
ODM Methods for Clinical Performance Measures

**For
Medicaid Health Homes**

FINAL

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OVERVIEW

Methodology

These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in the NCQA HEDIS 2014 Technical Specifications manual. They were modified according to ODM’s preferences. All HEDIS requirements for continuous enrollment were removed for quarterly report periods; in general, the primary enrollment requirement for the Health Homes measures is that members must be enrolled in a Health Home during the last month of the report period. For purposes of the quarterly reporting, both the monthly enrollment span and a claim for payment of monthly Health Home case management code (i.e., S0281) will be used to identify enrollment. For annual reporting, traditional continuous enrollment criteria at the Health Home level have been applied to the measures. Health Home enrollment spans (with or without a corresponding payment for the monthly Health Home case management code) will be used to identify enrollment for annual reporting.

Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a code is presented to the third digit, any valid fourth or fifth digits may be used for reporting. When necessary, a code may be specified with an “x,” representing a required digit.

Data Sources

All appropriate managed care plan (MCP) encounter data, fee-for-service (FFS) claims data, and Health Home data will be used for the purposes of calculating these performance measures. The encounter and claims data will not be limited to Health Home claims.

Reporting Schedule

The table below displays the reporting schedule for each measure. It indicates the report periods for the measures and any measures that will no longer be reported.

Measures	Reporting Schedule		
	Annual Reporting (CY 2013)	Quarterly Reporting (CY 2014)	Measure No Longer Reported (Beginning CY 2014)
Use of Appropriate Medications for People with Asthma	X	X	
Cholesterol Management for Patients with Cardiovascular Conditions	X	X	
Controlling High Blood Pressure	X	X	
Comprehensive Diabetes Care: HbA1c Level Below 7.0 Percent	X	X	
Comprehensive Diabetes Care: Cholesterol Management	X	X	
Client Perception of Care—National Outcome Measure (SPMI Health Home)	X		X
Proportion of Days Covered of Medication	X		X
Schizophrenia—Annual Assessment of Weight/BMI, Glycemic Control, Lipids	X		X

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Measures	Reporting Schedule		
	Annual Reporting (CY 2013)	Quarterly Reporting (CY 2014)	Measure No Longer Reported (Beginning CY 2014)
Bipolar—Annual Assessment of Weight/BMI, Glycemic Control, Lipids	X		X
Screening for Clinical Depression and Follow-up Plan	X	X	
Follow-up After Hospitalization for Mental Illness	X	X	
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	X	X	
Smoking & Tobacco Use Cessation	X	X	
Percent of Live Births Weighing Less than 2,500 Grams	X		X
Timeliness of Prenatal Care	X		
Postpartum Care	X		X
Adult BMI Assessment	X	X	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	X		X
Adolescent Well-Care Visits	X	X	
Adults' Access to Preventive/Ambulatory Health Services	X	X	
Appropriate Treatment for Children with Upper Respiratory Infections	X	X	
Annual Dental Visit	X		X
Ambulatory Care—Sensitive Condition Admission	X	X	
Inpatient & ED Utilization—Rates	X	X	
All-Cause Readmissions	X	X	
Timely Transmission of Transition Record	X	X	
Medication Reconciliation Post-Discharge	X	X	

ASTHMA

Use of Appropriate Medications for People with Asthma (ASM)

The percentage of members 5 through 64 years of age with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Numerator: For each member in the denominator, those who had at least one prescription for an asthma controller medication during the report period (Table ASM-E).

Denominator (Annual Reporting): Members 5 through 64 years of age who had 11 or more months of enrollment in the Health Home during the reporting period, 11 or more months of enrollment in Medicaid during the year prior to the reporting period, and were identified as having persistent asthma during both the report period and the year prior to the report period (Table ASM-A).

Denominator (Quarterly Reporting): Members 5 through 64 years of age who were enrolled in the Health Home during the last month of the reporting period and were identified as having persistent asthma during both the report period and the year prior to the report period (Table ASM-A).

Exclusions: Exclude from the eligible population (i.e., denominator) all members diagnosed with emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, or acute respiratory failure (Table ASM-F) any time on or prior to the last day of the reporting period.

Report Periods:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table ASM-A: Methods to Identify Members with Persistent Asthma

Members must meet one of the four criteria below during both the reporting year and the year prior to the reporting year (criteria need not be the same across both years).

1. Member has at least one emergency department visit (Table ASM-C) with asthma as the principal diagnosis (Table ASM-B).
2. Member has at least one acute inpatient encounter (Table ASM-C) with asthma as the principal diagnosis (Table ASM-B).
3. Member has at least four outpatient asthma visits or observation visits (Table ASM-C) on different dates of service, with asthma as one of the listed diagnoses (Table ASM-B) and at least two asthma medication dispensing events (Table ASM-D). Visit type need not be the same for the four visits.
4. Member has at least four asthma medication dispensing events (i.e., an asthma medication dispensed on four occasions) (Table ASM-D).** A member with at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed will be excluded from the denominator unless the member also has at least one diagnosis of asthma (Table ASM-B) in any setting in the same year as the leukotriene modifier.

A list of NDC codes for the appropriate denominator (i.e., members with persistent asthma) asthma medications may be found at www.ncqa.org.

