ILLINOIS DEPARTMENT OF Healthcare and Family Services

Illinois Department of Healthcare and Family Services

Quality Measures Specifications

For the

Care Coordination Program

January 2012

CONTENTS

Medication Tables for Measures

All non-HEDIS measures have the medication tables included in the measure specifications, or included at the end of this document. These tables will be updated annually. The medication tables for HEDIS measures may be downloaded from the NCQA website at www.ncqa.org.

Measure 1(BHRA) - Behavioral Health Risk Assessment and Follow-up (State Defined)

Description

This measure considers the percentage of new members who *completed* a behavioral health risk assessment (BHRA) within 60 days of enrollment. The measure also examines the percentage of members with a completed BHRA that had a positive finding and who received a follow-up visit with a mental health provider within 30 days of the completed assessment.

Eligible Population

Continuous enrollment

Newly enrolled between October 4 of the prior year and October 3 of the current measurement year, and continuously enrolled in the CCE or MCCN for at least 90 days. No gaps in enrollment.

"Newly enrolled members" for this measure is a member not previously enrolled in the CCE or MCCN in the prior six months. A member may be included in this measure multiple times if they have multiple "new" enrollments during the year, as enrollments more than 6 months apart would necessitate a new BHRA should be completed.

Administrative Specification

Denominator New members (as defined above) in the eligible population.

Numerators

BHRA Completion New members who completed a BHRA within 60 days of enrollment.

BHRA Follow-Up New members with a positive BHRA and an outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 30 days after the positive BHRA. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Table FUH-C: Codes to Identify Visits

CPT	HCPCS	
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.		
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	
CPT	**POS**	
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22,24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

Measure 2 (IET) - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

- *Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Definitions

Intake Period	January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
Index Episode	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD. *For ED visits that result in an inpatient stay*, the inpatient stay is the Index Episode.
IESD	Index Episode Start Date. The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD. *For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED (not resulting in an inpatient stay) claim/encounter,* the IESD is the date of service. *For an inpatient (acute or nonacute) claim/encounter,* the IESD is the date of discharge. *For an ED visit that results in an inpatient stay,* the IESD is the date of the inpatient discharge. *For direct transfers*, the IESD is the discharge date from the second admission.
Negative Diagnosis History	A period of 60 days before the IESD, during which the member had no claims/ encounters with a diagnosis of AOD dependence. *For an inpatient claim/encounter,* use the admission date to determine the Negative Diagnosis History. *For ED visits that result in an inpatient stay,* use the ED date of service to determine the Negative Diagnosis History. *For direct transfers,* use the first admission to determine the Negative Diagnosis History.

Measure 2 (IET) - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Eligible Population

Product lines

Medicaid.

Age

This measure uses the HEDIS specification specifications of 13-17 years, and 18+ years, along with a total rate.

- 13 - 17 years
- 18+ years
- Total

The total rate is the sum of the two numerators divided by the sum of the two denominators.

Continuous enrollment

60 days prior to the IESD through 44 days after the IESD (inclusive).

Allowable gap

None.

Anchor date

None.

Benefits

Medical and chemical dependency (inpatient and outpatient).

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/ diagnosis

New episode of AOD during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1

Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following.

- An outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with a diagnosis of AOD (Table IET-A)
- A detoxification visit (Table IET-C)
- An ED visit (Table IET-D) with a diagnosis of AOD (Table IET-A)
- An inpatient discharge with a diagnosis of AOD as identified by either of the following.
  - An inpatient facility code in conjunction with a diagnosis of AOD (IET-A)
  - An inpatient facility code in conjunction with an AOD procedure code (IET-E)

For members with more than one episode of AOD, use the first episode.

For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.

Select the IESD.

Measure 2 (IET) - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Table IET-A: Codes to Identify AOD Dependence

ICD-9-CM Diagnosis
291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

Table IET-B: Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization Visits

CPT	HCPCS	UB Revenue
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, G0409-G0411, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983

CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53

Table IET-C: Codes to Identify Detoxification Visits

HCPCS	ICD-9-CM Procedure	UB Revenue
H0008-H0014	94.62, 94.65, 94.68	0116, 0126, 0136, 0146, 0156

Table IET-D: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

Table IET-E: Codes to Identify AOD Procedures

ICD-9-CM Procedure
94.61, 94.63, 94.64, 94.66, 94.67, 94.69

Step 2 Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD (Table IET-A) during the 60 days before the IESD.

For an inpatient IESD, use the admission date to determine the Negative Diagnosis History.

For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled without any gaps 60 days before the IESD through 44 days after the IESD.

Measure 2 (IET) - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of AOD Treatment Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant
- If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with an AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive)
  - If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive)
- Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment

Exclude from the denominator, members whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Engagement of AOD Treatment Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.

- If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).
- Do not count engagement encounters that include detoxification codes (including inpatient detoxification)

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate (e.g., within 14 days of the IESD or within 30 days after the date of the initiation encounter).*

Measure 3 (FUP) - Follow-up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis (State Defined)

Description

This measure determines if a member had timely follow-up with a practitioner following their initial behavioral health diagnosis.

Eligible Population

Ages All

Continuous enrollment 30 days following the date of the initial behavioral health diagnosis.

Allowable gap No gaps in enrollment.

Event/ diagnosis Diagnosed with a mental illness between December 2 of the prior year and December 1 of the measurement year (Table FUH-A).Use the earliest diagnosis during the measurement year.

To be considered the initial diagnosis, the member should have negative claims / encounter history with a mental health diagnosis (principal or secondary diagnosis) for the six months prior to the current episode.

Table FUH-A: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
295–299, 300.3, 300.4, 301, 308, 309, 311–314

Administrative Specification

Denominator The eligible population.

Numerator An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with any practitioner within 30 days after the initial diagnosis.

Table FUH-C: Codes to Identify Visits

CPT	HCPCS	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	
CPT	**POS**	
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53
UB Revenue		
0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983		

Measure 3 (FUP) - Follow-up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis (State Defined)

Exclusions *(required)*

Mental health readmission or direct transfer

Exclude members admitted to or directly transferred to a *non-acute facility* for a mental health principal diagnosis (Tables MPT-A, MPT-B) within the 30-day follow-up period. These members are excluded from the measure because admission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify non-acute care.

Non-mental health readmission or direct transfer

Exclude members transferred directly or admitted within 30 days after the initial diagnosis to an acute or non-acute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These members are excluded from the measure because a hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Table FUH-B: Codes to Identify Non-acute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Measure 4 (FUH) - Follow-Up After Hospitalization for Mental Illness

Description

The percentage of discharges for members 19 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

- The percentage of members who received follow-up within 30 days of discharge
- The percentage of members who received follow-up within 7 days of discharge

Eligible Population

Product lines	Medicaid.
Ages	19 years and older as of the date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/ diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Table FUH-A) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

Table FUH-A: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
295–299, 300.3, 300.4, 301, 308, 309, 311–314

Measure 4 (FUH) - Follow-Up After Hospitalization for Mental Illness

Mental health readmission or direct transfer

If the discharge is followed by readmission or direct transfer to an *acute facility* for a mental health principal diagnosis (Tables MPT-A, MPT-B) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for a mental health principal diagnosis (Tables MPT-A, MPT-B) within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify nonacute care.

Non-mental health readmission or direct transfer

Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Table FUH-B: Codes to Identify Non-acute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Measure 4 (FUH) - Follow-Up After Hospitalization for Mental Illness

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Table FUH-C: Codes to Identify Visits

CPT	HCPCS	
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.		
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	
CPT	**POS**	
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*

Measure 5 (CCI) - Care Coordination – Influenza Immunization Rate (State Defined)

Description

The percentage of members 19 years of age and older who received at least one influenza immunization during the measurement year.

Eligible Population

Product line	Medicaid.
Ages	19 years old as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.

Administrative Specification

Numerator	One or more influenza immunizations during the measurement year. Influenza immunizations can be identified using the codes in Table INF-A.

Table INF -A: Codes to Identify Influenza Immunizations

CPT	ICD-9-CM Procedure	HCPCS
90654, 90656, 90658, 90660, 90661, 90662	99.52	G0008

Measure 6 (ADV) - Annual Dental Visit (State Defined)

Description

The percentage of members 19-20, and 21 years of age and older who had at least one dental visit during the measurement year.

Eligible Population

Product line	Medicaid / DD. The Medicaid product will be reported with DD included, and then the DD population will be reported separately.
Ages	19 years as of December 31 of the measurement year. Report two age stratifications and a total rate. • 19 – 20 years • 21 years and older • Total
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Dental.

Administrative Specification

Numerator	One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any code in Table ADV-A.

Table ADV-A: Codes to Identify Annual Dental Visits

CPT	HCPCS/CDT	ICD-9-CM Procedure
70300, 70310, 70320, 70350, 70355	D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97

Note: *Current Dental Terminology (CDT) is the equivalent dental version of the CPT Physician Procedural Coding System.*

Measure 7 (DERV) - Dental ER Visit (State Defined)

Description

The number of dental ER visits during the measurement year per 1,000 members.

Eligible Population

Product line	Medicaid.
Ages	All
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator	The eligible population
Numerator	The number of dental ER visits during the measurement year per 1,000 members. A member had a dental ER visit if a submitted claim/encounter contains any code in Table AMB-B in conjunction with Table ADV-B.

Table AMB-B: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

OR

CPT	*WITH*	POS
10040-69979		23

Table ADV-B: Codes to Identify Dental ER Visits

ICD-9-CM Procedure
521.01 – 521.05, 521.09, 522.0 – 523.1, 523.21 – 523.25, 523.3, 523.4, 523.5, 523.6, 523.8, 524.60, 524.63, 524.81, 524.82, 802.2x, 802.3x, 802.4, 802.5, 830.0, 830.1, 873.41, 873.43, 873.44, 873.49, 873.61 – 873.65, 873.73, 996.69

Measure 8A -8C (CDC) - Comprehensive Diabetes Care

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- Medical attention for nephropathy
- LDL-C screening

Eligible Population

Product lines	Medicaid and DD. The Medicaid product will be reported with DD included, and then the DD population will be reported separately for only the **HbA1c testing numerator.**
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/ diagnosis	There are two ways to identify members with diabetes: by pharmacy data and by claim/ encounter data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Pharmacy data.* Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year before the measurement year on an ambulatory basis (Table CDC-A). *Claim/encounter data.* Members who had *two* face-to-face encounters, in an outpatient setting or non-acute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table CDC-B), or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table CDC-C for codes to identify visit type.

Note: Measures 8A – 8C may be calculated using the hybrid methodology or the administrative methodology.

