DATA SPECIFICATIONS: PRELIMINARY RECOMMENDED MEASURES

MN Community Measurement
Direct Data Submission
2009 Guide for Depression Measures; Primary Care and Behavioral Health Providers

Update 1/19/2009

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Introduction and Impact of Depression:

According to National Institute of Mental Health (NIMH), 6.7% of the US population ages 18 and older (14.8 million) in any given year have a diagnosis of a major depressive disorder. Major depression is the leading cause of disability in the US for ages 15 – 44. Additionally, dysthymia accounts for an additional 3.3 million Americans.

Efforts to improve care and outcomes for patients with depression have been accelerated in Minnesota by two related initiatives. DIAMOND- "Depression Improvement Across MN, Offering a New Direction" is a new care model with payment restructuring and outcome measurement; primary care clinics are participating in this pilot project. MN Community Measurement is partnering with Bridges to Excellence (BTE) to provide depression outcome measurement for all adults with major depression or dysthymia who are treated in a primary care or behavioral health setting. Patient outcomes for both of these initiatives are tracked according to the patient's PHQ-9 depression scores over time.

Measures for the two initiatives are the same in terms of 6 and 12 month outcomes for depression; however the patient populations are slightly different. DIAMOND is measuring those patients who agree to be in the new care model, whereas MNCM measures are applied the whole adult population of patients with major depression or dysthymia. DIAMOND clinics that want to participate in the BTE program need to submit data for all their patients with depression. DIAMOND is also capturing additional measures for the care management process. For more information about the DIAMOND initiative, please access the ICSI website at http://www.icsi.org → healthcare redesign → DIAMOND.

MN Community Measurement would like to thank all the medical groups who have participated in the direct data submission pilot for depression and would like to encourage more groups to participate in the upcoming data submission timeframes. For those of you who have participated in other DDS measures (Diabetes and Ischemic Vascular Disease), the measures for depression are structured differently. Instead of a snapshot view of a patient's most recent data over the last year, this data is collected at a visit level on an ongoing, longitudinal basis over a period of 12 months. Patients are "activated" or start being measured when they have the correct diagnosis codes for major depression or dysthymia and a PHQ-9 score >9.

This guide is meant to be a set of comprehensive instructions for your submission of depression data. However, no guide is perfect. I urge you to contact support@mncm.org if the instructions don't address a question you have and you need help. The support e-mail address is found at the bottom of every page for your convenience.

Sincerely,

The MN Community Measurement Team

Depression Measures:

The following is a list of measures for the depression population. Not all measures will be used for public reporting or BTE's reward program, but all rates will be available to the medical groups. Internal = medical groups will see their own results and data may be used for reporting at a summary state-wide level but not by individual medical group, Public = measure rates will be reported publically by clinic site on the MNCM website and in the Healthcare Quality report, BTE = measure rates will be used to determine BTE rewards.

	Measure	Definition	Reporting
#1	Percentage of the adult population with major depression or dysthymia during the measurement period.	Adults age 18 & older with a diagnosis of major depression or dysthymia with at least one visit to a billable/ eligible provider during the measurement period. ICD-9 codes: o 296.2x - Major Depressive disorder, single episode o 296.3x – Major depressive disorder, recurrent episode o 300.4x – Dysthymic Disorder # adult patients with depression (296.2x, 296.3x and 300.4) total # adult patients	Internal
#2a	Percentage of the adult population with unspecified depression diagnosis during the measurement period. These patients will not be included in the subsequent outcome measures for depression.	Adults age 18 & older with a diagnosis of Depression; Not Otherwise Specified with at least one visit to a billable/ eligible provider during the measurement period ICD-9 codes: o 311 - Depressive disorder, not elsewhere classified # of adult patients with diagnosis of depression not elsewhere classified (311) # total adult patients Note: If a patient has both codes during the measurement period (311 and one of the major depression or dysthymia codes) count the patient as having major depression or dysthymia, not depression NOS	Internal
#2b	Percentage of the adult population with depression who have unspecified depression diagnosis during the measurement period.	Adults age 18 & older with a diagnosis of depression during the measurement period. This measure is tracking the rate of the use of 311unspecified depression as a percent of all patients diagnosed with depression. # of adult patients with diagnosis of depression not elsewhere classified (311) (# adult patients with 311) + (# adult patients with 296.2x, 296.3x and 300.4)	Internal

	Measure	Definition	Reporting
#3	Percentage of the adult population with major depression or dysthymia who had a PHQ-9 during the measurement period.	Percent of patients with a diagnosis of major depression or dysthymia (296.2, 296.3 or 300.4) with a completed PHQ-9 during the measurement period. This measure is determining the rate of the use of the PHQ-9 tool for the medical group's population of patients with major depression or dysthymia. # adult pts with depression (296.2x, 296.3x and 300.4) who had a PHQ-9 administered # adult patients with depression (296.2x, 296.3x and 300.4)	Public
#4	Percentage of the adult population with major depression or dysthymia whose index PHQ-9 score is > 9.	Percent of patients with a diagnosis of major depression or dysthymia (296.2, 296.3 or 300.4) with a completed PHQ-9 during the measurement period whose PHQ-9 score is > 9. Index contact is the first contact with confirming diagnosis and PHQ-9 score is > 9; serves at the starting measurement point for each patient included in the denominator. # adult pts with depression (296.2x, 296.3x and 300.4) and PHQ-9 > 9 # adult pts with depression (296.2x, 296.3x and 300.4) who had a PHQ-9 administered These patients are included in the denominator for the outcome measures.	Internal
#5	PHQ-9 follow-up assessment at six months	Percent of patients with a diagnosis of major depression or dysthymia (296.2, 296.3 or 300.4) and a PHQ-9 score at the index contact > 9 who have a follow-up PHQ-9 test at 6 months from the index contact date with a "grace period" of 60 days, + 30 or - 30 days from the date of the index contact. The most recent PHQ-9 score within this window is the score that will be used. # adult pts with depression & PHQ-9 > 9 who have 6 month PHQ-9 (+/- 30 days) # adult pts with depression with index contact PHQ-9 > 9	Internal
#6	PHQ-9 with a 50 % or more decrease in score (response) at six months	Based on the denominator of patients with major depression or dysthymia (296.2, 296.3 or 300.4) whose initial PHQ-9 is > 9, the percent of patients who have a reduction in their PHQ-9 score at 6 months by 50% or greater. This is the definition of a response. For example if a patient's initial PHQ-9 was 21 and the 6 month PHQ-9 is 10, this patient achieved a response outcome. # adult pts with > = 50% decrease in PHQ-9 score at 6 months(+/- 30 days) # adult pts with depression with index contact PHQ-9 > 9	Internal
#7	PHQ-9 score < 5 (remission) at six months	Based on the denominator of patients with major depression or dysthymia (296.2, 296.3 or 300.4) whose initial PHQ-9 is > 9, the percent of patients whose 6 month PHQ-9 score is less than 5. This is the definition of remission. # adult pts with a PHQ-9 score < 5 at 6 months(+/- 30 days) # adult pts with depression with index contact PHQ-9 > 9	Public and BTE

	Measure	Definition	Reporting
#8	PHQ-9 follow-up assessment at twelve months	Percent of patients with a diagnosis of major depression or dysthymia (296.2, 296.3 or 300.4) and a PHQ-9 score at the index contact > 9 who have a follow-up PHQ-9 test at 12 months from the index contact date with a "grace period" of 60 days, + 30 or - 30 days from the date of the index contact. The most recent PHQ-9 score within this window is the score that will be used. # adult pts with depression & PHQ-9 > 9 who have 12 month PHQ-9 (+/- 30 days) # adult pts with depression with index contact PHQ-9 > 9	Internal
#9	PHQ-9 with a 50 % or more decrease in score (response) at twelve months	Based on the denominator of patients with major depression or dysthymia (296.2, 296.3 or 300.4) whose initial PHQ-9 is > 9, the percent of patients who have a reduction in their PHQ-9 score at 12 months by 50% or greater. This is the definition of a response. For example if a patient's initial PHQ-9 was 16 and the 12 month PHQ-9 is 8, this patient achieved a response outcome. # adult pts with > = 50% decrease in PHQ-9 score at 12 months # adult pts with depression with index contact PHQ-9 > 9	Internal
#10	PHQ-9 score < 5 (remission) at twelve months	Based on the denominator of patients with major depression or dysthymia (296.2, 296.3 or 300.4) whose initial PHQ-9 is > 9, the percent of patients whose 6 month PHQ-9 score is less than 5. This is the definition of remission. # adult pts with a PHQ-9 score < 5 at 12 months # adult pts with depression with index contact PHQ-9 > 9	Public

- Response is defined as a 50% or more reduction of PHQ-9 score
- Remission is defined as a PHQ-9 score of less than 5
- PHQ-9 scores will be included if they are plus or minus 30 days of the point of measurement. For example a patient's index contact date (starting date) is 2/15/2008. The six month date from this time would be 8/15/2008, but the patients contact date for PHQ-9 is 8/27/2008; this PHQ-9 score and date would be accepted because it is within the 60 day grace period. The most recent PHQ-9 within the +/- 30 days will be used
- For the 2009 BTE rewards program, the only measure that will be used is the six-month remission rate defined as a six-month PHQ-9 score of < 5.

DDS Process; High Level Steps for Depression:

1. **Register your medical group with MNCM** at https://data.mncm.org
   If you are a new participant for the depression measures, email support@mncm.org indicating your interest in participating in the depression measures and the names of the individual clinic sites. You can also request a portal tour via the support email.
2. **Download a .pdf of the submission guide**
3. **Electronically sign the Site Agreement and Business Associate Agreements.**
4. **Verify all your clinic sites are correct & contact information is up to date**
5. **Indicate which clinics** will be participating in the depression measures and what level for participation in Bridges To Excellence → **now in the portal**
6. **Determine how you are going to identify your population**
   - Pay special attention to include records with subsequent PHQ-9 scores for patients who were submitted in a previous measurement period
7. **Determine your counts for the measurement period** (these are entered into the portal prior to uploading your denominator file)
8. **Prepare your written documentation of methodology**
   - Include: ages/ birth date ranges, ICD9 codes, exclusions, how you count your population and method for insuring you are capturing subsequent PHQ-9 contacts for patients already submitted
9. **Upload your documentation to MNCM for certification of your denominator**
   - MNCM will send an e-mail to you when your denominator has been certified (we aim to complete certification within 2 business days).
   - Don't start collecting data until denominator is approved.
10. **Collect the data;** refer to the guide for field specifications and abstraction definitions
11. **Keep a "cross-walk"** of your patient list for audit purposes; match the ID sent via direct data submission to your clinic's method of locating the patient/ chart
    - Have the ability to locate patients to pull charts or look-up in the EMR
    - Have an audit trail to document exclusions at the time of chart review
12. **Very Important → sort your file by patient ID and then by contact date.** Must be in order to correctly evaluate each incoming record in terms of new or subsequent contact.
13. **Create a .csv file** to submit to the portal and upload [data submission button]
    - **Do not re-open your CSV file** after creating it (opening in excel again destroys formatting)
    - Two types of errors: 1) Please check … just giving you a hint to validate and 2) Warning … these need to be corrected before the file can be submitted.
14. **Submit your file.** When ready to send your file, click "Submit To MNCM" button"

Timelines for Data Submission & Conditions of Participation

Will be requiring submission 3 times a year (not quarterly) to allow for the +/- 30 day window for the PHQ-9 scores.

Measurement Period		Portal Submission Deadline
Dates of Service Start	Dates of Service End	
10/1/2008	1/31/2009	2/23/2009
2/1/2009	5/31/2009	6/22/2009
6/1/2009	9/30/2009	10/26/2009
10/1/2009	1/31/2009	2/22/2010
2/1/2010	5/31/2010	6/25/2010
6/1/2010	9/30/2010	10/29/2010
10/1/2010	1/31/2011	2/25/2010

To participate in the DDS process, you must agree to:

- Follow given timelines, population identification rules and field specifications
- Determine BTE Level prior to submission of data and communicate to MNCM the decision about level of participation for each clinic in your medical group.
- Submit your data in the CSV template found on the data portal.
- Participate in all data validation processes, including making medical records available for an on-site MN Community Measurement review.

New →

All clinics agree to publically reported rates for the following measure:

- Percent of Adult Patients with Major Depression or Dysthymia who had a PHQ-9 tool administered during the measurement period.

adult pts w/ depression (296.2x, 296.3x and 300.4) who had a PHQ-9 score in the measurement period
adult patients with depression (296.2x, 296.3x and 300.4)

BTE Reward

Additional public reporting requirements for Level I BTE:

- **6-month remission rate defined as PHQ < 5 at 6 months (+/- 30 days)**
- This measure is eligible for BTE rewards for the top 20% of clinic sites

adult pts w/ depression (296.2x, 296.3x and 300.4) and a PHQ-9 score < 5 at 6 months +/- 30 days
adult pts w/ depression (296.2x, 296.3x and 300.4) with index contact PHQ-9 > 9

New →

- **12-month remission rate defined as PHQ < 5 at 12 months (+/- 30 days)**
- This measure is not eligible for additional BTE rewards and MNCM will evaluate data as it comes in during 2009 and develop a plan to publicly report rates in 2009/2010.

adult pts w/ depression (296.2x, 296.3x and 300.4) and a PHQ-9 score < 5 at 12 months +/- 30 days
adult pts w/ depression (296.2x, 296.3x and 300.4) with index contact PHQ-9 > 9

Bridges to Excellence: Levels of Participation for Depression

2008 Measurement Year (2009 Recognition/Reward Year)

Three levels of participation will be available to recognize that clinics and medical groups are at different stages of development in administering, tracking and improving the care of patients with depression as measured by PHQ 9 scores.

Level 1: Full BTE Participation

Those medical groups and clinics that have measured and tracked PHQ 9 scores for a period of time and want to be eligible for BTE rewards will be considered Level 1, Full BTE Participation and:

- Must inform MNCM of the level of participation (1, 2, or 3) of all clinics, both BH and PC, in their medical group by October 31, 2008 or before submitting data to MNCM
- Must submit data to MNCM by October 31, 2008 and January 31, 2009 and agree to public reporting of scores for Level 1 clinics (see MNCM Submission Guide for details)
- MNCM will publicly report performance scores indicating the percentage of patients who met the measurement criteria for improvement (remission in 6 months)
- Will be eligible for BTE Reward ($100/ BTE patient) if PHQ 9 improvement criteria are met and treat the top 20% of BTE patients

Level 2: "Recognition" for Willingness to be Transparent

Those medical groups and clinics that have started using the PHQ 9 to assess depression, are sending quarterly depression data files to MNCM, and are reluctant to commit to public reporting of their scores at this point, will be considered Level 2 providers.

- Must inform MNCM of the level of participation (1, 2, or 3) of all clinics, both BH and PC, in their medical group by October 31, 2008 or before submitting data to MNCM
- Must submit data to MNCM by October 31, 2008 and January 31, 2009
- MNCM will indicate Level 2 clinics who are assessing patients (compared to those providers who are not assessing patients) with a symbol or description on their website
- Scores will not be publicly reported in 2009
- Must commit to participate at Level 1 in 2009 Measurement Year
- BTE will publicly recognize participation at the BTE Recognition Event in 2009

Level 3: "Preparing" for Reporting and Transparency

Those clinics and groups who have received an orientation to Direct Data Submission (DDS) from MNCM staff, are committed to sending a *test* file of depression data, and are setting up a system to begin collecting and submitting PHQ 9 scores in 2009.

- No data submission to MNCM in measurement year 2008
- Commitment to progress to Level 1 or 2 in 2009 measurement year for 2010 recognition and Level 1 by the 2010 measurement year for 2011 rewards

2009 and 2010 Measurement Year (2010 and 2011 Recognition/Reward Year)

- Medical Groups may have clinics at each level (1, 2, or 3) in the measurement 2008 but must indicate the level for all clinics if any clinics are to be recognized or rewarded
- Each clinic must progress to the next level each year
- Level 3 will not be available after the 2008 measurement year

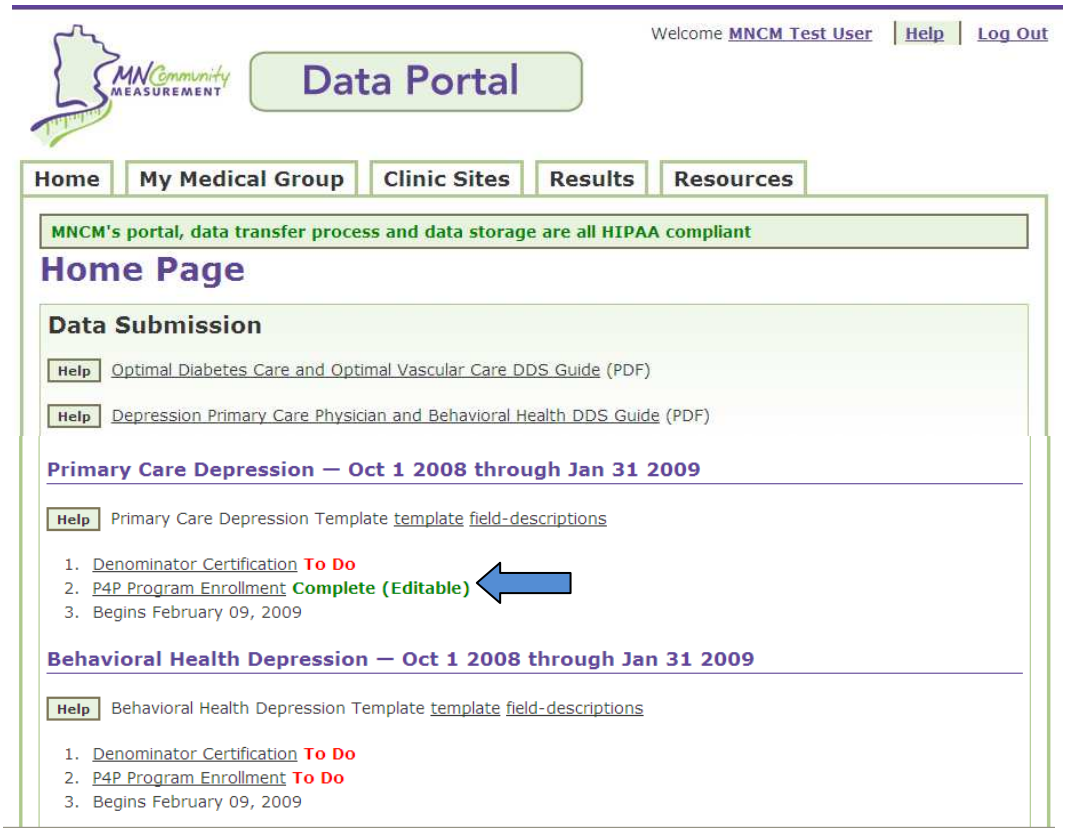
BTE Depression P4P Program
Participation Options

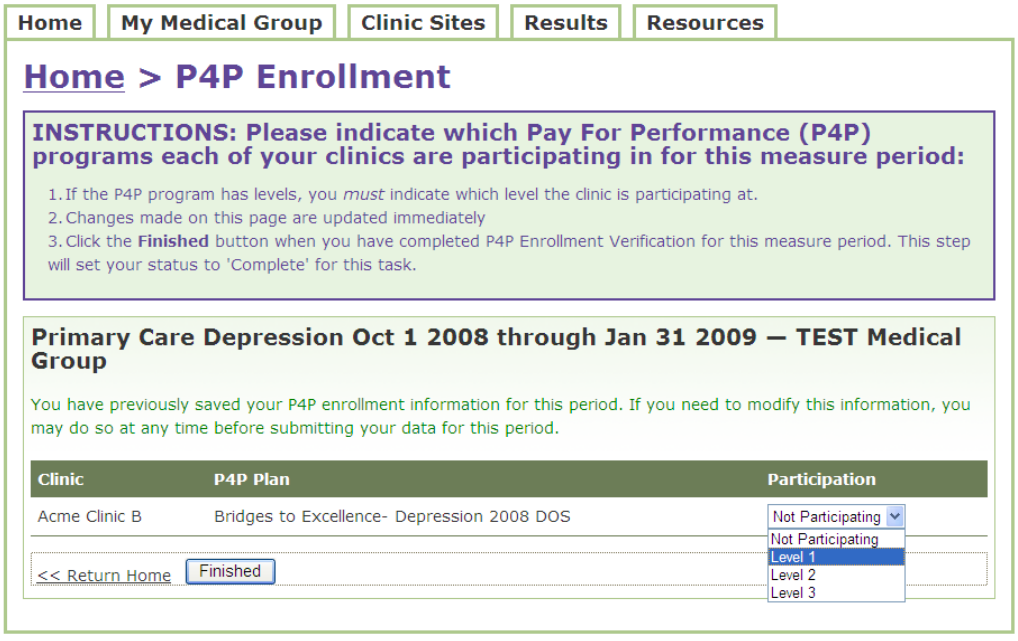
Measurement/ Reporting Year	2008/2009	2009/2010	2010/2011
Level 1 Clinic Designation			
Rewards and Transparency	• Medical group identifies participation levels 1, 2, or 3 for all primary care and behavioral health clinics for 2008 measurement year (2009 reporting year) by 10/31/08 • Medical Group submits data for clinics who want to be eligible for BTE P4P $ (Level 1) or recognized (Level 2)	2008 measurement year Level 2 clinics must transition to Level 1	All clinics at Level 1
Level 2 Clinic Designation			
Public Recognition for Reporting	• Medical group identifies participation level 2 or 3 (no level 1 clinics) for all primary care and behavioral health clinics • Medical group submits data to MNCM by October 31, 2008 for clinics who want to be recognized in 2009 reporting year (Level 2) • MNCM notes participation but does not report scores on website • Not eligible for BTE P4P $ rewards • Level 2 clinics must commit to move to Level 1 in 2010 reporting year	2008 measurement year Level 3 clinics must transition to Level 2	NO LONGER AVAILABLE
Level 3 Clinic Designation			
Preparation for Recognition and/or Rewards	• Medical group and clinics preparing for Level 1 or 2 in 2010 reporting year • No data submission	NO LONGER AVAILABLE	NO LONGER AVAILABLE

Entering the BTE Level in the Data Portal

← New

On the portal's home page, scroll to either the primary care depression or behavioral health depression section. Click into #2 and then complete the BTE level for each clinic





Providers Eligible for Participation & Encounter Types

Specialties that are included in the depression measurement are primary care and behavioral health providers. The following is a comprehensive list of billable providers who practice independently and diagnosis and treat patients with major depression or dysthymia:

Primary Care	Behavioral Health
Family Practice	Psychiatrist
General Practice	Physician Assistant
Internal Medicine	Nurse Practitioner
Internal Medicine/ Peds	Clinical Nurse Specialist
Geriatric Medicine	Psychologist (LP)
OB/GYN	Clinical Social Worker (LICSW)
Physician Assistant	Counselor (LPCC)
Nurse Practitioner	

Please note: Once a patient is seen by a provider listed above and has a diagnosis of major depression or dysthymia (ICD-9 codes of 296.2x, 296.3x, or 300.4) and has a PHQ-9 score greater than 9, it is acceptable to include other encounter types with other providers in order to capture all the subsequent PHQ-9 scores for the patient over the next 12 months.

Other acceptable encounter/ visit types for subsequent contact with the patient include:

- Office Visit
- Telephone Encounter
- E-Visit
- Any other contact with the patient in which a PHQ-9 is administered

Denominator (Population) Certification for Depression

To avoid rework (the need for medical groups to resubmit data because they inadvertently pulled the wrong data), we will be reviewing the source code/methodology used to produce the patients in your denominator.