**Note: The definition of dispensing event differs depending on whether the drug is oral, an inhaler, or an injection. For oral medications, a dispensing event for oral medications is defined as one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions lasting longer than 30 days, divide the days supply by 30 and rounded down to convert. For example, a 100-day prescription is equal to 3 dispensing events ($100/30=3.33$, rounded down to 3).

Multiple prescriptions for different oral medications dispensed on the same day should be assessed separately. If multiple prescriptions for the same oral medication are dispensed on the same day, the organization should sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different (the Drug ID is obtained from NCQA's list of NDC codes).

- Two prescriptions for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).
- Two prescriptions for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).
- Two prescriptions for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).
- Two prescriptions for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of

Medication B on the same date, it would count as two dispensing events. Injections count as one dispensing event. Multiple dispensing events of the same medication or a different medication count as separate dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Table ASM-B: Codes to Identify Asthma

Diagnosis	ICD-9-CM Diagnosis Codes
Asthma	493.0, 493.1, 493.8, 493.9

Table ASM-C: Codes to Visit Type

Description	CPT Codes	UB Revenue Codes	HCPCS Codes
Acute Inpatient	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99291	0100, 0101, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987	
Emergency Department (ED) Services	99281-99285	045x, 0981	
Outpatient Visit	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455-99456	051x, 0520-0523, 0526-0529, 0982, 0983	G0402, G0438, G0439
Observation Visit	99217-99220		

Table ASM-D: Asthma Medications

Description	Prescriptions
Antiasthmatic combinations	<ul style="list-style-type: none"> • Dyphylline-guaifenesin • Guaifenesin-theophylline
Antibody inhibitor	<ul style="list-style-type: none"> • Omalizumab
Inhaled steroid combinations	<ul style="list-style-type: none"> • Budesonide-formoterol • Fluticasone-salmeterol • Mometasone-formoterol
Inhaled corticosteroids	<ul style="list-style-type: none"> • Beclomethasone • Budesonide • Ciclesonide • Flunisolide • Fluticasone CFC free • Mometasone • Triamcinolone
Leukotriene modifiers	<ul style="list-style-type: none"> • Montelukast • Zafirlukast • Zileuton
Long-acting, inhaled beta-2 agonists	<ul style="list-style-type: none"> • Aformoterol • Formoterol • Salmeterol
Mast cell stabilizers	<ul style="list-style-type: none"> • Cromolyn
Methylxanthines	<ul style="list-style-type: none"> • Aminophylline • Dyphylline • Theophylline
Short-acting, inhaled beta-2 agonists	<ul style="list-style-type: none"> • Albuterol • Levalbuterol • Metaproterenol • Pirbuterol
<i>NCQA provides a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org).</i>	

Table ASM-E: Asthma Controller Medications

Description	Prescriptions
Antiasthmatic combinations	<ul style="list-style-type: none"> • Dyphylline-guaifenesin • Guaifenesin-theophylline
Antibody inhibitor	<ul style="list-style-type: none"> • Omalizumab
Inhaled steroid combinations	<ul style="list-style-type: none"> • Budesonide-formoterol • Fluticasone-salmeterol • Mometasone-formoterol
Inhaled corticosteroids	<ul style="list-style-type: none"> • Beclomethasone • Budesonide • Ciclesonide • Flunisolide • Fluticasone CFC free • Mometasone • Triamcinolone
Leukotriene modifiers	<ul style="list-style-type: none"> • Montelukast • Zafirlukast • Zileuton
Mast cell stabilizers	<ul style="list-style-type: none"> • Cromolyn
Methylxanthines	<ul style="list-style-type: none"> • Aminophylline • Dyphylline • Theophylline
<i>NCQA provides a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org).</i>	

Table ASM-F: Codes to Identify Required Exclusions

Description	ICD-9-CM Diagnosis Codes
Emphysema	492
Other Emphysema	518.1, 518.2
COPD	493.2, 496
Cystic fibrosis	277.0
Acute respiratory failure	518.81
Obstructive Chronic Bronchitis	491.20, 491.21, 491.22
Chronic Respiratory Conditions Due to Fumes/Vapor	506.4

CARDIOVASCULAR CARE

Cholesterol Management for Patients with Cardiovascular Conditions (CMC)

The percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the report period, or who had a diagnosis of ischemic vascular disease (IVD) during the report period and the year prior to the report period, and who had an LDL-C control level of less than 100 mg/dL during the report period.

Numerator: The number of members in the denominator whose most recent LDL-C test (Table CMC-D) was less than 100 mg/dL (CPT II code 3048F).

Denominator (Annual Reporting): The number of members 18 to 75 years of age who had 11 or more months of enrollment in the Health Home during the reporting year, 11 or more months of enrollment in Medicaid during the year prior to the reporting period, and met one of the following below.

Denominator (Quarterly Reporting): The number of members 18 to 75 years of age who were enrolled in a Health Home during the last month of the reporting period and met one of the following below.

- Discharged alive for AMI, CABG, or PCI (Table CMC-A) during the year prior to the report period. AMI and CABG should be from inpatient claims/encounters only (Table CMC-C). All cases of PCI should be included, regardless of setting (e.g., inpatient, outpatient, emergency department [ED]).
- At least one IVD diagnosis (Table CMC-B) during either an outpatient or an acute inpatient encounter (Table CMC-C) in both the report period and the year prior to the report period.

