ODJFS Methods for Clinical Performance Measures

For the Covered Families and Children (CFC) Managed Care Program

For the Provider Agreement effective through June 30, 2010

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Issued: **October, 2009**

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These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in NCQA HEDIS 2009 Technical Specifications manual. The main difference between the ODJFS methods and the HEDIS methods is that, in some cases, it has been necessary to include additional codes that are not listed in the HEDIS methods. Codes that are not listed in HEDIS, but have been added are identified with the symbol '+'.

The source of the data is as follows:
(1) MCP submitted encounter data to obtain encounters.
(2) ODJFS provider master file to identify primary care practitioners.
(3) ODJFS recipient master file to obtain recipient demographic and eligibility information.

PERINATAL MEASURES

Timeliness of Prenatal Care

The percentage of women who delivered (a) live birth(s) during the reporting year, who were enrolled in the MCP no more than 279 days but at least 43 days prior to delivery with no gaps in MCP enrollment, and who had their first prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stage of pregnancy.

Numerator: One (or more) prenatal care visit(s) within 42 days of enrollment in the MCP or within the first trimester if the member enrolled more than 42 days prior to the end of the first trimester.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

The last menstrual period (LMP) field is used to determine the end date of the first trimester. If no last menstrual period data is provided, as required, or the date is invalid, then the length of the pregnancy is set at 38.5 weeks except if an encounter is found for the newborn indicating a pre-term birth. The length of the pregnancy is set at 28 weeks where the diagnosis was 765.0x (Extreme immaturity). If there was a diagnosis of 765.1x (Other preterm infants) then the length of the pregnancy is set at 33 weeks.

If the LMP data is from 119 to 315 days before the date the recipient gave birth, then the LMP date is considered a valid date. The LMP date is obtained from encounter data.

Codes to Identify Live Births

ICD-9-CM Diagnosis Codes
650 -Normal Delivery
V27.0 - Single liveborn
V27.2 - Twins, both liveborn
V27.3 - Twins, one liveborn and one stillborn
V27.5 - Other multiple birth, all liveborn
V27.6 - Other multiple birth, some liveborn

ICD-9-CM Diagnosis Codes*
V30 - Single liveborn
V31 - Twin, mate liveborn
V32 - Twin, mate stillborn
V33 - Twin, unspecified
V34 - Other multiple, mates all liveborn
V35 - Other multiple, mates all stillborn
V36 - Other multiple, mates live- and stillborn
V37 - Other multiple, unspecified
V39 - Unspecified

* These codes must have a matching delivery encounter to be included.

The infant record contains (or is supposed to contain) the infant's Medicaid identification number. Therefore, it is necessary to match these encounters against the delivery encounters to obtain the mother's recipient identification number, which is used to obtain the prenatal and postpartum visits and to identify whether a C-section delivery occurred. Listed below are the codes used to identify deliveries (these are the same codes used to reimburse the plans for deliveries as part of the delivery payment).

Hospital claims for mother and baby are limited to:

- *Type of Bill = 111 (for Inpatient)*
- *Type of Bill = 131 (for Outpatient)*

Mother and baby claims are unduplicated by Medicaid recipient ID, with preference given to Inpatient type bill.

Mothers who deliver twice in the same year are included in analysis.

Codes Used To Identify Deliveries

ICD-9-CM Procedure Codes:

72.x Forceps, vacuum, and breech delivery
73.x Other procedures inducing or assisting delivery
74.0 Cesarean section and removal of fetus; Classical cesarean section
74.1 Cesarean section and removal of fetus; Low cervical cesarean section
74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section
74.4 Cesarean section and removal of fetus; Cesarean section of other specified type
74.99 Cesarean section of unspecified type

ICD-9-CM Diagnosis Codes to Identify Live Births:

650 Normal Delivery
V27.0 Single liveborn
V27.2 Twins, both liveborn
V27.3 Twins, one liveborn and one stillborn
V27.5 Other multiple birth, all liveborn
V27.6 Other multiple birth, some liveborn

The following codes must have a 5th digit equal to 1 or 2:

640-649; Complications mainly related to pregnancy
651-659 Normal delivery and other indications for care in pregnancy, labor, and delivery
660-669 Complications occurring mainly during the course of labor and delivery
670-676 Complications of the puerperium.