Measure 8A -8C (CDC) - Comprehensive Diabetes Care

Table CDC-A: Prescriptions to Identify Members With Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	• acarbose • miglitol
Amylin analogs	• pramlinitide
Antidiabetic combinations	• glimepiride-pioglitazone • glyburide-metformin • metformin-rosiglitazone • glimepiride-rosiglitazone • metformin-pioglitazone • metformin-sitagliptin • glipizide-metformin
Insulin	• insulin aspart • insulin aspart-insulin aspart protamine • insulin detemir • insulin glargine • insulin glulisine • insulin inhalation • insulin isophane beef-pork • insulin isophane human • insulin isophane pork • insulin isophane-insulin regular • insulin lispro • insulin lispro-insulin lispro protamine • insulin regular beef-pork • insulin regular human • insulin regular pork • insulin zinc beef-pork • insulin zinc extended human • insulin zinc human • insulin zinc pork
Meglitinides	• nateglinide • repaglinide
Miscellaneous antidiabetic agents	• exenatide • liraglutide • sitagliptin
Sulfonylureas	• acetohexamide • glimepiride • glyburide • tolbutamide • chlorpropamide • glipizide • tolazamide
Thiazolidinediones	• pioglitazone • rosiglitazone

Note: *Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Table CDC-B: Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Table CDC-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, , 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Measure 8A -8C (CDC) - Comprehensive Diabetes Care

Administrative Specification

Note: The Medicaid product will be reported with DD included; the DD population will be reported separately for only the ***HbA1c testing numerator.***

Numerators

HbA1c Testing An HbA1c test performed during the measurement year, as identified by claim/ encounter or automated laboratory data. Use any code listed in Table CDC-D.

Table CDC-D: Codes to Identify HbA1c Tests

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8, 62388-4

LDL-C Screening An LDL-C test performed during the measurement year, as identified by claim/ encounter or automated laboratory data. Use any code listed in Table CDC-H.

The organization may use a calculated or direct LDL for LDL-C screening and control indicators.

Table CDC-H: Codes to Identify LDL-C Screening

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2

Medical Attention for Nephropathy A nephropathy screening test ***or*** evidence of nephropathy, as documented through administrative data.

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

Nephropathy screening test A nephropathy screening test during the measurement year (Table CDC-J).

Table CDC-J: Codes to Identify Nephropathy Screening Tests

Description	CPT	CPT Category II	LOINC
Nephropathy screening test	82042, 82043, 82044, 84156	3060F, 3061F	1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13801-6, 14956-7, 14957-5, 14958-3, 14959-1, 13705-9, 14585-4, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1

Evidence of nephropathy

Any of the following meet criteria for evidence of nephropathy.

- A claim/encounter with a code to indicate evidence of treatment for nephropathy (Table CDC-K) during the measurement year.
- A nephrologist visit during the measurement year, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- A *positive* urine macroalbumin test in the measurement year, as documented by claim/encounter or automated laboratory data. Refer to Table CDC-K for codes to identify urine macroalbumin tests. "Trace" urine macroalbumin test results are not considered numerator-compliant.
- Evidence of ACE inhibitor/ARB therapy during the measurement year. Members who had a claim indicating therapy (Table CDC-K) or received an ambulatory prescription or were dispensed an ambulatory prescription for ACE inhibitors or ARBs during the measurement year are compliant. Table CDC-L lists the ACE inhibitors/ARBs included in this measure.

Table CDC-K: Codes to Identify Evidence of Nephropathy

Description	CPT	CPT Category II*	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Rev	UB Type of Bill	POS	LOINC
Urine macroalbumin test*	81000-81003, 81005	3062F							5804-0, 20454-5, 50561-0, 53525-2, 57735-3
Evidence of treatment for nephropathy	36145, 36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	3066F	G0257, G0392, G0393, S9339	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6	0367, 080x, 082x 083x 084x 085x, 088x	72x	65	
ACE inhibitor/ ARB therapy		4009F							

*A CPT Category II code indicates a positive result for urine macroalbumin; the organization must use automated laboratory data to confirm a positive result for tests identified by CPT or LOINC codes.

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription				
Angiotensin converting enzyme inhibitors	• benazepril • captopril	• enalapril • fosinopril	• lisinopril • moexipril	• perindopril • quinapril	• ramipril • trandolapril
Angiotensin II inhibitors	• candesartan • eprosartan	• irbesartan • losartan	• olmesartan • telmisartan	• valsartan • azilsartan	
Antihypertensive combinations	• aliskiren-valsartan • aliskiren-hydrochlorothiazide-amoldipine • amlodipine-benazepril • amlodipine-hydrochlorothiazide-valsartan • amlodipine-hydrochlorothiazide-olmesartan • amlodipine-olmesartan • amlodipine-telmisartan • amlodipine-valsartan • benazepril-hydrochlorothiazide		• candesartan-hydrochlorothiazide • captopril-hydrochlorothiazide • enalapril-hydrochlorothiazide • eprosartan-hydrochlorothiazide • fosinopril-hydrochlorothiazide • hydrochlorothiazide-irbesartan • hydrochlorothiazide-lisinopril	• hydrochlorothiazide-losartan • hydrochlorothiazide-moexipril • hydrochlorothiazide-olmesartan • hydrochlorothiazide-quinapril • hydrochlorothiazide-telmisartan • hydrochlorothiazide-valsartan • trandolapril-verapamil	

Hybrid Specification

Numerators

HbA1c Testing An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. The organization may count notation of the following in the medical record.

- A1c
- Hemoglobin A1c
- HgbA1c
- HbA1c
- Glycohemoglobin A1c

LDL-C Screening An LDL-C test performed during the measurement year as identified by claim/ encounter or automated laboratory data or medical record review.

At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result. The organization may use a calculated or direct LDL for LDL-C screening and control indicators.

Medical Attention for Nephropathy A nephropathy screening test during the measurement year ***or*** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

Measure 8A -8C (CDC) - Comprehensive Diabetes Care

Nephropathy screening test. At a minimum, documentation must include a note indicating the date when a urine microalbumin test was performed, and the result. Any of the following meet the criteria for a urine microalbumin test.

- 24-hour urine for microalbumin
- Timed urine for microalbumin
- Spot urine for microalbumin
- Urine for microalbumin/creatinine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio

Evidence of nephropathy. Any of the following meet the criteria for evidence of nephropathy.

- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type).
  - Diabetic nephropathy
  - ESRD
  - CRF
  - Chronic kidney disease (CKD)
  - Renal insufficiency or Renal dysfunction
  - Proteinuria
  - Albuminuria
  - Acute renal failure (ARF)
  - Dialysis, hemodialysis or peritoneal dialysis
- A positive urine macroalbumin test. At a minimum, documentation in the medical record must include a note indicating the date when the test was performed, and a positive result. Any of the following meet the criteria for a positive urine macroalbumin test.

- Positive urinalysis (random, spot or timed) for protein
- Positive urine (random, spot or timed) for protein
- Positive urine dipstick for protein
- Positive tablet reagent for urine protein
- Positive result for albuminuria
- Positive result for macroalbuminuria
- Positive result for proteinuria
- Positive result for gross proteinuria

Note: *"Trace" urine macroalbumin test results are not considered numerator compliant.*

- Evidence of ACE inhibitor/ARB therapy. Documentation in medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

Exclusions *(optional)*

- Members with a diagnosis of polycystic ovaries (Table CDC-O) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (CDC-B) during the measurement year or the year before the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by December 31 of the measurement year.

- Members with gestational or steroid-induced diabetes (CDC-O) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (CDC-B) during the measurement year or the year before the measurement year. Diagnosis may occur during the measurement year or the year before the measurement year, but must have occurred by December 31 of the measurement year.

Table CDC-O: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic ovaries	256.4
Steroid induced	249, 251.8, 962.0
Gestational diabetes	648.8

Medical Record Exclusions (optional)

- Exclusionary evidence in the medical record must include a note indicating a diagnosis of polycystic ovaries or gestational or steroid induced diabetes. Members must not have any face-to-face encounters, in any setting, with a diagnosis of diabetes during the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by December 31 of the measurement year.

Note

The organization may select data collection method (Administrative vs. Hybrid) at the indicator level, but the method for screening and control rates must be consistent.

Measure 8D -8E (CDCSA) - Comprehensive Diabetes Care Administrative Method (State Defined)

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Statin Therapy (non-HEDIS)
- ACE/ARB Therapy (non-HEDIS)

Eligible Population

Product lines	Medicaid.
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/ diagnosis	There are two ways to identify members with diabetes: by pharmacy data and by claim/ encounter data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Pharmacy data.* Members who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year before the measurement year on an ambulatory basis (Table CDC-A). *Claim/encounter data.* Members who had *two* face-to-face encounters, in an outpatient setting or non-acute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table CDC-B), or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table CDC-C for codes to identify visit type.

Note: Measures 8D – 8E must be calculated using the administrative methodology.

Measure 8D -8E (CDCSA) - Comprehensive Diabetes Care Administrative Method (State Defined)

Table CDC-A: Prescriptions to Identify Members With Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	• acarbose • miglitol
Amylin analogs	• pramlinitide
Antidiabetic combinations	• glimepiride-pioglitazone • glyburide-metformin • metformin-rosiglitazone • glimepiride-rosiglitazone • metformin-pioglitazone • metformin-sitagliptin • glipizide-metformin
Insulin	• insulin aspart • insulin aspart-insulin aspart protamine • insulin detemir • insulin glargine • insulin glulisine • insulin inhalation • insulin isophane beef-pork • insulin isophane human • insulin isophane pork • insulin isophane-insulin regular • insulin lispro • insulin lispro-insulin lispro protamine • insulin regular beef-pork • insulin regular human • insulin regular pork • insulin zinc beef-pork • insulin zinc extended human • insulin zinc human • insulin zinc pork
Meglitinides	• nateglinide • repaglinide
Miscellaneous antidiabetic agents	• exenatide • liraglutide • sitagliptin
Sulfonylureas	• acetohexamide • glimepiride • glyburide • tolbutamide • chlorpropamide • glipizide • tolazamide
Thiazolidinediones	• pioglitazone • rosiglitazone

Note: *Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Table CDC-B: Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Measure 8D -8E (CDCSA) - Comprehensive Diabetes Care Administrative Method (State Defined)

Table CDC-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, , 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Administrative Specification

Note: This measure uses the total number of days of enrollment as the denominator, rather than the number of eligible members.

Denominator The total number of days the member was enrolled during the measurement period.

Numerators

Statin Therapy 80% of the Time Total days supply for all statin prescriptions filled during the measurement period. Use any pharmacy code listed in Table CDC-M.

ACE/ARB Therapy 80% of the time Total days supply for all ACE/ARB prescriptions filled during the measurement period. Use any pharmacy code listed in Table CDC-L.