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- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

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

Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes
AMI (include only inpatient claims)			410.x1	
CABG (include only inpatient claims)	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209		36.1, 36.2
PCI	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995	G0290		00.66, 36.06, 36.07

Table CMC-B: Codes to Identify IVD

Description	ICD-9-CM Diagnosis Codes
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 Codes	UB Revenue Codes	HCPCS Codes
Outpatient	99201-99205, 99211- 99215, 99241-99245, 99341-99345, 99347- 99350, 99381-99387, 99391-99397, 99401- 99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526- 0529, 0982, 0983	G0402, G0438, G0439
Acute inpatient	99221-99223, 99231- 99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130- 0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987	

Table CMC-D: Codes to Identify LDL-C Levels

Description	CPT Category II Codes
LDL-C less than 100 mg/dL	3048F
LDL-C 100-129 mg/dL	3049F
LDL-C greater than or equal to 130 mg/dL	3050F

Controlling High Blood Pressure (CBP)*

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 report period.

Numerator: The number of members in the denominator whose most recent BP (Table CBP-C) after the diagnosis of hypertension is adequately controlled. For a member’s BP to be adequately controlled, the systolic BP must be less than 140 (CPT II codes 3074F or 3075F) and the diastolic BP must be less than 90 (CPT II codes 3078F or 3079F).

Denominator (Annual Reporting): The number of members age 18 to 85 who had 11 or more months of enrollment in the Health Home during the reporting period and had at least one outpatient visit (Table CBP-B) with a diagnosis of hypertension (Table CBP-A) during the first six months of the report period.

Denominator (Quarterly Reporting): The number of members age 18 to 85 who were enrolled in the Health Home during the last month of the reporting period and had at least one outpatient visit (Table CBP-B) with a diagnosis of hypertension (Table CBP-A) during the first six months of the report period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
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- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table CBP-A: Codes to Identify Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

Table CBP-B: Codes to Identify Outpatient Visits

Description	CPT Codes
Outpatient visits	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table CBP-C: Codes to Identify BP Measurements

Description	CPT Category II Codes
Systolic blood pressure less than 130	3074F
Systolic blood pressure 130-139	3075F
Systolic blood pressure 140 or greater	3077F
Diastolic blood pressure less than 80	3078F
Diastolic blood pressure 80-89	3079F
Diastolic blood pressure 90 or greater	3080F

DIABETES CARE

Comprehensive Diabetes Care: HbA1c Level Below 7.0 Percent (CDC1)

The percentage of members 18–65 years of age with diabetes (Types 1 and 2) who had a Hemoglobin A1c (HbA1c) less than 7.0 percent.

Numerator: The number of members in the denominator whose most recent Hemoglobin A1c (HbA1c) test (Table CDC-F) had levels less than 7.0 percent (CPT Category II Code 3044F) during the report period. The member is not numerator compliant if the result for the most recent HbA1c test is greater than or equal to 7.0 percent or if an HbA1c test was not performed during the report period.

Denominator (Annual Reporting): The number of members with Type 1 or 2 diabetes (Table CDC-A) age 18 through 65 who had 11 or more months of enrollment in a Health Home during the reporting period.

Denominator (Quarterly Reporting): The number of members with Type 1 or 2 diabetes (Table CDC-A) age 18 through 65 who were enrolled in a Health Home during the last month of the reporting period.

Exclusions for HbA1c rate: For the HbA1c rate, exclude members from the denominator who meet any of the criteria provided below. Use Table CDC-E unless otherwise specified.

- *CABG:* Members discharged alive for CABG in the report period or the year prior to the report period. Refer to Table CDC-E and use codes for CABG only. CABG cases should be from inpatient claims/encounters only. Use both facility and professional claims to identify CABG.
- *PCI:* Member who had PCI in any setting during the report period or the year prior to the report period. Refer to Table CDC-E and use codes for PCI only. Include all cases of PCI, regardless of setting (e.g., inpatient, outpatient, ED).
- *IVD:* Members who met at least one of the following criteria during both the report period and the year prior to the report period. Criteria need not be the same across both years.
 - At least one outpatient visit (Table CDC-D) with an IVD diagnosis (Table CDC-E), *or*
 - At least one acute inpatient claim/encounter (Table CDC-D) with an IVD diagnosis (Table CDC-E)
- *Thoracic aortic aneurysm:* Members who met at least one of the following criteria during both the report period and the year prior to the report period. Criteria need not be the same across both years.
 - At least one outpatient visit (Table CDC-D) with a thoracic aortic aneurysm diagnosis (Table CDC-E), *or*
 - At least one acute inpatient claim/encounter (Table CDC-D) with a thoracic aortic aneurysm diagnosis (Table CDC-E).