Items to be included in the documentation provided to MNCM include your methods for all of the following items:

Please refer to the next sections for detailed instructions about the population counts and criteria for inclusion in the denominator.

- If you are sourcing these measures with an EMR – your query/source code
- If you are using a registry - a description of the registry, including how it is sourced and maintained
- Count unique adult patients seen in your clinic during the measurement period
- Count of unique adult patients with major depression or dysthymia
- Count of unique adult patients with 311 Depression NOS
- Count of unique adult patients with major depression or dysthymia who had a PHQ-9 completed in the measurement period
- Birth date or age ranges to insure only including ages 18+
- ICD-9 codes used
- Provider specialties included
- Methods for exclusions taken
- Method for insuring that patients submitted previously have subsequent PHQ-9 scores included in ongoing submissions

Please note:

There is no sampling for this population; all eligible patients are to be included.

Do not include patient lists or PHI (personal health information) as part of your denominator document.

Please use a Word document; you can paste query source code into Word.

Don't start collecting data until denominator is approved.

After submitting two successful cycles of data without problems, a group does not need to continue submitting the denominator document for certification. If changes occur in method or definition, then population certification will need to occur.

Once you have submitted your documents for denominator certification, we will review them and notify you via email when your process has been certified. It is our aim to complete all certifications within 2 business days, however if you have not received a notification within five business days, contact support@mncm.org

Uploading your Denominator Certification Document

Login to the data portal at https://data.mncm.org

On the Home tab find the section for Primary Care Depression or Behavioral Health Depression. Click into #1 Denominator Certification. This brings you to an additional screen that allows you to upload your Word document.

Click the browse button, find your saved document and then click "Save"
For the depression measures your document does not need to address clinic location and provider attribution.

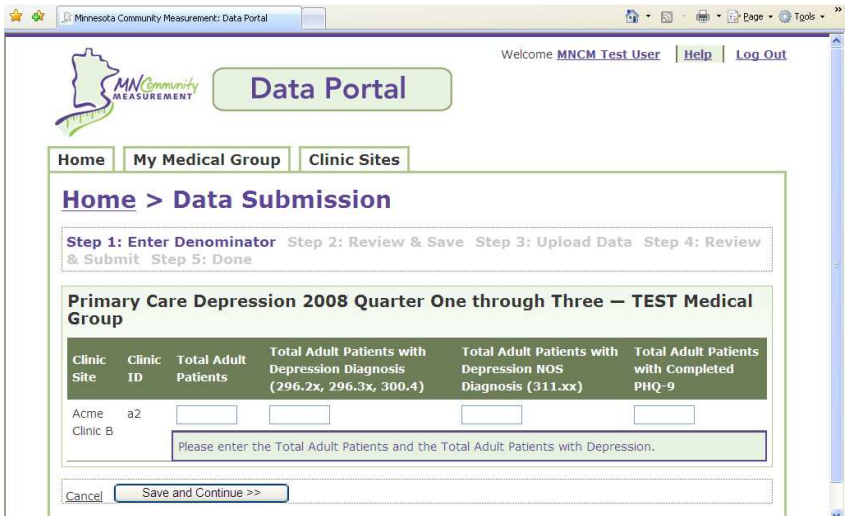
Patient Population Counts; Primary Care Providers

Purpose: To provide information about the population of patients cared for at each clinic site and to understand the processes related to diagnosis, monitoring and treatment of depression.

- The incidence of major depression/ dysthymia in the clinic's adult population
- The use or overuse of the non-specific ICD9 code for depression (311)
- The utilization of the PHQ-9 tool for patients with diagnosed depression/ dysthymia

These population counts are important and contribute to the measurement calculations.

Entering Patient Population Counts for Depression Measures - **Primary Care Clinics**



Entering your patient population counts for this screen:

All counts pertain to the current measurement period. For example, if the measurement period is October 1st 2008 through January 31st 2009 you would count the number of patients in each category during that time frame.
All are counts of unique patients; not the number of visits.

Total Adult Patients:

The total number of unique adult patients (ages 18+) seen in your clinic for any reason with a contact with a billable provider during the measurement period.

Billable providers for **primary care** clinics include: family practice, internal medicine, general medicine, OBGYN. geriatric medicine, medicine/pediatrics, physician assistants and nurse practitioners.

Total Adult Patients with Depression Diagnosis (296.2x, 296.3x and 300.4):

These ICD-9 codes define major depression and dysthymia and would be a subset of your total adult patients. The total number of adult patients with a contact with a billable provider who have at least one contact in the measurement period with the following ICD-9 codes: The codes can be in any position.

- 296.2.x Major depressive disorder, single episode
- 296.3x Major depressive disorder, recurrent episode
- 300.4 Dysthymic disorder

It does not matter if this is a new diagnosis or if the patient is returning for a follow-up visit, if they have these codes during the measurement period, include them in the count.

Total Adult Patients with Depression NOS (311) code:
This would be another subset of your adult population. The total number of adult patients with a contact with a billable provider with a 311 code (Depression NOS not elsewhere classified). Because one of the goals of measuring this population is accurate diagnosis (an subsequently coding); please only include in this count patients who have a 311 code and not the major depression/ dysthymia codes of (296.2, 296.3 or 300.4). One way you could structure your query would be to search for ICD9 code = 311 and is not equal to 296.2, 296.3 or 300.4.

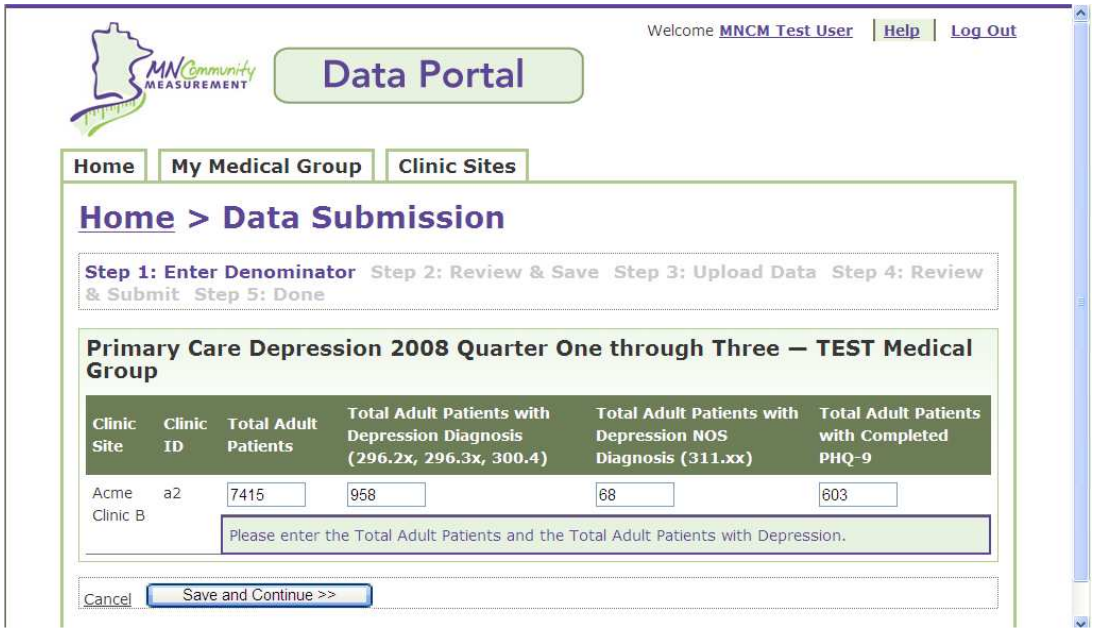
Total Adult Patients with a Completed PHQ-9:
This is a subset of the patients ages 18+ with the major depression/ dysthymia diagnosis codes of (296.2, 296.3 or 300.4) Count the number of these patients during the measurement period who also have a PHQ9 test done during the measurement period.

If the patient did not have one of the depression diagnoses during the measurement period, but had PHQ-9, **do not include** this patient in your count.

Example: for the measurement period of October 1, 2008 through January 31, 2009

A clinic site sees 7,415 patients age 18 or greater with dates of service between 10/1/2008 and 1/31/2009. Of these adult patients, 958 have a diagnosis of major depression or dysthymia (ICD-9 codes 296.2, 296.3 or 300.4) during that same timeframe. Additionally, 68 patients have a diagnosis code of 311 and do not have the major depression/ dysthymia diagnosis codes. Of the 958 patients with a diagnosis of major depression/ dysthymia, 603 patients have had a PHQ-9 done during the measurement time frame

Your data input screen would look like this:



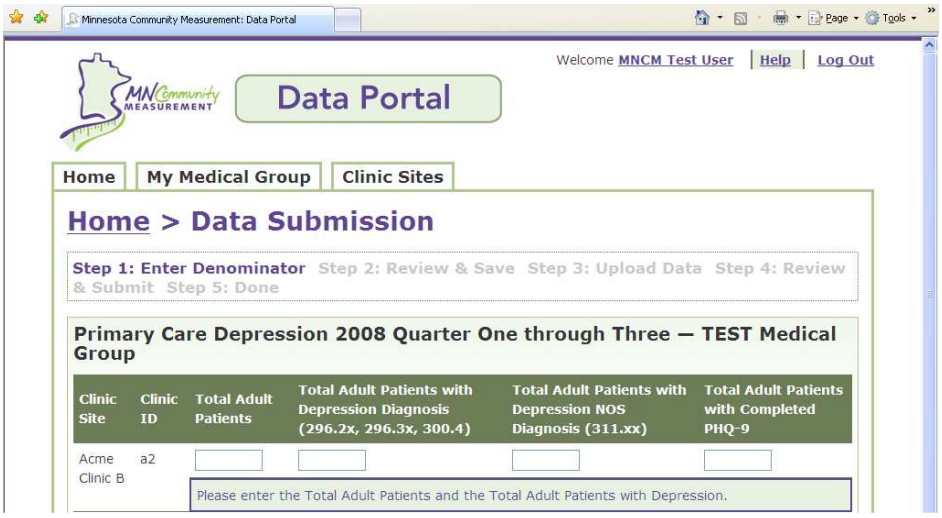
Patient Population Counts; Behavioral Health Specialists

Purpose: To provide information about the population of patients cared for at each clinic site and to understand the processes related to diagnosis, monitoring and treatment of depression.

- The incidence of major depression/ dysthymia in the clinic's adult population
- The use or overuse of the non-specific ICD9 code for depression (311)
- The utilization of the PHQ-9 tool for patients with diagnosed depression/ dysthymia

These population counts are important and contribute to the measurement calculations.

Entering Patient Population Counts for Depression Measures – **Behavioral Health**



Entering your patient population counts for this screen:

All counts pertain to the current measurement period. For example, if the measurement period is October 1st 2008 through January 31st 2009 you would count the number of patients in each category during that time frame.
All are counts of unique patients; not the number of visits.

Total Adult Patients:

The total number of unique adult patients (ages 18+) seen in your clinic for any reason with a contact with a billable provider during the measurement period.

Billable providers for **behavioral health** clinics include the following licensed providers: psychiatrist, physician assistant, nurse practitioner, clinical nurse specialist, psychologist (LP), clinical social worker (LICSW), or counselor (LPCC).

Total Adult Patients with Depression Diagnosis (296.2x, 296.3x and 300.4):

These ICD-9 codes define major depression and dysthymia and would be a subset of your total adult patients. The total number of adult patients with a contact with a billable provider who have at least one contact in the measurement period with the following ICD-9 codes: These diagnosis codes need to be in the primary position for behavioral health providers. This excludes patients with other psychiatric diagnoses with a secondary component of depression.

- 296.2.x Major depressive disorder, single episode
- 296.3x Major depressive disorder, recurrent episode
- 300.4 Dysthymic disorder

It does not matter if this is a new diagnosis or if the patient is returning for a follow-up visit, if they have these codes during the measurement period, include them in the count.

Total Adult Patients with Depression NOS (311) code:
This would be another subset of your adult population. The total number of adult patients with a contact with a billable provider with a 311 code (Depression NOS not elsewhere classified). Because one of the goals of measuring this population is accurate diagnosis (an subsequently coding); please only include in this count patients who have a 311 code and not the major depression/ dysthymia codes of (296.2, 296.3 or 300.4). One way you could structure your query would be to search for ICD9 code = 311 and is not equal to 296.2, 296.3 or 300.4.

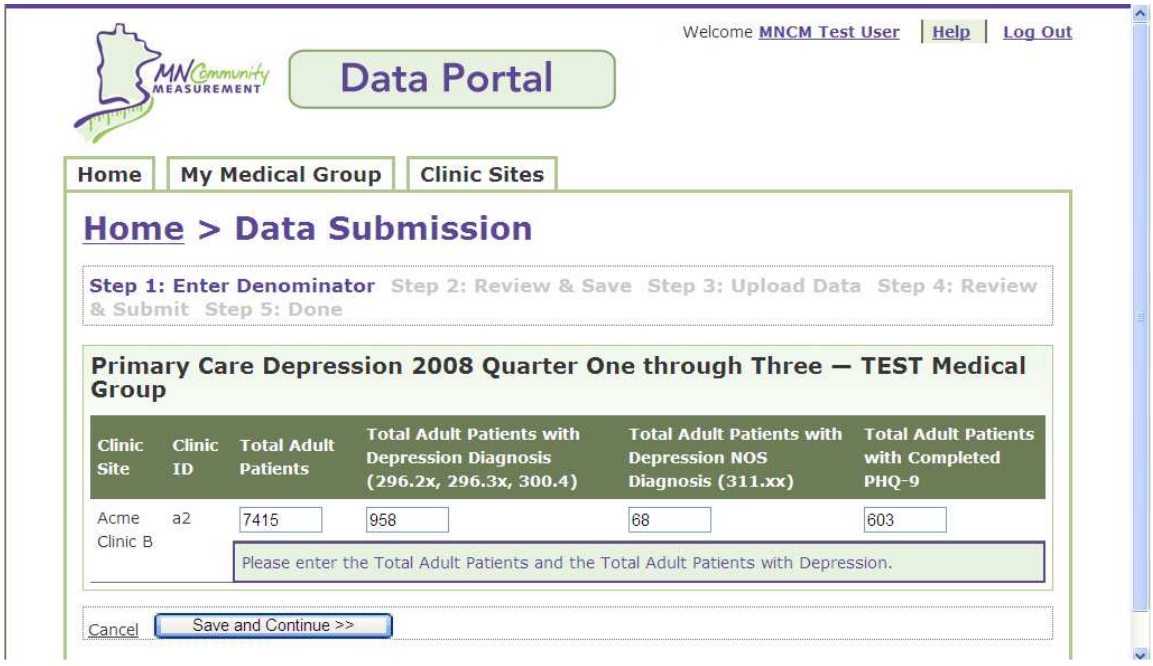
Total Adult Patients with a Completed PHQ-9:
This is a subset of the patients ages 18+ with the major depression/ dysthymia diagnosis codes of (296.2, 296.3 or 300.4) Count the number of these patients during the measurement period who also have a PHQ9 test done during the measurement period.

If the patient did not have one of the depression diagnoses during the measurement period, but had PHQ-9, **do not include** this patient in your count.

Example: for the measurement period of October 1, 2008 through January 31, 2009

A clinic site sees 7,415 patients age 18 or greater with dates of service between 10/1/2008 and 1/31/2009.
Of these adult patients, 958 have a diagnosis of major depression or dysthymia (ICD-9 codes 296.2, 296.3 or 300.4) during that same timeframe. Additionally, 68 patients have a diagnosis code of 311 and do not have the major depression/ dysthymia diagnosis codes (ICD-9 codes 296.2, 296.3 or 300.4). Of the 958 patients with a diagnosis of major depression/ dysthymia, 603 patients have had a PHQ-9 done during the measurement time frame

Your data input screen would look like this:



Patient Population; Patient Criteria for Denominator

Patient Criteria:

- Adults age 18 and older; no upper age limit
- Diagnosis of Major Depression or Dysthymia; ICD- codes include:
    - 296.2.x Major depressive disorder, single episode
    - 296.3x Major depressive disorder, recurrent episode
    - 300.4 Dysthymic disorder
- For primary care providers, these diagnosis codes can be in any position
- For behavioral health providers, the depression or dysthymia diagnosis codes need to be in the primary position. This is to insure that the patient is primarily being treated for major depression and does not have other more serious psychiatric conditions like psychoses, schizophrenia or bi-polar disease with underlying depression.
- To be included in the denominator for outcome measures, initial PHQ-9 score is > 9

Exclusions:

Exclusions for this population are:

- Patient death
- Documentation that the patient's care was transferred to another provider
- Hospice
- Permanent Resident of Nursing Home

If exclusions are known prior to population identification, the patient can be excluded from the denominator. Please document how you are handling exclusions in your denominator certification document. If an exclusion event occurs after a patient has already been submitted, a subsequent record could contain data for the "Exclusion Reason" and "Exclusion Date" fields. Having an exclusion reason and date would prevent the patient being counted in the outcome calculations. If you do not know the exact date of the event it is acceptable to enter a date that represents the month in which it occurs like 6/1/2008 to represent June of 2008

Please note that these exclusions may be taken by the medical group if the information is available, however it is optional. If the information is unknown to the clinic, the patient is to be included.

Patient Population; Portal Function

It's important to understand a few things about how the portal functions for this unique data set that is longitudinal and involves multiple submissions to capture a patient's experience over a twelve month time frame of measurement.

Records are submitted at a patient visit or contact level; not at the level of an individual patient like diabetes or IVD direct data submissions. It would be expected to have several records for one patient, one record for each contact and PHQ-9 score.

It is important to only submit records with dates of service **during the measurement period.** Dates of service outside of this range will cause file errors.

In order for the programming to correctly evaluate each patient record, the file must be in order of PatientID and Contact Date with the contact dates in ascending order.

The portal is structured to look at each incoming patient record according to Medical Group ID and PatientID. The portal determines if 1) this patient is already in the portal and then will add the subsequent visits, or 2) if not already in the portal will flag as a new patient with an index contact. The following criteria are needed to accept and flag a new patient record:

- Diagnosis code of any of the following
    - 296.2.x Major depressive disorder, single episode
    - 296.3x Major depressive disorder, recurrent episode
    - 300.4 Dysthymic disorder
- Provider
- Insurance information (Insurance Coverage Code, Health Plan/ Insurance plan Member ID)
- PHQ is > 9

The portal will then mark this index or starting visit as "activation" and it is from this date going forward that outcomes will be calculated.

The activation record will contain the information that is stored for each patient. This record contains the clinic ID, the provider ID, diagnosis code and insurance coverage information. The clinic site and the provider ID that are a part of this record is where all of the subsequent information matching this patient will be attributed to. The insurance coverage will be updated if it changes, but the rest of this record will remain the same.

Once a patient has a record that meets this criteria and is "activated", then the portal will allow subsequent records that have less information to come into the portal and match up to the patient. This is to allow for the various settings in which a PHQ-9 can be administered (phone, e-visit or other type of visit.) for which there may not be a diagnosis code or insurance information. Records that don't meet the initial criteria **or** find an existing matching patient are discarded during the file upload process and are not stored in the portal.

A patient's measurement period will end 12 months +/- 30 days from the activation date. If, after this point a patient does meet the inclusion criteria again (diagnoses and PHQ-9 score > 9) a new index/ activation record will be created and measurement will proceed.

File Structure

There are two different ways that a group could construct a file for submission. The preferred method is to submit all patient records regardless of what the patient's PHQ-9 score is; this allows records to match up with patients who are already in the database and the portal will use the above criteria to identify new patients. The second method would be to only submit data for patients whose PHQ-9 score is greater than 9 and all their subsequent PHQ-9 scores. For clinics without EMR query capability, this is frequently the only way information can be abstracted. The difficulty with this method is that during future submissions you would need to identify subsequent PHQ-9 scores for patients already submitted.

You will need to submit the following demographic data elements on the data submission form:

Data Element Number/ Name	**Notes**	**Type Format**	**Sample Value**
PatientID	Unique identifier for this patient assigned by the clinic. Please sort file by PatientID and then Contact Date to allow for programming logic	Text/Numeric	56609
Date of Birth	Patient's date of birth (must be 18+)	Date (mm/dd/yyyy)	05/08/1985
ClinicID	MNCM defined Clinic ID. The clinic ID from the index contact is the clinic site that the patient will be attributed to.	Text/Numeric	15a
Provider ID	ID of the Patient's primary care provider. This is a clinic generated ID number. Keep this log for MN Community Measurement audit. The provider ID from the index contact is the provider that the patient will be attributed to.	Text/Numeric	SLH
Insurance Coverage Code	Code for the appropriate insurance entity, regardless of product [For example, if a patient is Medica Advantage Medicare, code as 04=Medica]. If there is no insurance coverage, code as 16=Self-pay or 29=Uninsured. Only use 99=Other if you are not able to match the patient to one of the categories provided. Only include primary payer. *Note:* All numbers entered for insurance coverage code should be double-digit (ex: "01" instead of "1") 18=Aetna 22=American Family 27=America's PPO 15=Blue Cross Blue Shield (not MN) 01=Blue Cross Blue Shield of Minnesota (such as Aware Gold, Blue Plus , Options Blue, Preferred Gold, Simply Blue) 17=Cigna 23=Comprehensive Care Services 13=Department of Human Services	Text	01

Data Element Number/ Name	Notes	Type Format	Sample Value
	02=FirstPlan Minnesota 03=HealthPartners 14=Humana 21=Indian Health Services 11=Itasca Medical Care 04=Medica (such as Patient Choice, Definity Health, Elect, Essential, Insights, LaborCare, Premier, Primary, Select Care, UHC) 20=Medicaid (not MN) 08=Medicare Fee-for-Service and supplemental plans (such as Pyramid Life, Tricare, Unicare, ZMedicare) 05=Metropolitan Health Plan (MHP) 06=Preferred One 10=PrimeWest 25=Prudential 12=Sanford Health Plan 16=Self-pay 09=South Country Health Alliance (SCHA) 24=State Farm 26=Travelers Insurance 07=UCare 29=Uninsured 19=Veterans Administration (VA) 28=Wausau (not Patient Choice) 99=Other		
Insurance Coverage Other Description	If Insurance Coverage Code = 99, description must be entered here. If Insurance Coverage Code is not = 99, leave blank.	Text	BlueCross BlueShield of Wisconsin
Health Plan/ Insurance plan Member ID	Patient's Insurance Coverage ID	Text/Numeric	FBOXZ792699
Diagnosis	Depression Diagnosis with one of the following codes: 296.2x, 296.3x, or 300.4	Numeric	296.32
Contact Date	Date of visit, telephone call, e-visit or other contact. **Only submit contact dates within the range of the current measurement period.**	Date (mm/dd/yyyy)	08/31/2008
PHQ-9 Score	Score linked to contact. If no PHQ-9 was done, leave blank.	Numeric	13
Exclusion Reason	1 = Death 2 = Transferred Care 3 = Hospice 4 = Permanent Resident of Nursing Home	Numeric	1
Exclusion Date	Date Patient Exclusion is documented	Date (mm/dd/yyyy)	8/25/2008
Contact Type	* Not a part of the file submission * This data field is assigned by the MNCM data portal programs for all incoming records.	Text	Activation or New Score

Example of File for Submission & Portal Logic

Example of Data File for Submission (no phi, fake data)