Table CDC-M: Statins and Cholesterol Lowering Medications
(Refer to Pharmacy Reference Code Spreadsheet for Codes)

STCC	Description	Prescription		
D7L	Bile salt sequestrants	• Cholestyramine • Colesevelam	• Colestipol	
M4D, M4E, M4L, M4M	Lipotropics	• Fenofibrate • Gemfibrozil • Lovastatin • Niacin • Niacin/Lovastatin	• Omega-3 Acid Ethyl Esters • Pravastatin Sodium • Simvastatin • Aspirin/Calcium Carb/Mag/Pravastatin • Ezetimibe/Simvastatin	• Atrovastatin Calcium • Ezetimibe • Fluvastatin • Rosuvastatin

Measure 8D -8E (CDCSA) - Comprehensive Diabetes Care Administrative Method (State Defined)

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription				
Angiotensin converting enzyme inhibitors	• benazepril • captopril	• enalapril • fosinopril	• lisinopril • moexipril	• perindopril • quinapril	• ramipril • trandolapril
Angiotensin II inhibitors	• candesartan • eprosartan	• irbesartan • losartan	• olmesartan • telmisartan	• valsartan • azilsartan	
Antihypertensive combinations	• aliskiren-valsartan • aliskiren-hydrochlorothiazide-amoldipine • amlodipine-benazepril • amlodipine-hydrochlorothiazide-valsartan • amlodipine-hydrochlorothiazide-olmesartan • amlodipine-olmesartan • amlodipine-telmisartan • amlodipine-valsartan • benazepril-hydrochlorothiazide		• candesartan-hydrochlorothiazide • captopril-hydrochlorothiazide • enalapril-hydrochlorothiazide • eprosartan-hydrochlorothiazide • fosinopril-hydrochlorothiazide • hydrochlorothiazide-irbesartan • hydrochlorothiazide-lisinopril	• hydrochlorothiazide-losartan • hydrochlorothiazide-moexipril • hydrochlorothiazide-olmesartan • hydrochlorothiazide-quinapril • hydrochlorothiazide-telmisartan • hydrochlorothiazide-valsartan • trandolapril-verapamil	

Exclusions for Non-HEDIS Diabetes Indicators

- Members with a contraindication for Statin Therapy (Table CDC-S)
- Members with a contraindication for ACE Inhibitors and ARB (Table CHF-E)

Table CDC-S: Exclusions / Contraindications for Statin Therapy

• (V22) Pregnancy • (V24.1) Lactation	• (995.27) Hypersensitivity or allergy to previous Statin therapy • (571.4, 571.49, 070) Active liver disease or unexplained persistent elevations of hepatic transaminases

Table CHF-E: Exclusions / Contraindications for ACE / ARB

• (V22) Pregnancy • (V24.1) Lactation • (440.1) Renal artery stenosis	• (425.1) Hypertrophic cardiomyopathy • (995.27) Hypersensitivity or allergy to previous ACE or ARB treatment • (995.1) Angioedema due to previous treatment with ACE inhibitors • (277.6) Hereditary angioedema

Measure 9A-9C (CHF) - Congestive Heart Failure (State Defined)

Description

The percentage of members with congestive heart failure (CHF) who had following:

- ACE/ARB Therapy 80% of the Time
- Beta Blocker 80% of the Time
- Diuretic 80% of the Time

Eligible Population

Product lines	Medicaid
Ages	19 and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/ diagnosis	A diagnosis (***primary or secondary***) of CHF in any setting during the measurement period or the year prior to the measurement period. Use Table CHF-A for ICD-9-CM codes to determine a diagnosis of CHF.

Table CHF-A: Codes to Identify CHF

Description	ICD-9-CM Diagnosis
Congestive Heart Disease	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.xx

Measure 9A-9C (CHF) - Congestive Heart Failure (State Defined)

Administrative Specification

Denominator The total number of days the member was enrolled during the measurement period.

Numerators

ACE/ARB Therapy 80% of the time Total days supply for all ACE/ARB prescriptions filled during the measurement period. Use any pharmacy code listed in Table CDC-L.

Beta Blocker 80% of the time Total days supply for all Beta Blocker prescriptions filled during the measurement period. Use any pharmacy code listed in Table PBH-B.

Diuretic 80% of the time Total days supply for all Diuretic prescriptions filled during the measurement period. Use any pharmacy code listed in Table MPM-C.

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription				
Angiotensin converting enzyme inhibitors	• benazepril • captopril	• enalapril • fosinopril	• lisinopril • moexipril	• perindopril • quinapril	• ramipril • trandolapril
Angiotensin II inhibitors	• candesartan • eprosartan	• irbesartan • losartan	• olmesartan • telmisartan	• valsartan • azilsartan	
Antihypertensive combinations	• aliskiren-valsartan • aliskiren-hydrochlorothiazide-amoldipine • amlodipine-benazepril • amlodipine-hydrochlorothiazide-valsartan • amlodipine-hydrochlorothiazide-olmesartan • amlodipine-olmesartan • amlodipine-telmisartan • amlodipine-valsartan • benazepril-hydrochlorothiazide		• candesartan-hydrochlorothiazide • captopril-hydrochlorothiazide • enalapril-hydrochlorothiazide • eprosartan-hydrochlorothiazide • fosinopril-hydrochlorothiazide • hydrochlorothiazide-irbesartan • hydrochlorothiazide-lisinopril	• hydrochlorothiazide-losartan • hydrochlorothiazide-moexipril • hydrochlorothiazide-olmesartan • hydrochlorothiazide-quinapril • hydrochlorothiazide-telmisartan • hydrochlorothiazide-valsartan • trandolapril-verapamil	

Table PBH-B: Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	• carteolol • carvedilol • labetalol	• nadolol • penbutolol • pindolol	• propranolol • timolol • sotalol
Cardioselective beta-blockers	• acebutolol • atenolol	• betaxolol • bisoprolol	• metoprolol • nebivolol
Antihypertensive combinations	• atenolol-chlorthalidone • bendroflumethiazide-nadolol • bisoprolol-hydrochlorothiazide		• hydrochlorothiazide-metoprolol • hydrochlorothiazide-propranolol

Measure 9A-9C (CHF) - Congestive Heart Failure (State Defined)

Table MPM-C: Drugs to Identify Members on Diuretics

Description	Prescription	
Antihypertensive combinations	• aliskiren-hydrochlorothiazide • aliskiren-hydrochlorothiazide-amlodipine • amiloride-hydrochlorothiazide • amiloride-hydrochlorothiazide-olmesartan • amlodipine-hydrochlorothiazide-valsartan • amlodipine-hydrochlorothiazide-olmesartan • atenolol-chlorthalidone • benazepril-hydrochlorothiazide • bendroflumethiazide-nadolol • bisoprolol-hydrochlorothiazide • candesartan-hydrochlorothiazide • captopril-hydrochlorothiazide • chlorthalidone-clonidine •	• enalapril-hydrochlorothiazide • eprosartan-hydrochlorothiazide • fosinopril-hydrochlorothiazide • hydrochlorothiazide-irbesartan • hydrochlorothiazide-lisinopril • hydrochlorothiazide-losartan • hydrochlorothiazide-methyldopa • hydrochlorothiazide-metoprolol • hydrochlorothiazide-moexipril • hydrochlorothiazide-olmesartan • hydrochlorothiazide-propranolol • hydrochlorothiazide-quinapril • hydrochlorothiazide-spironolactone • hydrochlorothiazide-telmisartan • hydrochlorothiazide-timolol • hydrochlorothiazide-triamterene • hydrochlorothiazide-valsartan
Loop diuretics	• bumetanide • ethacrynic acid	• furosemide • torsemide
Potassium-sparing diuretics	• amiloride • eplerenone	• spironolactone • triamterene
Thiazide diuretics	• chlorothiazide • chlorthalidone • hydrochlorothiazide	• indapamide • methyclothiazide • metolazone

Exclusions

- Members with a contraindication for ACE Inhibitors and ARB (Table CHF-E)
- Members with a contraindication for Beta Blockers (Tables CHF-F and G)
- Members with a contraindication for Diuretics (Table CHF-H).

Table CHF-E: Exclusions / Contraindications for ACE / ARB

• (V22) Pregnancy • (V24.1) Lactation • (440.1) Renal artery stenosis	• (425.1) Hypertrophic cardiomyopathy • (995.27) Hypersensitivity or allergy to previous ACE or ARB treatment • (995.1) Angioedema due to previous treatment with ACE inhibitors • (277.6) Hereditary angioedema

Use administrative data to look as far back as possible in the member's history through the end of the continuous enrollment period for evidence of a contraindication to beta-blocker therapy. Refer to Table PBH-C and Table PBH-D for codes and medications representing contraindications to beta-blocker therapy.

Measure 9A-9C (CHF) - Congestive Heart Failure (State Defined)

Table PBH-C: Codes to Identify Exclusions for Beta Blockers

Description	ICD-9-CM Diagnosis
History of asthma	493
Hypotension	458
Heart block >1 degree	426.0, 426.12, 426.13, 426.2-426.4, 426.51-426.54, 426.7
Sinus bradycardia	427.81
COPD	491.2, 496, 506.4
Intolerance or allergy to beta-blocker therapy	

Table PBH-D: Medications to Identify Exclusions (History of Asthma)

Description	Prescription		
Bronchodilator combinations	• Albuterol-ipratropium • budesonide-formoterol	• fluticasone-salmeterol • Mometasone-formoterol	
Inhaled corticosteroids	• beclomethasone • budesonide • flunisolide	• fluticasone • mometasone • triamcinolone	• fluticasone CFC free • ciclesonide

Table CHF – H: Exclusions / Contraindications for Diuretics

• (255.41) Adrenalcortical insufficiency • (572.2) Hepatic coma	• (572.2) Hepatic encephalopathy • (995.27) Hypersensitivity or allergy to previous diuretic treatment • (788.5) Anuria and Oliguria

Measure 10A - 10C *(CAD)* - Coronary Artery Disease (State Defined)

Description

The percentage of members with coronary artery disease (CAD) who had following.

- Cholesterol Testing
- Statin Therapy 80% of the Time
- ACE/ARB Therapy 80% of the Time

Eligible Population

Product lines	Medicaid
Ages	19 and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/ diagnosis	A diagnosis (***primary or secondary***) of CAD in any setting during the measurement period or the year prior to the measurement period. Use Table CAD-A for ICD-9-CM codes to determine a diagnosis of CAD.

Table CAD-A: Codes to Identify CAD

Description	ICD-9-CM Diagnosis	CPT-4 Codes	ICD-9 Procedures
Coronary Artery Disease	410.xx – 413.xx, 414.01, 414.8x, 414.9x	33510-33514, 33516-33519, 33521-33523, 33530, 33533-33536, 33572, 92980-92982, 92984, 92995, 92996, 92975, 92977, 92973	00.66, 36.0x – 36.3x, 36.9x

Measure 10A - 10C *(CAD)* - Coronary Artery Disease (State Defined)

Administrative Specification

Denominator The total number of members with CAD meeting the eligible population criteria.

Numerator

Cholesterol Testing (LDL-C Screening) Members in the denominator who had cholesterol tested at least once during the measurement year. Codes to identify cholesterol testing are listed in Table CDC-H.

Table CDC-H: Codes to Identify Cholesterol Testing (LDL-C Screening)

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2

Denominator The total number of days the member was enrolled during the measurement period.

Numerators

Statin Therapy 80% of the time Total days supply for all Statin prescriptions filled during the measurement period. Use any pharmacy code listed in Table CAD-B.

ACE/ARB Therapy 80% of the time Total days supply for all ACE/ARB prescriptions filled during the measurement period. Use any pharmacy code listed in Table CDC-L.