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- *Chronic heart failure (CHF)*: Members who had at least one encounter, in any setting, with a code to identify CHF (Table CDC-E). Look as far back as possible in the member's history through the end of report period.
- *Prior myocardial infarction (MI)*: Members who had at least one encounter, in any setting, with any code to identify prior MI (Table CDC-E). Look as far back as possible in the member's history through the end of report period.
- *Chronic Kidney Disease (Stage 4)*: Members who had at least one encounter, in any setting, with a code to identify chronic kidney disease (stage 4) (Table CDC-E). Look as far back as possible in the member's history through the end of report period.
- *End stage renal disease (ESRD)*: Members who had at least one encounter, in any setting, with a code to identify ESRD (Table CDC-E). Look as far back as possible in the member's history through the end of report period.
- *Dementia*: Members who had at least one encounter, in any setting, with a code to identify dementia (Table CDC-E). Look as far back as possible in the member's history through the end of report period.
- *Blindness*: Members who had at least one encounter, in any setting, with a code to identify blindness (Table CDC-E). Look as far back as possible in the member's history through the end of report period.
- *Amputation (lower extremity)*: Members who had at least one encounter, in any setting, with a code to identify lower extremity amputation (Table CDC-E). Look as far back as possible in the member's history through the end of report period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
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- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table CDC-A: Methods to Identify Diabetic Members

Methods to Identify Diabetic Members*	
Method 1: Pharmacy	
Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-B).	
Method 2: Inpatient, Outpatient, & Emergency Department Visits	
Members who had:	
i.	Two (2) visits with different dates of service in an outpatient, observation, or nonacute inpatient setting (Table CDC-D) with a diagnosis of diabetes (Table CDC-C). Visit type need not be the same for the two visits, OR
ii.	One (1) visit in an acute inpatient <u>or</u> emergency department setting (Table CDC-D) with a diagnosis of diabetes (Table CDC-C)
<i>*To be included in the measure, a member needs to be identified using <u>only one</u> method. Members are included in the denominator if they are identified as diabetic in either the report period or the year prior to the report period.</i>	

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

Description	Prescription
Alpha-glucosidase inhibitors	<ul style="list-style-type: none"> • Acarbose • Miglitol
Amylin analogs	<ul style="list-style-type: none"> • Pramlintide
Antidiabetic combinations	<ul style="list-style-type: none"> • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Saxagliptin • Sitagliptin-simvastatin
Insulin	<ul style="list-style-type: none"> • Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin inhalation • Insulin isophane beef-pork • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human
Meglitinides	<ul style="list-style-type: none"> • Nateglinide • Repaglinide
Miscellaneous antidiabetic agents	<ul style="list-style-type: none"> • Exenatide • Linagliptin • Liraglutide • Metformin-repaglinide • Sitagliptin
Sodium glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> • Canagliflozin
Sulfonylureas	<ul style="list-style-type: none"> • Acetohexamide • Chlorpropamide • Glimepiride • Glipizide • Glyburide • Tolazamide • Tolbutamide
Thiazolidinediones	<ul style="list-style-type: none"> • Pioglitazone • Rosiglitazone

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. A comprehensive list of medications and NDC codes are available on NCQA’s Web site (www.ncqa.org).

Table CDC-C: Codes to Identify Diabetes

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

Table CDC-D: Codes to Identify Visit Type

Description	CPT Codes	UB Revenue Codes	HCPCS Codes
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 0982, 0983	G0402, G0438, G0439
Observation	99217-99220		
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x	
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987	
Emergency Department	99281-99285	045x, 0981	

Table CDC-E: Codes to Identify HbA1c Denominator Exclusions

Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes	UB Revenue Codes	UB Type of Bill	POS Codes
CABG	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209		36.1, 36.2			
PCI	92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995	G0290		00.66, 36.06, 36.07			

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Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes	UB Revenue Codes	UB Type of Bill	POS Codes
IVD			411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445				
Thoracic aortic aneurysm			441.01, 441.03, 441.1, 441.2, 441.6, 441.7				
MI			410, 412				
CKD/ESRD	36145, 36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0308-G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339	585.4, 585.5, 585.6, V45.1	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98	080x, 082x-085x, 088x	072X	65
Blindness			369.0, 369.1, 369.2, 369.4, 369.6, 369.7				

ODM Methods for Health Homes Clinical Performance Measures

Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes	UB Revenue Codes	UB Type of Bill	POS Codes
Amputation (lower extremity)	27290, 27295, 27590-27592, 27594, 27596, 27598, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28800, 28805, 28810, 28820, 28825			84.1			
CHF			425, 428				
Dementia			290, 291.2, 292.82, 294.0-294.2, 331.0, 331.1, 331.82				

Table CDC-F: Codes to Identify HbA1c Levels

Description	CPT Category II Codes
HbA1c <7.0%	3044F
HbA1c ≥7.0%	3045F, 3046F

Comprehensive Diabetes Care: Cholesterol Management (CDC2)

The percentage of members 18–75 years of age with diabetes (Types 1 and 2) who had: 1) LDL-C screening and 2) LDL-C level less than 100 mg/dL.

Numerator: The number of members in the denominator who met each of the following:

1. Had an LDL-C screening (Table CDC-G)
2. Whose most recent LDL-C screening (Table CDC-H) during the report period is less than 100 mg/dL (CPT Category II code 3048F). If the result for the most recent LDL-C test during the last quarter of the report period is ≥ 100 mg/dL or if an LDL-C test was not performed during the report period, the member is not numerator compliant.

Denominator (Annual Reporting): The number of members with Type 1 or 2 diabetes (Table CDC-A) age 18 through 75 who had 11 or more months of enrollment in a Health Home during the reporting period.

