

# How to Close HEDIS Gaps in Care (GIC) for 2020



HEDIS GIC Measure	Documentation to Submit for a “Pass”	Documentation to Submit for Exclusion from Measure
<p><b>BCS</b></p> <p><b>Breast Cancer Screening</b></p> <p>Women age 50–74</p>	<p>A mammogram completed on or between October 1 and 2 years prior to measure year through December 31 of the measure year.</p> <ul style="list-style-type: none"> <li>Send test report (only Film, Digital, or 3D mammos).</li> <li>DO NOT SEND biopsies, US, or MRIs of the breasts.</li> <li><b>OR</b> send an office note showing the name of screening and date completed.</li> </ul>	<p>Mastectomy—both breasts removed any time in the member’s history through December 31, 2020. This may take place during the same or separate operations.</p> <ul style="list-style-type: none"> <li>Send an office note showing the date and name of the procedure(s).</li> <li><b>OR</b> the Report(s) of Operation.</li> </ul>
<p><b>CCS</b></p> <p><b>Cervical Cancer Screening</b></p> <p>Women age 21–64</p>	<p>Women age 21–64 who had Pap smear in 2018, 2019 or 2020; <b>OR</b></p> <p>Women age 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing or had a pap smear/(hrHPV) cotesting any year from 2016-2020.</p> <ul style="list-style-type: none"> <li>The HPV must be run at the same time as the cytology portion, regardless of the Pap result. HPV reflex tests cannot be submitted.</li> <li>Cervical biopsies cannot be substituted (they are not primary cervical cancer screening).</li> <li>Send the Pap or Pap/HPV report.</li> <li>Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.</li> <li><b>OR</b> send an office note showing the date, name of procedure AND the result.</li> </ul>	<p>Evidence of a hysterectomy with no residual cervix:</p> <ul style="list-style-type: none"> <li>History of “complete”, “radical”, “total”, “TAH”, or “TVH”.</li> <li>“Hysterectomy” alone does not meet criteria as it does not indicate absence of cervix.</li> <li>Send an office note showing the date of the surgery</li> <li><b>OR</b> a Report of Operation for the hysterectomy procedure</li> <li><b>OR</b> a GU physical exam notation to indicate cervix is not present.</li> <li>Cervical agenesis, or acquired absence of cervix are also exclusions; send an office note showing this history</li> <li><b>OR</b> a GU physical exam notation to indicate cervix is not present.</li> </ul> <p>If the type of hysterectomy is unknown:</p> <ul style="list-style-type: none"> <li>documentation of “hysterectomy” and “vaginal pap smear” together will be accepted <b>OR</b></li> <li>documentation of both “hysterectomy” and a statement to indicate “the pt. no longer requires cervical cancer screening.”</li> </ul> <p>These exclusions may occur any time in the member’s history through December 31, 2020.</p>
<p><b>CHL</b></p> <p><b>Chlamydia Screening in Women</b></p> <p>Women age 16–24</p>	<p>Sexually active females must be tested at least annually.</p> <ul style="list-style-type: none"> <li>Send lab report AND the result from 2020.</li> <li><b>OR</b> send an office note showing the name of test and date completed.</li> </ul>	<ul style="list-style-type: none"> <li>A pregnancy test during 2020 and a prescription for Accutane (Isotretinoin) on the date of the pregnancy test or the six days after the pregnancy test.</li> <li>A pregnancy test during 2020 and an x-ray on the date of the pregnancy test or the six days after the pregnancy test.</li> </ul>

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<p><b>COL</b></p> <p><b>Colorectal Cancer Screening</b></p> <p>Members age 50–75</p>	<ul style="list-style-type: none"> <li>The record must indicate the name of the test and date the screening was performed. This can include visit notes, procedure notes or pathology reports that indicate the name of the procedure.</li> <li>A result is not required if the procedure documentation is clearly part of the Medical History, Preventive Maintenance, or Health Care Maintenance section of the record showing the name of the test and date of COMPLETION.</li> </ul> <p>Any one of these tests, within the specified timeframe will close a COL gap:</p> <ul style="list-style-type: none"> <li>FOBT in 2020—Guaiac stool cards or FIT kit—Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.</li> <li>Colonoscopy from 2011-2020</li> <li>Flexible sigmoidoscopy from 2016-2020</li> <li>FIT-DNA (Cologuard) from 2018-2020</li> <li>CT Colonography (virtual colonoscopy) from 2016-2020</li> <li>Submit procedure reports, path reports or office notes that show the name and date of the completed procedure.</li> </ul>	<ul style="list-style-type: none"> <li>A note indicating a diagnosis of colorectal cancer any time through December 31, 2020</li> <li>An office note showing documentation of a total colectomy any time through December 31, 2020</li> <li><b>OR</b> a Report of Operation.</li> </ul>