PatientID	Date Of Birth	ClinicID	Provider ID	Insurance Coverage Code	Insurance Coverage Other Description	Health Plan/Insurance plan Member ID	Diagnosis	Contact Date	PHQ-9 Score	Exclusion Reason	Exclusion Date
Patient 001	1/09/1948	test	5	99	CHAMPUS/CHA	MB469545211	296.32	02/01/2008	18		
Patient 002	05/7/1961	test	1	1		Z259324326	296.22	06/09/2008	13		
Patient 003	05/21/1981	test	3	29			296.32	09/25/2008	16		
Patient 003	05/21/1981	test						01/30/2008	16		
Patient 003	05/21/1981	test						05/06/2008	8		
Patient 004	10/12/1980	test	4	1		XAG80142780	296.25	08/08/2008	14		
Patient 004	10/12/1980	test						05/09/2008	10		
Patient 004	10/12/1980	test						09/19/2008	14		
Patient 004	10/12/1980	test						08/20/2008	17		
Patient 005	12/16/1963	test	2	15		GBV140780780	296.22	04/11/2008	10		
Patient 005	12/16/1963	test	2	15		GBV140780780	296.22	03/12/2008	17		
Patient 005	12/16/1963	test						06/03/2008	9		
Patient 006	06/17/1966	test	3	8		MP475924083	296.32	09/11/2008	17		
Patient 007	0/11/1932	test	1	7		7633401900	296.32	09/04/2008	21		
Patient 007	0/11/1932	test						05/20/2008	7		
Patient 008	05/16/1984	test	2	99	SELECTCARE	10946010857	296.32	03/10/2008	17		
Patient 009	02/4/1964	test	1	3		M0150772860	296.22	09/16/2008	13		
Patient 009	02/4/1964	test						04/08/2008	14		
Patient 009	02/4/1964	test						01/28/2008	4		
Patient 010	11/23/1933	test	4	3		7562014235	296.32	02/26/2008	14		
Patient 010	11/23/1933	test	4	3		7562014235	296.32	06/17/2008			
Patient 011	07/18/1978	test	2	3		P0332651110	296.21	08/26/2008	10		
Patient 011	07/18/1978	test	2	3		P0332651110	296.21	01/11/2008	14		
Patient 012	08/20/1965	test	4	29			296.22	04/18/2008	13		
Patient 013	02/12/1964	test	3	1		T0158187080	296.32	02/11/2008	17		
Patient 013	02/12/1964	test	3	1		T0158187080	296.32	03/10/2008	5		
Patient 013	02/12/1964	test	3	1		T0158187080	296.32	06/20/2008			

Sample File with Portal Logic

PatientID	Date of Birth	ClinicID	Provider ID	Insurance Coverage Code	ance Coverage	Member ID	Diagnosis	Contact Date	PHQ-9 Score	Exclusion Reason	Exclusion Date	How the portal will review the record	Portal Action
Patient A	03/07/1962	103a	45692	29		123456789	296.32	04/19/2008	**11**			Intial Visit PHQ9 > 9	Index Visit
Patient B	04/29/1963	103a	12987	29		234567891	296.32	08/07/2008	**9**			PHQ < 10	Exclude
Patient C								01/03/2008	**11**			No Dx PHQ prior contact	Exclude
Patient C								06/25/2008	**15**			No Dx PHQ prior contact	Exclude
Patient C	08/14/1964	103a	56402	29		345678912	296.32	07/16/2008	**8**			PHQ < 10	Exclude
Patient E	06/06/1957	103a	23651	29		456789123	296.22	05/24/2008	**9**			PHQ < 10	Exclude
Patient E	06/06/1957	103a	23651	29		456789123	296.22	06/25/2008	**0**			PHQ < 10	Exclude
Patient H								04/17/2008	**9**			No Dx PHQ prior contact	Exclude
Patient I	07/08/1956	103a	12987	03		5678912345	296.22	04/18/2008	**16**			Intial Visit PHQ9 > 9	Index Visit
Patient I	07/08/1956	103a	12987	03		5678912345	296.22	07/09/2008	**2**			Subsequent visit	New Score
Patient J								02/11/2008	**12**			No Dx PHQ prior contact	Exclude
Patient J								06/04/2008	**5**			No Dx PHQ prior contact	Exclude
Patient J	01/03/1968	103a	23651	29		6789123456	296.33	08/22/2008	**17**			Intial Visit PHQ9 > 9	Index Visit
Patient J								09/02/2008	**14**			Subsequent visit	New Score
Patient L								05/05/2008	**18**			No Dx PHQ prior contact	Exclude
Patient L	08/16/1975	103a	12987	15		789123456	296.22	05/21/2008	**7**			PHQ < 10	Exclude
Patient M	07/06/1953	103a	45692	15		891234567	296.22	06/11/2008	**7**			PHQ < 10	Exclude
Patient M	07/06/1953	103a	45692	15		891234567	296.31	06/30/2008	**7**			PHQ < 10	Exclude
Patient M	07/06/1953	103a	45692	15		891234567	296.31	08/04/2008	**2**			PHQ < 10	Exclude

Suggestions for getting started

The most important step a group can take is to implement the use of the PHQ-9 tool for patients with major depression or dysthymia. The timing of this process dictates how much historical information is available for your medical group.

If your group has not been using the PHQ-9 and wishes to start → fantastic!
Data collection could begin at the start of the next measurement period (see table on page 8). One way to jump start the process would be to identify patients in the billing system with major depression ICD-9 codes and contact patients to schedule a visit and administer a PHQ-9

If your group has been using the PHQ-9 tool → even better!
The more historical information a group has, the easier it will be to have patients with six months of data to capture outcome measures. Historical data needs to fall within the dates of service for the measurement period. If you have questions about historical information please contact support@mncm.org to formulate a data submission plan.

As long as you are including all your patients with major depression (ICD-9 codes 296.2, 296.3 or 300.4), there are several different ways that the data collection process can be achieved.

- Extract information from your EMR by query
- Combination of extract info from EMR and chart abstraction (for example when PHQ-9 tools are scanned into the system and scores need to be abstracted) Recommend moving towards an integrated PHQ-9 tool within your EMR so that scores can be extracted by query.
- Registry populated with patients with depression and their visits
- Download as much information as can be attained from a billing system into Excel and then abstract remaining data elements.

You can use the data submission template as a registry, but make sure you only send us what we need and in the original CSV format when downloaded from the portal. If changes are made to the spreadsheet, it will not upload correctly into the MNCM portal.

Submitting Your Data File

- Download the depression template file from the Home page of the portal and save a copy to your own files.
- This sheet is formatted according to the field specifications and can be used for data entry if needed. If data is queried from an EMR system, make sure that the column headings match the template exactly as irregularities will prevent the file from loading.
- It's always a good idea to keep a copy of your work, you may have extra fields like patient name and medical record number that are useful in re-locating the de-identified patients that are sent to the portal, or perhaps a column for indicating if the patient had a PHQ-9 done. Keep this excel copy for yourself, but as you are creating a .csv copy to upload to the portal, make sure that this file matches the specs in terms of column placement and field formatting and content.
- All clinics must be uploaded in a single spreadsheet; include your ClinicID as part of every record
- **Sort your file by PatientID and then Contact Date in ascending order prior to creating your .csv file**

Instructions for Safe Sorting in Excel

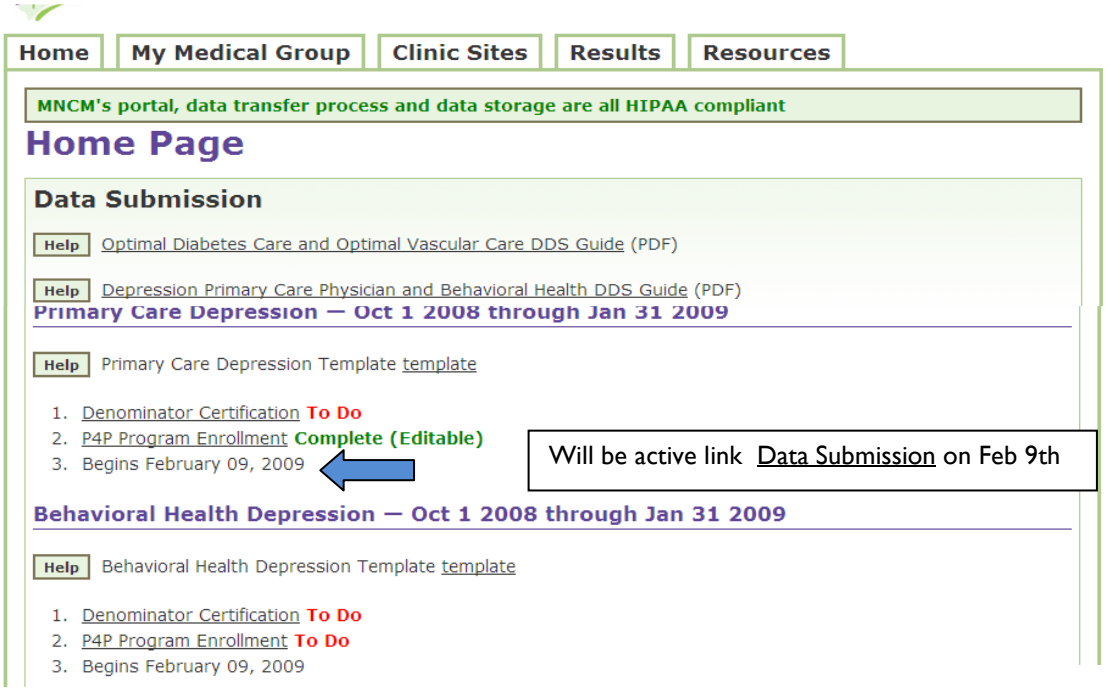
In the upper left hand corner of the spreadsheet between Column A and Row 1 there is a blank gray cell. Click on this cell to highlight your entire spreadsheet. If you don't highlight every row and column you could lose the integrity of your data. Go to the menu bar and select Data and then Sort. This will bring up a window that asks what fields you wish to sort by. In the first box select PatientID and ascending. In the second box select Contact Date and ascending. The data range defaults to selecting a Header Row and this is fine. Select the OK button and the records will sort in the correct order.

How to create a .csv file

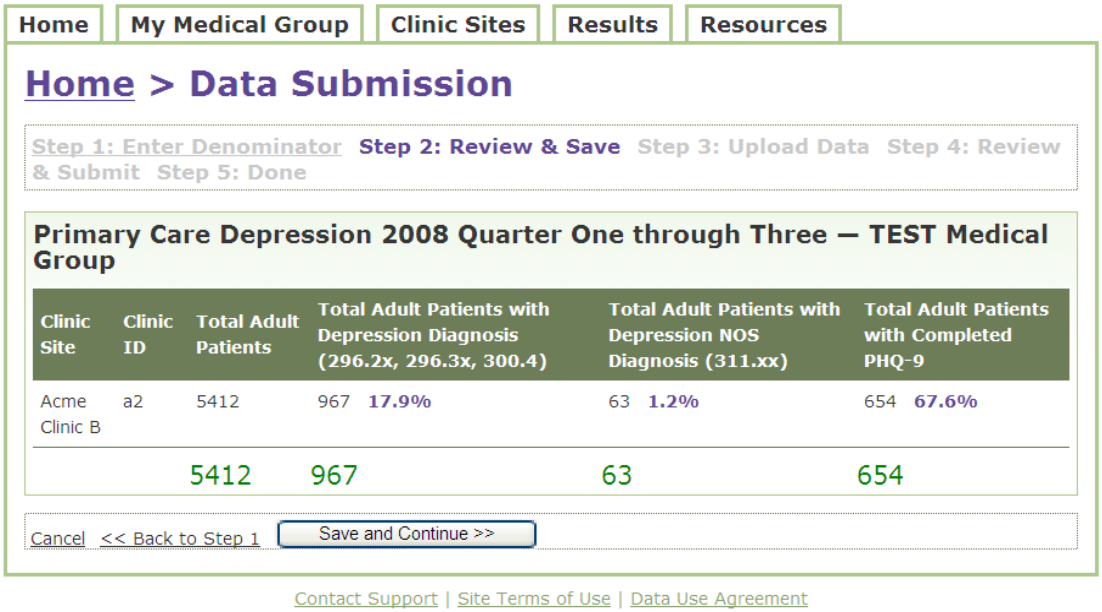
- Start with your excel work book tab that is formatted according to specs (no extra columns or data or notes), make sure that this tab is active, then do the following steps:
    - Edit
    - Move or Copy Sheet
    - Create Copy (check this box)
    - To book (new book) – this is a drop-down selection
    - In the new book, save as a CSV by clicking File, Save As. In the lower part of the window, there is a choice to save the file as a particular type. Choose Save as type → CSV (comma delimited)
- Once you have created the .csv file **Do Not Open It Again in Excel!** Re-opening a .csv file in excel to check it ruins the formatting that you created during data entry. If you accidently re-open the file in excel … make yourself a new .csv file by repeating the steps above. If you do have to make changes in your file (errors or warnings on upload) go back to your excel file, make the changes and then save it to a new .csv file.

Uploading Your File to the Portal

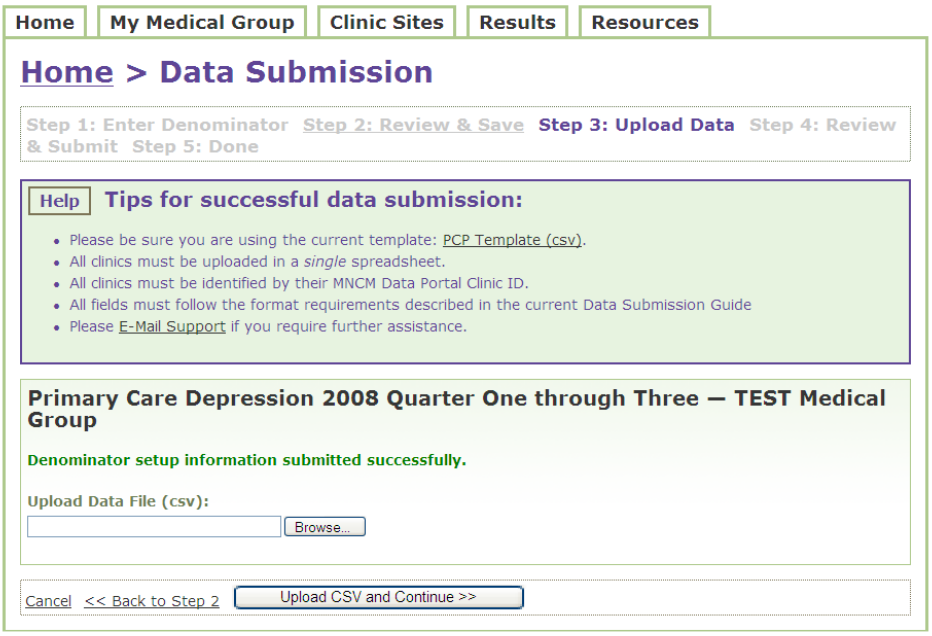
Have you population counts by clinic ready to enter in the portal prior to actual file upload. (see pages 15 – 18 for instructions and portal screen shots)
Click on the link for Data Submission



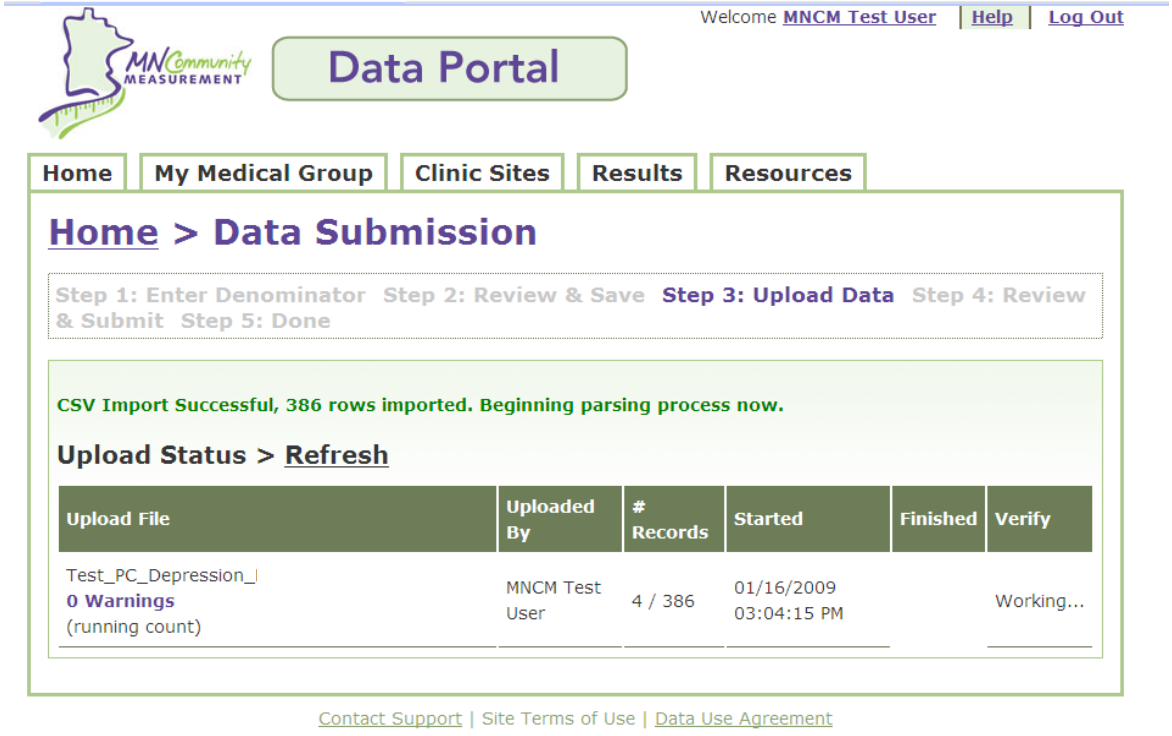
After you have loaded your population counts you will see a screen similar to this:



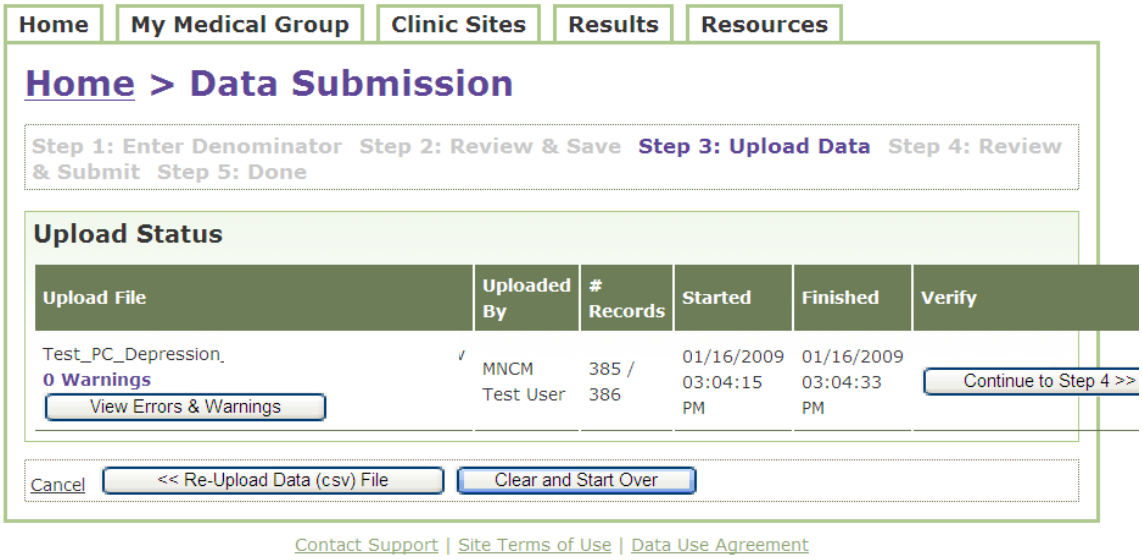
Click Save and Continue



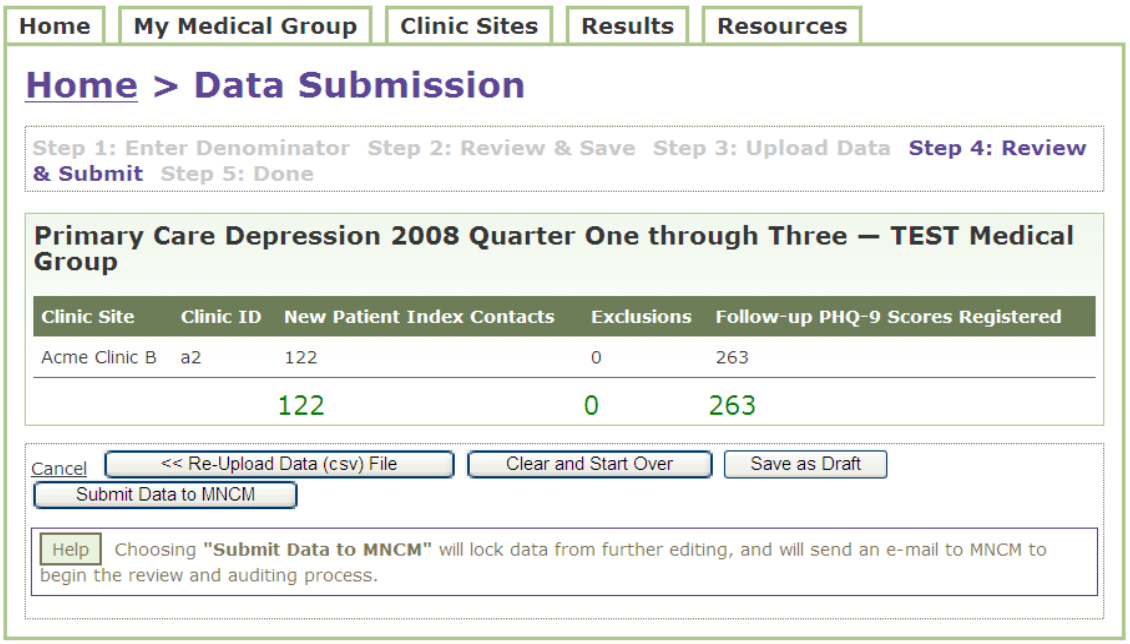
Browse to find your saved .csv file. After you upload you file you will see a processing screen



After the file is finished you can review errors (must be fixed) and warnings (just fyi). For groups that are sending large files of all depression patients many of the warnings are for records that do not qualify (ie PHQ-9 score < 9). The errors that must be fixed are listed by row, however the warnings are summarized. You can view these by clicking on the errors and warnings button on this page on the next screen.



You have several choices, depending if you are ready to submit the file or save as draft. After you are satisfied with your file submission, proceed to send the data to MNCM.

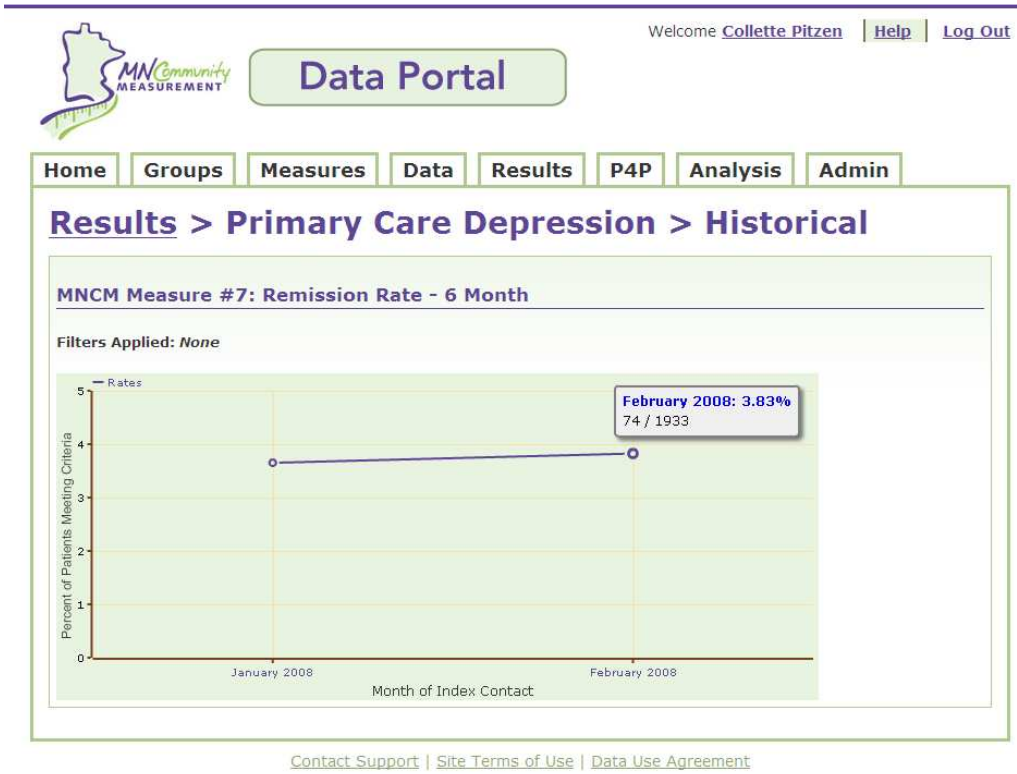


"Submit Data to MNCM" completes the data submission process. You don't need to do anything else until MNCM contacts you about auditing or next steps, and you can review your prelinary results within the portal.