Denominator (Quarterly Reporting): The number of members with Type 1 or 2 diabetes (Table CDC-A) age 18 through 75 who were enrolled in a Health Home during the last month of the reporting period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

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

CPT	CPT Category II Codes
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F

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

Description	CPT Category II Codes
LDL-C <100 mg/dL	3048F
LDL-C 100-129 mg/dL	3049F
LDL-C ≥ 130 mg/dL	3050F

MANAGEMENT OF BEHAVIORAL HEALTH CONDITIONS

Client Perception of Care—National Outcome Measure (SPMI Health Home)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

Note: This measure will be specified and calculated by ODMH.

Proportion of Days Covered of Medication (PDC)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

The percentage of members who met the Proportion of Days Covered (PDC) threshold of 80 percent during the report period for cardiovascular disease, mental illness, diabetes, or asthma prescriptions.

Numerator: The number of members who meet the PDC threshold of 80 percent (Table PDC-A).

Denominator: The four separate denominators include members who filled at least one prescription for 1) cardiovascular disease, 2) mental illness, 3) diabetes, or 4) asthma (Table PDC-B) and who had 11 or more months of enrollment in a Health Home during the reporting period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013

Table PDC-A: Method to Determine Numerator Events

Steps to Determine Members with Greater than 80 Percent of Day Covered
1. Determine the index prescription date, which is the first occurrence during the report period of a prescription for a qualifying drug.
2. Determine the member's measurement period, defined as the index prescription date to the end of the calendar year, disenrollment, or death.
3. Within the report period, count the days the patient was covered by at least one prescription for each class based on the prescription fill date and days supply. If prescriptions for the same drug overlap, then adjust the prescription start date to the day after the previous fill has ended. To ensure that days supply that extends beyond the reporting year is not counted, subtract any days supply that extends beyond December 31 of the report period.
4. Divide the number of covered days (Step 3) by the number of days in Step 2. Multiply this number by 100 to obtain the PDC as a percentage.
5. Calculate the number of members who had a PDC greater than 80 percent of the days in their report period covered by medication.

Table PDC-B: Codes to Identify Denominator-Qualifying Medications

Description	Prescription		
Cardiovascular disease	Therapeutic class: A1A, A2A, A2C, A4A, A4B, A4C, A4D, A4F, A4G, A4H, A4I, A4J, A4K, A4T, A4U, A4V, A4W, A4X, A4Y, A4Z, A7B, A7C, A7E, A7H, A7J, A9A, J7A, J7B, J7C, J7E, J7G, J7H, M4D, M4E, M4I, M4J, M4L, M4M, M9L, M9P, M9T, M9V, R1F, R1H, R1K, R1L, R1M		
Mental illness	Therapeutic class: H2G, H2H, H2J, H2L, H2M, H2S, H2U, H2W, H2X, H7B, H7C, H7D, H7E, H7J, H7O, H7P, H7R, H7S, H7T, H7U, H7X, H7Z, H8H, H8I, H8J, H8P		
Diabetes	<ul style="list-style-type: none"> • acarbose • acetohexamide • chlorpropamide • exenatide • glimepiride • glimepiride-pioglitazone • glimepiride-rosiglitazone • glipizide • glipizide-metformin • glyburide • glyburide-metformin • insulin aspart • insulin aspart-insulin aspart protamine • insulin detemir • insulin glargine • insulin glulisine • insulin inhalation • insulin isophane human • insulin isophane-insulin regular human • insulin lispro • insulin lispro-insulin lispro protamine • insulin regular human • liraglutide • metformin-pioglitazone • metformin-repaglinide • metformin-repaglinide 5 • metformin-rosiglitazone • metformin-sitagliptin • miglitol • nateglinide • pioglitazone • pramlintide • repaglinide • rosiglitazone • saxagliptin • sitagliptin • tolazamide • tolbutamide 		
Asthma	<ul style="list-style-type: none"> • montelukast • theophylline • dyphylline • dyphylline-guaifenesin • triamcinolone • zileuton • formoterol • theophylline • albuterol • mometasone • formoterol-mometasone • salmeterol • fluticasone • pirbuterol • budesonide • aminophylline • cromolyn • salmeterol • fluticasone • fluticasone-salmeterol • budesonide-formoterol • potassium iodide-theophylline • metaproterenol • flunisolide • nedocromil • zafirlukast • levalbuterol • oxtriphylline • guaifenesin-theophylline • omalizumab • beclomethasone • ciclesonide CFC free • metaproterenol • guaifenesin-theophylline • arformoterol 		

Note: This list was provided by ODMH.

MENTAL ILLNESS OUTCOMES

Schizophrenia—Annual Assessment of Weight/BMI, Glycemic Control, Lipids (SSD1)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

The percentage of members 18-64 years of age diagnosed with schizophrenia, who were dispensed an antipsychotic medication, and received a BMI assessment, a glycemic control assessment, and a lipid screening during the report period.

Numerator: The number of members in the denominator who received a BMI assessment, a glycemic control assessment, and a lipid screening (Table SSD-D).

Denominator: The number of members ages 18-64 who had 11 or more months of enrollment in the Health Home during the reporting period, had a primary or secondary diagnosis of schizophrenia (Table SSD-B) on a Health Home claim, and who had at least two outpatient encounters on different days or one inpatient discharge (Table SSD-A) with a diagnosis of schizophrenia, and who were prescribed an antipsychotic medication (Table SSD-C).