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<p><b>CDC</b></p> <p><b>Comprehensive Diabetes Care –Retinal Eye Exam</b></p> <p>Members age 18–75 with Type I or Type II Diabetes</p>	<ul style="list-style-type: none"> <li>• Submit a report of retinal exam by an ophthalmologist or optometrist in 2020.</li> <li>• <b>OR</b> submit a report of retinal exam by an ophthalmologist or optometrist in 2019 ONLY IF THE RESULT IS NEGATIVE for diabetic retinopathy or hypertensive retinopathy.</li> </ul> <p>Documentation does not specifically have to state “no diabetic retinopathy” to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal exam and that retinopathy was not present.</p> <ul style="list-style-type: none"> <li>• <b>OR</b> submit an office note stating the date and result of the retinal exam AND the name and credentials of the eye care professional.</li> <li>• Documentation of “normal findings” for a dilated or retinal exam meets criteria and can be used.</li> <li>• Notations limited to a statement that indicates “diabetes without complications” cannot be submitted.</li> <li>• <b>OR</b> submit proof of bilateral eye enucleation (removal of both eyes) or acquired absence of both eyes any time during the member’s history through December 31, 2020—send office note or Report of Operation.</li> </ul>	<ul style="list-style-type: none"> <li>• Members who do not have a diagnosis of diabetes during 2019 or 2020 and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting during 2019 or 2020.</li> <li>• Blindness is not an exclusion for a diabetic eye exam.</li> </ul>

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<p><b>CDC</b></p> <p><b>Comprehensive Diabetes Care</b></p> <p>Medical Attention for Nephropathy</p>	<ul style="list-style-type: none"> <li>• Submit a urine test for albumin or protein done in 2020. Any of the following meet the criteria:                             <ul style="list-style-type: none"> <li>◦ "Microalbumin", "macroalbumin", or "micral"</li> <li>◦ Spot urine (urine dipstick or test strip) for albumin or protein</li> <li>◦ 24-hour urine for albumin or protein</li> <li>◦ Timed urine for albumin or protein</li> <li>◦ Urine for albumin/creatinine ratio</li> <li>◦ Random urine for protein/creatinine ratio</li> </ul> </li> <li>• <b>OR</b> submit an office note showing medical attention for any of the following in 2020:                             <ul style="list-style-type: none"> <li>◦ Diabetic nephropathy</li> <li>◦ End stage renal disease (ESRD)</li> <li>◦ Chronic renal failure (CRF)</li> <li>◦ Chronic kidney disease (CKD)</li> <li>◦ Renal insufficiency</li> <li>◦ Proteinuria</li> <li>◦ Albuminuria</li> <li>◦ Renal dysfunction</li> <li>◦ Acute renal failure (ARF)</li> <li>◦ Dialysis (any method)</li> </ul> </li> <li>• <b>OR</b> submit an office note showing a visit to a nephrologist in 2020.</li> <li>• <b>OR</b> submit an office note or Report of Operation showing a history of renal transplant on or before December 31, 2020.</li> <li>• <b>OR</b> submit an office note or medication list showing an ACEI or ARB drug was prescribed in 2020. <i>(see next page for related drug list)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Members who do not have a diagnosis of diabetes during 2019 or 2020 and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting during 2019 or 2020.</li> </ul>

## HEDIS 2020 ACE/ARB List

Angiotensin converting enzyme inhibitors (ACE) and Angiotensin-receptor blockers (ARB) are sorted by brand name on the left and by generic name on the right. The same medications are included in each list.

Submit an office note or medication list showing an ACE or ARB drug was prescribed in 2020 to close the CDC-nephropathy gap.

Use of drugs listed here will score the sub-measure as compliant. Refer to the MVP Formulary to learn which of these medications are covered by the member's plan; visit [mvphealthcare.com](http://mvphealthcare.com), then select *Providers*, then *Pharmacy*, and then *MVP Formularies*.