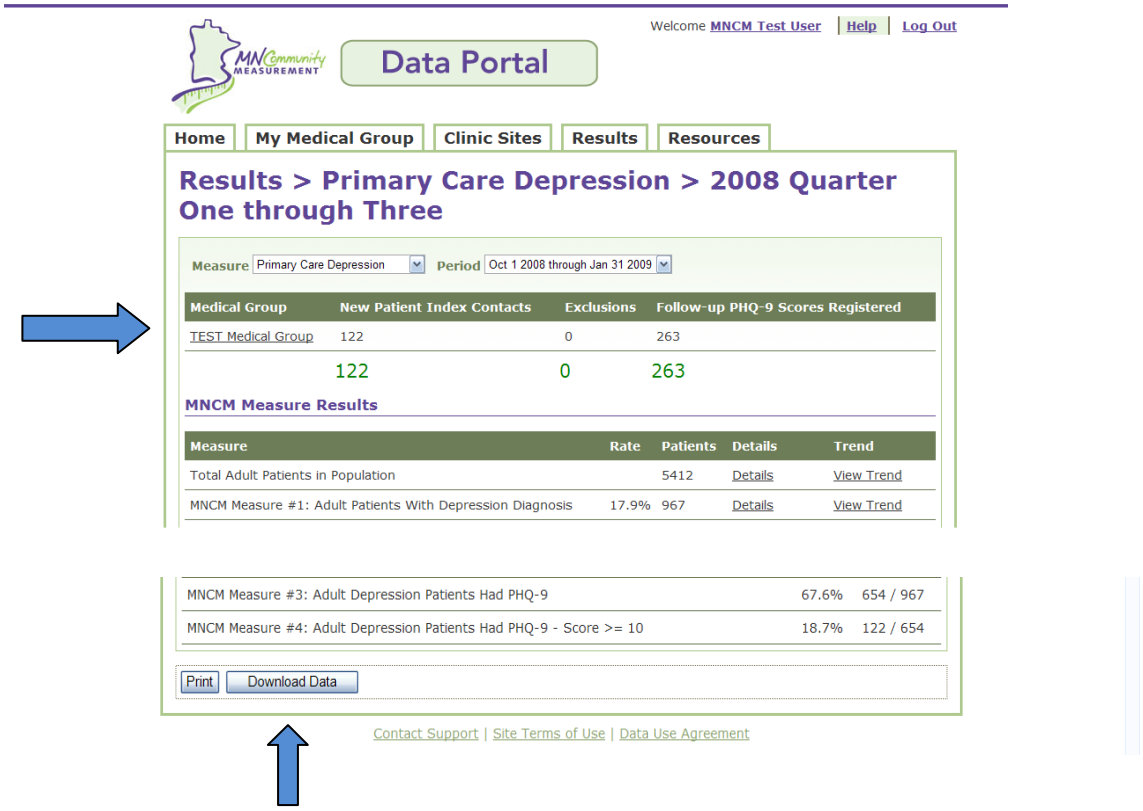
Reviewing Your Preliminary Results in the Portal

There was an enhancement made within the data to provide more functionality to medical groups for viewing results, retrieving data and analysis. Check out the new Results tab in the portal.

For the depression measures a medical group currently can review their own preliminary results in the portal right after the data is uploaded. Results are displayed by the month of the patient's index contact and trend data can be viewed by clicking into "View Trend"

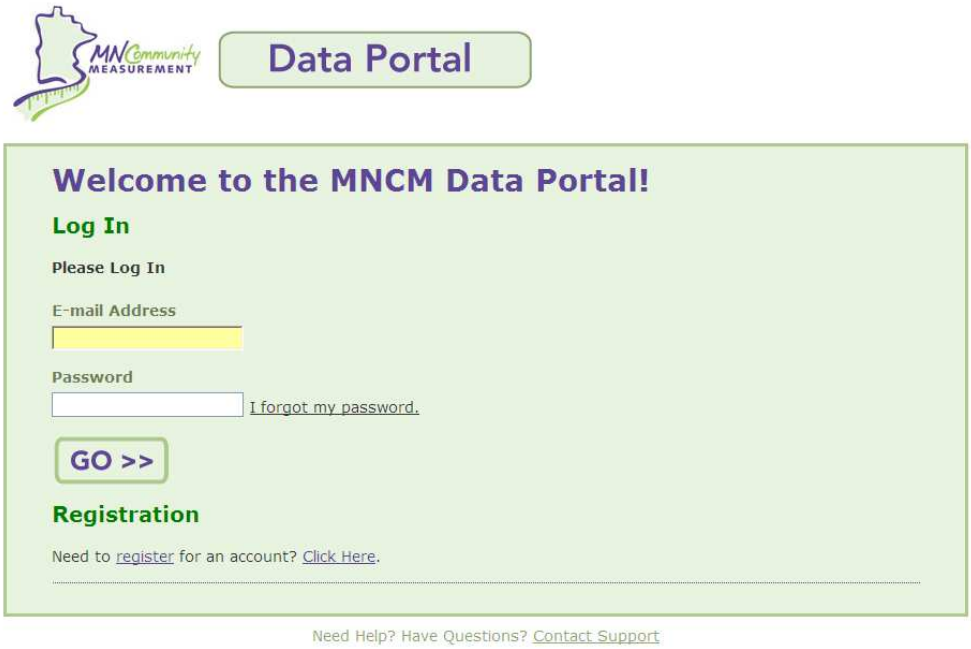


You can also download the detailed record results for your medical group for purposes of creating internal reports if desired. From the results page click into your medical group name. At the bottom of the screen is a download button, this will generate an excel file for your use.



Appendix A: Register for an Account or Reset Password

Go to https://data.mncm.org/login. This will bring you to MN Community Measurement's login screen



If you already have an account and login information: Great! Your login information will be the same as it was for the Optimal Diabetes Care and Optimal Vascular Care measures. Go ahead and log in.

If you already have an account, but forgot your login information: Click on the "I forgot my password" link. It is directly next to the blank where you would enter your password. This will bring you to a new page. Enter your email address (it MUST be the SAME one you registered with) and you will be assigned a new password. It will be sent to your email account.

If you need to register for an account: You will need to register for an account by clicking on the "register for an account" link. It will bring you to a new page. Fill out this page and click "submit." You will be taken back to the home page. Your request has been submitted and will be reviewed by a member of our staff. The email address that you submit during this step will be contacted within two business days with login details and information about how to set up your medical group on the portal.

If you want to participate in a new measure: If you already have an account set up and wish to participate in a new measure that is not currently visible on your home page, please contact support@mncm.org to have your clinic/s assigned to the measure.

Note that your password for the data portal *is* case sensitive.

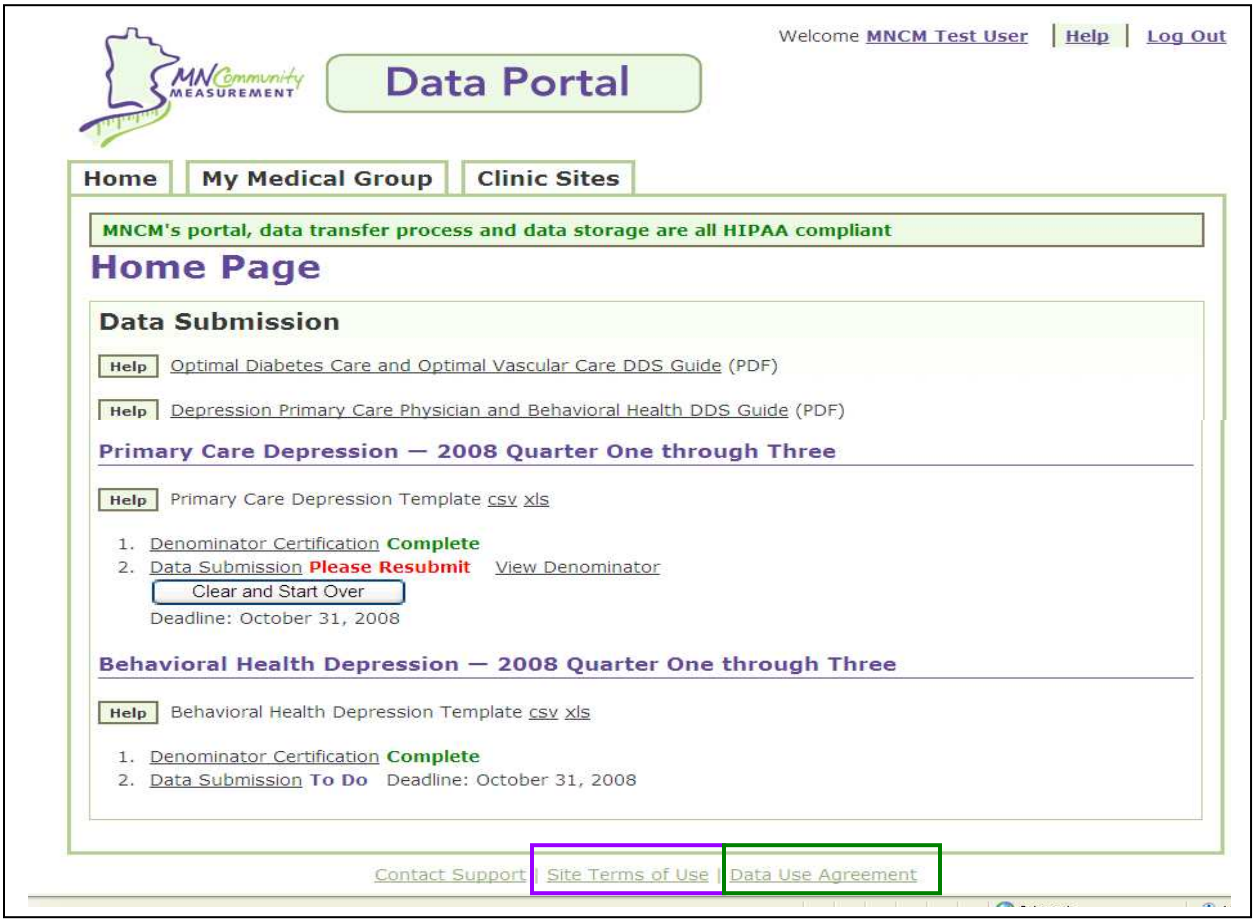
Appendix B: HIPAA, Site Terms of Agreement, Data Use/ Business Associates Agreement

HIPAA Confidentiality Concerns: We have been asked how we are approaching validation with HIPAA law and Minnesota statute. The legal firm we consulted with, Lindquist & Vennum P.L.L.P., has assured us that this type of audit fits within the scope of lawful compliance with HIPAA and MN statute given we have a signed business associate agreement with the medical group.

Data Use Agreement: We would like you to sign a copy of our business associate agreement. This document can be electronically signed on the portal and is to be updated annually. If you have a document standard to your organization, we would be open to signing your version.

Site Terms of Use Agreement

The first time you log in, you will be brought to MN Community Measurement's site terms of use agreement. You must review this form and agree to it before you can access the data portal; document is signed electronically by clicking "I Agree" to the terms If you have questions about the terms of agreement, please contact support@mnhealthcare.org



HIPAA Law:

- This activity is considered within the scope of "health care operations" associated with the medical group quality improvement efforts.
- The federal HIPAA law specifically allows release of individually identifiable health information - without the consent or authorization of the individual - for treatment, payment and health care operations of, or for, the provider.

Minnesota Statute:

- The primary governing Minnesota statute is MN Stat. Section 144.335.
- Sub. 3a. entitled "Patient consent to release of records; liability" states: (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law.
- **However**, the statute *does not restrict release* (without patient authorization) to only those circumstances authorized by state law.

Legal opinion thinks it is reasonable to conclude that the HIPAA privacy regulation does specifically address authorization for release of such information. The appropriate method for a covered entity to allow such release and to make sure the release is for a certain, narrow purpose, is either via a data confidentiality agreement or, if the auditor or other entity to whom the information is released will be maintaining any individually identifiable health information, a business associate agreement.

Appendix C: Updating Medical Group and Clinic Site Information

1. **Review your Medical Group contact information and update if needed.** The contact information will only be used for official MNCM communications, data portal communications, validation audits or to facilitate pay for performance programs such as Bridges to Excellence. If you are part of a medical group with only one clinic site, you still need to fill out information under both the clinic site section and the "My Medical Group" page. It is okay if this information is the same.
2. **Review that your list of clinic sites is complete and accurate:** To do this, go to the data portal's home page and click the tab that says "Clinic Sites." See below for an image of the clinic site page. Review each clinic site by clicking the "Edit" button on the same row. Make sure the listed information is up-to-date. It's possible that some clinics might not report for all measures, but all your medical group clinics should still be included on this list.
   How to define a clinic on the data portal: MNCM asks you to add all the clinics in your medical group to the portal.
   Clinic Site: A single Clinic Site is first defined as a building/separate space/or an entity with a separate address. If a Clinic Site has more than 30 physicians practicing at that site, the Clinic Site may further define themselves (i.e., by department or call group) as long as all data are included. The goal of reporting by Clinic Site is to move toward more granularity of data so that results are not hidden behind a large entity. Clinic Sites should be a functional unit that is easily understood by patients.
3. **If you need to add a clinic:** Contact support@mncm.org with a request to add a clinic. We will add it on our end and send you an e-mail message to let you know when you can complete the editing process for that clinic site.
4. **Please note:** Failure to have all your clinics accurately defined prior to submission of data files can cause significant re-work and re-entry of population counts at each clinic site.

Appendix D: MN Community Measurement Mission

Mission of Minnesota Community Measurement (MNCM)

The mission of MNCM is to accelerate the improvement of health by publicly reporting health care information.

What is MNCM?

MNCM is a nonprofit entity dedicated to improving the quality of health care in Minnesota. The organization has three goals:

- Improve care and support the quality initiatives of providers and the Institute for Clinical Systems Improvement (ICSI).
- Reduce reporting-related expenses for medical groups, health plans, and regulators through more efficient and effective regulation.
- Communicate findings in a fair, usable and reliable way to medical groups, regulators, purchasers and consumers.

For more information, please visit our website at www.mnhealthcare.org.

Benefits of Direct Data Submission (DDS)

The goal of DDS is to collect data on health care conditions and report comparable rates of health care quality at the clinic site level. Benefits to medical groups include more representative patient population than those calculated from health plan data and more timely results. Other uses of DDS include fulfilling participation requirements in pay-for-performance programs, utilizing data for quality improvement purposes, and publicly reporting results to patients and the community.

Appendix E: MNCM Validation of Submitted Data

After you submit data to the data portal, an auditor from MN Community Measurement will randomly select 30 medical records to audit and validate the data you submitted for accuracy.

Validation Process:

- MNCM will utilize NCQA's "8 and 30" File Sampling Procedure.
- 33 charts for each clinic site will be selected for the validation process.
- At most 30 charts for each clinic site will be reviewed.
- Reviewers will start by examining the first 8 charts of the first clinic site's selected sample to verify:
    - Compliance with the submission instructions
    - That the data submitted matches the source data.
- ***If all of the first 8*** charts reviewed are in perfect compliance, the clinic site is determined to be in high compliance and the reviewers may determine that no further chart review for that site is necessary.
- If the first clinic site is in high compliance and the data submission process for all clinic sites within the medical group is identical, further review *may* be abbreviated at the discretion of the reviewers.
- If clinic sites are not in high compliance after review of the first 8 charts, the reviewers will continue to review the remaining 22 charts. If after review of all 30 charts and the clinic site is not in high compliance on all factors, MNCM reviewer and the medical group staff will work to develop a mutually agreed upon remedy or corrective action plan.
- Clinic sites that are not in high compliance or have not been in high compliance in a previous MNCM audit may be held to a more rigorous denominator certification and on-site validation process.

Site Visit Process:

All sites going through the validation process will provide:

- The source code or methodology used to produce the denominator list
- The denominator list itself, showing the total number of patients identified

Clinic sites with paper charts:

- The clinic site will have the requested charts available for on-site review on the scheduled day.
- A medical group/clinic site staff person must be present to retrieve and display the selected data information the day of chart review.

Clinic sites with Electronic Health Records:

On the day scheduled for the review, a medical group/clinic site staff person will retrieve and display the selected records in the electronic record.

Appendix F: Definitions/Acronym Guide

BTE: Bridges to Excellence
Clinic Site: A single Clinic Site is first defined as a building/separate space/or an entity with a separate address. If a Clinic Site has more than 30 physicians practicing at that site, the Clinic Site may further define themselves (i.e., by department or "Call Group) as long as all data are included. The goal of reporting by Clinic Site is to move toward more granularity of data so that results are not hidden behind a large entity. Clinic Sites should be a functional unit that is easily understood by patients.
Contact: A contact can be a phone call, Web visit, office visit, or email. Basically, anytime the patient is ***evaluated***. A visit with the clinic in which a practitioner evaluation is not able to be given, (such as getting blood drawn), does *not* count as a "contact."
.CSV: Comma Separated Value
Data portal: A secure Web site where you will submit your data to MN Community Measurement. The MNCM portal uses the standard encryption used by any site that transfers sensitive data. All data and file uploads are encrypted so they can't be "stolen" by someone else while being submitted.
DDS: Direct Data Submission
Denominator: The total number of patients eligible for a measure. The bottom number in a ratio - such as in 10/125 (the number 125 is the denominator)
Depression Measure: A measurement of the quality of depression care. All the data you are submitting is for a set of depression metrics
DOB: Date of Birth
FTE: Full-Time Equivalent
Index Contact: The starting visit associated with a contact date in which the patient has a PHQ-9 score > 9 and ICD9 codes identifying the patient as having major depression or dysthymia. This may be during an initial query or abstraction, or may occur at a later date if the patient's PHQ-9 score increases. Each patient can only have one index contact during a 12 month episode; all other contacts after this date of service are linked to the index contact.
Medical group: A single clinic or multiple clinic sites operated by a single organization. For example, Fairview Health System is a medical group with multiple clinics.
MNCM: MN Community Measurement. Minnesota Community Measurement is an independent, community-based, non-profit organization dedicated to accelerating the improvement of health in Minnesota and surrounding communities through measurement and public reporting of health care performance. For more information, visit www.mnhealthcare.org.
MNCM Clinic ID: The function of the ID is the same as the MNCM ID except that the number is unique to a clinic. The clinic ID will be the medical group ID with a letter added to it.
MNCM ID: A number, unique to your medical group, assigned by MNCM staff, that is sometimes used instead of your medical group name. This is either for brevity or for privacy.
NOS: Not otherwise specified
P4P: Pay for Performance

MN Community Measurement
Patient Experience of Care Survey Pilot

Specifications for Medical Group Participation
21 May 2008

Objective: To collect data for a comparable, statewide measure of patient experience and report at the clinic-site level on the MN Community Measurement (MNCM) Web site. This information is intended to complement the existing clinical measures currently reported on the MNCM Web site, for use by consumers to assess clinic performance, and for use by groups and clinics for internal improvement. The methods by which standardized survey data are collected and reported are intended to complement the quality improvement focus of existing patient survey practices of participating medical groups.

Survey Questions: Visit-specific module of the CAHPS Clinician and Group Survey (CG-CAHPS) core survey items for adult primary care. Questions framed in terms of the patient's most recent visit. Major domains covered include:

- Access to care
- Doctor communication
- Office staff
- Overall rating

The survey will also include a question assessing the respondent's likelihood of recommending the clinic to family and friends.

Sample Frame: English-speaking, primary care (i.e., family practice and internal medicine, including med-peds), adult (age 18 or over) patients who had an in-person clinic visit at least once in the prior three months (exact dates of service will be specified according to the start date of the project). The sample should be drawn irrespective of reason for visit and duration of patient/physician relationship, so that the full range of patients is represented.

Sample Size: Required number of surveys will be specified according to the size of the clinic site (based on number of primary care doctors). See Table 1. Example of Variable Sampling. All primary care clinics with at least 3 practicing physicians of a participating medical group will be included.

Response Rate: The target response rate is 40 percent.

Mode of Survey Administration: Two-wave mailed survey.

Data Collection Options: Option 1: Groups use their current survey vendor (or CMS-certified in-house operation) to:

- Select sample according to specs
- Administer survey questions according to specs (as stand-alone survey or by integrating questions at the front of an existing survey, according to CAHPS protocols)
- Submit respondent-level data files to the CAHPS Database according to submission specs

Option 2: Groups use MNCM central vendor (selected by MNCM, with guidance from implementation workgroup) to:

- Submit sample frame according to specs
- Administer survey according to specs and submit respondent-level data files to the CAHPS Database according to submission specs

Field Date: Begin fielding in September 2008. Survey will be in the field for 10 weeks.

Data Aggregation: CAHPS Database will aggregate and analyze respondent-level data file submissions from current vendors and MNCM central vendor to calculate clinic-level scores.

National Database: Data submitted by participating groups will become part of the CAHPS Database and, combined with submissions from other medical groups around the country per standardized protocols, used to create:

- National benchmarks
- Data available for research

Medical groups and clinics will not be identified by name. Medical groups to submit characteristics on each clinic.

Public Reporting: Clinic-level scores will be reported on the MNCM Web site according to methods to be determined by the Reporting Advisory Committee.

Reporting Timeline: To follow analysis and assurance of valid results. Will not be tied to MN Community Measurement's current data release timeline.

Funding for Pilot:

- Costs for data collection Option 1 absorbed by medical groups.
- Costs for data collection Option 2 covered by medical group contributions to MNCM central vendor function.

- Costs for data aggregation and analysis covered through AHRQ-supported CAHPS III User Network contract.
- Costs for coordination and reporting supported in part by The Robert Wood Johnson Foundation and MNCM.

Pilot Participants: Allina, Fairview Clinics, Fairview Physician Associates, HealthEast, HealthPartners, Park Nicollet, Quello Clinic, Stillwater Medical Group, SuperiorHealth Center

Participation Agreement: Participating medical groups will sign an Intent to Participate form and a Public Reporting Agreement.

Data Use Agreement and Attestation: MN Community Measurement and the CAHPS Database will each provide a data use agreement for medical groups to sign. Medical groups will also sign an attestation for MN Community Measurement that submitted data is accurate and in accordance with the specifications and protocols established by the Implementation Workgroup.

