value your support of our efforts to measure and improve quality. We look forward to demonstrating your quality of care in our statistics this year.

Sincerely,

A handwritten signature in cursive script that reads "Wendy Myers".

Wendy Myers, M.D.
President/Chief Medical Officer