Quality Ribbon Rating (QRT) Corrections

If the information on your report needs updating based on the report period timeframe indicated on the "patient data" page of the report and per your clinic records, please provide the Quality Improvement Team with the documentation indicated in the "Documentation Requirements" section below and they will "correct" your data in our system. Take note of the "Screening Timeframes" section to know what timeframes are acceptable for corrections.

SCREENING TIMEFRAMES

If the screening occurred within the last 90 days then it could be claims lag, so please wait until 90 days have passed before submitting a correction. If the screening occurred further back than what is indicated in these recommendations then the patient needs the screening done again. Please note that the "report period" is referring to what is listed on the report to indicate when the data is listed through. Here is a list of the timeframes that any correction submitted must be within:

Preventive Screenings

- **Breast Cancer Screening:** Mammogram within the last 27 months since the most recent report period.
- **Colorectal Cancer Screening:** Colonoscopy within the last 10 years since the most recent report period; or fecal occult blood test in the last 12 months since the most recent report period; or FIT-DNA aka FIT Cologuard testing in the last 3 years since the most recent report period; or flexible sigmoidoscopy in the last 5 years since the most recent report period; or CT Colonography in the last 5 years since the most recent report period.
- **Cervical Cancer Screening:** Pap within the last 3 years since the most recent report period; or if the woman is over the age of 30 when testing was completed and had HPV testing done with or without the pap within the last 5 years since the most recent report period.

  Pap smears are recommended by the CDC, ACS, and ACOG every three years starting at age 21 regardless of sexual activity. It is also not an exclusion reason for the cervical cancer screening HEDIS measurement either. For these reasons, a patient is not excluded from needing a pap smear even if she is not sexually active.
- **Chlamydia Screening:** Within the last 12 months since the most recent report period.

  Because the national standardized measurements do not exclude patients for abstinence or monogamy, we do not accept corrections for these things either.

Pediatric Monitoring

Well-Child Visits: Well-child visit in the last 12 months since the most recent report period.

Diabetes Screenings

- **A1C Testing with A1C<8:** A1C testing with results <8 within the last 12 months since the most recent report period. The most recent A1C test must always be used for compliance.
- **Eye Exam:** Positive or negative retinal eye exam by an optometrist/ophthalmologist within the last 12 months or negative retinal eye exam by an optometrist/ophthalmologist within the last 24 months since the most recent report period.
- **Kidney Health Evaluation:** Estimated glomerular filtration rate (eGFR) and urine albumin-creatinine ratio (uACR) within the last 12 months since the most recent report period.

DOCUMENTATION REQUIREMENTS

If the screening has been done within the recommended timeframe per your clinic records, and you can provide us with the documentation indicated below then we will "correct" your data in our system. Here is a summary of the documentation requirements that must accompany any correction submitted (please note that

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documentation stated by the provider in the official medical record can qualify):

- **Mammogram:** Copy of EMR note or progress note signed by provider indicating the date of the mammogram. A copy of the testing results would be acceptable. Can be bilateral or two unilateral but must specify somehow that all necessary breasts were evaluated.
- **Mastectomy:** Copy of EMR note or progress note signed by provider indicating the date of the mastectomy. Must be bilateral, or unilateral at two different points in a women's history so that both breasts were eventually removed, to exclude her from needing a mammogram.
- **Colonoscopy/Other Colon Tests:** Copy of EMR note or progress note signed by provider indicating the date of the colorectal cancer screening exam and what exam was used (Note: for iFOBT or FIT-DNA the sample(s) must be obtained at home, not in the ER or clinic).
- **Total Colectomy:** Copy of EMR note or progress note signed by provider indicating the date of the total colectomy. Must be documented as a "total" colectomy to exclude from the measurement.
- **History of Colorectal Cancer:** Copy of EMR note or progress note signed by provider indicating the date of the diagnosis. This documentation of colorectal cancer anytime in the patient's history excludes them from the measure.
- **Pap/HPV Test:** Copy of EMR note or progress note signed by provider indicating the pap and/or HPV testing date and result. A copy of the testing results would be acceptable.
- **Hysterectomy:** Copy of EMR note or progress note signed by provider indicating the date of the cervix being removed. Documentation of a hysterectomy must address the status of the woman's cervix. Not all women with hysterectomies have their cervix removed. To meet this documentation requirement the words "total," "complete," "radical," or "vaginal" hysterectomy work. The words "cervix surgically absent" also work. Operative reports or pathology reports are acceptable.
- **Chlamydia Screening:** Copy of EMR note or progress note signed by provider indicating the date and the result of the screening. This can be documentation by the provider in the medical record or the actual screening report.
- **Immunizations:** For these corrections please enter the information into USIIS for data extraction. If it is already in USIIS please send either a snapshot of the USIIS report showing they are up to date and/or a copy of an EMR note or progress note signed by the provider indicating the date of the vaccination(s). If the patient has had a history of reactions to the vaccine please submit patient information signed by the provider with a chart note supporting the reaction to the vaccine.
- **Well Visits:** Copy of EMR note or progress note signed by provider indicating the date of the visit and indication that it was a well visit and not a sick visit. Although not required, documentation including information on nutrition, physical activity and BMI percentile is preferred.
- **Diabetes Screenings:** Copy of EMR note or progress note signed by provider indicating the date and the result for the following testing situations:
  - Most recent A1C testing documentation with a distinct numeric result less than 8. Ranges and thresholds do not meet the criteria. If the most recent testing was not less than 8 then the patient is not compliant.
  - Eye exam documentation must specify that it was completed by an optometrist/ophthalmologist and have specific results pertaining to retinopathy. (Note again: if they are positive for retinopathy they need a result each year and if they are negative for retinopathy they can go 2 years before their next screening).

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  - Kidney health evaluations must include results for both an estimated glomerular filtration rate (eGFR) and urine albumin-creatinine ratio (uACR).

  If you feel a patient is included as a diabetic by mistake, please reach out to us. We will investigate these situations and get back to you. There is a two year look back for a diabetes diagnosis to be included in these screenings.

- **Medication Adherence:** No corrections are available for medication adherence measurements.
- **"Not my patient"** situations need backup information including patient name, EMPI/DOB and PCP. We will research the claims data for visits to other providers. In most cases, these patients have been attributed to you as their provider based on you being the PCP/OB/GYN/CNM that has seen them most in the last 18 months. A patient will automatically fall off your report if they are not seen by you for 18 months or if they regularly start seeing someone new within your specialty.

  Sometimes these situations are because of after-hours/Instacare work. If this shows in the documentation then we can remove patients for this reason.

If you participate in the Quality Provider Program (QPP) and are familiar with the Select Health correction tool then you may also submit the documentation through that tool. Otherwise, please send your documentation to our Quality Improvement Team via fax at **801-442-0920** or email us at **qualityimprovement@selecthealth.org**.

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