Table 1. Estimated Variable Sampling Schedule*

Number of MDs per clinic site	Target number of completes per clinic site	Starting sample (assuming 35% response rate)
3	90	257
4-9	180	514
10-13	225	643
14-18	263	751
19-27	338	966
28-45	360	1,029

*Based on a model developed by Massachusetts Health Quality Partners

YOUR DOCTOR

1. Our records show that you had a recent visit with the doctor named below.

NAME OF DOCTOR LABEL GOES HERE
DATE OF VISIT

Is that right?

1☐ Yes
2☐ No➔ **If No, go to #25**

The questions in this survey booklet will refer to the doctor named above as "this doctor" and the date above as "your visit." Please think of this doctor and visit as you answer the questions.

2. Was this the most recent visit with this doctor?

1☐ Yes
2☐ No

3. Is this the doctor you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

1☐ Yes
2☐ No

4. How long have you been going to this doctor?

1☐ Less than 6 months
2☐ At least 6 months but less than 1 year
3☐ At least 1 year but less than 3 years
4☐ At least 3 years but less than 5 years
5☐ 5 years or more

YOUR CARE FROM THIS DOCTOR

Please answer only for your own health care. Do <u>not</u> include care you got when you stayed overnight in a hospital.

5. In the last 12 months, how many times did you visit this doctor to get care for yourself?

☐ None➔ **If None, go to #25**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10

6. Was your visit with this doctor for an illness, injury or condition that **needed care right away**?

1☐ Yes
2☐ No➔ **If No, go to #8**

7. On your visit, did you see this doctor as soon as you thought you needed?

1☐ Yes
2☐ No

8. Was your visit with this doctor an appointment for a **check-up or routine care**?

1☐ Yes
2☐ No➔ **If No, go to #10**

9. When you made the appointment for your visit, did you get that appointment as soon as you thought you needed?

1☐ Yes
2☐ No

10. During your visit, did this doctor order a blood test, x-ray or other test for you?

1☐ Yes
2☐ No➔ **If No, go to #12**

11. Did someone from this doctor's office follow up to give you those results?

1☐ Yes
2☐ No

12. Wait time includes time spent in the waiting room and exam room. During your visit, did you see this doctor **within 15 minutes** of your appointment time?

1☐ Yes
2☐ No

13. During your visit, did this doctor explain things in a way that was easy to understand?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

14. During your visit, did this doctor listen carefully to you?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

15. During your visit, did you talk with this doctor about any health problems or concerns?

1☐ Yes
2☐ No➔ **If No, go to #17**

16. During your visit, did this doctor give you easy to understand instructions about taking care of these health problems or concerns?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

17. During your visit, did this doctor seem to know the important information about your medical history?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

18. During your visit, did this doctor show respect for what you had to say?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

19. During your visit, did this doctor spend enough time with you?

1☐ Yes, definitely
2☐ Yes, somewhat
3☐ No

20. Using any number from 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate this doctor?

- ☐ 0 Worst doctor possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best doctor possible

21. Would you recommend this doctor's office to your family and friends?

- 1☐ Yes, definitely
- 2☐ Yes, somewhat
- 3☐ No

22. Please tell us how this doctor's office could have improved the care you received during your visit? (Please print)

_____
_____
_____
_____
_____
_____

CLERKS AND RECEPTIONISTS AT THIS DOCTOR'S OFFICE

23. During your visit, were clerks and receptionists at this doctor's office as helpful as you thought they should be?

- 1☐ Yes, definitely
- 2☐ Yes, somewhat
- 3☐ No

24. During your visit, did clerks and receptionists at this doctor's office treat you with courtesy and respect?

- 1☐ Yes, definitely
- 2☐ Yes, somewhat
- 3☐ No

ABOUT YOU

25. In general, how would you rate your overall health?

- 1☐ Excellent
- 2☐ Very good
- 3☐ Good
- 4☐ Fair
- 5☐ Poor

26. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

27. Are you male or female?

- 1☐ Male
- 2☐ Female

28. What is the highest grade or level of school that you have completed?

1☐ 8th grade or less
2☐ Some high school, but did not graduate
3☐ High school graduate or GED
4☐ Some college or 2-year degree
5☐ 4-year college graduate
6☐ More than 4-year college degree

29. Are you of Hispanic or Latino origin or descent?

1☐ Yes, Hispanic or Latino
2☐ No, not Hispanic or Latino

30. What is your race? Please mark one or more.

1☐ White
2☐ Black or African American
3☐ Asian
4☐ Native Hawaiian or Other Pacific Islander
5☐ American Indian or Alaskan Native
6☐ Other

31. Did someone help you complete this survey?

1☐ Yes
2☐ No➔ **Thank you. Please return the completed survey in the postage-paid envelope.**

32. How did that person help you? (Mark all that apply.)

1☐ Read the questions to me
2☐ Wrote down the answers I gave
3☐ Answered the questions for me
4☐ Translated the questions into my language
5☐ Helped in some other way
(Please print)

_____
_
_____
_

THANK YOU!
Please return the completed survey in the postage-paid envelope to:

{Insert address to which the completed questionnaire should be mailed.}

If you have questions about this survey, please call {insert vendor toll free number}.

HIT Survey

1. Welcome!

This is the second annual MN Community Measurement (MNCM) Health Information Technology (HIT) Survey. The purpose of this survey is to publicly report medical group use of electronic information technology in managing the care of their patients. This information will be publicly reported on the MNCM website (www.mnhealthcare.org) in 2009. We also will share this information with health plans to use when responding to employer group requests for information.

If you are not able to answer all of these questions or if you think someone else should complete this survey, please forward the survey invitation to the right person. Also, please copy MNCM with the name and e-mail address of that person so we can update our records.

If you have any questions about the survey content, please contact either Nathan Hunkins at hunkins@mnhealthcare.org or Diane Mayberry at mayberry@mnhealthcare.org.

We greatly appreciate your participation.

MN Community Measurement

2. Instructions

There are 16 questions in this survey. The majority of the survey's questions are multiple choice and should take less than 20 minutes to complete.

WE ASK THAT YOU COMPLETE THE SURVEY BY CLOSE OF BUSINESS NOVEMBER 20.

You can exit an incomplete survey at any time and resume it later as long as you use the same computer to resume (click exit in the upper right corner of the survey). You can also edit earlier responses.

ONCE YOU HAVE INDICATED YOU HAVE COMPLETED THE SURVEY (CLICKING DONE ON THE THANK YOU PAGE), YOU WILL NOT BE ABLE TO COME BACK TO IT.

Thanks so much for your participation. Please contact Diane Mayberry or Nathan Hunkins at MNCM if you have any questions (612-455-2911).

3. Medical Group Contact Information

1. Name and medical group:

Name:

Medical Group:

Clinic (If necessary):

Address:

City/Town:

State/Province:

ZIP/Postal Code:

2. Name and e-mail address of person completing this form:

Name

E-mail address

3. What are the Tax ID Numbers of the medical group(s) you represent?

4. How many physicians, nurse practitioners and physician assistants provide care in this medical group? Answer as full time positions (FTEs).

Number of FTEs

4. Your Medical Group Electronic Data System

Your medical group may use one or all of the following electronic systems to communicate with your patients and/or manage their care. We use the phrase "electronic data system" as a comprehensive, generic term to reference one or more of these systems. If you use a manual and/or paper-based system for any of the purposes listed below, you would indicate NONE as this is not an electronic based system.

5. What percent of the time do the CLINIC SITES in your medical group use the following electronic data systems?

	Most or all (75-100%)	About half (~50%)	Some (~25%)	None	I don't know
Electronic Medical Record (EMR) or Electronic Health Record (EHR)	◯	◯	◯	◯	◯
Electronic Lab system	◯	◯	◯	◯	◯
Electronic Radiology/Imaging System	◯	◯	◯	◯	◯
Electronic Pharmacy System	◯	◯	◯	◯	◯
Clinical or Disease Registry (uses data to identify patients with key diagnoses for management)	◯	◯	◯	◯	◯

Comments

6. If you have an EMR/EHR, is it certified by CCHIT (Certification Commission for Healthcare Information Technology)?

- ◯ Yes
- ◯ No
- ◯ I don't know

If yes, what is the year of certification?

7. Please indicate which of these systems electronically integrate with the medical group's EMR/EHR. Select all that apply.

- ☐ Pharmacy System
- ☐ Lab System
- ☐ Radiology/Imaging System
- ☐ Clinical/Disease Registry
- ☐ None of the above

5. Medical Group Use of Electronic Data Systems

8. Do the clinicians in your medical group use any of the following EMR/EHR system capabilities and care management functions at the point of care? Please select all that apply.

- [ ] The ability to identify specific patients by disease, diagnosis, or medication use
- [ ] The capacity to present alerts for disease management, preventative services and wellness
- [ ] The ability to provide support for standard care plans, guidelines and protocols
- [ ] None of the above

9. Do the clinicians in your medical group use a Practice-based or individual Quality Database Registry that is capable of the following functions? Please select all that apply.

- [ ] Generating population based reports relating to published guideline goals or benchmarking data
- [ ] Providing comparisons to the practitioner
- [ ] Providing feedback that is related to guideline goals
- [ ] Capturing data for one or more chronic disease conditions (i.e diabetes,vascular) or preventative care measures (i.e. U.S. Preventive Services Task Force recommendations) for all patients eligible for the measures
- [ ] None of the above

10. Do the clinicians in your medical group use the EMR/EHR system to track the following clinical results between patient visits? Please select all that apply.

- [ ] Pending laboratory tests
- [ ] Diagnostic tests (including common preventative screenings
- [ ] Patient referrals
- [ ] None of the above

11. Do your clinicians use the EMR/EHR to provide reminders when clinical results are not received within a predefined timeframe?

- ◯ Yes
- ◯ No
- ◯ I don't know

12. Do the clinicians in your medical group use an electronic system to facilitate e-prescribing?

- ◯ Yes
- ◯ No
- ◯ I don't know

If yes, please list the E-prescribing vendor name:

13. Does your medical group offer electronic appointment scheduling for patients?

- [ ] Yes
- [ ] No
- [ ] I don't know

Other (please specify)

14. Does your medical group offer e-visits for patients?

- [ ] Yes
- [ ] No
- [ ] I don't know

15. Does your medical group collect patient level race/ethnicity information?

- ◯ Yes
- ◯ No
- ◯ Plans to implement in the next 6 months
- ◯ Don't know

16. Does your medical groups collect primary language information?

- ◯ Yes
- ◯ No
- ◯ Plans to implement in the next 6 months
- ◯ Don't know

6. Thank You!

This completes the MNCM Health Information Technology (HIT) survey. Thanks for your participation.

MNCM Staff
Diane Mayberry (mayberry@mnhealthcare.org)
Nathan Hunkins (hunkins@mnhealthcare.org)

Lead Screening in Children (LSC)

SUMMARY OF CHANGES TO HEDIS 2009

No changes to this measure.

Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Eligible Population

Product line	Medicaid.
Age	Children who turn 2 years during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. 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	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	At least one capillary or venous blood test (Table LSC-A) on or before the child's second birthday.

Table LSC-A: Codes to Identify Lead Tests

CPT	LOINC
83655	5671-3, 5674-7, 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate or last year's audited product line specific rate.

Organizations that use the Hybrid Method to report the *Childhood Immunization Status* and *Lead Screening in Children* measures may use the same sample for both measures and reduce the sample size using the current year's LSC administrative rate or prior year's audited LSC or Medicaid-specific CIS Combination 3 rate. If using the prior year's rate option, the organization must use the lower of the two rates (LSC or Medicaid-specific CIS Combination 3).

If the organization applies optional exclusions to the CIS measure and uses the CIS systematic sample, the same children will be excluded from the LSC measure. Excluding these members will not create a statistically significant difference in the LSC eligible population.

Numerator

At least one capillary or venous blood test on or before the child's second birthday as documented through either administrative data or medical record review.

Administrative

Refer to the *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

Documentation in the medical record must include the following.

A note indicating the date the test was performed, ***and***

The result or finding (i.e., the actual blood lead level)

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table LSC-1: Data Elements for Lead Screening in Children

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

SUMMARY OF CHANGES TO HEDIS 2009

Deleted CPT code 99499 from Table AAB-B.

Deleted optional data elements in Table AAB-1/2.

Description

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Calculation

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were *not* prescribed).

Definitions

Intake Period January 1–December 24 of the measurement year. The Intake Period captures eligible episodes of treatment.

Episode Date The date of service for any outpatient or ED visit (Table AAB-B) during the Intake Period with any diagnosis of acute bronchitis (Table AAB-A).

IESD Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria.

- A 30-day Negative Medication History prior to the Episode Date (Table AAB-D)
- A 12-month Negative Comorbid Condition History prior to and including the Episode Date (Table AAB-C)
- A Negative Competing Diagnosis during the 30 days prior to the Episode Date through 7 days after the Episode Date (inclusive) (Table URI-C)
- The member was continuously enrolled one year prior to the Episode Date through seven days after the Episode Date

Negative Medication History To qualify for Negative Medication History, the following criteria must be met.

- A period of 30 days prior to the Episode Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug
- No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date (Table AAB-D)

A prescription is considered **active** if the "days supply" indicated on the date the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Negative Comorbid Condition History — A period of 12 months prior to and including the Episode Date, during which time the member had no claims/encounters containing either a principal or secondary diagnosis for a comorbid condition (Table AAB-C).

Negative Competing Diagnosis — A period of 30 days prior to the Episode Date through 7 days after the Episode Date (inclusive), during which time the member had no claims/encounters with any competing diagnosis (Table URI-C).

Eligible Population

Product lines — Commercial, Medicaid (report each product line separately).

Ages — Adults 18 years as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year.

Continuous enrollment — One year prior to the Episode Date through seven days after the Episode Date (inclusive).

Allowable gap — No more than one gap of 45 days is permitted from 365 days prior to through 7 days after the Episode Date. 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 — Episode Date.

Benefits — Medical and pharmacy.

Event/diagnosis — Outpatient or ED visit with any diagnosis of acute bronchitis during the Intake Period. Follow the steps below to identify the eligible population:

Step 1 Identify all members in the specified age range who during the Intake Period had an outpatient or ED visit (Table AAB-B) with any diagnosis of acute bronchitis (Table AAB-A).

Table AAB-A: Codes to Identify Acute Bronchitis

Description	ICD-9-CM Diagnosis
Acute bronchitis	466.0

Table AAB-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 077x, 0982, 0983
ED*	99281-99285	045x, 0981

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

Step 2 Determine all acute bronchitis Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with a diagnosis of acute bronchitis.

Step 3 Test for Negative Comorbid Condition History. Exclude Episode Dates for which the member had a claim/encounter with a diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date (Table AAB-C).

Table AAB-C: Codes to Identify Comorbid Conditions

Description	ICD-9-CM Diagnosis
HIV disease; asymptomatic HIV	042, V08
Cystic fibrosis	277.0
Disorders of the immune system	279
Malignancy neoplasms	140-208
Chronic bronchitis	491
Emphysema	492
Bronchiectasis	494
Extrinsic allergic alveolitis	495
Chronic airway obstruction, chronic obstructive asthma	493.2, 496
Pneumoconiosis and other lung disease due to external agents	500-508
Other diseases of the respiratory system	510-519
Tuberculosis	010-018

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date (Table AAB-D).

Step 5 Test for Negative Competing Diagnosis. Exclude Episode Dates where during the period 30 days prior to the Episode Date through 7 days after the Episode Date (inclusive) the member had a claim/encounter with any competing diagnosis (Table URI-C).

Step 6 Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days prior to the Episode Date through 7 days after the Episode Date.

Step 7 Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for antibiotic medication (Table AAB-D) on or three days after the IESD.

Table AAB-D: Antibiotic Medications

5-aminosalicylates	sulfasalazine		
Aminoglycosides	amikacin gentamicin	kanamycin neomycin	streptomycin tobramycin
Aminopenicillins	amoxicillin	ampicillin	
Antipseudomonal penicillins	piperacillin	ticarcillin	
Beta-lactamase inhibitors	amoxicillin-clavulanate ampicillin-sulbactam	piperacillin-tazobactam	ticarcillin-clavulanate
First generation cephalosporins	cefadroxil cefazolin	cephalexin cephradine	
Fourth generation cephalosporins	cefepime		
Ketolides	telithromycin		
Lincomycin derivatives	clindamycin	lincomycin	
Macrolides	azithromycin clarithromycin	erythromycin erythromycin ethylsuccinate	erythromycin lactobionate erythromycin stearate
Miscellaneous antibiotics	aztreonam chloramphenicol dalfopristin-quinupristin	daptomycin erythromycin-sulfisoxazole linezolid	metronidazole vancomycin
Sulfamethoxazole-trimethoprim DS	sulfamethoxazole-trimethoprim		
Natural penicillins	penicillin G benzathine-procaine penicillin G potassium	penicillin G procaine penicillin G sodium	penicillin V potassium
Penicillinase resistant penicillins	dicloxacillin	nafcillin	oxacillin
Quinolones	ciprofloxacin gatifloxacin gemifloxacin	levofloxacin lomefloxacin moxifloxacin	norfloxacin ofloxacin sparfloxacin
Rifamycin derivatives	rifampin		
Second generation cephalosporin	cefaclor cefotetan	cefoxitin cefprozil	cefuroxime loracarbef
Sulfonamides	sulfadiazine sulfamethoxazole-trimethoprim	sulfisoxazole	
Tetracyclines	doxycycline	minocycline	tetracycline
Third generation cephalosporins	cefdinir cefditoren cefixime	cefotaxime cefpodoxime ceftazidime	ceftibuten ceftizoxime ceftriaxone
Urinary anti-infectives	fosfomycin nitrofurantoin nitrofurantoin macrocrystals	nitrofurantoin macrocrystals-monohydrate trimethoprim	

Note: *NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 14, 2008.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AAB-1/2: Data Elements for Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Total numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

2009 DATA SPECIFICATIONS: EXISTING MEASURES

MN Community Measurement – Reporting Advisory Committee
Recommendations of MNCM Measures for 2009 Reporting

Clinical Measures	Data Source	Data Collection Method	Matches ICSI Guideline?	NQF Endorsed?	Recommend for 2009 reporting?	Eligible for future DDS reporting?
Prevention Measures						
Breast Cancer Screening	MCO	admin	Yes	Yes	Yes, report ages 50-69 only	
Childhood Immunization Status	MCO	hybrid	Yes	Yes	Yes, Combo 3	Yes; priority 3
Cervical Cancer Screening	MCO	admin	Yes	Yes	Yes	
Colorectal Cancer Screening	MCO	hybrid	Yes	Yes	Yes	Yes; priority 2
Cancer Screening Combined	MCO	hybrid	Yes	Yes	Yes	Yes
Chlamydia Screening in Women	MCO	admin	Yes	Yes	Yes	
Lead Screening in Children	MCO	admin	Yes	Yes	Yes, pending variation testing – **NEW**	
Cardiovascular Measures						
Controlling High Blood Pressure	MCO	hybrid	Yes	Yes	Yes	Yes; priority 4
Optimal Vascular Care	MCO/Medical Group	hybrid and DDS	Yes	Yes	Yes	
Diabetes Measures						
Optimal Diabetes Care -HbA1C Control <7 -Blood Pressure Control <130/80 -LDL –C level <100 -Documented Tobacco Free -Daily Aspirin Therapy	MCO/Medical Group	hybrid and DDS	Yes	Seeking NQF endorsement in 2009	Yes	
Asthma Measure						
Use of Appropriate Meds for People w/ Asthma Age 5-56	MCO	admin	Yes	Yes	Yes	Yes; priority 1 Develop new asthma composite measure
Depression Measure						
Depression measures aligned with DIAMOND project	Medical Group	DDS only	Yes	Seeking NQF endorsement in 2009	Yes	
Overuse/Misuse Measures						
Appropriate Treatment for Children w/ URI	MCO	admin	Yes	Yes	Yes	
Appropriate Testing for Children w/ Pharyngitis	MCO	admin	Yes	Yes	Yes	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	MCO	admin	Yes	Yes	Yes – **NEW**	
Patient Experience Measures						
CG-CAHPS Pilot	Medical Groups	survey	NA	Yes	Yes – **NEW**	
Health IT Measures						
MNCM survey aligned with health plan eValu8 requirements	Medical Group	survey	NA	NA	Yes	
Specialty Measures						
Orthopedic Measures – Total Hips and Knees	TBD	TBD	TBD	TBD	TBD	
Cost of Care/Efficiency of Care						
Under development	TBD	TBD	TBD	TBD	TBD	

2009 MN Community Measurement (MNCM)
Optimal Diabetes Care
Measurement Specifications

Introduction

MN Community Measurement has developed a methodology that allows for the aggregation of managed care data at the medical group level. "Optimal Diabetes Care" is an expanded version the HEDIS Comprehensive Diabetes Care (CDC) measure based on the Institute for Clinical Systems Improvement (ICSI) guideline recommendations. The HEDIS components of this measure are based on the CDC specifications in HEDIS 2009, Vol. 2. For purposes of MNCM, the specifications for some numerator components were modified.

Modified HEDIS specifications for additional MNCM-specific components are shaded in gray. (HEDIS is a registered trademark of the National Committee for Quality Assurance)

Description

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

- HbA1c (A1c) test
- HbA1c <7.0
- LDL-C screening performed
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- Eye exam (retinal) performed
- Blood Pressure control <130/80
- Blood Pressure Reading performed
- On Daily Aspirin Therapy if age 41 and older
- Documented tobacco free

In addition to calculating a rate for each of the components listed above**, composite rate of Optimal Diabetes Care** will be calculated based on the following 5 components:

-Optimal Diabetes Care- Targets (A1c<7.0; LDL<100; BP<130/80; Aspirin Use; Documented tobacco free)

Eligible Population

Product line Reporting Product lines will be combined for reporting by medical group.

Product lines included in data Commercial (HMO/POS,/PPO) Medicaid, Medicare Advantage, Medicare Cost, MSHO

Age 18-75 years as of December 31 of the measurement year.

Continuous enrollment MCO continuous enrollment for 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 Enrolled as of December 31 of the measurement year.

Benefit Medical.

Event/diagnosis Two methods are provided to identify diabetic members: pharmacy data and claims/encounter data. The MCO must use *both* methods 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 measurement year or the year prior to measurement year.

Pharmacy data. Members dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Refer to Table CDC-A.

Table CDC-A: Prescriptions to Identify Diabetics Using Pharmacy Data

Description	Prescriptions		
Alpha-glucosidase inhibitors	acarbose	miglitol	
Amylin analogs	• pramlinitide		
Antidiabetic combinations	glimepiride-pioglitazone glimepiride-rosiglitazone glipizide-metformin glyburide-metformin		metformin-pioglitazone metformin-rosiglitazone metformin-sitagliptin
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	pramlintide	sitagliptin
Sulfonylureas	acetohexamide chlorpropamide glimepiride	glipizide glyburide	tolazamide tolbutamide
Thiazolidinediones	pioglitazone	rosiglitazone	

Note: *Glucophage/metformin is not included because it is used to treat conditions other than diabetes Diabetic members on these medications are identified through diagnosis coding only. NCQA's Web site at www.ncqa.org will provide a list of medications by November 15, 2008.*

Claim/encounter data. Members who had *two* face-to-face encounters with different dates of service in an outpatient setting or nonacute inpatient setting or *one* face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. The MCO may count services that occur over both years.

Use the codes in Table CDC-B to identify outpatient or nonacute inpatient and acute inpatient or emergency department encounters. Refer to Table CDC-C for codes to identify visit type.