Exclusions: Exclude members with diabetes. Identify diabetic members using the methods outlined in the Comprehensive Diabetes Care measure specifications. Exclude members who had no antipsychotic medications dispensed during the measurement year.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013

Table SSD-A: Codes to Identify Visit Type

Description	UB Revenue Codes		
Acute inpatient	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987		
	CPT Codes		POS Codes
	90791-90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	<i>WITH</i>	21, 51
Outpatient, intensive outpatient and partial hospitalization	CPT Codes		HCPCS Codes
	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	
	CPT Codes		POS Codes
	90791-90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	<i>WITH</i>	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
ED	CPT Codes		UB Revenue Codes
	99281-99285		045x, 0981
	CPT Codes		POS Codes
90791-90792, 90801, 90802, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	<i>WITH</i>	23	
Nonacute inpatient	CPT Codes		HCPCS Codes
	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	H0017-H0019, T2048	
		UB Revenue Codes	
		0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1000, 1001, 1003-1005	

	CPT Codes		POS Codes
	90791-90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	<i>WITH</i>	31, 32, 56

Table SSD-B: Codes to Identify Schizophrenia

Description	ICD-9-CM Diagnosis Codes
Schizophrenia	295

Table SSD-C: Codes to Identify Antipsychotic Medications

Description	Prescription			J-Codes
Miscellaneous antipsychotic agents	<ul style="list-style-type: none"> • Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone 	<ul style="list-style-type: none"> • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone 	<ul style="list-style-type: none"> • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone 	
Phenothiazine antipsychotics	<ul style="list-style-type: none"> • Chlorpromazine • Fluphenazine • Perphenazine 	<ul style="list-style-type: none"> • Perphenazineami triptyline • Prochlorperazine 	<ul style="list-style-type: none"> • Thioridazine • Trifluoperazine 	
Psychotherapeutic combinations	<ul style="list-style-type: none"> • Fluoxetine-olanzapine 			
Thioxanthenes	<ul style="list-style-type: none"> • Thiothixene 			
Long-acting injections	<ul style="list-style-type: none"> • Fluphenazine decanoate • Haloperidol decanoate 	<ul style="list-style-type: none"> • Olanzapine • Paliperidone palmitate 	<ul style="list-style-type: none"> • Risperidone 	J1631, J2358, J2426, J2680, J2794

Table SSD-D: Codes to Identify Required Assessments

Description	CPT Codes	CPT Category II Codes	ICD-9-CM Diagnosis Codes
BMI assessment	G8417-G8420	3008F, 2001F	V85.0-V85.4
Glycemic control assessment	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951,		
Lipid assessment	83036, 83037	3044F, 3045F, 3046F	

Bipolar Disorder—Annual Assessment of Weight/BMI, Glycemic Control, Lipids (SSD2)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

The percentage of members 18-64 years of age diagnosed with bipolar disorder, who were dispensed an antipsychotic medication, and received a BMI assessment, a glycemic control assessment, and a lipid screening.

Numerator: The number of members in the denominator with bipolar disorder who received a BMI assessment, a glycemic control assessment, and a lipid screening (Table SSD-D).

Denominator: The number of Health Home members 18-64 years of age who had 11 or more months of enrollment in the Health Home during the reporting period, had a primary or secondary diagnosis of bipolar disorder (Table SSD-E) on a Health Home claim, who had at least two outpatient encounters on different days or one inpatient discharge (Table SSD-A) with a diagnosis of bipolar disorder, and who were prescribed an antipsychotic medication (Table SSD-C).

Exclusions: Exclude members with diabetes. Identify diabetic members using the methods outlined in the Comprehensive Diabetes Care measure specifications. Exclude members who had no antipsychotic medications dispensed during the measurement year.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013

Table SSD-E: Codes to Identify Bipolar Disorder

Description	ICD-9-CM Diagnosis Codes
Bipolar disorder	296.0, 296.1, 296.4, 296.5, 296.6, 296.7

Screening for Clinical Depression and Follow-up Plan (SCD)*

The percentage of members 18 years of age and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Numerator: The number of members in the denominator who received screening and, if positive, a follow-up plan is documented on the date of the positive screen. Numerator compliance can be determined with either of two methods:

1. Codes to document clinical depression screen (Table SCD-B).
2. Codes that indicate screening for depression (Table SCD-C) occurring in conjunction with an ODMH service or visit with a mental health practitioner (Table SCD-D).

Denominator (Annual Reporting): Members age 18 years and older (as of the encounter date) who had a qualifying encounter (Table SCD-A) and were enrolled in the Health Home on the day of the encounter.

Denominator (Quarterly Reporting): Members age 18 years and older (as of the encounter date) who were enrolled in the Health Home during the last month of the reporting period and who had a qualifying encounter (Table SCD-A).