CPT Codes:

59400 Routine obstetrical care including atepartum and postpartum care and vaginal delivery
59409 Vaginal delivery (with or without episiotomy and/or forceps)
59410 Obstetrical care for vaginal delivery only, including postpartum care
59510 Cesarean delivery
59514 Cesarean delivery only
59515 Cesarean delivery only; including postpartum care
59610 VBAC delivery
59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614 VBAC care after delivery; vaginal delivery only, after previous cesarean delivery, including postpartum care
59618 Attempted VBAC delivery
59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622 Attempted VBAC after care, cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

Codes Used To Identify Deliveries continued

Exclude Deliveries not Resulting in a Live Birth:

630-637 Other abnormal product of conception, hydatidiform mole, ectopic or abdominal pregnancy, missed or spontaneous abortion, legally/illegally induced abortion, legally unspecified abortion
639 Complications following abortion or ectopic and molar pregnancies
656.4 Intrauterine death affecting management of mother
768.0 Fetal death from asphyxia or anoxia before onset of labor or at unspecified time
768.1 Fetal death from asphyxia or anoxia during labor
V27.1 Outcome of delivery, single stillborn
V27.4 Outcome of delivery, twins, both stillborn
V27.7 Outcome of delivery, other multiple birth, all stillborn

Births are included in the denominator only if mother is older than 12 years of age AND the provider type (from the ODJFS provider master file) is 01 (General Hospital), 15 (Birthing Center), 71 (Nurse Midwife) or the provider type is 20 (Physician, Ind.), 21 (Physician, Group), 22 (Osteopath, Ind.), 23 (Osteopath, Group) with a specialty code of 01 (General Practice), 15 (Internal Medicine), 16 (Pediatrics), 51 (General Surgery), 53 (OB/GYN-MD), 60 (Emergency Medicine), or 71 (OB/GYN-DO).

Methods for Matching Infants and Mothers Encounters

The infants and mothers encounters are matched using the following two methods:

1) Same last name, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay;

OR

2) Same address and zip code, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay.

If a newborn encounter matches to more than one mother delivery encounter and, consequently, it is not possible to determine which mother the newborn is associated with, then the matched encounter will not be included in the denominator. However, it continues to be possible for the mother's encounter to be included in the denominator if the mother's encounter contains one of the following diagnosis codes:

650 - Normal Delivery
V27.0 - Single liveborn
V27.2 - Twins, both liveborn
V27.3 - Twins, one liveborn and one stillborn
V27.5 - Other multiple birth, all liveborn
V27.6 - Other multiple birth, some liveborn

Prenatal Care Visit Codes

HEDIS 2009 outlines four decision rules for identifying prenatal visits. The first decision rule includes using codes specific to antepartum care such as CPT-4 code 59425. The second rule requires a visit to a midwife or OB provider with procedure or diagnosis based evidence of prenatal care. The third decision rule requires a visit to a family practitioner or other primary care provider with diagnostic and procedure based evidence of prenatal care. The fourth decision rule uses CPT-4 codes in conjunction with a plan's internal codes.

In an attempt to capture all prenatal visits, ODJFS used decision rule one and a modified version of decision rule two to select prenatal visits. Under the first ODJFS decision rule, a visit was selected if any of the codes listed below were present, the visit occurred not more than 44 weeks prior to delivery, and the visit date preceded the hospital admission date in which the baby was delivered. This latter requirement was imposed since some of the same codes cover antepartum care, intrapartum care, and postpartum care.