Table CAD-B: Statins and Cholesterol Lowering Medications
(Refer to Pharmacy Reference Code Spreadsheet for Codes)

STCC	Description	Prescription		
D7L	Bile salt sequestrants	• Cholestyramine • Colesevelam	• Colestipol	
M4D, M4E, M4L, M4M	Lipotropics	• Fenofibrate • Gemfibrozil • Lovastatin • Niacin • Niacin/Lovastatin	• Omega-3 Acid Ethyl Esters • Pravastatin Sodium • Simvastatin • Aspirin/Calcium Carb/Mag/Pravastatin • Ezetimibe/Simvastatin	• Atrovastatin Calcium • Ezetimibe • Fluvastatin • Rosuvastatin
M4I	Antihyperlip (HMGCOA) & Calcium channel blocker CMB	• Amlodipine / Atorvastatin		

Measure 10A - 10C *(CAD)* - Coronary Artery Disease (State Defined)

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription				
Angiotensin converting enzyme inhibitors	• benazepril • captopril	• enalapril • fosinopril	• lisinopril • moexipril	• perindopril • quinapril	• ramipril • trandolapril
Angiotensin II inhibitors	• candesartan • eprosartan	• irbesartan • losartan	• olmesartan • telmisartan	• valsartan • azilsartan	
Antihypertensive combinations	• aliskiren-valsartan • aliskiren-hydrochlorothiazide-amoldipine • amlodipine-benazepril • amlodipine-hydrochlorothiazide-valsartan • amlodipine-hydrochlorothiazide-olmesartan • amlodipine-olmesartan • amlodipine-telmisartan • amlodipine-valsartan • benazepril-hydrochlorothiazide		• candesartan-hydrochlorothiazide • captopril-hydrochlorothiazide • enalapril-hydrochlorothiazide • eprosartan-hydrochlorothiazide • fosinopril-hydrochlorothiazide • hydrochlorothiazide-irbesartan • hydrochlorothiazide-lisinopril	• hydrochlorothiazide-losartan • hydrochlorothiazide-moexipril • hydrochlorothiazide-olmesartan • hydrochlorothiazide-quinapril • hydrochlorothiazide-telmisartan • hydrochlorothiazide-valsartan • trandolapril-verapamil

Exclusions (for Statin and ACE/ARB numerators only)

- Members with a contraindication for ACE Inhibitors and ARB (Table CHF-E)
- Members with a contraindication for Statins (Table CDC-S)

Table CHF-E: Exclusions / Contraindications for ACE / ARB

• (V22) Pregnancy • (V24.1) Lactation • (440.1) Renal artery stenosis	• (425.1) Hypertrophic cardiomyopathy • (995.27) Hypersensitivity or allergy to previous ACE or ARB treatment • (995.1) Angioedema due to previous treatment with ACE inhibitors • (277.6) Hereditary angioedema

Table CDC-S: Exclusions / Contraindications for Statin Therapy

• (V22) Pregnancy • (V24.1) Lactation	• (995.27) Hypersensitivity or allergy to previous Statin therapy • (571.4, 571.49, 070) Active liver disease or unexplained persistent elevations of hepatic transaminases

Measure 10D (PBH) - Persistence of Beta-Blocker Treatment After a Heart Attack

Description

The percentage of members 19 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Definition

Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (i.e., a prescription of a 90-day supply dispensed on the 100th day will have 80 days counted in the 180-day interval).

Eligible Population

Product lines	Medicaid
Ages	19 years and older as of December 31 of the measurement year.
Continuous enrollment	Discharge date through 180 days after discharge.
Allowable gap	No more than one gap in enrollment of up to 45 days within the 180 days of the event. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Discharge date.
Benefit	Medical and pharmacy.
Event/diagnosis	Discharged alive from an acute inpatient setting with an AMI (Table PBH-A) from July 1 of the year prior to the measurement year through June 30 of the measurement year. If a member has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year, the organization should only include the first discharge.

Measure 10D (PBH) - Persistence of Beta-Blocker Treatment after a Heart Attack

Table PBH-A: Codes to Identify AMI

Description	ICD-9-CM Diagnosis
AMI	410.x1*

*****An organization that does not have fifth-digit specificity must develop a methodology to ensure that only the first eligible episode of an AMI is included in the measure.

Transfers to acute facilities. Include hospitalizations in which the member was transferred directly to another acute inpatient facility for any diagnosis. Count the discharge from the subsequent acute inpatient facility, not the initial discharge. The discharge date from the facility to which the member was transferred must occur on or before June 30 of the measurement year.

Transfers to nonacute facilities. Exclude from the denominator, hospitalizations in which the member was transferred directly to a nonacute care facility for any diagnosis.

Readmissions. If the member was readmitted to an acute or nonacute care facility for any diagnosis, include the member in the denominator and use the discharge date from the original hospitalization.

Administrative Specification

Denominator The eligible population.

Numerator A 180-day course of treatment with beta-blockers (PBH-A).

Identify all members in the denominator population whose dispensed days supply is ≥135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days' supply filled.

To determine continuity of treatment during the 180-day period, identify all prescriptions filled within 180 days of the Discharge Date, and add the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days + 45 gap days = 180 days);

To account for members who are on beta-blockers prior to admission, the organization should factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.

Table PBH-B: Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	• carteolol • carvedilol • labetalol	• nadolol • penbutolol • pindolol	• propranolol • timolol • sotalol
Cardioselective beta-blockers	• acebutolol • atenolol	• betaxolol • bisoprolol	• metoprolol • nebivolol
Antihypertensive combinations	• atenolol-chlorthalidone • bendroflumethiazide-nadolol • bisoprolol-hydrochlorothiazide		• hydrochlorothiazide-metoprolol • hydrochlorothiazide-propranolol

Exclusion (optional)

- Members identified as having an intolerance or allergy to beta-blocker therapy. Use administrative data to look as far back as possible in the member's history through the end of the continuous enrollment period for evidence of a contraindication to beta-blocker therapy. Refer to Table PBH-C and Table PBH-D for codes and medications representing contraindications to beta-blocker therapy.

Table PBH-C: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
History of asthma	493
Hypotension	458
Heart block >1 degree	426.0, 426.12, 426.13, 426.2-426.4, 426.51-426.54, 426.7
Sinus bradycardia	427.8x
COPD	491.2, 496, 506.4

Table PBH-D: Medications to Identify Exclusions (History of Asthma)

Description	Prescription		
Bronchodilator combinations	• budesonide-formoterol • albuterol-ipratropium	• fluticasone-salmeterol • mometasone-formoterol	
Inhaled corticosteroids	• beclomethasone • budesonide • flunisolide	• fluticasone • mometasone • triamcinolone	• fluticasone CFC free • ciclesonid

Measure 11A – 11B (PCE) - Pharmacotherapy Management of COPD Exacerbation

Description

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported.

1. Dispensed a systemic corticosteroid within 14 days of the event
2. Dispensed a bronchodilator within 30 days of the event

Note: *The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.*

Definitions

Intake Period	An 11-month period that begins on January 1 of the measurement year and ends on November 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any acute inpatient discharge or ED claim/encounter during the Intake Period with a principal diagnosis of COPD. *For an acute inpatient claim/encounter,* the Episode Date is the date of discharge. *For an ED claim/encounter,* the Episode Date is the date of service.
Active prescription	A prescription is considered active if the "days' supply" indicates the date the member filled the prescription, which is the number of days or more between that date and the relevant date. *For an acute inpatient claim/encounter,* the relevant date is the date of admission. *For an ED claim/encounter,* the relevant date is the date of service.

Eligible Population

Product lines	Medicaid.
Ages	40 years or older as of January 1 of the measurement year.
Continuous enrollment	Episode Date through 30 days after the Episode Date.
Allowable gap	None.
Anchor date	Episode Date.
Benefits	Medical and pharmacy.
Event/ diagnosis	A COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD. Follow the steps below to identify the eligible population.
Step 1	Identify all members who during the Intake Period had an acute inpatient discharge or an ED visit with a primary diagnosis of COPD (Table PCE-A). Use Table PCE-B to identify acute inpatient discharges and ED visits.

Measure 11A – 11B (PCE) - Pharmacotherapy Management of COPD Exacerbation

Table PCE-A: Codes to Identify COPD

Description	ICD-9-CM Diagnosis
Chronic bronchitis	491
Emphysema	492
COPD	496

Table PCE-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Acute inpatient		010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 0987
ED*	99281-99285	045x, 0981

*Do not include ED visits that result in an inpatient admission.

Step 2 Determine all COPD Episode Dates. For each member identified in step 1, identify all acute inpatient discharges and ED visits. Do not include ED visits that result in an inpatient admission.

Step 3 Test for transfers. Exclude Episode Dates on which the member was transferred directly to an acute or nonacute care facility for any diagnosis.

Step 4 Test for readmission and additional ED visits. Exclude Episode Dates when the member was readmitted to an acute or nonacute care facility for any diagnosis within 14 days after the Episode Date. Exclude Episode Dates when the member had an ED visit for any diagnosis within 14 days after the Episode Date.

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from the Episode Date through 30 days after the Episode Date.

Note: *All Episode Dates that were not excluded should remain in the denominator. The denominator for this measure is based on acute inpatient discharges and ED visits, not members.*

Measure 11A – 11B (PCE) - Pharmacotherapy Management of COPD Exacerbation

Administrative Specification

Denominator The eligible population.

Numerators

Systemic corticosteroid Dispensed prescription for systemic corticosteroid (Table PCE-C) on or 14 days after the Episode Date. The organization may count systemic corticosteroids that are active on the Episode Date.

Table PCE-C: Systemic Corticosteroids

Description	Prescription			
Glucocorticoids	• betamethasone • dexamethasone	• hydrocortisone • methylprednisolone	• prednisolone • prednisone	• triamcinolone

Bronchodilator Dispensed prescription for a bronchodilator (Table PCE-D) on or 30 days after the Episode Date. The organization may count bronchodilators that are active on the Episode Date.

Table PCE-D: Bronchodilators

Description	Prescription		
Anticholinergic agents	• albuterol-ipratropium	• ipratropium	• tiotropium
Beta 2-agonists	• albuterol • arformoterol • budesonide-formoterol	• fluticasone-salmeterol • formoterol • levalbuterol	• metaproterenol • pirbuterol • salmeterol • mometasone-formoterol
Methylxanthines	• dyphylline-guaifenesin • guaifenesin-theophylline • potassium iodide-theophylline	• aminophylline • dyphylline • theophylline	

Measure 11C (SPR) - Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Description

The percentage of members 40 years of age and older with a new diagnosis or newly active COPD, and who received appropriate spirometry testing to confirm the diagnosis.

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures the first COPD diagnosis.
IESD	Index Episode Start Date. The earliest date of service for an eligible visit (Table SPR-C) during the Intake Period with any diagnosis of COPD (Table SPR-A). *For an outpatient claim/encounter,* the IESD is the date of service. *For an acute inpatient claim/encounter,* the IESD is the date of discharge. *For a transfer or readmission*, the IESD is the discharge date of the original admission.
Negative Diagnosis History	A period of 730 days (2 years) prior to the IESD (inclusive), when the member had no claims/encounters containing any diagnosis of COPD (Table SPR-A). *For an acute inpatient IESD*, use the date of admission to determine the Negative Diagnosis History.