Exclusion: Members that had a diagnosis of depression (SCD-E) or bipolar disorder (Table SSD-E) in the 120 days prior to the screening.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table SCD-A: Codes to Identify Qualifying Encounters

CPT	HCPCS
90791, 90792, 90832, 90834, 90837, 90839, 90801, 90802, 90804-90809, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201-99205, 99212-99215	G0101, G0402, G0438, G0439, G0444

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table SCD-B: Codes to Document Clinical Depression Screen

Description	HCPCS
Positive screen for clinical depression using a standardized tool and a follow-up plan documented	G8431
Negative screen for clinical depression using a standardized tool, patient not eligible/appropriate for follow-up plan documented	G8510
Screening for clinical depression not documented, patient not eligible/appropriate	G8433
Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate	G8940
Clinical depression screening not documented, reason not given	G8432
Positive screen for clinical depression documented, follow-up plan not documented, reason not given	G8511

Table SCD-C: Codes to Identify Screening for Depression

CPT Codes	HCPCS
90801	H0031, G8511

Table SCD-D: Codes to Identify Mental Health Practitioner

Provider Type	Specialty Code
04	042
20	213
42	420
51	511, 512
65	213
72	213
84	840, 841

AND

Table SCD-E: Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis Codes
Major Depression	296.20-296.25, 296.30-296.35, 298.0, 311

Follow-up After Hospitalization for Mental Illness (FUH)*

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner, and who received follow-up within seven days of discharge.

Numerator: The number of discharges for which the member received follow-up on the date of discharge or within seven days of discharge. Follow-up includes:

- An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table FUH-D) with a mental health practitioner, or
- A transitional care management services (Table FUH-F) where the date of service on the claim is 29 days after the date the member was discharged with a principal diagnosis of mental illness.

Denominator (Annual Reporting): The number of discharges for members 6 years of age and older who were discharged alive from an acute inpatient setting with a principal mental illness diagnosis (Table FUH-A) during the first 11 months of the report period. Use only facility claims to identify discharges. Do not use diagnoses from professional claims. In addition, the member must have been enrolled in a Health Home on discharge through seven days after discharge.

Denominator (Quarterly Reporting): The number of discharges for members 6 years of age and older who were enrolled in a Health Home during the last month of the reporting period and were discharged alive from an acute inpatient setting with a principal mental illness diagnosis (Table FUH-A) during the first 11 months of the report period. Use only facility claims to identify discharges. Do not use diagnoses from professional claims. In addition, the member must have been enrolled in Medicaid on discharge through seven days after discharge.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table FUH-A: Codes to Identify Mental Illness Diagnosis

Description	ICD-9-CM Diagnosis Codes
Mental illness diagnosis	295–299, 300.3, 300.4, 301, 308, 309, 311–314

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

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the 11th month of the report period.

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

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

Table FUH-B: Codes to Identify Mental Health Diagnosis for Readmissions/Transfers

Description	ICD-9-CM Diagnosis Codes
Mental health diagnosis	290, 293-302, 306-316

Table FUH-C: Codes to Identify Nonacute Care

Description	HCPCS	UB Revenue Codes	UB Type of Bill	POS Codes
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	081x, 082x	34
SNF		019x	021x, 022x, 028x	31, 32
Hospital transitional care, swing bed or rehabilitation			018x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Table FUH-D: Codes to Identify Visits

CPT Codes		HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner (Table FUH-E).		
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510		G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
CPT Codes		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner (Table FUH-E).		
90791, 90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	<i>WITH</i>	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	<i>WITH</i>	52, 53
CPT Category II		Modifier
1110F	<i>WITH</i>	U4
UB Revenue Codes		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

Table FUH-E: Methods to Identify Mental Health Practitioner

Provider Type	WITH	Specialty Codes
04	<i>WITH</i>	042
20	<i>WITH</i>	213
42	<i>WITH</i>	420
51	<i>WITH</i>	511 or 512
65	<i>WITH</i>	213
72	<i>WITH</i>	213
84	<i>WITH</i>	840 or 841

Table FUH-F: Codes to Identify Transitional Care Management Services

CPT Code
99495

SUBSTANCE ABUSE

Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)*

***Initiation:** The percentage of members diagnosed with AOD dependence who initiate treatment through an inpatient AOD admission or an outpatient service with an AOD service within 14 days of diagnosis.*

***Engagement:** The percentage of members who initiated treatment and who have two or more additional AOD services within 30 days after the date of the initiation visit.*

Numerator:

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

1. Identify all members in the denominator whose index episode was an inpatient discharge with any AOD diagnosis. This visit counts as the initiation event.
2. Identify all members in the denominator whose index episode start date was an outpatient, intensive outpatient, partial hospitalization, detoxification, or emergency department visit. Use
3. Table IET-B and Table IET-A to determine if the members had an additional outpatient visit or inpatient admission with any AOD diagnosis within 14 days of the index episode start date (inclusive). If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the index episode start date (inclusive). If the index episode start date and the initiation visit occur on the same day, they must be with different providers in order to count.
4. Exclude from the denominator members whose initiation service was an inpatient stay with a discharge date during the last month of the report period.
5. Note: Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment.

Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period. If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive). Do not count engagement encounters that include detoxification codes (including inpatient detoxification).

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Denominator (Annual Reporting): Members 13 years and older who were enrolled in a Health Home 60 days prior to the index episode start date through 44 days after the index episode start date and had a new episode of AOD during the first ten and a half months of the report period. Follow the steps below to determine new episodes of AOD.

Denominator (Quarterly Reporting): Members 13 years and older who were enrolled in a Health Home during the last month of the reporting period and had a new episode of AOD during the first ten and a half months of the report period. Follow the steps below to determine new episodes of AOD.