Decision Rule 1:	
CPT-4	**Description**
59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care, 7 or more visits
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
CPT Category II	**Description**
0500F	Initial prenatal care visit
0501F	Prenatal flow sheet
0502F	Subsequent prenatal care

The CPT codes listed above are global codes (i.e., more than one visit is billed under the same code) that are not reimbursed under the fee-for-service system. However, a number of MCPs submitted these codes and so they were included. It is not possible for ODJFS to determine the number of visits that occurred unless there is a separate date of service for each visit that is included in the global code. As a result, the only visits that were counted under these codes were those where there was a separate date of service. For example, if code 59425 was submitted and had one date of service then only one prenatal visit was counted. However, if this same code was submitted along with three dates of service for the MCP member, then three prenatal visits were counted.

Under the second ODJFS decision rule, a visit was selected if all of the following criteria were met and the date of the visit proceeded the hospital admission date in which the baby was delivered:

Decision Rule 2: The member must meet criteria in Part A or Part B.

PART A:
CPT-4 = 99201-99205 (office visit) or 99211-99215 or 99241-99245 or 99271-99275 or UB-92 Revenue Code 0514 (OB/GYN Clinic)

with either

CPT-4 = 76801 (ultrasound, pregnant uterus),
76802+ (ultrasound, each additional gestation),
76805 (ultrasound, pregnant uterus),
76810+ (ultrasound, pregnant uterus, each additional gestation)
76811 (ultrasound, pregnant uterus),
76812+ (ultrasound, each additional gestation),
76813 (ultrasound, pregnant uterus),
76815 (limited echography, pregnant uterus),
76816 (follow-up or repeat echography, pregnant uterus),
76817 (ultrasound, pregnant uterus),
76818 (fetal biophysical profile),
80055 (obstetric panel lab),
86644 (CMV, IgM) & (86694 or 86695 or 86696 (herpes simplex)) & 86762 (rubella) & 86777 (toxoplasma),
86762 (rubella immunoassay) with 86900 (Blood Typing; ABO),
86762 (rubella immunoassay) with 86901 (Blood Typing; RhD),

OR

ICD-9-CM Diagnosis = 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3

V code = V22-V23 or V28

PART B:
HCPCS = H1000-H1004, H1005

+ Code not in HEDIS method.

Under decision rule two, HEDIS only includes the visits if they were made to a midwife or OB provider. At this time, this requirement will not be imposed to ensure that all visits are counted.

Frequency of Ongoing Prenatal Care

The percentage of Medicaid-enrolled women who had a live birth during the reporting year and who received less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Numerator: Women who had an unduplicated count of less than 21%, 21% through 40%, 41% through 60%, 61% through 80%, or greater than or equal to 81% of the expected number of prenatal care visits, adjusted for gestational age and the month the member enrolled in the MCP.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

Prenatal care visits are selected using the same codes as outlined in the 'Timeliness of Prenatal Care' measure. When calculating the Frequency of Ongoing Prenatal Care measure, a prenatal visit on the date of delivery can count as a prenatal visit.

The ODJFS made adjustments for the length of gestation and the length of time that a member was in the MCP prior to giving birth. For example, a recipient who enrolled in the MCP during the first month of pregnancy and who had a pregnancy lasting 38 weeks would be expected to have 12 prenatal visits whereas a recipient who enrolled in the MCP during the fifth month of pregnancy with a pregnancy of 30 weeks would be expected to have only two prenatal visits. The ODJFS used the index (shown below) to determine the expected number of visits, which is based on recommendations from the American College of Obstetricians and Gynecologists (ACOG).