Eligible Population

Product lines	Medicaid.
Ages	42 years or older as of December 31 of the measurement year.
Continuous enrollment	730 days (2 years) prior to the IESD through 180 days after the IESD.
Allowable gap	One gap in enrollment of up to 45 days is allowed in each of the 12-month periods prior to the IESD or in the 6-month period after the IESD, for a maximum of two gaps total. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IESD.

Measure 11C (SPR) - Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Event/ diagnosis The first visit with a diagnosis of COPD diagnosis during the Intake Period. Follow the steps below to identify the eligible population for the measure.

Step 1 Identify all members who had an outpatient, ED or acute inpatient visit (Table SPR-C) with a principal diagnosis of COPD (Table SPR-A) during the Intake Period. If the member had more than one visit for COPD, include only the first one.

Table SPR-A: Codes to Identify COPD

Description	ICD-9-CM Diagnosis
Chronic bronchitis	491
Emphysema	492
COPD	496

Table SPR-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Step 2 Test for Negative Diagnosis History. Exclude members who had an outpatient, ED or acute inpatient visit (Table SPR-C) with a COPD diagnosis during the 730 days (2 years) prior to the IESD.

For an acute inpatient IESD, use the date of admission to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled in the organization 730 days (2 years) prior to the IESD through 180 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator At least one claim/encounter with any code in Table SPR-B for spirometry in the 730 days (2 years) before the IESD to 180 days after the IESD.

Table SPR-B: Codes to Identify Spirometry Testing

Description	CPT
Spirometry	94010, 94014-94016, 94060, 94070, 94375, 94620

Measure 12 (AMB) - Emergency Department Visits Per 1,000 Enrollees

Description

This measure summarizes utilization of ambulatory care in the following categories.

- Outpatient Visits
- ED Visits (**Required**)

Note: The CCEs and MCCNs will be only be responsible for the ED Visits section of this HEDIS measure.

Calculations

Product	Medicaid and DD. The Medicaid product will be reported with DD included, and then the DD population will be reported separately.
Member months	For each product line and table, report all member months for the measurement year. IDSS automatically produces member year's data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.
Counting multiple services	*For combinations of multiple ambulatory services* falling in different categories on the same day, report each service that meets the criteria in the appropriate category.
Outpatient visits	Use Table AMB-A to identify outpatient visits. Count each occurrence of the CPT codes listed in Table AMB-A if rendered by different practitioners (a CPT code may count more than once on the same date of service if rendered by different practitioners). Report services without regard to practitioner type, training or licensing.

Table AMB-A: Codes to Identify Outpatient Visits

Description	CPT	UB Revenue
Office or other outpatient visits	99201-99205, 99211-99215, 99241-99245	051x, 0520-0523, 0526-0529, 0982, 0983
Home visits	99341-99345, 99347-99350	
Nursing facility care	99304-99310, 99315, 99316, 99318	0524, 0525
Domiciliary or rest home care	99324-99328, 99334-99337	
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	
Ophthalmology and optometry	92002, 92004, 92012, 92014	
Newborn Care*	99461	

**Note: Newborn care is in the table to reflect the HEDIS specifications, but it does not apply to the IL ABD population.*

ED visits Use Table AMB-B to identify ED visits. Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

Table AMB-B: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

OR

CPT	*WITH*	POS
10040-69979		23

Note: The rates will be reported as rates per 1000 member months. Rates for Medicaid will include DD members, and then DD will be reported separately.

Exclusions *(required)*

- The measure does not include mental health or chemical dependency services. Exclude (from all categories) claims and encounters that contain any code in Table AMB-C.

Table AMB-C: Codes to Identify Exclusions

CPT	Principal ICD-9-CM Diagnosis	ICD-9-CM Procedure
90801-90899	290-316	94.26, 94.27, 94.6
Principal ICD-9-CM Diagnosis	***WITH***	**Secondary ICD-9-CM Diagnosis**
960-979		291-292, 303-305

Note

- *This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.*

Measure 13 (APE) - Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit (State Defined)

Description

This measure determines if there was an ambulatory care follow-up with a provider after having an ED visit.

Eligible Population

Product lines	Medicaid.
Ages	All
Continuous enrollment	Date of ED discharge through 14 days after ED discharge.
Allowable gap	No gaps in enrollment.
Event/ diagnosis	Discharged alive from an ED (Table AMB-B) on or between December 18 of the prior year and December 17 of the measurement year. This measure excludes ED visits with a principal diagnosis for mental illness. The denominator for this measure is based on ED visits, not members. Include all events for those members who have more than one ED visit on or between December 18 of the prior year and December 17 of the measurement year.

ED visits Use Table AMB-B to identify ED visits. Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

Table AMB-B: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

OR

CPT	*WITH*	POS
10040-69979		23

Measure 13 (APE) - Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit (State Defined)

Administrative Specification

Denominator The eligible population

Numerator An ambulatory care follow-up visit with a provider within 14 days of the ED visit. Use Table AAP-A to determine follow-up visits.

Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Note: Newborn care has been removed from this table since it does not apply to the IL ABD population.

Exclusions *(required)*

- Exclude ED discharges in which the patient was transferred directly or readmitted within 14 days to an acute or non-acute facility. These ED discharges are excluded from the measure because the hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- The measure does not include services for ED visits with a principal diagnosis of mental health or chemical dependency. Exclude claims and encounters that contain any of the following codes.

Table IPU-C: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis	*WITH*	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Measure 14 (IPU) - General Hospital – Inpatient Admits Per 1,000 Enrollees

Description

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Total inpatient
- Medicine
- Surgery
- Maternity

Calculations

Member months

For each product line and table, report all member months for the measurement year. IDSS automatically produces member year's data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Maternity rates are reported per 1,000 male and per 1,000 female total member months in order to capture deliveries as a percentage of the total inpatient discharges.

Discharges

Refer to the codes in Table IPU-A to identify total inpatient discharges, then use Table IPU-B to separate discharges into *Maternity, Surgery* and *Medicine*. Count each discharge in the Total category and only one other category based on the hierarchy below.

Table IPU-A: Codes to Identify Total Inpatient Discharges

Principal ICD-9-CM Diagnosis		MS—DRG
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Days

Count all days associated with the identified discharges. Report days for total inpatient, maternity, surgery and medicine.

ALOS

Refer to the *Specific Instructions for Use of Services Tables* for the formula. Calculate average length of stay for total inpatient, maternity, surgery and medicine.

Total inpatient

Use Table IPU-A to identify all acute inpatient discharges.

The Total Inpatient should be the sum of the three categories *(Medicine, Surgery, and Maternity)* and any MS-DRGs defined as "principal diagnosis invalid as discharge diagnosis or ungroupable."

Categorize each inpatient discharge using the hierarchy below.

Measure 14 (IPU) - General Hospital – Inpatient Admits Per 1,000 Enrollees

Maternity Include birthing center deliveries in this measure and count them as one day of stay. Refer to Table IPU-B for ICD-9-CM Principal Diagnosis codes, UB Revenue, UB Type of Bill and DRG codes. A delivery is not required to be included in the Maternity category; any maternity-related stay is included in the Maternity category.

Surgery DRGs are the preferred method to identify surgical discharges. An organization that uses ICD-9-CM Diagnosis codes must identify total inpatient, remove maternity-related discharges and include the remaining discharges accompanied by UB revenue code 036X.

Medicine DRGs are the preferred method to identify medical discharges. An organization that uses ICD-9-CM Diagnosis codes must identify total acute inpatient discharges, remove maternity related discharges and remove all discharges accompanied by UB revenue code 036X.

Newborn care rendered from birth to discharge home from delivery is not included in this measure. Only report MS-DRGs 789–795 under *Medicine* if newborn care is rendered after the baby has been discharged home from delivery and is subsequently rehospitalized.

Note: The use of DRGs is preferred to report discharges in all categories. Organizations that use DRGs should categorize them by the hierarchy described above (i.e., Maternity, then Surgery, then Medicine). If DRGs are unavailable, use the other specified codes (e.g., ICD-9-CM codes) and categorize these codes by hierarchy.

Table IPU-B: Codes to Identify Medicine, Surgery and Maternity Inpatient Discharges

Description	Principal ICD-9-CM Diagnosis	UB Revenue	UB Type of Bill	MS—DRG
Maternity	630-676, 678-679, V24.0	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	765-770, 774-782
Surgery	Total—Maternity*	036x		001-013, 020-042, 113-117, 129-139, 163-168, 215-264, 326-358, 405-425, 453-517, 573-585, 614-630, 652-675, 707-718, 734-750, 799-804, 820-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-989
Medicine	Total—Maternity—Surgery			052-103, 121-125, 146-159, 175-208, 280-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-700, 722-730, 754-761, 789-795, 808-816, 834-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977

* If the organization uses ICD-9-CM Diagnosis codes to report this measure, all discharges reported in the *Surgery* group must be in conjunction with UB revenue code 036x.

Exclusions *(required)*

- The measure does not include services for discharges with a principal diagnosis of mental health or chemical dependency. Exclude claims and encounters that contain any of the following codes.

Table IPU-C: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis	*WITH*	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Measure 15 (MPT) - Mental Health Utilization

Description

The number and percentage of members receiving the following mental health services during the measurement year:

- Any service
- Outpatient or ED
- Inpatient
- Intensive outpatient or partial hospitalization

Calculations

Product lines

Count members who received inpatient, intensive outpatient, partial hospitalization, outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits.

Count members in the *Any Service* column only if they had at least one inpatient, intensive outpatient, partial hospitalization, outpatient or ED claim/encounter during the measurement year.

For members who had more than one encounter, count only the first visit in the measurement year and report the member in the respective age category as of the date of service or discharge.

Member months

For each product line and table, report all member months during the measurement year for members with the benefit. IDSS automatically produces member year's data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the "Any" column should include all members with any mental health benefit.

Inpatient

Include inpatient care at either a hospital or a treatment facility with mental health as the principal diagnosis.

Use one of the following criteria to identify inpatient services.

- An inpatient facility code in conjunction with a principal mental health diagnosis (Table MPT-A), ***or***
- DRGs (Table MPT-B)

Include discharges associated with residential care and rehabilitation.

Table MPT-A: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
290, 293-302, 306-316

Note: *DSM-IV codes mirror ICD-9-CM codes. A CCE or MCCN that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for ICD-9-CM codes.*

Table MPT-B: Codes to Identify Inpatient Services

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Intensive out-patient and partial hospitalization

Report intensive outpatient and partial hospitalization claims/encounters (Table MPT-C) in conjunction with a principal mental health diagnosis (Table MPT-A).

Count services provided by physicians and non-physician practitioners.

Exclude services the CCE or MCCN knows to be inpatient based on type of bill, place of service or location of service codes.