Table CDC-B: Codes to Identify Diabetics Using Claims/Encounter Data

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

Table CDC-C: Codes to Identify Visit Type

Description	CPT Codes	UB Revenue Codes
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, 99499	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, 0524, 0525, 055x, 066x
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

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

Numerators

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

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

Table CDC-D: Codes to Identify HbA1c Tests

CPT Codes	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F, 3047F	4548-4, 4549-2, 17856-6

Medical record Documentation in medical record must include at a minimum a note indicating the date on which the HbA1c test was performed and the result. MCOs may count notation of the following in the medical record:

A1c

HbA1c

hemoglobin A1c

HgbA1c

Glycohemoglobin A1c

2. HbA1c Level The most recent HbA1c level (performed during the measurement year) as identified by automated laboratory record or medical record review. The member is numerator compliant if the most recent automated HbA1c level is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≥7.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

NOTE: Test level must be taken from most recent test.

3. 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.

Administrative Use any code listed in table CDC-H.

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, 24331-1, 39469-2, 49132-4

Medical record Documentation in medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result. The organization uses a calculated LDL for LDL-C screening and control indicators.

4. LDL-C level The *most recent* LDL-C level performed during the measurement year as documented through automated laboratory data or medical record review. The member is numerator compliant if the most recent automated LDL-C level is <100 mg/dL. If the result for the most recent LDL-C test during the measurement year is >= 100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the member is not numerator compliant.
NOTE: Test level must be taken from most recent test.

Refer to the HEDIS 2009 Comprehensive Diabetes Care measure for information on how to calculate LDL-C from total cholesterol, HDL-C and triglycerides.

In cases where the triglyceride is >400 or "triglycerides are too high to calculate.

5. Blood Pressure level <130/80 mm Hg: The most recent BP <130/80 mm Hg (taken during the measurement years) as documented through administrative or medical record review.

Administrative

Identify the most *recent* BP during the measurement year using automated data. Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP The member is numerator compliant if the most recent reading is <130/80 mm Hg. If the reading for the most recent BP is >=130/80 mm Hg or if there is no automated BP reading taken during the measurement year, the member is not compliant.

Medical Record:

A BP <130/80 mm Hg as documented through medical record review.

To determine if a member's BP is adequately controlled, the MCO must identify the representative BP. The MCO should follow the steps below to determine representative BP.

Indentifying the medical record: The MCO should use the medical record from which it abstracts data for the other CDC indicators. If the MCO does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the MCO may use the medical record of another PCP or specialist from which the member receives care.

STEP 1

Identify the most recent BP reading notated during the measurement year.

- Do not include BP readings taken during an acute inpatient stay or ED visit.
- Do not include BP readings from outpatient visits which were for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Do not include BP readings obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) or at an emergency room visit.
- Do not include BP readings taken by the member/patient.

STEP 2

● Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

6. Tobacco Non-user:	
Medical Record:	Documentation in medical record of non-tobacco user status defined as: Through the chart (any year) there is documentation that supports the member doesn't use tobacco. A label or mark anywhere on the chart or general forms like a problem list or the most recent visit progress note that shows the patient has been asked at least once and reported not using tobacco. NOTE: If tobacco status changes during measurement year, use most recent status available as of 12/31/08.

7. Daily Aspirin Use or Documented Contraindication:	Percent of members aged 41-75 as of 12/31 of the measurement year with diabetes who had documentation of daily aspirin or anti-platelet use anytime during the measurement year or a documented contraindication.
Numerator	Members aged 41-75 as of December 31 of the measurement year with diabetes who had documentation of daily aspirin or anti-platelet use during the measurement year or have a documented contraindication to aspirin use. Two methods are provided to identify members with documented use of aspirin, anti-platelet use or a contraindication: pharmacy data or medical record data.
Pharmacy Data/Electronic Collection:	**Aspirin or Anti-Platelet Use:** Member is numerator compliant if he/she was dispensed aspirin (81-325mg daily), a product containing aspirin (see attached list) or anti-platelets (Using NDC code list). Use the most recent fill date to determine if the prescription is active in the measurement year. Aspirin use includes: • Low dose enteric coated (81mg) ASA (Ecotrin or Bayer) Anti-platelet list includes: • Dipyridamole (with aspirin = Aggrenox) • Clopidogrel (Plavix) • Ticlopidine (Ticlid) • **NEW!** Pravigard (aspirin/pravastatin)

Contraindications to Aspirin or Anti-platelet Use: Member has a contraindication to aspirin if they are prescribed an anti-coagulant.

Anticoagulant list includes:

- Warfarin (Coumadin)
- Enoxaparin (Lovenox)

NOTE: Some patients may be on ASA therapy even though they are taking an anti-coagulant medication. You should give numerator positive credit for ASA therapy rather than counting it as a contraindication.

Medical Record data:

Aspirin or Anti-Platelet Use: Member is numerator compliant if he/she has a dated medication list or progress note indicating the date on which aspirin, a product containing aspirin (see attached list) or an anti-platelet was prescribed. A prescription or notation from another treating physician indicating aspirin or anti-platelet taken during the measurement year is also acceptable.

Aspirin use includes:

- Low dose enteric coated (81mg) ASA (Ecotrin or Bayer).

Anti-platelet list includes:

- Dipyridamole (with aspirin = Aggrenox)
- Clopidogrel (Plavix)
- Ticlopidine (Ticlid)
- **NEW!** Pravigard (aspirin/pravastatin)

NOTES:

- If ASA has been discontinued prior to a surgical procedure **Do Not** count this as a contraindication, rather document this patient as taking aspirin during the measurement period.
- Conversely, if the only documentation of aspirin in the record is on a standard pre-op stating something like "Do not take aspirin seven days prior to the procedure" you can't assume that the patient has been taking aspirin. There must be other documentation in the record that the patient is taking aspirin.

NOTE:

- Some patients may be on ASA therapy even though they are taking an anti-coagulant medication. You should give numerator positive credit for ASA therapy by entering a date for aspirin therapy rather than counting it as a contraindication.

Clinical Contraindications:	**Contraindications to Aspirin or Anti-platelet Use:** Member has a contraindication to aspirin if they are prescribed an anti-coagulant. Anticoagulant list includes: • Warfarin (Coumadin) • Enoxaparin (Lovenox) Member may have a clinical contraindication to aspirin; a clinical contraindication can occur at any time; it does not need to happen within the measurement year. The following clinical contraindications are acceptable: 1. **NEW!** Active peptic ulcer 2. **NEW!** Bleeding disorders including hemophilia, von Willebrand's disease, Thrombocytopenia and severe liver disease. 3. Patients with *history* of a GI bleed 4. Patients with *any history* of an intracranial hemorrhage (ICH) 5. Patients allergic to aspirin or allergy or hypersentivity to NonSteroidal Anti-Inflammatory Drugs (NSAIDS) The following additional Clinical Contraindications are acceptable **IF** the provider specifically documents in the record that the patient is not on ASA therapy due to these contraindications: • Patients with uncontrolled hypertension -systolic blood pressure >180 mm Hg; -diastolic blood pressure >110 mm Hg • Any other provider documented reason for not being on ASA therapy **NOTES:** • Gastroesophageal reflux disease (GERD) is not automatically considered a contraindication, but may be included if specifically documented as such by the provider. • If abstractor is reviewing an EMR, the "snapshot" view includes only the most current medication list. Abstractors must check to be sure that this person was on aspirin therapy during the measurement year

8. Eye exam An eye screening for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- Retinal or dilated eye exam by an eye care professional in the measurement year (optometrist or ophthalmologist),.
- The MCO is also allowed to count toward the numerator a *negative* retinal exam by an eye-care professional with (no evidence of retinopathy) performed in the year prior to the measurement year.

Administrative A claim/encounter with one of the codes listed in Table CDC-G.

Table CDC-G Codes to Identify Eye Exams*

CPT Codes	CPT Category II**	HCPCS	ICD-9-CM Codes
67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107-67108, 67110, 67112, 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***	S0625**, S3000, S0620, S0621	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16 V72.0

* Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.
** The organization does not need to limit CPT Category II codes or HCPCS S0625 to an optometrist or an ophthalmologist. These codes indicate an eye exam was performed by an eye care professional.
***CPT Category II code 3072F can only be used if the claim/encounter was during measurement year because it indicates the member had "no evidence of retinopathy in the prior year." Additionally, because the coce definition itself indicates results were negative, an automated result is not required.

Medical record

At a minimum, documentation in the medical record must include one of the following:

a note or letter from an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional summarizing the date on which the procedure was performed and the results of a retinal evaluation performed by an eye-care professional, ***or***

a chart or photograph of retinal abnormalities indicating the date on which the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center, as long as it operates under the direction of a medical director who is a retinal specialist.

9. 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. This measure is intended to assess if diabetic patients are being monitored for nephropathy. The MCO is allowed to count toward the numerator:

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

Nephropathy Screening Test

Administrative A nephropathy screening test during the measurement year Table CDC-J.

Evidence of Nephropathy

- A nephrologist visit during the measurement year, as identified by the MCO'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-J: Codes to Identify Nephropathy Screening Tests

Description	CPT Codes	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, 34535-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50561-0, 50949-7, 53121-0, 53525-2, 53530-2

Table CDC-K: Codes to Identify Evidence of Nephropathy

Description	CPT	CPT Category II	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB-92 Revenue	UB Type of Bill	POS	LOINC*
Urine macro-albuminuria test*	81000-81003, 81005	3062F							5804-0, 20454-5, 24356-8, 24357-6,50556-0, 50561-0, 50564-4
Evidence of treatment for nephropathy	36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512	3066F	G0257, G0314-G0319, G0322, G0323, G0326, G0327, GO392, GO393, S9339	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0 ***V Codes:*** V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6,	0367, 080x, 082x,-085x, 088x	72x	65	
ACE inhibitor/ARB therapy		4009F							

*A CPT Category II code indicates a positive result for urine macroalbumin; MCOs 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	Drugs			
Angiotensin converting enzyme inhibitors	benazepril captopril ramipril	enalapril fosinopril trandolaprilt	lisinopril moexipril	perindopril quinapril
Angiotensin II inhibitors	candesartan eprosartan irbesartan losartan	olmesartan telmisartan valsartan		

Antihypertensive combinations	*Amlodipine-benazepril* *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
Angiotensin converting enzyme inhibitors	*benazepril* captopril	*enalapril* fosinopril	*lisinopril* moexipril

Note: *NCQA will provide a comprehensive list of NDC codes on its Web site at www.ncqa.org by November 15, 2008.*

Medical record ***Nephropathy screening test***. At a minimum, documentation in medical record must include a note indicating the date on which a urine microalbumin test was performed, and the result. The MCO may count notation of the following in the medical record for 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 criteria for evidence of nephropathy:

- Documentation of a visit to a nephrologist
- Documentation of medical attention for any of the following (no restriction on provider type)
    - Diabetic nephropathy
    - End-stage renal disease (ESRD)
    - Chronic renal failure (CRF)
    - Chronic kidney disease (CKD)
    - Renal insufficiency
    - Proteinuria
    - Albuminuria
    - Renal dysfunction
    - Acute renal failure (ARF)
    - Dialysis, hemodialysis or peritoneal dialysis

- A positive urine mactroalbumin test. At a minimum, documentation in medical record must include a note indicating the date on which the test was performed, and a positive result. Any of the following meet criteria for a positive urine macroalbumin test.
    - Positive urinalysis (random, spot or time) 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 mactroalbumin 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 within the measurement year.

Exclusions *(optional):*

- Exclude members with a diagnosis of polycystic ovaries who did not have any face-to-face encounters with the diagnosis of diabetes (CDC-B), in any setting, during the measurement year or year prior to the measurement year. Diagnosis of polycystic ovaries can occur at any time in the member's history, but must have occurred by December 31 of the measurement year. Use the codes in Table CDC-O to identify a diagnosis of polycystic ovaries.
- Exclude any members with gestational diabetes or steroid-induced diabetes, who did not have any face-to-face encounters with the diagnosis of diabetes (CDC-B) (in any setting), during the measurement year or year prior to the measurement year. Diagnosis of gestational diabetes or steroid-induced diabetes can occur during the measurement year or year prior to the measurement year, but must have occurred by December 31 of the measurement year. Use the codes in Table CDC-O to identify gestational diabetes and steroid-inducted diabetes.

Table CDC-O: Codes to Identify Exclusions

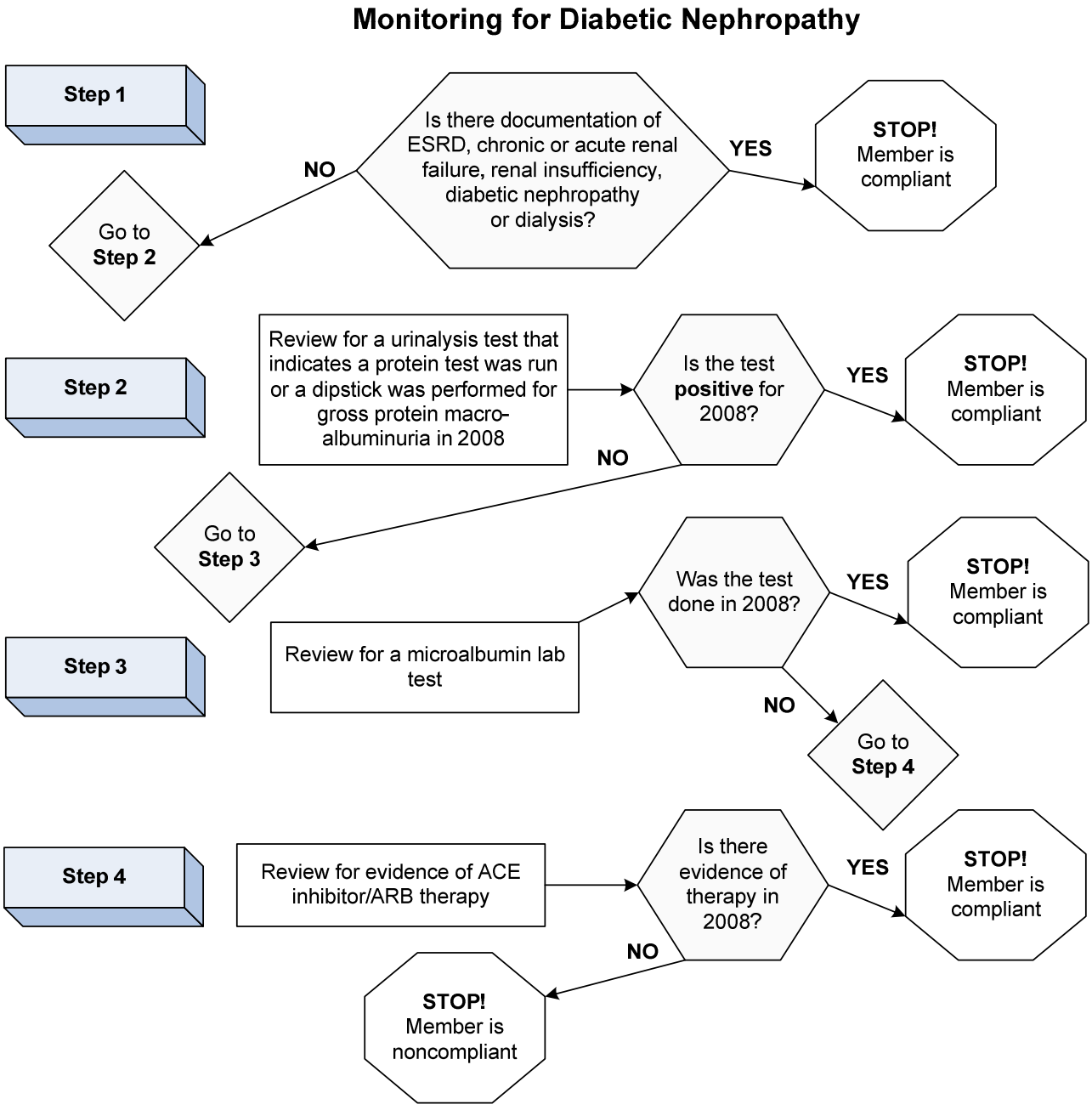
Description	ICD-9-CM Codes
Polycystic ovaries	256.4
Steroid induced	251.8, 962.0
Gestational diabetes	648.8

Notes:

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

*Blindness is **not** an exclusion for a diabetic eye exam due to the difficulty of distinguishing between individuals who are legally blind but who require a retinal exam and those who are completely blind and therefore do not require an exam.*

Monitoring for Diabetic Nephropathy need to change year from 2007 to 2008 in diagram below**



Products Containing Aspirin, Anti-platelets and Anti-coagulants for MNCM 2009 Reporting (2008 dates of service)

Products Containing Aspirin		
1/2HALFPRIN TAB 162MG EC	BAYER ASA TAB 325MG	ENDODAN TAB
ADLT ASA LOW TAB 81MG EC	BUFFERED ASA TAB 325MG	EXCEDRIN TAB EX STR
ANACIN TAB 400-30MG	BUT/ASA/CAF/ CAP COD 30MG	FIORINAL CAP
ASA LO-DOSE TAB 81MG EC	BUT/ASA/CAFF CAP	FIORINAL/COD CAP 30MG
ASA LOW DOSE TAB 81MG EC	BUT/ASA/CAFF TAB	FORTABS TAB
ASA/CODEINE TAB 325-30MG	BUTALBITAL CAP CPD	GENACED TAB
ASCOMP CAP COD 30MG	BUTALBITAL TAB CPD	GENACOTE TAB 325MG EC
ASPIR-81 TAB 81MG EC	BUTALBITAL-ASA-CAFF W/ CODEINE	HCA ASPIRIN TAB 325MG
ASPIRIN	BUTALBITAL-ASPIRIN-CAFFEINE	HCA ASPIRIN TAB 325MG EC
ASPIRIN CHW 81MG	CARISOPR/ASA TAB 200-325	HCA ASPIRIN TAB 81MG
ASPIRIN TAB 325MG	CARISOPRODOL TAB ASA/COD	LO-DOSE ASA TAB 81MG EC
ASPIRIN TAB 325MG EC	CARISOPRODOL W/ ASPIRIN	ORPHEN CPD TAB DS
ASPIRIN TAB 81MG E/C	CARISOPRODOL W/ ASA & CODEINE	ORPHENADRINE TAB CPD
ASPIRIN TAB 81MG EC	CHILD ASA CHW 81MG	ORPHENADRINE W/ ASA & CAFF
ASPIRIN BUFF TAB 325MG	CHO MAG TRIS TAB 500MG	OXYCOD/ASA TAB
ASPIRIN BUFFERED	CHO MAG TRIS TAB 750MG	OXYCODONE W/ ASPIRIN
Aspirin Buff (Ca Carb-Mg Carb-Mg Ox)	CHOLINE & MAGNES SALICYLATES	PERCODAN TAB
ASPIRIN CHLD CHW 81MG	CVS ASPIRIN TAB 325MG	SM ASA CHLD CHW 81MG
ASPIRIN EC TAB 325MG	CVS ASPIRIN TAB 325MG EC	SM ASPIRIN CHW 81MG
ASPIRIN W/ CODEINE	CVS ASPIRIN TAB 81MG EC	SM ASPIRIN TAB 325MG
ASPIRIN-ACETAMINOPHEN-CAFFEIN	EC ASPIRIN TAB 325MG	SM ASPIRIN TAB 325MG EC
ASPIRIN-CAFFEINE	ECOTRIN LOW TAB 81MG EC	SM ASPIRIN TAB 81MG EC
ASPIR-LOW TAB 81MG EC	ECPIRIN TAB 325MG EC	

Oral Anti-Platelet Medications		
Aggrenox® (aspirin and dipyridamole)	Clopidogrel (Plavix®)	Pletal® (cilostazol)
Aspirin and dipyridamole (Aggrenox®)	Dipyridamole (Persantine®)	Pravigard Pac® (aspirin/pravastatin)
Aspirin and pravastatin (Pravigard Pac®)	Plavix® (dipyridamole)	Ticlid® (ticlodipine)
Cilostazol (Pletal®)	Persantine® (dipyridamole)	Ticlodipine (Ticlid®)

Injectable Anti-Platelet Medications		
Abciximab (ReoPro®) injectable	Tirofiban (Aggrastat®) injectable	Eptifibatide (Integrelin®) Injectable

2009 MN Community Measurement (MNCM)
Optimal Vascular Care (OVC)
Technical Specifications

Introduction: MN Community Measurement has developed a methodology that allows for the aggregation of managed care data at the medical group level. "Optimal Vascular Care" is an expanded version of the HEDIS Cholesterol Management for Patients with Cardiovascular Conditions (CMC) measure based on the Institute for Clinical Systems Improvement (ICSI) guideline recommendations. The HEDIS components of this measure are based on the CMC specifications in HEDIS 2009, Vol. 2. For purposes of MNCM, the specifications for some numerator components were modified.

Modified HEDIS specifications for additional MNCM-specific components are shaded in gray. (HEDIS is a registered trademark of the National Committee for Quality Assurance)

Definition: The percentage of members 18-75 years of age as of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1 –November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had each of the following during the measurement year.

- LDL-C screening
- LDL-C control (<100 mg/dL)
- Blood Pressure Reading performed
- Blood Pressure control <130/80
- On Daily Aspirin Therapy
- Documented Tobacco Free

Members in the eligible population will be attributed to a Provider Group (Primary Care and Cardiology) for purposes of MNCM public reporting. *See 2009 MNCM Member/Patient Attribution Methodology.*

Method Hybrid

Reporting Level: Optimally managed and individual risk factors by:
-Selected provider group level
-Community level

Ages included: 18-75 as of December 31 of the measurement year.

Products: Product lines will be combined for public reporting of results.
Commercial (HMO/POS), Medicaid, Medicare Advantage, Medicare Cost, MSHO
Medicare FFS

Continuous Enrollment: Continuously enrolled within the MCO for two years (as of December 31 during the reporting year and the year prior to the reporting year), with not more than one gap of up to 45 days break in coverage during each year of continuous enrollment.

Medical Group Sample Size: A minimum of 60 members per selected medical group + 15% oversample. The population size for medical groups must be >= 60.

Anchor Date: Enrolled as of December 31 of the measurement year.

Sampling method: Random sample by provider group – Primary Care and Cardiology groups

Reported: All provider groups sampled with minimum 60 observations.

Denominator: A systematic sample drawn from the eligible population.

Event/ diagnosis

Members are identified for the eligible population in two ways: event or diagnosis.

The organization must use *both* to identify the eligible population, but a member only needs to be identified in one to be included in the measure.

Event. Discharged alive for AMI, CABG or PTCA on or between January 1 and November 1 of the year prior to the measurement year. Refer to Table CMC-A for codes to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, ED).

Table CMC-A: Codes to Identify AMI, PTCA and CABG

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
AMI (inpatient only)			410.x1	
CABG (inpatient only)	33510-33514, 33516-33519, 33521-33523, 33533-33536,	S2205-S2209		36.1, 36.2
PTCA	33140, 92980, 92982, , 92995			00.66,36.06, 36.07, 36.09

Diagnosis. Identify members as having IVD who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

At least one outpatient visit (**Table CMC-C**) with any IVD diagnosis (**Table CMC-B**), ***or***

At least one acute inpatient visit (**Table CMC-C**) with any IVD diagnosis (**Table CMC-B**)

Table CMC-B: Codes to Identify IVD

Description	ICD-9-CM Diagnosis
IVD	411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445

Table CMC-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	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, 0982, 0983
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

Numerator:	Persons must be included in the denominator and met all **four targets** for optimal management of vascular care.
1. Tobacco Non-User:	Documentation in medical record as non-tobacco user defined as:
Tobacco Non-User ***Medical Record***	• **Through the chart (any year) there is documentation that supports the member doesn't use tobacco.** A label or mark anywhere on the chart or general forms like a problem list or the most recent visit progress note that shows the patient has been asked at least once and reported not using tobacco. **NOTE:** If tobacco status changes during measurement year, use most recent status available as of 12/31/08.
2. Blood Pressure level <130/80 mm Hg:	The most recent BP <130/80 mm Hg (taken during the measurement years) as documented through administrative or medical record review.
Administrative	Identify the most *recent* BP during the measurement year using automated data. Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP The member is numerator compliant if the most recent reading is <130/80 mm Hg. If the reading for the most recent BP is >=130/80 mm Hg or if there is no automated BP reading taken during the measurement year, the member is not compliant.
Medical Record:	A BP <130/80 mm Hg as documented through medical record review.