Expected Number of Prenatal Visits for a Given Gestational Age and Month the Member Enrolled in the MCP

Month of Pregnancy Member Enrolled in the MCP	Gestational Age in Weeks																
	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
9th	-	-	-	-	-	-	-	-	-	-	-	1	1	2	3	4	5
8th	-	-	-	-	-	-	1	1	1	2	3	4	5	6	7	8	9
7th	-	-	1	1	1	1	2	2	3	4	5	6	7	8	9	10	11
6th	1	1	1	1	2	2	3	3	4	5	6	7	8	9	10	11	12
5th	1	1	2	2	3	3	4	4	5	6	7	8	9	10	11	12	13
4th	3	3	4	4	5	5	6	6	7	8	9	10	11	12	13	14	15
3rd	4	4	5	5	6	6	7	7	8	9	10	11	12	13	14	15	16
2nd	5	5	6	6	7	7	8	8	9	10	11	12	13	14	15	16	17
1st	6	6	7	7	8	8	9	9	10	11	12	13	14	15	16	17	18

For deliveries with a gestational age less than 28 weeks, the expected number of visits is calculated based on the month of pregnancy the member enrolled in the MCP and ACOG's recommended schedule of visits (one visit every four weeks).

The last menstrual period field is used to help determine the 'gestational age.' Gestational age is defined as the number of completed weeks that have elapsed between the first day of the lat menstrual period and the date of deliver. If gestational age is calculated in fractions of a week, then the number is rounded down to the lower whole number.

Cesarean Section Rate

The percentage of women who had a live birth during the reporting year who delivered by a Cesarean Section.

Numerator: Number of discharges for women who had a C-section resulting in a live birth during the reporting year.

Denominator: Number of discharges for women who had a delivery (vaginal or C-section) resulting in a live birth during the reporting year. Live births are identified using the same codes outlined in the 'Timeliness of Prenatal Care' measure.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

Codes to Identify C-Sections
ICD-9-CM Procedure Codes 74.0-74.2, 74.4, or 74.99 **CPT Codes** 59510, 59514, 59515, 59618, 59620, 59622

Low Birth Weight Measure

The percentage of women who gave birth to a low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 2,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth. Live births are identified using the same codes outlined in the Timeliness of Prenatal Care measure.

Data Source: Encounter Data, birth weight is obtained from condition code fields.

Report Period: January 1, 2009-December 31, 2009

Very Low Birth Weight Measure

The percentage of women who gave birth to a very low-birth weight newborn during the reporting year.

Numerator: The number of births in the denominator with a birth weight less than or equal to 1,500 grams.

Denominator: The number of Medicaid MCP members who had a live birth during the reporting year and who had at least five months of continuous enrollment immediately prior to the birth. Live births are identified using the same codes outlined in the Timeliness of Prenatal Care measure.

Data Source: Encounter Data, birth weight is obtained from condition code fields.

Report Period: January 1, 2009-December 31, 2009

Postpartum Care

The percentage of enrolled women who delivered (a) live birth(s) during the reporting year who were continuously enrolled for 56 days after delivery and who had a postpartum visit on or between 21 days and 56 days after delivery.

Numerator: A postpartum visit on or between 21 and 56 days after delivery.

Denominator: The eligible population. Live births are identified using the same codes outlined in the 'Timeliness of Prenatal Care' measure.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

Codes to Identify Postpartum Visits

ICD-9-CM Diagnosis and Procedure Codes

89.26	Gynecological examination
91.46	Microscopic exam of specimen from female genital tract
V24.1	Lactating mother
V24.2	Routine postpartum follow-up
V25.1	Insertion of intrauterine contraceptive device
V72.3	Gynecological exam
V76.2	Special screening for malignant neoplasm (cervix)

UB-92 Revenue Codes

0923 (Pap Smear)

CPT-4	Description
57170	Diaphragm cervical cap fitting
58300	Insertion of intrauterine device
59400	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care
59410	Vaginal delivery, including postpartum care
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only, including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care after previous cesarean delivery
59614	Vaginal delivery only, after previous cesarean delivery, including postpartum care
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
88141-88143	Cytopathology, cervical or vaginal
88147-88148	Cytopathology smears
88150	Cytopathology slides
88152-88155	Cytopathology slides
88164-88167	Cytopathology slides
88174-88175	Cytopathology, cervical or vaginal