Table MPT-C: Codes to Identify Intensive Outpatient and Partial Hospitalization Services

HCPCS	UB Revenue		
Visits identified by the following HCPCS, UB revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).			
G0410, G0411, H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913		
CPT		***WITH***	**POS**
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876		***WITH***	52, 53*
Visits identified by the following CPT/POS codes must be with a mental health practitioner.			
99221-99223, 99231-99233, 99238, 99239, 99251-99255		***WITH***	52, 53*

Outpatient and ED

Report outpatient and ED claims/encounters (Table MPT-D) in conjunction with a principal mental health diagnosis (Table MPT-A). Count services provided by physicians and non-physicians.

Only include observation stays and ED visits that do not result in an inpatient stay.

Table MPT-D: Codes to Identify Outpatient and ED Services

CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
90804-90815, 96101-96103, 96105, 96110, 96111, 96116, 96118-96120, 96125	G0155, G0176, G0177, G0409, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485	0513, 0900-0904, 0911, 0914-0919

CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 23, 24, 33, 49, 50, 53*, 71, 72

CPT	UB Revenue
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.	
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510	045x, 0510, 0515-0517, 0519-0523, 0526-0529, 0762, 0981-0983

*** POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization uses POS 53 for reporting, it must have a system to confirm the visit was in an intensive outpatient or partial hospitalization setting.**

Measure 16 (API) - Ambulatory Care Follow-up Visit with Assigned PCP within 14 Days of Inpatient Discharge (State Defined)

Description

This measure determines if a member had an ambulatory care follow-up with their assigned PCP after having an inpatient hospital stay.

Eligible Population

Product lines	Medicaid.
Ages	All
Continuous enrollment	Date of discharge through 14 days after discharge.
Allowable gap	No gaps in enrollment.
Event/ diagnosis	Discharged alive from an inpatient setting (Table IPU-A) on or between December 18 of the prior year and December 17 of the measurement year. This measure excludes inpatient discharges with a principal diagnosis for mental illness, or chemical dependency. The denominator for this measure is based on inpatient discharges, not members. Include all events for those members who have more than one discharge on or between December 18 of the prior year and December 17 of the measurement year.

Table IPU-A: Codes to Identify Total Inpatient Discharges

Principal ICD-9-CM Diagnosis		MS—DRG
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Measure 16 (API) - Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge (State Defined)

Administrative Specification

Denominator The eligible population

Numerator An ambulatory care follow-up visit with an assigned PCP or a provider affiliated with an assigned PCP within 14 days of the inpatient discharge. Use Table AAP-A to determine follow-up visits.

Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982,0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Exclusions *(required)*

- Exclude inpatient hospitalizations for deliveries (births).

Table IPU-B: Codes to Identify Maternity Inpatient Discharges

Description	Principal ICD-9-CM Diagnosis	UB Revenue	UB Type of Bill	MS—DRG
Maternity	640-676, 678, 679, V24.0, V27.x, V30-V37, V39	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	765-770, 774-782

- Exclude discharges in which the patient was transferred directly or readmitted within 14 days after discharge to an acute or non-acute facility. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- The measure does not include services for inpatient discharges with a principal diagnosis of mental health or chemical dependency. Exclude claims and encounters that contain any of the following codes.

Table IPU-C: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis	*WITH*	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Measure 17A (IHR) - Inpatient Hospital 30-Day Readmission Rate (State Defined)

Description

This measure determines if a member had an inpatient hospital readmission ***for the same discharge diagnosis*** after having an initial inpatient hospital stay.

Eligible Population

Product	Medicaid
Ages	All
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Event/ diagnosis	Discharged alive from an inpatient setting (Table IPU-A) on or between December 18 of the prior year and December 1 of the measurement year. This measure excludes inpatient discharges with a principal diagnosis for mental illness defined in Table MPT-A below.

Table MPT-A: Codes to Identify Mental Health Diagnosis (Exclusions)

ICD-9-CM Diagnosis
290, 293-302, 306-316

The denominator for this measure is based on discharges, not members. Include all events for those members who have more than one discharge on or between December 18 of the prior year and December 1 of the measurement year. Exclude admissions for pregnancies / deliveries: DRG codes 370-375, ICD-9 codes 630 – 679.

Table IPU-A: Codes to Identify Total Inpatient Discharges

Principal ICD-9-CM Diagnosis		MS—DRG
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Measure 17A (IHR) - Inpatient Hospital 30-Day Readmission Rate (State Defined)

Administrative Specification

Denominator

The eligible population

Numerator

An inpatient hospital readmission within 30 days from the initial discharge. **The inpatient diagnosis for the readmission must be the same as the discharge diagnosis from the initial hospitalization.**

For measure 17A, exclude inpatient hospitalizations for mental illness, since these will be examined with measure 17B.

Exclude transfers to an *acute facility* following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.

Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the measurement year.

Exclude direct transfer to a *non-acute facility* within the 30-day follow-up period. Refer to Table FUH-B for codes to identify non-acute care.

Table FUH-B: Codes to Identify Non-acute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Measure 17B (IMR) –Inpatient Mental Hospital 30-Day Readmission Rate (State Defined)

Description

This measure determines if a member had an inpatient mental hospital readmission ***for the same discharge diagnosis*** after having an initial inpatient mental hospital stay.

Eligible Population

Product	Medicaid
Ages	All
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Event/ diagnosis	Discharged alive from a mental hospital inpatient setting (Table IPU-A) on or between December 18 of the prior year and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all events for those members who have more than one discharge on or between January 1 and December 1 of the measurement year.
Inpatient	Include inpatient care at either a hospital or a treatment facility with mental health as the principal diagnosis. Use one of the following criteria to identify inpatient services: • An inpatient facility code in conjunction with a principal mental health diagnosis (Table MPT-A), ***or*** • MS-DRGs (Table MPT-B)

Table MPT-A: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
290, 293-302, 306-316

Table MPT-B: Codes to Identify Inpatient Services

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Note: *DSM-IV codes mirror ICD-9-CM codes. A CCE or MCCN that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for ICD-9-CM codes.*

Measure 17B (IMR) –Inpatient Mental Hospital 30-Day Readmission Rate (State Defined)

Administrative Specification

Denominator The eligible population

Numerator An inpatient hospital readmission within 30 days from the initial discharge.

Exclude transfers to an *acute facility* following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.

For measure 17B, exclude inpatient hospitalizations that were not related to mental illness, since these will be examined with measure 17A.

Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the measurement year.

Exclude direct transfer to a *non-acute facility* within the 30-day follow-up period. Refer to Table FUH-B for codes to identify nonacute care.

Table FUH-B: Codes to Identify Non-acute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Measure 18 (UTI) – Long Term Care
Urinary Tract Infection Admission Rate (State Defined)

Description

This measure summarizes Long Term Care (LTC) hospital utilization due to urinary tract infections.

Calculations

Product	Long Term Care.
Member months	Report all LTC member months for the measurement year. Rates will be reported per 1,000 member months.
Continuous Enrollment	Must be enrolled in Long Term Care at least 30 days prior to the inpatient hospital admission, with no gaps in enrollment.
Admissions	Refer to the codes in Table URI-A to identify total LTC inpatient admissions for urinary tract infections listed as a ***principal diagnosis***.

Table UTI-A: Codes to Identify Urinary Tract Infections

Principal ICD-9-CM Diagnosis
590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 590.9, 595.0, 595.9, 599.0

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Exclusions *(required)*

- Exclude transfers from another hospital
- Exclude claims and encounters that contain any of the following codes:

Table UTI-B: Codes to Identify Exclusions

Exclusions	ICD-9-CM Diagnosis	ICD-9-CM Procedure Codes
Kidney/Urinary Tract Disorder	590.00, 590.01, 593.70-593.73, 753.0, 753.10 – 753.17, 753.19 – 753.23, 753.29, 753.3 – 753.6, 753.8, 753.9	
Immunocomprimised States	042, 136.3, 199.2, 238.73, 238.76-238.79, 260-262, 279.00-279.06, 279.09-279.13, 279.19, 279.2-279.4, 279.41, 279.49-279.53, 279.8, 279.9, 284.09, 284.1, 288.0, 288.00 – 288.03, 288.09, 288.2, 288.4, 288.50, 288.51, 288.59, 289.53, 289.83, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 579.3, 585, 585.5, 585.6, 996.8, 996.80-996.87, 996.89, V42.0, V42.1, V42.6 – V42.8, V42.81-V42.84, V42.89, V45.1, V45.11, V56.0, V56.1, V56.2	00.18, 33.5, 33.6, 37.5, 41.00-41.09, 50.51, 50.59, 52.80-52.83, 52.85, 52.86, 55.69

Measure 19 (BPR) –Long Term Care
Bacterial Pneumonia Admission Rate (State Defined)

Description

This measure summarizes Long Term Care (LTC) hospital utilization due to bacterial pneumonia.

Calculations

Product	Long Term Care.
Member months	Report all LTC member months for the measurement year. Rates will be reported per 1,000 member months.
Continuous Enrollment	Must be enrolled in Long Term Care and the CCE or MCCN at least 30 days prior to the inpatient hospital admission, with no gaps in enrollment.
Admissions	Refer to the codes in Table PNU-A to identify total inpatient admissions for bacterial pneumonia listed as a ***principal diagnosis***.

Table PNU-A: Codes to Identify Bacterial Pneumonia

Principal ICD-9-CM Diagnosis
481, 482.2, 482.30-482.32, 482.39, 482.41, 482.42, 482.9, 483.0, 483.1, 483.8, 485, 486

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Exclusions *(required)*

- Exclude transfers from another hospital.
- Exclude claims and encounters that contain any of the following codes:

Table PNU-B: Codes to Identify Exclusions

Exclusions	ICD-9-CM Diagnosis	ICD-9-CM Procedure Codes
Sickle Cell or HB-S Disease	282.41, 282.42, 282.60-282.64, 282.68, 282.69	
Immunocomprimised States	042, 136.3, 199.2, 238.73, 238.76-238.79, 260-262, 279.00-279.06, 279.09-279.13, 279.19, 279.2-279.4, 279.41, 279.49-279.53, 279.8, 279.9, 284.09, 284.1, 288.0, 288.00 – 288.03, 288.09, 288.2, 288.4, 288.50, 288.51, 288.59, 289.53, 289.83, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 579.3, 585, 585.5, 585.6, 996.8, 996.80-996.87, 996.89, V42.0, V42.1, V42.6 – V42.8, V42.81-V42.84, V42.89, V45.1, V45.11, V56.0, V56.1, V56.2	00.18, 33.5, 33.50-33.52, 33.6, 37.5, 41.00-41.09, 50.51, 50.59, 52.80-52.83, 52.85, 52.86, 55.69

Measure 21 *(MPM)* - *Annual Monitoring for Patients on Persistent Medications*

Description

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for members on digoxin
- Annual monitoring for members on diuretics
- Annual monitoring for members on anticonvulsants
- Total rate (the sum of the four numerators divided by the sum of the four denominators)

Eligible Population

Product lines	Medicaid.
Ages	19 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Members on persistent medications—defined as members who received at least 180 treatment days of ambulatory medication in the measurement year. Refer to Additional Eligible Population Criteria for each rate. Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days' supply dispensed on December 1 of the measurement year counts as 30 treatment days). **Note:** Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

Administrative Specification

For each product line, report each of the four rates separately and as a combined rate. The total rate is the sum of the four numerators divided by the sum of the four denominators.