Brand (A–Z)	Generic	Generic (A–Z)	Brand
Accupril	Quinapril	Amlodipine/HCTZ/Olmesartan	Tribenzor
Accuretic	Quinapril/HCTZ	Amlodipine/Olmesartan	Azor
Aceon	Perindopril	Amlodipine/Perindopril	Coveram
Altace	Ramipril	Amlodipine/Perindopril	Prestalia
Atacand	Candesartan	Amlodipine/Telmisartan	Twynsta
Atacand HCT	Candesartan/HCTZ	Amlodipine/Valsartan	Exforge
Avalide	Irbesartan/HCTZ	Amlodipine/Valsartan/HCTZ	Exforge HCT
Avapro	Irbesartan	Azilsartan	Edarbi
Azor	Amlodipine/Olmesartan	Azilsartan/Chlorthalidone	Edarbyclor
Benicar	Olmesartan	Benazepril	Lotensin
Benicar HCT	Olmesartan/HCTZ	Benazepril/Amlodipine	Lotrel
Capoten	Captopril	Benazepril/HCTZ	Lotensin HCT
Capozide	Captopril/HCTZ	Candesartan	Atacand
Coveram	Amlodipine/Perindopril	Candesartan/HCTZ	Atacand HCT
Cozaar	Losartan	Captopril	Capoten
Diovan	Valsartan	Captopril/HCTZ	Capozide
Diovan HCT	Valsartan/HCTZ	Enalapril	Vasotec
Edarbi	Azilsartan	Enalapril/HCTZ	Vaseretic
Edarbyclor	Azilsartan/Chlorthalidone	Eprosartan	Teveten
Entresto	Sacubitril/Valsartan	Fosinopril	Monopril
Exforge	Amlodipine/Valsartan	Fosinopril/HCTZ	Monopril HCT
Exforge HCT	Amlodipine/Valsartan/HCTZ	Irbesartan	Avapro
Hyzaar	Losartan/HCTZ	Irbesartan/HCTZ	Avalide
Lotensin	Benazepril	Lisinopril	Prinivil
Lotensin HCT	Benazepril/HCTZ	Lisinopril	Zestril
Lotrel	Benazepril/Amlodipine	Lisinopril/HCTZ	Prinzide
Mavik	Trandolapril	Lisinopril/HCTZ	Zestoretic
Micardis	Telmisartan	Losartan	Cozaar
MicardisHCT	Telmisartan/HCTZ	Losartan/HCTZ	Hyzaar
Monopril	Fosinopril	Moexipril	Univasc
Monopril HCT	Fosinopril/HCTZ	Moexipril/HCTZ	Uniretic
Prestalia	Amlodipine/Perindopril	Olmesartan	Benicar
Prinivil	Lisinopril	Olmesartan/HCTZ	Benicar HCT
Prinzide	Lisinopril/HCTZ	Perindopril	Aceon
Tarka	Trandolapril/Verapamil	Quinapril	Accupril
Teveten	Eprosartan	Quinapril/HCTZ	Accuretic
Tribenzor	Amlodipine/HCTZ/Olmesartan	Ramipril	Altace
Twynsta	Amlodipine/Telmisartan	Sacubitril/Valsartan	Entresto
Uniretic	Moexipril/HCTZ	Telmisartan	Micardis
Univasc	Moexipril	Telmisartan/HCTZ	Micardis HCT
Vaseretic	Enalapril/HCTZ	Trandolapril	Mavik
Vasotec	Enalapril	Trandolapril/Verapamil	Tarka
Zestoretic	Lisinopril/HCTZ	Valsartan	Diovan
Zestril	Lisinopril	Valsartan/HCTZ	Diovan HCT

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<p><b>IMA</b></p> <p><b>Immunizations for Adolescents—Human Papillomavirus Vaccine (HPV) series only</b></p> <p>Female and male adolescents who completed an HPV vaccine series by the 13th birthday. (Two- or three-dose series as ordered by provider)</p> <p><b>Two-dose HPV Vaccination Series:</b></p> <ul style="list-style-type: none"> <li>At least two HPV vaccines, with different dates of service, on or between the member’s 9th and 13th birthdays.</li> </ul> <p>There must be at least 146 days (5 months, 4 days) between the first and second dose of the HPV vaccine.</p> <p><b>Three-dose HPV Vaccination Series:</b></p> <ul style="list-style-type: none"> <li>At least three HPV vaccines, with different dates of service, on or between the member’s 9th and 13th birthdays.</li> </ul>	<ul style="list-style-type: none"> <li>Submit a note indicating the name of the specific vaccine and the dates of administration.</li> <li><b>OR</b> submit an Immunization Record with completed HPV series.</li> <li><b>OR</b> submit a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and names of immunizations administered.</li> <li>HPV brand names: Gardasil, Gardasil 9, Cervarix</li> </ul>	<ul style="list-style-type: none"> <li>Members with documented anaphylactic reaction to the vaccine (or its components) are excluded. The exclusion must have occurred by the member’s 13th birthday. Submit evidence in the form of an office note, allergy list or immunization record with notation of the contraindication.</li> </ul>