CPT Category II Codes

0503F Postpartum care visit

HCPCS Codes

G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
G0123-G0124	Screening cytopathology, cervical or vaginal (any reporting system)
G0141	Screening cytopathology smears, cervical or vaginal
G0143-G0145	Screening cytopathology smears, cervical or vaginal
G0147-G0148	Screening cytopathology smears, cervical or vaginal
P3000-P3001	Screening Papanicolaou smear, cervical or vaginal
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

CARE OF CHILDREN MEASURES

Well Child Visits in the First 15 Months of Life

The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from the month after the month in which they were born through their 15 month of life (allowing for a one month gap in MCP enrollment), who were enrolled during their 15 month of life, and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner during their first 15 months of life. Note, for those cases in which a member turns 15 months old in the 16th month of enrollment, the member must be enrolled for 14 out of 15 months. For those cases in which a member turns 15 months old in the 15th month of enrollment, the member must be enrolled for 13 out of 14 months.

Numerator: Seven separate numerators are calculated, corresponding to the number of members who received: zero, one, two, three, four, five, and six or more well-child visits with a primary care practitioner during their first 15 months of life. A child is included in only one numerator (e.g., a child receiving six well child visits is not included in the rate for five, four, or fewer well child visits).

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

NOTE: Age is calculated for a member who turned '15 months of age' is as follows: Date of Birth (DOB) + 1 year + 90 days (i.e., a member born 1/1/08 turns 15 months old on 4/1/09).

Codes to Identify Well-Child Visits

CPT-4 Codes

99381 Initial preventive medicine - New Patient (Age Group Infant)
99382 Initial preventive medicine - New Patient (Age Group 1-4 year old)
99391 Periodic preventive medicine - Established Patient (Age Group Infant)
99392 Periodic preventive medicine - Established Patient (Age Group 1-4 year old)
99432 Other than Hospitals or Birthing Rooms (Age Group Newborn)

ICD-9-CM Diagnosis Codes

V20.2 Routine Infant or Child Health Check
V70.0 Routine general medical exam at a health care facility
V70.3 Other Medical Examination for Administrative Purposes
V70.5 Health examination of defined subpopulation
V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examinations

The provider number currently given on the encounter data claim is incorrectly, in some cases, the provider number of the hospital where the physician gives services and is not the provider number of the physician who provided services. Therefore, it was not possible to match the PCPs listed in the Provider Verification System against the encounter data claims as a way of identifying visits that were made to PCPs. For this reason, it was necessary to use the ODJFS Provider Master File as the source of the PCP information. The following codes were used to accomplish this task:

Codes to Identify Primary Care Practitioners

Provider Type
01 (General Hospital)
04 (Outpatient Health Facility)
05 (Rural Health Facility)
09 (Maternal/Child Health Clinic - 9 mo.)
12 (Federally Qualified Health Center)
50 (Comprehensive Clinic)
52 (Public Health Dept. Clinic)
65 (Certified Nurse, Specialist)
71 (Certified Nurse, Midwife)
72 (Certified Nurse, Practitioner)

OR

Physician Specialty Code

01 (General Practice)
11 (Allergy)
12 (Cardiovascular Disease)
14 (Gastroenterology)
15 (Internal Medicine)
16 (Pediatrics)
18 (Preventative Medicine)
19 (Pulmonary Diseases)
21 (Child Psychiatry)
22 (Neurology)
23 (Psychiatry)
53 (Obstetrics & Gynecology)
56 (Otolaryngology)
59 (Urology)
71 (Obstetrics & Gynecology – Osteopath)
72 (Ophthalmology/Otolaryngology – Osteopath)
75 (Psychiatry Neurology – Osteopath)
99 (Other – includes Endocrinology, Nephrology, Oncology, and Rheumatology)

OR

Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where specialty code is 99 (unspecified) or is not indicated.