	To determine if a member's BP is adequately controlled, the MCO must identify the representative BP. The MCO should follow the steps below to determine representative BP. Identifying the medical record: The MCO should use the medical record from which it abstracts data for the other OVC indicators. If the MCO does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the MCO may use the medical record of another PCP or specialist from which the member receives care. **STEP 1** Identify the most recent BP reading notated during the measurement year. • Do not include BP readings taken during an acute inpatient stay or ED visit. • Do not include BP readings from outpatient visits which were for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole). • Do not include BP readings obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) or at an emergency room visit. • Do not include BP readings taken by the member/patient. **STEP 2** • Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.
LDL-C screening	An LDL-C test performed during the measurement year as determined by administrative data or medical record review.
Administrative	An LDL-C test performed any time during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in Table CMC-D. The MCO may use a calculated LDL or LDL-C screening and control indicators.

Table CMC-D: 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, 24331-1, 39469-2, 49132-4

Medical Record: Documentation in the medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result.

3. LDL Level <100 mg/dL

Administrative Using automated laboratory data, the member is numerator compliant if the most recent LDL-C level during the measurement year is <100 mg/dL or is noncompliant if the automated result for the most recent LDL-C test is >=100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year.
NOTE: Test level must be taken from most recent test.

Medical Record Documentation in medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result.

Refer to the HEDIS 2009 Cholesterol Management for Patients with Cardiovasc Condition for information on how to calculate LDL-C from total cholesterol, HDL triglycerides.

In cases where the triglyceride is >400 or "triglycerides are too high to calculate.

4. Daily Aspirin Use or Documented Contraindication:

Percent of members aged 18-75 as of 12/31 of the measurement year with vascular disease (as defined above) that had documentation of daily aspirin or anti-platelet use anytime during the measurement year or a documented contraindication.

Numerator

Members aged 18-75 as of December 31 of the measurement year with diabetes who had documentation of daily aspirin or anti-platelet use during the measurement year or have a documented contraindication to aspirin use. Two methods are provided to identify members with documented use of aspirin, anti-platelet use or a contraindication: pharmacy data or medical record data.

Pharmacy Data/Electronic Collection:

Aspirin or Anti-Platelet Use: Member is numerator compliant if he/she was dispensed aspirin (81-325mg daily), a product containing aspirin (see attached list) or anti-platelets (Using NDC code list). Use the most recent fill date to determine if the prescription is active in the measurement year.

Aspirin use includes:

- Low dose enteric coated (81mg) ASA (Ecotrin or Bayer)

Anti-platelet list includes:

- Dipyridamole (with aspirin = Aggrenox)
- Clopidogrel (Plavix)
- Ticlopidine (Ticlid)
- **NEW!** Pravigard (aspirin/pravastatin)

Contraindications to Aspirin or Anti-platelet Use: Member has a contraindication to aspirin if they are prescribed an anti-coagulant.

Anticoagulant list includes:

- Warfarin (Coumadin)
- Enoxaparin (Lovenox)

NOTE: Some patients may be on ASA therapy even though they are taking an anti-coagulant medication. You should give numerator positive credit for ASA therapy rather than counting it as a contraindication.

Medical Record data:

Aspirin or Anti-Platelet Use: Member is numerator compliant if he/she has a dated medication list or progress note indicating the date on which aspirin, a product containing aspirin (see attached list) or an anti-platelet was prescribed. A prescription or notation from another treating physician indicating aspirin or anti-platelet taken during the measurement year is also acceptable.

Aspirin use includes:

- Low dose enteric coated (81mg) ASA (Ecotrin or Bayer).

Anti-platelet list includes:

- Dipyridamole (with aspirin = Aggrenox)
- Clopidogrel (Plavix)
- Ticlopidine (Ticlid)
- **NEW!** Pravigard (aspirin/pravastatin)

NOTES:

- If ASA has been discontinued prior to a surgical procedure **Do Not** count this as a contraindication, rather document this patient as taking aspirin during the measurement period.
- Conversely, if the only documentation of aspirin in the record is on a standard pre-op stating something like "Do not take aspirin seven days prior to the procedure" you can't assume that the patient has been taking aspirin. There must be other documentation in the record that the patient is taking aspirin.

Clinical Contraindications:

NOTE:

- Some patients may be on ASA therapy even though they are taking an anti-coagulant medication. You should give numerator positive credit for ASA therapy by entering a date for aspirin therapy rather than counting it as a contraindication.

Contraindications to Aspirin or Anti-platelet Use: Member has a contraindication to aspirin if they are prescribed an anti-coagulant.

Anticoagulant list includes:

- Warfarin (Coumadin)
- Enoxaparin (Lovenox)

Member may have a clinical contraindication to aspirin; a clinical contraindication can occur at any time; it does not need to happen within the measurement year.

The following clinical contraindications are acceptable:

1. **NEW!** Active peptic ulcer

2. **NEW!** Bleeding disorders including hemophilia, von Willebrand's disease, Thrombocytopenia and severe liver disease.

3. Patients with *history* of a GI bleed

4. Patients with *any history* of an intracranial hemorrhage (ICH)

5. Patients allergic to aspirin or allergy or hypersentivity to NonSteroidal

Anti-Inflammatory Drugs (NSAIDS)

The following additional Clinical Contraindications are acceptable **IF** the provider specifically documents in the record that the patient is not on ASA therapy due to these contraindications:

• Patients with uncontrolled hypertension

-systolic blood pressure >180 mm Hg; -diastolic blood pressure >110 mm Hg

• Any other provider documented reason for not being on ASA therapy

NOTES:

- Gastroesophageal reflux disease (GERD) is not automatically considered a contraindication, but may be included if specifically documented as such by the provider.

If abstractor is reviewing an EMR, the "snapshot" view includes only the most current medication list. Abstractors must check to be sure that this person was on aspirin therapy during the measurement year

Products Containing Aspirin, Anti-platelets and Anti-coagulants for MNCM 2009 Reporting (2008 dates of service)

Products Containing Aspirin		
1/2HALFPRIN TAB 162MG EC	BAYER ASA TAB 325MG	ENDODAN TAB
ADLT ASA LOW TAB 81MG EC	BUFFERED ASA TAB 325MG	EXCEDRIN TAB EX STR
ANACIN TAB 400-30MG	BUT/ASA/CAF/ CAP COD 30MG	FIORINAL CAP
ASA LO-DOSE TAB 81MG EC	BUT/ASA/CAFF CAP	FIORINAL/COD CAP 30MG
ASA LOW DOSE TAB 81MG EC	BUT/ASA/CAFF TAB	FORTABS TAB
ASA/CODEINE TAB 325-30MG	BUTALBITAL CAP CPD	GENACED TAB
ASCOMP CAP COD 30MG	BUTALBITAL TAB CPD	GENACOTE TAB 325MG EC
ASPIR-81 TAB 81MG EC	BUTALBITAL-ASA-CAFF W/ CODEINE	HCA ASPIRIN TAB 325MG
ASPIRIN	BUTALBITAL-ASPIRIN-CAFFEINE	HCA ASPIRIN TAB 325MG EC
ASPIRIN CHW 81MG	CARISOPR/ASA TAB 200-325	HCA ASPIRIN TAB 81MG
ASPIRIN TAB 325MG	CARISOPRODOL TAB ASA/COD	LO-DOSE ASA TAB 81MG EC
ASPIRIN TAB 325MG EC	CARISOPRODOL W/ ASPIRIN	ORPHEN CPD TAB DS
ASPIRIN TAB 81MG E/C	CARISOPRODOL W/ ASA & CODEINE	ORPHENADRINE TAB CPD
ASPIRIN TAB 81MG EC	CHILD ASA CHW 81MG	ORPHENADRINE W/ ASA & CAFF
ASPIRIN BUFF TAB 325MG	CHO MAG TRIS TAB 500MG	OXYCOD/ASA TAB
ASPIRIN BUFFERED	CHO MAG TRIS TAB 750MG	OXYCODONE W/ ASPIRIN
Aspirin Buff (Ca Carb-Mg Carb-Mg Ox)	CHOLINE & MAGNES SALICYLATES	PERCODAN TAB
ASPIRIN CHLD CHW 81MG	CVS ASPIRIN TAB 325MG	SM ASA CHLD CHW 81MG
ASPIRIN EC TAB 325MG	CVS ASPIRIN TAB 325MG EC	SM ASPIRIN CHW 81MG
ASPIRIN W/ CODEINE	CVS ASPIRIN TAB 81MG EC	SM ASPIRIN TAB 325MG
ASPIRIN-ACETAMINOPHEN-CAFFEIN	EC ASPIRIN TAB 325MG	SM ASPIRIN TAB 325MG EC
ASPIRIN-CAFFEINE	ECOTRIN LOW TAB 81MG EC	SM ASPIRIN TAB 81MG EC
ASPIR-LOW TAB 81MG EC	ECPIRIN TAB 325MG EC	

Oral Anti-Platelet Medications		
Aggrenox® (aspirin and dipyridamole)	Clopidogrel (Plavix®)	Pletal® (cilostazol)
Aspirin and dipyridamole (Aggrenox®)	Dipyridamole (Persantine®)	Pravigard Pac® (aspirin/pravastatin)
Aspirin and pravastatin (Pravigard Pac®)	Plavix® (dipyridamole)	Ticlid® (ticlodipine)
Cilostazol (Pletal®)	Persantine® (dipyridamole)	Ticlodipine (Ticlid®)

Injectable Anti-Platelet Medications		
Abciximab (ReoPro®) injectable	Tirofiban (Aggrastat®) injectable	Eptifibatide (Integrelin®) Injectable

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS 2009

Clarified that BP readings taken during an acute inpatient stay or ED visit should not be included.

Added UB Type of Bill code 72x to Table CBP-C.

Deleted DRGs from Table CBP-C.

Added POS code 65 to Table CBP-C.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.

Definitions

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high normal range).
Representative BP	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of HTN was made). If multiple BP measurements occur on the same date or are notated in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–85 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous 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 one-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	Medical.
Event/diagnosis	*Hypertensive.* A member is considered hypertensive if there is at least one outpatient encounter (Table CBP-B) with a diagnosis of HTN (Table CBP-A) during the first six months of the measurement year.

Table CBP-A: Codes to Identify Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

Table CBP-B: Codes to Identify Outpatient Visits

Description	CPT
Outpatient visits	99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line whose diagnosis of hypertension is confirmed by chart review. The organization may reduce the sample size using the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

To confirm the diagnosis of HTN, the organization must find notation of one of the following in the medical record on or before June 30 of the measurement year.

- HTN
- High BP (HBP)
- Elevated BP (↑BP)
- Borderline HTN
- Intermittent HTN
- History of HTN
- Hypertensive vascular disease (HVD)
- Hyperpiesia
- Hyperpiesis

The notation of HTN may appear anytime on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if HTN was treated or is currently being treated. The notation indicating a diagnosis of HTN may be recorded in any of the following documents.

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see ***Note*** at the end of this section)
- Office note
- Subjective, Objective, Assessment, Plan (SOAP) note
- Encounter form
- Telephone call record
- Diagnostic report
- Hospital discharge summary

Statements such as "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the *only* notations of HTN in the medical record.

The organization should use only the medical records of one practitioner or provider team for both the confirmation of the diagnosis of HTN and the representative BP. All eligible BP measurements recorded in the records from one practitioner or provider

Identifying the medical record

team (even if obtained by a different practitioner) should be considered (e.g., from a consultation note or other note relating to a BP reading from a health care practitioner or provider team). If the organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

The organization should use the following algorithm to find the appropriate medical record to review.

Step 1 Identify the member's primary care practitioner (PCP).

If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.

If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.

If a practitioner other than the member's PCP manages the HTN, the organization may use the medical record of that practitioner, instead.

Step 2 Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the organization may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.

If a member sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of HTN and BP reading may be identified through two different medical records.

If a member has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the member's HTN after June 30, the organization may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the organization may elect to use this chart for the most recent BP reading. If the member did not have any visits with the specialist prior to June 30 of the measurement year, the organization must go to another medical record to confirm the diagnosis of HTN.

Numerator

The number of members in the denominator whose most recent BP is adequately controlled during the measurement year. For a member's BP to be controlled, *both* the systolic and diastolic BP *must be* <140/90 (adequate control). To determine if a member's BP is adequately controlled, the organization must identify the representative BP.

Administrative

None.

Medical record

Follow the steps below to determine representative BP.

Step 1 Identify the most recent BP reading noted during the measurement year. The reading must occur after the date on which the diagnosis of HTN was made or confirmed. Do not include BP readings that meet the following criteria.

BPs taken during an acute inpatient stay or an ED visit

BPs taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)

BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)

BP readings taken by the member

Step 2 Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

Exclusions *(optional)*

Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (Table CBP-C) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

Exclude from the eligible population all members with a diagnosis of pregnancy (Table CBP-C) during the measurement year.

Exclude from the eligible population all members who had an admission to a nonacute inpatient setting any time during the measurement year. Refer to Table FUH-B for codes to identify nonacute care.

Table CBP-C: Codes to Identify Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS
Evidence of ESRD	36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512	G0257, G0308-G0313 G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339	585.5, 585.6, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.6	0367, 080x, 082x-085x, 088x	72x	65
Pregnancy			630-677, V22, V23, V28				

Note

The organization may use an undated notation of HTN on problem lists. Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator.

Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of HTN.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CBP-1/2/3: Data Elements for Controlling High Blood Pressure

	Hybrid
Measurement year	✓
Data collection methodology (Hybrid)	✓
Eligible population	✓
Number of numerator events by administrative data in eligible population (before exclusions)	✓
Current year's administrative rate (before exclusions)	✓
Minimum required sample size (MRSS) or other sample size	✓
Oversampling rate	✓
Final sample size (FSS)	✓
Number of numerator events by administrative data in FSS	✓
Administrative rate on FSS	✓
Number of original sample records excluded because of valid data errors	✓
Number of records excluded because of false positive diagnoses	✓
Number of administrative data records excluded	✓
Number of medical record data records excluded	✓
Number of employee/dependent medical records excluded	✓
Records added from the oversample list	✓
Denominator	✓
Numerator events by administrative data	✓
Numerator events by medical records	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Use of Appropriate Medications for People With Asthma (ASM)

SUMMARY OF CHANGES TO HEDIS 2009

Clarified dispensing event and inhaler dispensing event criteria.

Clarified in step 2 that a member prescribed a leukotriene modifiers only need at least one diagnosis of asthma in the same year as the leukotriene modifier dispensing event.

Deleted CPT code 99499 from Table ASM-B.

Added the following sentence to the end of Definitions-Dispensing Event: For two prescriptions dispensed on the same day, sum the days supply to determine the number of dispensing events.

Description

The percentage of members 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Definitions

Dispensing event

A **dispensing event** is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled. For two different prescriptions dispensed on the same day, sum the days supply to determine the number of dispensing events.

Inhaler dispensing event

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 (as identified by Drug ID in the NDC list) filled on the same date of service should be counted as one dispensing event; for example a member may obtain two inhalers on the same day (one for home and one for work), but intend to use both during the same 30-day period. The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Eligible Population

Product lines

Commercial, Medicaid (report each product line separately).

Ages

5–56 years by December 31 of the measurement year. Report three age stratifications and a total rate.

5–9 years	18–56 years
10–17 years	Total

The total is the sum of the three numerators divided by the sum of the three denominators.

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 year.

Anchor date December 31 of the measurement year.

Benefits Medical. Pharmacy during the measurement year.

Event/ diagnosis Follow the steps below to identify the eligible population for the measure.

Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

At least one ED visit (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A)

At least one acute inpatient discharge (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A)

At least four outpatient asthma visits (Table ASM-B) with asthma as one of the listed diagnoses (Table ASM-A) and at least two asthma medication dispensing events (Table ASM-C)

At least four asthma medication dispensing events (Table ASM-C)

Table ASM-A: Codes to Identify Asthma

Description	ICD-9-CM Diagnosis
Asthma	493

Table ASM-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	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
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
ED	99281-99285	045x, 0981

Table ASM-C: Asthma Medications

Description	Prescriptions		
Antiasthmatic combinations	dyphylline-guaifenesin	guaifenesin-theophylline	potassium iodide-theophylline
Antibody inhibitor	omalizumab		
Inhaled steroid combinations	budesonide-formoterol	fluticasone-salmeterol	
Inhaled corticosteroids	beclomethasone budesonide	flunisolide fluticasone CFC free	mometasone triamcinolone
Leukotriene modifiers	montelukast	zafirlukast	zileuton
Long-acting, inhaled beta-2 agonists	aformoterol	formoterol	salmeterol
Mast cell stabilizers	cromolyn	nedocromil	
Methylxanthines	aminophylline dyphylline	oxtriphylline theophylline	
Short-acting, inhaled beta-2 agonists	albuterol levalbuterol	metaproterenol pirbuterol	

Note: *NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 14, 2008.*

Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also meet the following criterion.

Have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Administrative Specification

Denominator The eligible population.

Numerator Dispensed at least one prescription for a preferred therapy during the measurement year (Table ASM-D).

Table ASM-D: Preferred Asthma Therapy Medications

Description	Prescriptions		
Antiasthmatic combinations	dyphylline-guaifenesin	guaifenesin-theophylline	potassium iodide-theophylline
Antibody inhibitor	omalizumab		
Inhaled steroid combinations	budesonide-formoterol	fluticasone-salmeterol	
Inhaled corticosteroids	beclomethasone budesonide	flunisolide fluticasone CFC free	mometasone triamcinolone
Leukotriene modifiers	montelukast	zafirlukast	zileuton
Mast cell stabilizers	cromolyn	nedocromil	
Methylxanthines	aminophylline dyphylline	oxtriphylline theophylline	

Exclusion *(optional)*

Members diagnosed with emphysema or COPD (Table ASM-E) any time on or prior to December 31 of the measurement year.

Table ASM-E: 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

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ASM-1/2: Data Elements for Use of Appropriate Medications for People With Asthma

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO HEDIS 2009

Deleted CPT code 99499 from Table URI-B.

Description

The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Calculation

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics *were not* prescribed).

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 eligible episodes of treatment.

Episode Date The date of service for any outpatient or ED visit (Table URI-B) during the Intake Period with only a diagnosis of URI (Table URI-A). Exclude claims/encounters with more than one diagnosis.

IESD Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria.

- A 30-day Negative Medication History prior to the Episode Date
- A Negative Competing Diagnosis on or 3 days after the Episode Date
- The member was continuously enrolled 30 days prior to the Episode Date through 3 days after the Episode Date

Negative Medication History To qualify for Negative Medication History, the following criteria must be met.

- A period of 30 days prior to the Episode Date during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug
- No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date (Table CWP-C)

A prescription is considered **active** if the "days supply" indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Negative Competing Diagnosis The Episode Date and three days following the Episode Date during which the member had no claims/encounters with any competing diagnosis (Table URI-C).

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Ages Children 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.

Continuous enrollment 30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date Episode Date.

Benefits Medical and pharmacy.

Event/ diagnosis Outpatient or ED visit with only a diagnosis of URI during the Intake Period.

Follow the steps below to identify the eligible population:

Step 1 Identify all members who had an outpatient or ED visit (Table URI-B) with only a diagnosis of URI (Table URI-A) during the Intake Period. Exclude claims/encounters with more than one diagnosis.

Table URI-A: Codes to Identify URI

Description	ICD-9-CM Diagnosis
Acute nasopharyngitis (common cold)	460
URI	465

Table URI-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 077x, 0982, 0983
ED*	99281-99285	045x, 0981

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

Step 2 Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with a URI diagnosis.

Step 3 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date (Table CWP-C).

Step 4 Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis (Table URI-C) on or three days after the Episode Date.

Table URI-C: Codes to Identify Competing Diagnoses

Description	ICD-9-CM Diagnosis
Intestinal infections	001-009
Pertussis	033
Bacterial infection unspecified	041.9
Lyme disease and other arthropod-borne diseases	088
Otitis media	382
Acute sinusitis	461
Acute pharyngitis	034.0, 462
Acute tonsillitis	463
Chronic sinusitis	473
Infections of the pharynx, larynx, tonsils, adenoids	464.1-464.3, 474, 478.21-478.24, 478.29, 478.71, 478.79, 478.9
Prostatitis	601
Cellulitis, mastoiditis, other bone infections	383, 681, 682, 730
Acute lymphadenitis	683
Impetigo	684
Skin staph infections	686
Pneumonia	481- 486
Gonococcal infections and venereal diseases	098, 099, V01.6, V02.7, V02.8
Syphilis	090-097
Chlamydia	078.88, 079.88, 079.98
Inflammatory diseases (female reproductive organs)	131, 614-616
Infections of the kidney	590
Cystitis or UTI	595, 599.0

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6 Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for antibiotic medication (Table CWP-C) on or three days after the IESD.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table URI-1/2: Data Elements for Appropriate Treatment for Children With Upper Respiratory Infection

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Appropriate Testing for Children With Pharyngitis (CWP)

SUMMARY OF CHANGES TO HEDIS 2009

Deleted CPT code 99499 from Table CWP-B.

Added LOINC code 49610-9 to Table CWP-D (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Deleted LOINC code 11475-1 from Table CWP-D (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Description

The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

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 eligible episodes of treatment.

Episode Date

The date of service for any outpatient or ED visit (Table CWP-B) during the Intake Period with only a diagnosis of pharyngitis (Table CWP-A). Exclude claims/ encounters with more than one diagnosis.

IESD

Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria.

- Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date
- A 30-day Negative Medication History prior to the Episode Date
- The member was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date

Negative Medication History

To qualify for Negative Medication History, the following criteria must be met.

- A period of 30 days prior to the Episode Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug
- No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date (Table CWP-C)

A prescription is considered **active** if the "days supply" indicated on the date the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Ages Children 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.

Continuous enrollment 30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date None.

Benefits Medical and pharmacy.

Event/ diagnosis Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period.

Follow the steps below to identify the eligible population.

Step 1 Identify all members who had an outpatient or ED visit (Table CWP-B) with only a diagnosis of pharyngitis (Table CWP-A) during the Intake Period. Exclude claims/ encounters with more than one diagnosis.

Table CWP-A: Codes to Identify Pharyngitis

Description	ICD-9-CM Diagnosis
Acute pharyngitis	462
Acute tonsillitis	463
Streptococcal sore throat	034.0

Table CWP-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 077x, 0982, 0983
ED*	99281-99285	045x, 0981

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

Step 2 Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with only a diagnosis of pharyngitis.

Step 3 Determine if antibiotics (Table CWP-C) were dispensed for any of the Episode Dates. For each Episode Date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to three days after. Exclude Episode Dates if the member did not receive antibiotics on or three days after the Episode Date.