HEDIS GIC Measure	Documentation to Submit for a “Pass”	Documentation to Submit for Exclusion from Measure
<p><b>LSC</b></p> <p><b>Lead Screening in Children</b></p> <p>Children two years old in 2020 who had at least one lead blood test by their second birthday.</p> <p>Lab test can either be capillary or venous lead blood testing.</p>	<ul style="list-style-type: none"> <li>Submit a note indicating the date the lead test was performed and the result. A result may be documented as a numeric value, or stated as “WNL” or “negative” for this measure.</li> <li><b>OR</b> submit the lab report(s) showing the result.</li> </ul>	<ul style="list-style-type: none"> <li>There are no exclusions for this measure.</li> </ul>
<p><b>CWP</b></p> <p><b>Appropriate Testing for Children with Pharyngitis</b></p> <p>Children ages 3–18, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode in the seven-day period from three days prior through three days after the dx date in 2019 or 2020.</p>	<ul style="list-style-type: none"> <li>Submit a visit note clearly indicating that a rapid strep test was performed and the date of service.</li> <li><b>OR</b> submit the lab report showing the result in 2020.</li> </ul>	<ul style="list-style-type: none"> <li>There are no exclusions for this measure.</li> </ul>
<p><b>The following medications will make your patient a pass for this measure.</b></p>		
<p><b>Description</b></p>		<p><b>Prescription</b></p>
<p>Aminopenicillins</p>	<p>Amoxicillin, Ampicillin</p>	
<p>Beta-lactamase inhibitors</p>	<p>Amoxicillin-clavulanate</p>	
<p>First generation cephalosporins</p>	<p>Cefadroxil, Cephalexin, Cefazolin</p>	
<p>Folate antagonist</p>	<p>Trimethoprim</p>	
<p>Lincomycin derivatives</p>	<p>Clindamycin</p>	
<p>Macrolides</p>	<p>Azithromycin, Clarithromycin, Erythromycin, Erythromycin ethylsuccinate, Erythromycin lactobionate, Erythromycin, Erythromycin stearate</p>	
<p>Natural penicillin</p>	<p>Penicillin G potassium, Penicillin G sodium, Penicillin V potassium, Penicillin G benzathine</p>	
<p>Penicillinase-resistant penicillin</p>	<p>Dicloxacillin</p>	
<p>Quinolones</p>	<p>Ciprofloxacin, Moxifloxacin, Levofloxacin, Ofloxacin</p>	
<p>Second generation cephalosporins</p>	<p>Cefaclor, Cefuroxime, Cefprozil</p>	
<p>Sulfonamides</p>	<p>Sulfamethoxazole-trimethoprim</p>	
<p>Tetracyclines</p>	<p>Doxycycline, Tetracycline, Minocycline</p>	
<p>Third generation cephalosporins</p>	<p>Cefdinir, Ceftibuten, Cefixime, Cefditoren, Cefpodoxime, Ceftriaxone</p>	

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<p><b>OMW</b></p> <p><b>Osteoporosis Management in Women Who Had a Fracture</b></p> <p>Women age 67-85 who suffered a fracture and had a bone mineral density (BMD) study or DEXA Scan on the fracture date or prescription for a drug to treat osteoporosis in the six months after the fracture.</p> <p>Women age 67-85 who suffered a fracture and had a bone mineral density (BMD) study or DEXA Scan on the fracture date, or prescription for a drug to treat osteoporosis in the six months after the fracture in 2019 or 2020.</p>	<ul style="list-style-type: none"> <li>Submit a note stating that the BMD test (Dexa Scan) was performed and the date of service.</li> <li><b>OR</b> submit the test report.</li> <li>BMD testing that is done in the inpatient setting will make your patient a pass for this measure. Ensure that you obtain this documentation for your records.</li> </ul>	<p>Note: Fractures of fingers, toes, face, and skull are not included in this measure.</p> <p>Exclude patients who had a BMD test during the 730 days (24 months) prior to the Episode Date.</p> <p>Exclude patients who received a dispensed prescription or had a active prescription to treat osteoporosis during the 365 days (12 months) prior to the Episode Date.</p>
<p><b>The following Osteoporosis medications will make your patient a pass for this measure.</b></p>		
<p><b>Description</b></p>	<p><b>Prescription</b></p>	
<p>Bisphosphonates</p>	<p>Alendronate, Risedronate, Alendronate-cholecalciferol, Zoledronic acid, Ibandronate</p>	
<p>Other Agents</p>	<p>Abaloparatide, Teriparatide, Denosumab, Raloxifene</p>	