If a provider was identified on the Provider Master File with any of the preceding codes, then they were recognized as a PCP.

Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

The percentage of members who were three, four, five, or six during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received one or more well-child visit(s) with a primary care practitioner during the reporting year.

Numerator: At least one well-child visit with a primary care practitioner during the reporting year. The primary care practitioner does not have to be the practitioner assigned to the child.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

Codes to Identify Well-Child Visits

CPT-4 Codes

99382 Initial preventive medicine - New patient - (Age Group 1 through 4)
99383 Initial preventive medicine - New patient (Age Group 5 through 11)
99392 Periodic preventive medicine - Established Patient (Age Group 1 through 4)
99393 Periodic preventive medicine - Established Patient (Age Group 5 through 11)

ICD-9-CM Diagnosis Codes

V20.2 Routine Infant or Child Health Check
V70.0 Routine general medical exam at a health care facility
V70.3 Other Medical Examination for Administrative Purposes
V70.5 Health examination of defined subpopulation
V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examinations

See method for identifying primary care practitioners under 'Well Child Visits in the First 15 Months of Life' performance measure.

Adolescent Well-Care Visits

The percentage of enrolled members who were age 12 through 21 during the reporting year, who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received at least one comprehensive well-care visit with a primary care practitioner during the reporting year.

Numerator: At least one well-child visit with a primary care practitioner during the reporting year. The primary care practitioner does not have to be the practitioner assigned to the member.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

Codes to Identify Adolescent Well-Care Visits

CPT-4 Codes

99383 Initial preventive medicine - New patient (Age Group 5 through 11)
99384 Initial preventive medicine - New patient (Age Group 12 through 17)
99385 Initial preventive medicine - New patient (Age Group 18 through 39)
99393 Periodic preventive medicine - Established Patient (Age Group 5 through 11)
99394 Periodic preventive medicine - Established Patient (Age Group 12 through 17)
99395 Periodic preventive medicine - Established Patient (Age Group 18 through 39)

ICD-9-CM Diagnosis Codes

V20.2 Routine Infant or Child Health Check
V70.0 Routine General Medical Examination at a Health Care Facility (Health Checkup)
V70.3 Other Medical Examination for Administrative Purposes
V70.5 Health examination of defined subpopulation
V70.6 Health examination in population surveys
V70.8 Other specified general medical examinations
V70.9 Unspecified general medical examinations

See method for identifying primary care practitioners under 'Well Child Visits in the First 15 Months of Life' performance measure.

Annual Dental Visit

The percentage of enrolled members age 4 through 21 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who had at least one dental visit during the reporting year.

Numerator: One (or more) dental visits with a dental practitioner during the reporting year.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

Codes to Identify Annual Dental Visits		
CPT Codes	**ICD-9-CM Procedure Codes**	**HCPCS Codes**
70300, 70310, 70320, 70350, 70355	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97	D0120-D0999, D1110-D1550, D1555, D2140-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999, T1015+ with a modifier of U2

+ Code not in HEDIS Methods.

Lead Screening in Children

The percentage of enrolled members who turned 2 years old during the reporting year, who were enrolled in the MCP 11 out of 12 months prior to their second birthday, who were enrolled in the MCP during their second birthday, and who received one or more capillary or lead bloods tests for lead poisoning by their second birthday.

Numerator: The number of children in the denominator who received at least one capillary or venous blood test on or before the child's second birthday. The CPT-4 code of 83655 is used to identify that the member had a lead screening test.

Denominator: The number of enrolled members who turned 2 years old during the reporting year, who were enrolled in the MCP 11 out of 12 months prior to their second birthday, and who were enrolled in the MCP during their second birthday.