Table CWP-C: Antibiotic Medications

Description	Prescription	
Aminopenicillins	amoxicillin	ampicillin
Beta-lactamase inhibitors	amoxicillin-clavulanate	
First generation cephalosporins	cefadroxil cefazolin	cephalexin cephradine
Folate antagonist	trimethoprim	
Lincomycin derivatives	clindamycin	
Macrolides	azithromycin clarithromycin erythromycin erythromycin ethylsuccinate	erythromycin lactobionate erythromycin estolate erythromycin stearate
Miscellaneous antibiotics	erythromycin-sulfisoxazole	
Natural penicillins	penicillin G potassium penicillin G sodium	penicillin V potassium
Penicillinase-resistant penicillins	dicloxacillin	
Quinolones	ciprofloxacin gatifloxacin levofloxacin lomefloxacin	moxifloxacin ofloxacin sparfloxacin
Second generation cephalosporins	cefaclor cefprozil	cefuroxime loracarbef
Sulfonamides	sulfamethoxazole-trimethoprim	sulfisoxazole
Tetracyclines	doxycycline minocycline	tetracycline
Third generation cephalosporins	cefdinir cefixime cefpodoxime	ceftibuten cefditoren ceftriaxone

Note: *NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 14, 2008.*

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6 Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator A group A streptococcus test (Table CWP-D) in the seven-day period from three days prior to the IESD through three days after the IESD.

Table CWP-D: Codes to Identify Group A Streptococcus Tests

CPT	LOINC
87070, 87071, 87081, 87430, 87650-87652, 87880	626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 17656-0, 18481-2, 31971-5, 49610-9

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CWP-1/2: Data Elements for Appropriate Testing for Children With Pharyngitis

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO HEDIS 2009

Removed age stratifications.

Added HCPCS codes G0204, G0206 to Table BCS-A.

Added UB Revenue code 0401 to Table BCS-A.

Deleted CPT code 76083 from Table BCS-A.

Description

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
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.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
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 one of the codes in Table BCS-A.

Table BCS-A: Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
76090-76092, 77055-77057	G0202, G0204, G0206	V76.11, V76.12	87.36, 87.37	0401, 0403

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.

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.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table BCS-1/2/3: Data Elements for Breast Cancer Screening

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO HEDIS 2009

Added LOINC code 47528-5 to Table CCS-A.

Added CPT codes 58570–58573 to Table CCS-B.

Deleted HCPCS code G0101 from Table CCS-A. (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

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	Commercial, Medicaid (report each product line separately).
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	*Commercial:* The measurement year and the two years prior to the measurement year. *Medicaid:* 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.
Benefit	Medical.
Event/diagnosis	None.

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 one of the codes in Table CCS-A.

Table CCS-A: Codes to Identify Cervical Cancer Screening

CPT	HCPCS	ICD-9-CM Diagnosis	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	V72.32, V76.2	91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Exclusion *(optional)*

Women who had a hysterectomy with no residual cervix. Look as far back as possible in the member's history for evidence of hysterectomy through December 31 of the measurement year. Refer to Table CCS-B for codes to identify a hysterectomy.

Table CCS-B: Codes to Identify Exclusions

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Hysterectomy	51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, V67.01, V76.47	68.4-68.8

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 year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator One or more Pap tests during the measurement year or the two years prior to the measurement year as documented through either administrative data or medical record review.

Administrative Refer to the *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include the following.

A note indicating the date on which the test was performed, ***and***

The result or finding

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Exclusion *(optional)*

Refer to the *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix. The hysterectomy must have occurred by December 31 of the measurement year. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix has been removed.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CCS-1/2: Data Elements for Cervical Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO HEDIS 2009

Added HCPCS code G0394 to Table COL-A.

Clarified when result is required in the medical record documentation.

Added LOINC code 50196-5 in FOBT row to Table COL-A. (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Replaced in Numerator-Medical record section the following:

- Replaced first bullet: If the medical record indicates that fewer than three samples were returned but does not indicate the type of test, the member does not meet the criteria for inclusion in the numerator.
- Replaced second bullet: If the medical record indicates the type of test but does not indicate how many samples were returned, assume that the required number of samples was returned. (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Description

The percentage of members 50–80 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product lines	Commercial, Medicare (report each product line separately).
Ages	51–80 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.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerator One or more screenings for colorectal cancer. Appropriate screenings are defined by any 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
- Double contrast barium enema (DCBE) or air contrast barium enema 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 Diagnosis	ICD-9-CM Procedure	LOINC
FOBT	82270, 82274	G0107, G0328, G0394	V76.51		2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 50196-5
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104		45.24	
DCBE	74280				
Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121		45.22, 45.23, 45.25, 45.42, 45.43	

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

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 year's 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 any 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
- DCBE or air contrast barium enema during the measurement year or the four years prior to the measurement
- Colonoscopy during the measurement year or the nine years prior to the measurement year

Administrative Refer to the *Administrative Specification* to identify positive numerator hits from the administrative data.

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, then 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 indicates that fewer than three samples were returned but does not indicate the type of test, the member does not meet the criteria for inclusion in the numerator.

If the medical record indicates the type of test but does not indicate how many samples were returned, assume that the required number of samples was returned.

Immunochemical (iFOBT) tests may require fewer than three samples. If the medical record indicates that fewer than three samples were returned and an iFOBT was done, the member meets the screening criteria for inclusion in the numerator.

Do not count the following as evidence of a colorectal screening.

Digital rectal exam because it is not specific or comprehensive enough to screen for colorectal cancer

Single contrast barium enema or notation of barium enema because they are not as specific or as comprehensive as the double contrast or air contrast barium enema

Exclusion *(optional)*

Refer to the *Administrative Specification* for exclusion criteria. 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.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table COL-2/3: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

2009 MN Community Measurement (MNCM)
Cancer Screening Combined (Ages 50-80)
Technical Specifications

Introduction: MN Community Measurement has developed a methodology that allows for the aggregation of managed care data at the medical group level. "Cancer Screening Combined (Ages 50-80)" is a composite version of the HEDIS Colrectal Cancer Screening (COL), Ceverical Cancer Screening (CCS) and Breast Cancer Screening (BCS) measure based on Institute for Clinical Systems Improvement (ICSI) guideline recommendations. The HEDIS components of this measure are based on the COL, CCS, and BCS specifications in HEDIS 2009, Vol. 2. For purposes of MNCM, the specifications for some numerator components were modified.

Modified HEDIS specifications for additional MNCM-specific components are shaded in gray. (HEDIS is a registered trademark of the National Committee for Quality Assurance)

Definition: The percentage of adults 50-80 years of age who were up-to-date for all appropriate cancer screening services (colorectal, breast, cervical). **Males need only be up-to-date for the colorectal cancer screening component to be considered up-to-date for the Cancer Screening Combined measure.**

Members in the eligible population will be attributed to a provider group for purposes of MNCM public reporting. See current year MNCM Member/Patient Attribution specifications for details.

Method: Hybrid/Administrative – Hybrid method for colorectal cancer screening; administrative method for breast and cervical cancer screening components.

Reporting Levels: Optimal Cancer Screening combined and individual components by:
-Selected provider group level
-Community level

Ages included: Ages 51-80 as of December 31st of the measurement year.

Products: Commercial (HMO/POS/PPO), Medicare Cost, Medicare Advantage, MSHO, Medicare FFS. Product lines will be combined for public reporting at provider group level.

Continuous Enrollment: Continuously enrolled during the measurement year and the year prior, with no more than a 45 day break in coverage each year of continuous enrollment.

Medical Group Size: A minimum of 60 members per selected medical group + 15% oversample. The population size for medical groups must be >=60.

Attribution: See current year MNCM Member/Patient Attribution Methodology.

Sampling Method: Random sample by provider group – Primary Care

Reported: All provider groups sampled that meet minimum 60 observations.

Measures: The percentage of adults (male and female) who were up-to-date for all appropriate cancer screening services. **Males receive a positive numerator hit if received colorectal cancer screening only**.

Denominator: Eligible members from the HEDIS 2008 Colorectal Cancer Screening hybrid sample (after administrative and medical record review exclusions – see below)

Numerator: Adults must be included in the denominator and must have had appropriate cancer screening services based on age and gender.

FEMALES

		AGE			
Service	**Timeframe**	**51-53**	**54-64**	**65-69**	**70-80**
Colon Cancer Screening		**x**	**x**	**x**	**x**
FOBT (set of 3), or	**In 2008**				
Flex sig, Double Contrast BE, or air contrast barium enema, or	**Last 5 years**				
Colonoscopy	**Last 10 yrs.**				
Breast Cancer Screening	**Last 2 years**	**x**	**x**	**x**	
Cervical Cancer Screening	**Last 3 years**	**x**	**x**		

MALES

		AGE
Service	**Timeframe**	**51-80**
Colon Cancer Screening		**x**
FOBT (set of 3), or	**in 2008**	
Flex sig or Double Contrast BE, or	**last 5 years**	
Colonoscopy	**Last 10 years**	

NOTE: For any given component, if exclusions apply, the member is considered up-to-date for that component.

Colon Cancer Screening: A member is considered up-to-date for **Colon Cancer Screening** if they were aged 51-80 and screened by December 31 of the measurement year.

Administrative

One or more screenings for colorectal cancer. Appropriate screenings are defined by any 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

Double contrast barium enema (DCBE) or air contrast barium enema 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 Diagnosis	ICD-9-CM Procedure	LOINC
FOBT	82270, 82274	G0107, G0328, G0394	V76.51		2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104		45.24	
DCBE	74280				
Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121		45.22, 45.23, 45.25, 45.42, 45.43	

Exclusion

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

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, then 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 indicates that fewer than three samples were returned but does not indicate the type of test, the member does not meet the screening criteria for inclusion in the numerator.

If the medical record indicates the type of test but does not indicate how many samples were returned, assume that the required number of samples were returned.

Immunochemical (iFOBT) tests may require fewer than three samples. If the medical record indicates that fewer than three samples were returned and an iFOBT was done, the member meets the screening criteria for inclusion in the numerator.

Do not count the following as evidence of a colorectal screening.

Digital rectal exam because it is not specific or comprehensive enough to screen for colorectal cancer

Single contrast barium enema or notation of barium enema because they are not as specific or as comprehensive as the double contrast or air contrast barium enema

Exclusion

Refer to the *Administrative Specification* for exclusion criteria. 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.

Numerator

Breast Cancer Screening:

A female (age 50-69) is considered up-to-date for **Breast Cancer Screening** for the Cancer Screening Combined measure, if they were screened or if they meet the exclusions criteria by December 31 of the measurement year. Screening includes one or more mammograms during the measurement year or the year prior to the measurement year. Exclusions include women who had a bilateral mastectomy. Refer to tables **BCS-A** and **BCS-B** to identify screenings and exclusions.

Table BCS-A: Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
76090-76092, 77055-77057	G0202, G0204, G0206	V76.11, V76.12	87.36, 87.37	0401, 0403

NOTE: A female over age 69 is also considered up-to-date.
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.

Numerator

Cervial Cancer Screening:
A female (age 50-64) is considered up-to-date for **Cervical Cancer Screening** for the Cancer Screening Combined measure, if they were screened or if they meet the exclusions criteria by December 31 of the measurement year. Screening includes one or more Pap tests during the measurement year or the two years prior to the measurement year. Exclusions include women who had a hysterectomy with no residual cervix. Refer to tables **CCS-A** and **CCS-B** in the *HEDIS 2009 Volume 2 Technical Specifications* to identify screenings and exclusions.

Table CCS-A: Codes to Identify Cervical Cancer Screening

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	LOINC
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V72.32, V76.2	91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Table CCS-B: Codes to Identify Exclusions

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Hysterectomy	51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, V67.01, V76.47	68.4-68.8

NOTE: A female over age 64 is also considered up-to-date.

Cancer Screening Combined:

A female member must be up-to-date for all three components to be considered up-to-date for the Cancer Screening Combined measure. Males need only be up-to-date for the colorectal cancer screening component to be considered up-to-date for the Cancer Screening Combined measure.

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO HEDIS 2009

Decreased upper age limit to 24 years.

Added ICD-9-CM Diagnosis code V73.81 to Table CHL-B.

Deleted ICD-9-CM Diagnosis code 078.10, 078.19 from Table CHL-B.

Added LOINC codes 47527-7, 47528-5 to Table CHL-B.

Added LOINC codes 34147-9, 34954-8, 40679-3, 40680-1, 41273-4, 41274-2, 43305-2, 43403-5,43798-8, 44543-7, 44544-5, 44546-0, 44547-8, 44549-4, 44550-2, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6,45095-7, 45098-1, 45100-5, 45327-4, 45331-6, 45332-4, 46731-6, 46989-0, 47211-8, 47212-6, 47236-5, 47237-3, 47238-1, 47387-6, 48030-1, 48039-2, 48560-7, 48781-9, 49096-1,49246-2, 49318-9, 49891-5, 49896-4, 50387-0, 50388-8, 50690-7, 51838-1, 51839-9 to Table CHL-B (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*)..

Deleted LOINC codes 16602-5, 20993-2, 23908-7 to Table CHL-B (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*)..

Added LOINC codes 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7,45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0 to Table CHL-C (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*)..

Delete LOINC codes 16602-5, 20993-2 from Table CHL-C. (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Eligible Population

Product lines

Commercial, Medicaid (report each product line separately).

Ages

Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate.

16–20 years

21–24 years

Total

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

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

Medical.

Event/diagnosis

Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use *both* methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.

Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (Table CHL-A).

Table CHL-A: Prescriptions to Identify Contraceptives

Description	Prescription	
Contraceptives	desogestrel-ethinyl estradiol	ethinyl estradiol-norgestimate
	drospirenone-ethinyl estradiol	ethinyl estradiol-norgestrel
	estradiol-medroxyprogesterone	etonogestrel
	ethinyl estradiol-ethynodiol	levonorgestrel
	ethinyl estradiol-etonogestrel	levonorgestrel-medroxyprogesterone
	ethinyl estradiol-levonorgestrel	medroxyprogesterone
	ethinyl estradiol-norelgestromin	mestranol-norethindrone
	ethinyl estradiol-norethindrone	
Diaphragm	diaphragm	
Spermicide	nonxynol 9	

Note: *NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 14, 2008.*

Claim/encounter data. Members who had at least one encounter during the measurement year with any code listed in Table CHL-B.

Table CHL-B: Codes to Identify Sexually Active Women

Description	Codes
CPT	11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84703, 86592-86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87660, 87800, 87801, 87808, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269
HCPCS	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0180, S0199, S4981, S8055
ICD-9-CM Diagnosis	042, 054.10, 054.11, 054.12, 054.19, 078.11, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 614-616, 622.3, 623.4, 626.7, 628, 630-677, 795.0, 996.32, V01.6, V02.7, V02.8, V08, V15.7, V22-V28, V45.5, V61.5-V61.7, V69.2, V72.3, V72.4, V73.81, V73.88, V73.98, V74.5, V76.2
ICD-9-CM Procedure	69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 97.24, 97.71, 97.73
UB Revenue	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925
LOINC	557-9, 560-3, 660-1, 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 1832-5, 1834-1, 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9,2114-7, 2115-4, 2118-8, 2119-6, 4993-2, 5028-6, 5291-0, 5292-8, 5392-6, 5393-4, 5394-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 6487-3, 6488-1, 6489-9, 6510-2, 6511-0, 6514-4, 6516-9, 6561-5, 6562-3, 7975-6, 8041-6, 10524-7, 10705-2, 11083-3, 11084-1, 11481-9, 11597-2, 12222-6, 12223-4, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 14509-4, 14510-2, 14513-6, 15019-3, 16280-0, 16600-9, 16601-7, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 18500-9, 19080-1, 19171-8, 19176-7, 19177-5, 19180-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 20403-2, 20404-0, 20415-6, 20507-0, 20508-8, 20994-0, 21189-6, 21190-4, 21191-2, 21192-0, 21198-7, 21414-8, 21415-5, 21416-3, 21440-3, 21441-1, 21613-5, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 23838-6, 24110-9, 24111-7, 24312-1, 24364-2, 25372-4, 25373-2, 26009-1, 29311-8, 30167-1, 31147-2, 31771-9, 31772-7, 31775-0, 31777-6, 31905-3, 31906-1, 31993-9, 32198-4, 32199-2, 32705-6, 33717-0, 33773-3, 34382-2, 34493-7, 34656-9, 34670-0, 34718-7, 35457-1, 36902-5, 36903-3, 38372-9, 42316-0, 42481-2, 42931-6, 43304-5, 43404-3, 43406-8, 47527-7, 47528-5, 34147-9, 34147-9, 34954-8, 40679-3, 40680-1, 41273-4, 41274-2, 43305-2, 43403-5, 43798-8, 44543-7, 44544-5, 44546-0, 44547-8, 44549-4, 44550-2, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 45327-4, 45331-6, 45332-4, 46731-6, 46989-0, 47211-8, 47212-6, 47236-5, 47237-3, 47238-1, 47387-6, 48030-1, 48039-2, 48560-7, 48781-9, 49096-1,49246-2, 49318-9, 49891-5, 49896-4, 50387-0, 50388-8, 50690-7, 51838-1, 51839-9

Denominator The eligible population.

Numerator At least one chlamydia test during the measurement year as documented through administrative data. A woman is counted as having had a test if she had a claim/ encounter with a service date during the measurement year with one or more of the codes in Table CHL-C.

Table CHL-C: Codes to Identify Chlamydia Screening

CPT	LOINC
87110, 87270, 87320, 87490, 87491, 87492, 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1,45100-5, 47211-8, 47212-6, 49096-1, 50387-0

Exclusion *(optional)*

Members who had a pregnancy test during the measurement year, followed within seven days (inclusive) by ***either*** a prescription for isotretinoin (Accutane) ***or*** an x-ray. This exclusion does not apply to members who qualify for the denominator based on services other than the pregnancy test alone. Refer to Table CHL-D for codes to identify exclusions.

Table CHL-D: Codes to Identify Exclusions

Description	CPT	UB Revenue	LOINC
Pregnancy test	81025, 84702, 84703	0925	2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0
WITH			
Diagnostic radiology	70010-76499	032x	
Prescription for isotretinoin			

Note: *An NDC list for isotretinoin will be available on the NCQA Web site (www.ncqa.org) by November 14, 2008.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CHL-1/2: Data Elements for Chlamydia Screening

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO HEDIS 2009

Revised the required number of doses for the Hib vaccine, per ACIP recommendations to defer the third Hib booster during vaccine shortage.

Deleted ICD-9-CM Procedure code 99.37 from Table CIS-A. Vaccine for acellular pertussis antigen only is no longer produced.

Clarified medical record review requirements for immunizations documented using a generic header of *DTaP/DTP/DT*.

Deleted CPT codes 90702, 90703, 90719 from Table CIS-A. Rationale: Because the member needs 4 DTaP for numerator compliance and because the vaccine for acellular pertussis antigen only is no longer produced, these codes cannot be used to demonstrate numerator compliance (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Deleted ICD-9-CM Procedure codes 99.36, 99.38 from Table CIS-A. Rationale: Because the member needs 4 DTaP for numerator compliance and because the vaccine for acellular pertussis antigen only is no longer produced, these codes cannot be used to demonstrate numerator compliance (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Description

The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), two H influenza type B (Hib), three hepatitis B, one chicken pox (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	Children who turn two years of age during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. 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	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	

For DTaP, IPV, Hib and pneumococcal conjugate, count *only* the following.

Evidence of the antigen or combination vaccine

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.

DTaP Four DTaP vaccinations, with different dates of service on or before the child's second birthday. Do not count any vaccination administered prior to 42 days after birth.

IPV At least three IPV vaccinations, with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted.

MMR At least one MMR vaccination, with a date of service falling on or before the child's second birthday.

Hib At least two Hib vaccinations, with different dates of service on or before the child's second birthday. Hib administered prior to 42 days after birth cannot be counted.

Note: *Due to the Hib shortage, only two of the three doses are required for HEDIS 2009.*

Hepatitis B Three hepatitis B vaccinations, with different dates of service on or before the child's second birthday.

VZV At least one VZV vaccination, with a date of service falling on or before the child's second birthday.

Pneumococcal conjugate At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday.

Combination 2 (DTaP, IPV, MMR, Hib, hepatitis B, VZV) Children who received four DTaP; three IPV; one MMR; two Hib; three hepatitis B; and one VZV vaccination on or before the child's second birthday.

Combination 3 (DTaP, IPV, MMR, Hib, hepatitis B, VZV, pneumococcal conjugate) Children who received all antigens listed in Combination 2 and four pneumococcal conjugate vaccinations on or before the child's second birthday.

Table CIS-A: Codes to Identify Childhood Immunizations

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
DTaP	90698, 90700, 90721, 90723			99.39
Diphtheria and tetanus***				
Diphtheria***				
Tetanus***				
IPV	90698, 90713, 90723			99.41
MMR	90707, 90710			99.48
Measles and rubella	90708			
Measles	90705		055	99.45
Mumps	90704		072	99.46
Rubella	90706		056	99.47
Hib	90645-90648, 90698, 90721, 90748			
Hepatitis B**	90723, 90740, 90744, 90747, 90748	G0010	070.2, 070.3, V02.61	
VZV	90710, 90716		052, 053	
Pneumococcal conjugate	90669	G0009		

* ICD-9-CM Diagnosis codes indicate evidence of disease.

** The two-dose hepatitis B antigen Recombivax is recommended for children between 11 and 14 years of age only and is not included in this table.

*** Because the member needs 4 DTaP for numerator compliance and because the vaccine for acellular pertussis antigen only is no longer produced, these codes cannot be used to demonstrate numerator compliance (Revised: *HEDIS 2009 Volumne 2 Technical Update 10/1/09*).

Exclusion *(optional)*

Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. An organization that excludes contraindicated children may do so only if the administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred on or before the second birthday. Refer to Table CIS-B for codes to identify exclusions.

Table CIS-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.4
DTaP	Encephalopathy	323.51* ***with*** (E948.4 or E948.5 or E948.6)
IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin	
MMR and VZV	Immunodeficiency, including genetic (congenital) immuno-deficiency syndromes	279
MMR and VZV	HIV disease; asymptomatic HIV	042, V08
MMR and VZV	Cancer of lymphoreticular or histiocytic tissue	200-202
MMR and VZV	Multiple myeloma	203
MMR and VZV	Leukemia	204-208
MMR and VZV	Anaphylactic reaction to neomycin	
Hepatitis B	Anaphylactic reaction to common baker's yeast	

* Use ICD-9-CM Diagnosis code 323.5 (with no fifth digit) to identify DTaP prior to October 1, 2006; the date of service must be before October 1, 2006.

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 for Combination 3 or the prior year's audited, product-line specific results for Combination 3. For information on reducing sample size, refer to the *Guidelines for Calculations and Sampling*.

Numerators

Count any of the following for MMR, hepatitis B and VZV.

Evidence of the antigen or combination vaccine, ***or***

Documented history of the illness, ***or***

A seropositive test result

Count *only* the following For DTaP, Hib, IPV and pneumococcal conjugate.

Evidence of the antigen or combination vaccine

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.

Administrative

Refer to the *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

For immunization evidence obtained from the medical record, the organization may count members where there is evidence that the antigen was rendered from one of the following.

A note indicating the name of the specific antigen and the date of the immunization, ***or***

A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, the organization must find a note indicating the date of the event. The event must have occurred by the member's second birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header of "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to any risk associated with data integrity.

Exclusion *(optional)*

Refer to the *Administrative Specification* for exclusion criteria. The exclusion must have occurred on or before the member's second birthday.

Note

NCQA follows the CDC and the ACIP guidelines for immunizations. HEDIS implements any changes to the guidelines (e.g., new vaccine recommendations) after three years to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CIS-1/2: Data Elements for Childhood Immunization Status

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 9 rates*
Current year's administrative rate (before exclusions)		*Each of the 9 rates*
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		*Each of the 9 rates*
Administrative rate on FSS		*Each of the 9 rates*
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 9 rates*	*Each of the 9 rates*
Numerator events by medical records		*Each of the 9 rates*
Reported rate	*Each of the 9 rates*	*Each of the 9 rates*
Lower 95% confidence interval	*Each of the 9 rates*	*Each of the 9 rates*
Upper 95% confidence interval	*Each of the 9 rates*	*Each of the 9 rates*