Measure 21 *(MPM)* - *Annual Monitoring for Patients on Persistent Medications*

Rate 1: *Annual Monitoring for Members on ACE Inhibitors or ARBs*

Additional eligible population criteria

Members who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year. Refer to Table CDC-L to identify ACE inhibitors and ARBs.

Note: *Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).*

Numerator

At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table MPM-A). The member must meet one of the following criteria to be compliant.

- A code for a *lab panel* test during the measurement year
- A code for a serum potassium ***and*** a code for serum creatinine during the measurement year
- A code for serum potassium ***and*** a code for blood urea nitrogen during the measurement year

Note: *The tests do not need to occur on the same service date, only within the measurement year.*

Table MPM-A: Codes to Identify Physiologic Monitoring Tests

Description	CPT	LOINC
Lab panel	80047, 80048, 80050, 80053, 80069	
Serum potassium (K+)	80051, 84132	2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 29349-8, 32713-0, 39789-3, 39790-1, 41656-0, 51618-7
Serum creatinine (Scar)	82565, 82575	2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 26752-6, 31045-8, 33558-8, 35203-9, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4, 39955-0, 39956-8, 39957-6, 39958-4, 39959-2, 39960-0, 39961-8, 39962-6, 39963-4, 39964-2, 39965-9, 39966-7, 39967-5, 39968-3, 39969-1, 39970-9, 39971-7, 39972-5, 39973-3, 39974-1, 39975-8, 39976-6, 40112-5, 40113-3, 40114-1, 40115-8, 40116-6, 40117-4, 40118-2, 40119-0, 40120-8, 40121-6, 40122-4, 40123-2, 40124-0, 40125-7, 40126-5, 40127-3, 40128-1, 40248-7, 40249-5, 40250-3, 40251-1, 40252-9, 40253-7, 40254-5, 40255-2, 40256-0, 40257-8, 40258-6, 40264-4, 40265-1, 40266-9, 40267-7, 40268-5, 40269-3, 40270-1, 40271-9, 40272-7, 40273-5, 44784-7, 50380-5, 50381-3, 51619-5, 51620-3, 59826-8, 59834-2, 62425-3
Blood urea nitrogen (BUN)	84520, 84525	3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 44734-2, 49071-4, 59570-2

Measure 21 *(MPM)* - *Annual Monitoring for Patients on Persistent Medications*

Rate 2: *Annual Monitoring for Members on Digoxin*

Additional eligible population criteria

Members who received at least 180 treatment days of digoxin (Table MPM-B) during the measurement year.

Table MPM-B: Drugs to Identify Members on Digoxin

Description	Prescription
Inotropic agents	• digoxin

Numerator

At least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table MPM-A). The member must meet one of the following criteria to be compliant.

- A code for a *lab panel* test during the measurement year
- A code for a serum potassium ***and*** a code for serum creatinine during the measurement year
- A code for serum potassium ***and*** a code for blood urea nitrogen during the measurement year

Note: *The two tests do not need to occur on the same service date, only within the measurement year.*

Rate 3: *Annual Monitoring for Members on Diuretics*

Additional eligible population criteria

Members who received at least 180 treatment days of a diuretic (Table MPM-C), during the measurement year.

Note: *Members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days supply for those medications count toward the total 180 treatment days.*

Table MPM-C: Drugs to Identify Members on Diuretics

Description	Prescription	
Antihypertensive combinations	• aliskiren-hydrochlorothiazide • aliskiren-hydrochlorothiazide-amlodipine • amiloride-hydrochlorothiazide • amiloride-hydrochlorothiazide-olmesartan • amlodipine-hydrochlorothiazide-valsartan • amlodipine-hydrochlorothiazide-olmesartan • atenolol-chlorthalidone • benazepril-hydrochlorothiazide • bendroflumethiazide-nadolol • bisoprolol-hydrochlorothiazide • candesartan-hydrochlorothiazide • captopril-hydrochlorothiazide • chlorthalidone-clonidine •	• enalapril-hydrochlorothiazide • eprosartan-hydrochlorothiazide • fosinopril-hydrochlorothiazide • hydrochlorothiazide-irbesartan • hydrochlorothiazide-lisinopril • hydrochlorothiazide-losartan • hydrochlorothiazide-methyldopa • hydrochlorothiazide-metoprolol • hydrochlorothiazide-moexipril • hydrochlorothiazide-olmesartan • hydrochlorothiazide-propranolol • hydrochlorothiazide-quinapril • hydrochlorothiazide-spironolactone • hydrochlorothiazide-telmisartan • hydrochlorothiazide-timolol • hydrochlorothiazide-triamterene • hydrochlorothiazide-valsartan
Loop diuretics	• bumetanide • ethacrynic acid	• furosemide • torsemide
Potassium-sparing diuretics	• amiloride • eplerenone	• spironolactone • triamterene
Thiazide diuretics	• chlorothiazide • chlorthalidone • hydrochlorothiazide	• indapamide • methyclothiazide • metolazone

Numerator

At least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table MPM-A). The member must meet one of the following criteria to be compliant.

- A code for a *lab panel* test during the measurement year
- A code for a serum potassium ***and*** a code for serum creatinine during the measurement year
- A code for serum potassium ***and*** a code for blood urea nitrogen during the measurement year

Note: *The two tests do not need to occur on the same service date, only within the measurement year.*

Measure 21 *(MPM)* - *Annual Monitoring for Patients on Persistent Medications*

Rate 4: Annual Monitoring for Members on Anticonvulsants

Rate 4: Annual Monitoring for Members on Anticonvulsants

Additional eligible population criteria

Members who received at least 180 treatment days for an anticonvulsant (Table MPM-D) during the measurement year.

Note: *Members who are on multiple anticonvulsant drugs count toward the denominator multiple times if they meet the persistent medications criteria for each drug taken during the measurement year (i.e., a member who received at least 180 days of phenytoin and 180 days of valproic acid is counted twice in the denominator for Rate 4, once for each drug).*

Table MPM-D: Drugs to Identify Members on Anticonvulsants

Description	Drugs
Barbiturate anticonvulsants	• phenobarbital
Dibenzazepine anticonvulsants	• carbamazepine
Hydantoin anticonvulsants	• phenytoin
Miscellaneous anticonvulsants	• divalproex sodium • valproic acid

Numerator

At least one drug serum concentration level monitoring test for the prescribed drug in the measurement year (Table MPM-E).

If a member received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication (i.e., a member on phenytoin received a drug serum test for phenytoin).

If a member persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a member on both phenytoin and valproic acid with at least 180 treatment days for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug (Table MPM-E) to be considered numerator-compliant for each drug).

Table MPM-E: Codes to Identify Drug Serum Concentration Monitoring Tests

Description	CPT	LOINC
Drug serum concentration for phenobarbital	80184	3948-7, 3951-1, 10547-8, 14874-2, 34365-7, 60468-6
Drug serum concentration for phenytoin	80185, 80186	3968-5, 3969-3, 14877-5, 32109-1, 40460-8, 65361-8
Drug serum concentration for valproic acid or divalproex sodium	80164	4086-5, 4087-3, 4088-1, 14946-8, 18489-5, 21590-5, 32119-0, 32283-4
Drug serum concentration for carbamazepine	80156, 80157	3432-2, 3433-0, 9415-1, 14056-6, 14639-9, 18270-9, 29147-6, 29148-4, 32058-0, 32852-6, 47097-1

Exclusion *(optional)*

Members from each eligible population rate who had an inpatient (acute or non-acute) claim/encounter during the measurement year.

Measure 22 – 23 (AMM) - Antidepressant Medication Management

Description

The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

- *Effective Acute Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression that meets the following criteria. • A 120-day Negative Diagnosis History • A 90-day Negative Medication History *For an inpatient (acute or nonacute) claim/encounter*, the IESD is the date of discharge. *For a direct transfer*, the IESD is the discharge date from the facility to which the member was transferred.
Negative Diagnosis History	A period of 120 days (4 months) prior to the IESD, during which time the member had no claims/encounters with any diagnosis of major depression or prior episodes of depression. *For an inpatient (acute or nonacute) claim/encounter,* use the date of admission to determine Negative Diagnosis History. *For direct transfers,* use the first admission to determine Negative Diagnosis History.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).
Negative Medication History	A period of 90 days (3 months) prior to the IPSD, during which time the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Measure 22 – 23 (AMM) - Antidepressant Medication Management

Eligible Population

Product lines	Medicaid.
Ages	19 years and older as of April 30 of the measurement year.
Continuous enrollment	120 days prior to the IESD through 245 days after the IESD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IESD.
Benefits	Medical, pharmacy and mental health (inpatient and outpatient).
Event/ diagnosis	The organization should follow the steps below to identify the eligible population, which should be used for both rates.
Step 1	Identify all members who met at least one of the following criteria during the Intake Period.

- At least one principal diagnosis of major depression (Table AMM-A) in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B), ***or***
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B) on different dates of service with any diagnosis of major depression (Table AMM-A), ***or***
- At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table AMM-A)

Table AMM-A: Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311

Measure 22 – 23 (AMM) - Antidepressant Medication Management

Table AMM-B: Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
	CPT		**POS**
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Step 2 Determine the IESD. For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/encounter for any diagnosis of major depression (Table AMM-A) or prior episodes of depression (Table AMM-C) during the 120 days prior to the IESD.

Table AMM-C: Additional Codes to Identify Depression

Description	ICD-9-CM Diagnosis
Depression	296.26, 296.36, 296.4-296.9, 309.0, 309.28

Step 4 Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Table AMM-D) during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period.

Step 5 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD.

Step 6 Calculate continuous enrollment. Members must be continuously enrolled for 120 days prior to the IESD to 245 days after the IESD.

Measure 22 – 23 (AMM) - Antidepressant Medication Management

Administrative Specification

Numerators

Effective Acute Phase Treatment

At least 84 days (12-weeks) of continuous treatment with antidepressant medication (Table AMM-D) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. The organization should count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Table AMM-D: Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• bupropion	• Vilazodone	
Monoamine oxidase inhibitors	• isocarboxazid • phenelzine	• selegiline • tranylcypromine	
Phenylpiperazine antidepressants	• nefazodone	• trazodone	
Psychotherapeutic combinations	• amitriptyline-chlordiazepoxide • amitriptyline-perphenazine		• fluoxetine-olanzapine
SSNRI antidepressants	• desvenlafaxine • duloxetine	• venlafaxine	
SSRI antidepressants	• citalopram • escitalopram	• fluoxetine • fluvoxamine	• paroxetine • sertraline
Tetracyclic antidepressants	• maprotiline	• mirtazapine	
Tricyclic antidepressants	• amitriptyline • amoxapine • clomipramine	• desipramine • doxepin • imipramine	• nortriptyline • protriptyline • trimipramine

Effective Continuation Phase Treatment

At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, gap days may total no more than 51. The organization should count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame specified (e.g., during the Intake Period).*

Measure 24 (MMS) - Medication Monitoring for Patients with Schizophrenia (State Defined)

Description

The percentage of members with schizophrenia who remained on an antipsychotic medication during the measurement year. Rates will be reported for 6 months of medication adherence and one year of medication adherence. Members will be considered to be compliant if they fill their prescription for the medication.