Data Source: Encounter Data

Report Period: January 1, 2009-December 31, 2009

CHRONIC CARE MEASURES

Use of Appropriate Medications for People with Asthma

The percentage of members aged 5 through 56 with persistent asthma who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled at least 11 months during the year prior to the reporting year, and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Members are identified as having persistent asthma by having ANY of the following during both the reporting year and the year prior to the reporting year:

1. at least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions)*

OR

2. at least one Emergency Department (ED) visit based on the visit codes below with asthma (ICD-9-CM code 493) as the principal diagnosis

OR

3. at least one hospitalization based on the visits codes below with asthma (ICD-9-CM code 493) as the principal diagnosis

OR

4. at least four outpatient asthma visits based on the visit codes below, with asthma (ICD-9-CM code 493) as one of the listed diagnoses AND at least two asthma medication dispensing events.**

** Exclusions: Members who were prescribed monotherapy of leukotriene modifiers and who do not have a diagnosis of asthma are excluded from the denominator.*

*** Note: A dispensing event is defined as one prescription of an amount lasting 30 days or less. Two different prescriptions dispensed on the same day are counted as two different dispensing events. To calculate dispensing events for prescriptions lasting longer than 30 days, ODJFS divided the drug quantity by 30 and rounded down to convert. For example, a 100-day prescription is equal to 3 dispensing events (100/30=3.33, rounded down to 3). Inhalers count as one dispensing event; for example, an inhaler with a 90-day supply is considered one dispensing event. In addition, multiple inhalers of the same medication filled on the same date of service are counted as one dispensing event; for example, a member may obtain two inhalers on the same date (one for home and one for work), but intend to use both during the same 30-day period. Dispensing events should be allocated to the appropriate year based on the date on which the prescription is filled.*

Numerator: For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the reporting year. The NDC list provided on NCQA's Web site at www.ncqa.org is used to identify these medications.

Denominator: The eligible population.

Data Source: Encounter Data

Report Period: January 1, 2009 -December 31, 2009

Codes to Identify ED and Inpatient Asthma Encounters			
Description	**ICD-9-CM Diagnosis**	**CPT Codes**	**UB-92 Revenue Codes**
Asthma	493		
Acute Inpatient		99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99291	010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150- 0154, 0159, 016x, 020x-022x, 072x, 0987
Emergency Department (ED) services		99281-99285	045x, 0981
Outpatient Visit		99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983

Exclusion

Exclude from the eligible population all members diagnosed with emphysema or chronic obstructive pulmonary disease (COPD) any time on or prior to December 31 of the measurement year (i.e. in the measurement year or year prior to the measurement year), as identified by the following codes:

Table ASM-4: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Emphysema	492, 506.4, 518.1, 518.2
COPD	491.2, 493.2, 496, 506.4

Members in the eligible population (i.e., denominator) will be excluded if they meet the exclusion criteria and are numerator non-compliant.

Comprehensive Diabetes Care

The percentage of members with diabetes (Types 1 and 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year, who were enrolled during the last month of the reporting year, and who received each of the following: (1) Hemoglobin A1c (HbA1c) testing; (2) a retinal exam by an optometrist or ophthalmologist; (3) LDL-C screening; and (4) screening or treatment for nephropathy. Individual rates are also calculated.

Numerator: The number of members in the denominator who received each of the following: (1) HbA1c testing during the reporting year; (2) a retinal exam by an optometrist or ophthalmologist during the reporting year; (3) LDL-C screening during the reporting year; and (4) screening or treatment for nephropathy.

Denominator: The number of members with diabetes (Types 1 or 2) age 18 through 75 who were enrolled for at least 11 months with the plan during the reporting year and who were enrolled during the last month of the reporting year.

Data Source: Encounter Data

Report Period: January 1, 2009 -December 31, 2009

Two methods are provided to identify diabetic members - pharmacy encounter data and non-pharmacy encounter data. Both methods are used to identify the eligible population. However, a member only needs to be identified in one method to be included in the measure. Members may be identified as having diabetes during the reporting year or the year prior to the reporting year.