Eligible Population

Product lines	Medicaid
Ages	19 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Members diagnosed with schizophrenia (ICD-9-CM code 295.xx) in the year prior to the measurement year. Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (e.g., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days).

Administrative Specification

Denominator	The eligible population.
Numerators	A six-month and 12-month course of treatment with antipsychotic medications as defined in Table MMS-A below. To determine continuity of medication treatment, identify all prescriptions filled during the year and count the days supplied. Two or more prescriptions on the same date of service count as one prescription. To account for the possible one month gap of enrollment or for members with prescriptions prior to the start of the measurement year, the total days supplied should be adjusted: For the first numerator, the member is compliant if they received 150 days supply within the year. For the second numerator, the member is compliant if they received 335 days supply during the year.

Measure 24 (MMS) - Medication Monitoring for Patients with Schizophrenia (State Defined)

Table MMS – A: Medications for Schizophrenia
(Refer to Pharmacy Reference Code Spreadsheet for Codes)

Description	Therapeutic Class Code	Medication List
Antipsychotics	H2G	• Chlorpromazine • Fluphenazine • Perphenazine • Perphenazine; Amitriptyline • • Thioridazine • Trifluoperazine
	H6J	• Prochlorperazine
	H70	• Haloperidol
	H7P	• Thiothixene
	H7S	• Molindone
	H7T	• Clozapine • Lurasidone • Olanzapine • Paliperidone • Quetiapine • Risperidone • Ziprasidone • Fanapt (iloperidone) • Saphris (asenapine)
	H7U	• Loxapine
	H7X	• Aripiprazole
Antidepressants	H2S H2S H7R	• Citalopram † • Fluvoxamine † • Pimozide †

† are medications that are not currently FDA-approved for Schizophrenia, but have been used in clinical practice. Promazine was removed from Class Code H2G since it is no longer available in the US. Two drugs, Fanapt and Saphris, were added to the table under H7T (this classification has not been confirmed).

Measure 25 (COL) - Colorectal Cancer Screening

Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product lines	Medicaid.
Ages	51–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator

The eligible population.

Numerator

One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following criteria.

- Fecal occult blood test (FOBT) during the measurement year. Regardless of FOBT type, guaiac (gFOBT) or immunochemical (iFOBT), assume that the required number of samples was returned.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

A member had an appropriate screening if a submitted claim/encounter contains any code in Table COL-A.

Table COL-A: Codes to Identify Colorectal Cancer Screening

Description	CPT	HCPCS	ICD-9-CM Procedure	LOINC
FOBT	82270, 82274	G0328		2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104	45.24	
Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121	45.22, 45.23, 45.25, 45.42, 45.43	

Measure 25 (COL) - Colorectal Cancer Screening

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line. The organization may reduce the sample size using the current year's administrative rate or the prior years audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator

One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following criteria.

- FOBT during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year

Medical record

Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record. If it is unclear whether the documentation is part of the medical history, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication as to how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member would only meet the screening criteria if the number of samples specified is greater than or equal to three samples. If the number of samples is less than three, the member does not meet the screening criteria for inclusion in the numerator.
- iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the member meets the screening criteria for inclusion in the numerator regardless of the number of returned samples.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
  - *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that three or more samples were returned,* the member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that fewer than three samples were returned,* the member does not meet the screening criteria.

Do not count *digital rectal exam* as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

Measure 25 (COL) - Colorectal Cancer Screening

Exclusion *(optional)*

- Members with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the member's history. Refer to Table COL-B for codes to identify exclusions.

Table COL-B: Codes to Identify Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Colorectal cancer		G0213-G0215, G0231	153, 154.0, 154.1, 197.5, V10.05	
Total colectomy	44150-44153, 44155-44158, 44210-44212			45.8

Medical Record Exclusion *(optional)*

- Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy. The diagnosis must have occurred by December 31 of the measurement year. Use the codes in Table COL-B as synonyms for a diagnosis of colorectal cancer or total colectomy.

Measure 26 (BCS) - Breast Cancer Screening

Description

The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.

Eligible Population

Product lines	Medicaid.
Ages	Women 42–69 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.

Administrative Specification

Numerator	One or more mammograms during the measurement year or the year prior to the measurement year. A woman had a mammogram if a submitted claim/encounter contains any code in Table BCS-A.

Table BCS-A: Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue
77055-77057	G0202, G0204, G0206	87.36, 87.37	0401, 0403

Note: *The purpose of this measure is to evaluate primary screening. Do not count biopsies, breast ultrasounds or MRIs for this measure because they are not appropriate methods for primary breast cancer screening.*

Exclusion *(optional)*

- Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through December 31 of the measurement year. Exclude members for whom there is evidence of two unilateral mastectomies. Refer to Table BCS-B for codes to identify exclusions.

Table BCS-B: Codes to Identify Exclusions

Description	CPT	ICD-9-CM Procedure
Bilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307 ***WITH*** Modifier 50 or modifier code 09950*	85.42, 85.44, 85.46, 85.48
Unilateral mastectomy (members must have 2 separate occurrences on 2 different dates of service)	19180, 19200, 19220, 19240, 19303-19307	85.41, 85.43, 85.45, 85.47

*50 and 09950 modifier codes indicate the procedure was bilateral and performed during the same operative session.

Measure 27 (CCS) - Cervical Cancer Screening (Administrative Method Only)

Description

The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.

Eligible Population

Product lines	Medicaid.
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	One or more Pap tests during the measurement year or the two years prior to the measurement year. A woman had a Pap test if a submitted claim/encounter contains any code in Table CCS-A.

Table CCS-A: Codes to Identify Cervical Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue	LOINC
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Measure 28 (ABA) - Adult BMI Assessment (Administrative Method Only)

Description

The percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.

Definitions

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among those of the same sex and age.

Eligible Population

Product lines	Medicaid.
Ages	18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/diagnosis	Members who had an outpatient visit (Table ABA-A) during the measurement year or the year prior to the measurement year.

Table ABA-A: Codes to Identify Outpatient Visits

CPT	HCPCS	UB Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0344, G0402	051x, 0520-0523, 0526-0529, 0982, 0983

Administrative Specification

Denominator	The eligible population.
Numerator	BMI (Table ABA-B) during the measurement year or the year prior to the measurement year.

Measure 28 (ABA) - Adult BMI Assessment (Administrative Method Only)

Table ABA-B: Codes to Identify BMI

ICD-9-CM Diagnosis
V85.0-V85.5

Exclusions *(optional)*

- Members who have a diagnosis of pregnancy (Table ABA-C) during the measurement year or the year prior to the measurement year.

Table ABA-C: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Pregnancy	630-679, V22, V23, V28

Measure 29 (AMP) – Enrollees Who Had an Annual Ambulatory or Preventive Care Visit with Enrollee's Assigned PCP (State Defined)

Description

The percentage of members who had an ambulatory or preventive care visit with the member's assigned PCP during the measurement year.

Eligible Population

Product lines	Medicaid
Ages	All Ages.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	One or more ambulatory or preventive care visits (Table AAP-A) during the measurement year with the member's assigned PCP. For group practices, the provider may be any provider assigned to that group. Count members who changed providers during the year, if they had an ambulatory care visit with any of their assigned providers during the year.

Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402 G0438, G0439		
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Additional Measures

On Hold

Measure On Hold

Measure 20 –Prevalence of Pressure Ulcers (State Defined)

Description

This measure summarizes the total number of Long Term Care patients 19 years of age and older that have category/stage II or greater pressure ulcers during the measurement year.

Calculations

Product Long Term Care.

Member months Report all member months for the measurement year. Rates will be reported per 1,000 member months.

Continuous Enrollment Must be enrolled in Long Term Care at least 30 days prior to the inpatient hospital admission, with no gaps in enrollment.

Admissions Refer to the codes in Table ULC-A to identify pressure ulcers.

Table ULC-A: Codes to Identify Pressure Ulcers

CPT-4 Codes	ICD-9-CM Diagnosis
15920, 15922, 15931, 15933-15937, 15940, 15941, 15944-15946, 15950-15953, 15956, 15958, 15999	707.0, 707.10 – 707.15, 707.19, 707.8, 707.9

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Numerator An ulcer of category/stage II or greater observed after the first 24 hours from the time of inpatient admission AND for which there is **no documentation** in the record, or no prior claims/encounters indicating the date of first discovery; should be considered as hospital-acquired. Skin breakdown due to arterial occlusion, venous insufficiency, diabetes related neuropathy, or incontinence dermatitis are not considered pressure ulcers.

Exclusions *(required)*

- Patients who refuse to be assessed.
- Patients who are medically unstable at the time of the study for whom assessment would be contraindicated (i.e., unstable blood pressure, uncontrolled pain, or fracture waiting repair). The term “Medically unstable” is used to characterize patients who cannot safely be turned for physiological reasons. “Medically unstable” people may have poor hemodynamic profiles or distress so severe that they cannot safely be turned for examination of the back, sacrum scapula, ischea, back of head, etc. The nature of the instability will vary e.g., some will require upright position to breathe, others cannot tolerate movement because of changes in hemodynamics (reduction) or intracranial pressure (increase).
- Patients who are actively dying and pressure ulcer prevention is no longer a treatment goal. The term “actively dying” is used to characterize patients who cannot safely be turned for physiological reasons. Actively dying is considered the last few days of life when blood flow to organs (e.g., brain, heart, kidneys) is decreasing, respiratory distress is increasing, and physiological instability is apparent, making turning unrealistic.

Measure On Hold

Measure 30 - Retention Rate for Long Term Care (LTC) and DD Enrollees Served in the Community (State Defined)

Description

This measure determines if a LTC members and DD enrollees served in the community continued to be served in the community during the year.

Eligible Population

Product	DD-waiver and non-DD waiver
Continuous enrollment	The measurement year (at least 11 out of 12 months).
Allowable gap	A one month gap in enrollment.

Administrative Specification

Denominator	Develop methods to identify the different HCBS type members when this measure is implemented.
Numerator	Members in the denominator who were still enrolled with the CCE or MCCN and in the HCBS at the end of the measurement period. This rate will be reported for both non-DD waiver and DD waivers.

Exclusions *(required)*

Members who involuntarily disenrolled during the measurement period due to one or more of the following conditions:

- Death
- Not eligible or lost Medicaid eligibility
- Moved out of service area
- Fraudulent use of Medicaid ID card
- Incarceration

Measure 31 – Medication Review of all Enrollees Taking More than Five Prescription Medications (State Defined)

Description

Complete a medication review of all Enrollees taking 5 or more prescription medications with documented plan for reducing medications when appropriate.

Eligible Population

Product lines	Medicaid
Ages	All Populations.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	A medication review and a documented plan for reducing a member's medications, when appropriate, for members who are taking five or more prescription medications.

*The Department is developing specifications for what a medication review must include, and the manner in which reviews must be reported to the Department. We will publish these specifications as soon as they are completed.