Pharmacy Encounter Data: Those who were dispensed insulin and/or oral hypoglycemics/ antihyperglycemics on an ambulatory basis during the reporting year or the year prior to the reporting year. A list of these medications and the corresponding NDC codes can be found at www.ncqa.org.

Medical Encounter Data: Those who had <u>two</u> face-to-face encounters with different dates of service in an ambulatory setting or non-acute setting or <u>one</u> face-to-face encounter in an acute inpatient or emergency department (ED) setting during the reporting year or the year prior to the reporting year with a diagnosis (principal or secondary) of diabetes. The following codes are used to identify ambulatory or non-acute inpatient and acute inpatient or ED encounters:

Codes to Identify Diabetics Using Encounter Data			
Description	**ICD-9-CM Diagnosis Codes**	**CPT Codes**	**UB-92 Revenue Codes**
Diabetes Diagnosis	250.x, 357.2, 362.0, 366.41, 648.0		
Outpatient		92002-92014, 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, 077x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient		99301-99313, 99315, 99316, 99318,99321-99328, 99331-99337	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x, 0524, 0525
Acute inpatient		99221-99223, 99231-99233,99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
Emergency Department		99281-99285	045x, 0981

Exclusions: Members with steroid induced or gestational diabetes are excluded.

Codes to Identify Steroid Induced and Gestational Diabetes	
Description	**ICD-9-CM Diagnosis Codes**
Polycystic Ovaries	256.4
Steroid Induced	251.8, 962.0
Gestational Diabetes	648.8

Numerator(s):

1. HbA1c Testing: One (or more) HbA1c test(s) conducted during the reporting year identified through encounter data. CPT code of 83036 (hemoglobin, glycated) or 83037 (hemoglobin, glycated by device cleared by FDA for home use) and CPT Category II codes of 3044F, 3045F, 3046F, and 3047F are used to identify the test.

2. Eye Exam: An eye screening for diabetic retinal disease during the reporting year by an eye care professional (optometrist or ophthalmologist).

Codes to Identify Eye Exams*

CPT Codes	CPT Category II Codes**	ICD-9-CM Procedure and Diagnosis Codes	HCPCS
67028, 67030, 67031, 67036, 67038-67040, 67041-67043, 67101, 67105, 67107-67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16, V72.0	S0620, S0621, S0625**, S3000

* These eye exams by eye care professionals are a proxy for dilated eye examinations because administrative claims alone cannot determine that a dilated exam was performed.

** CPT Category II Codes and HCPCS S0625 do not need to be billed by an optometrist or an ophthalmologist.

Codes to Identify Eye Care Professionals

Provider Type		Specialty Code
'35' (Optometrist, Individual) '55' (Professional School Clinic - Optometry) '61' (Optometrist, Group)	**OR**	'54' (Ophthalmology) '72' (Ophthalmology, Otology, Laryngology)

The provider type and specialty code information is obtained from the ODJFS provider master file.

3. LDL-C Screening: An LDL-C test done during the reporting year.

Codes to Identify LDL-C Screening	
CPT Codes	**CPT Category II Codes**
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F

4. Monitoring for Diabetic Nephropathy: Screening or treatment for nephropathy. This measure is intended to assess whether diabetic patients are being monitored for nephropathy. The following are counted toward the numerator:

- those patients who have been screened for microalbuminuria during the reporting year.
- those patients who already have evidence of nephropathy, as demonstrated by evidence of medical attention for nephropathy during the reporting year.

Codes to Identify Microalbuminuria Test	
CPT Codes	**CPT Category II Codes**
82042, 82043, 82044, 84156	3060F, 3061F

Codes to Identify Diabetic Nephropathy					
Description	**CPT Codes**	**CPT Category II Codes**	**HCPCS Codes**	**ICD-9-CM Diagnosis and Procedure Codes**	**Revenue Codes**
Evidence of diagnosis and/or treatment of nephropathy	36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512	3066F	G0257, G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1, V56	0367, 080x, 082x-085x, 088x