Step 1: Identify the index episode. Identify members who had one of the following during the first ten and a half months of the report period.

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

Step 2: Determine the index episode start date. For each member identified in step 1, determine the index episode start date by identifying the date of the member's earliest encounter during the report period (e.g., outpatient, detoxification or emergency department visit date; inpatient discharge date). For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.

Step 3: Determine if the index episode start date is a new episode. Members with a new episode of AOD dependence have a negative diagnosis history, defined as a period of 60 days prior to the index episode start date, during which the member had no claims/encounters with any diagnosis of AOD dependence (Table IET-A). For members with an inpatient visit, use the admission date to determine negative diagnosis history. For ED visits that result in an inpatient admission, use the ED date of service to determine the negative diagnosis history.

Step 4: Calculate continuous enrollment. The member must be continuously enrolled in Medicaid (Quarterly Reporting)/Health Home (Annual Reporting) without any gaps for 60 days prior through 44 days after the index episode start date.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table IET-A: Codes to Identify AOD Dependence

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

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

CPT Codes		HCPCS Codes		UB Revenue Codes
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	<i>OR</i>	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	<i>OR</i>	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983
CPT Codes		POS Codes		
90791, 90792, 90801, 90802, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	<i>WITH</i>	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72	<i>WITH</i>	52, 53
90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	<i>WITH</i>		<i>WITH</i>	

Table IET-C: Detoxification Services Codes

HCPCS Codes		ICD-9-CM Procedure Codes		UB Revenue Codes
H0008-H0014	<i>OR</i>	94.62, 94.65, 94.68	<i>OR</i>	0116, 0126, 0136, 0146, 0156

Table IET-D: Emergency Department Services Codes

CPT Codes		UB Revenue Codes
99281-99285	<i>OR</i>	045x, 0981

Table IET-E: Codes to Identify AOD Procedures

ICD-9-CM Procedure Codes	HCPCS Codes		UB Revenue Codes	Provider Type
94.61, 94.63, 94.64, 94.66, 94.67, 94.69		<i>WITH</i>	011x, 012x, 018x, 021x, 022x, 041x, 042x, 084x	
	H0003-H0005, H0007, H0014-H0016, H0020, A9999	<i>WITH</i>		95

Table IET-F: Codes to Identify Inpatient Services

UB Bill Type Codes
11x, 12x, 18x, 21x, 22x, 41x, 42x, 84x

Smoking & Tobacco Use Cessation (MSC)

The percentage of tobacco-using members who received a tobacco cessation intervention.

Numerator: The number of tobacco-using members who received a tobacco cessation intervention (Table MSC-B) during the report period.

Denominator (Annual Reporting): The number of members who were enrolled in the Health Home for 11 months during the report period and who were identified as tobacco users (Table MSC-A) during the report period.

Denominator (Quarterly Reporting): The number of members who were enrolled in the Health Home during the last month of the reporting period who were identified as tobacco users (Table MSC-A) during the report period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table MSC-A: Codes to Identify Tobacco Users

ICD-9-CM Diagnosis Codes	CPT Category II Codes
305.1, 649.0, 989.84	1034F, 1035F

Table MSC-B: Codes to Identify Tobacco Cessation Interventions

CPT Category II Codes	Prescription
4000F, 4001F, 4004F	<i>OR</i> Chantix, smoking cessation patch (therapeutic classes J3A, J3C, or H7N)

PREVENTIVE CARE

Percent of Live Births Weighing Less than 2,500 Grams (LBW)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

The percentage of women who delivered live births less than 2,500 grams.

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

Denominator: The number of live births during the report period (see *Steps for Identifying Live Births* below).

Annual Report Period: January 1, 2013 – December 31, 2013

Steps for Identifying Live Births:

Step 1: Identify live births. For the desired date range, identify all members that have claims containing any of the codes listed in Table LBW-A. Exclude all deliveries whose admission date (first date of service) is not during the reporting year.

Table LBW-A: Codes to Identify Live Births

ICD-9-CM Diagnosis Codes

650 -Normal Delivery
V27.0 - Single liveborn
V27.2 - Twins, both liveborn
V27.3 - Twins, one liveborn and one stillborn
V27.5 - Other multiple birth, all liveborn
V27.6 - Other multiple birth, some liveborn
V30 - Single liveborn
V31 - Twin, mate liveborn
V32 - Twin, mate stillborn
V33 - Twin, unspecified
V34 - Other multiple, mates all liveborn
V35 - Other multiple, mates all stillborn
V36 - Other multiple, mates live- and stillborn
V37 - Other multiple, unspecified
V39 - Unspecified

Step 2: Identify deliveries for members not identified in Step 1. For the reporting period, identify all members that have encounters containing any of the codes listed in Table LBW-B. Exclude all deliveries whose admission date (first date of service) is not during the reporting year.

Table LBW-B: Codes Used To Identify Deliveries

ICD-9-CM Procedure Codes
72.x Forceps, vacuum, and breech delivery
73.x Other procedures inducing or assisting delivery
74.0 Cesarean section and removal of fetus; Classical cesarean section
74.1 Cesarean section and removal of fetus; Low cervical cesarean section
74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section
74.4 Cesarean section and removal of fetus; Cesarean section of other specified type
74.99 Cesarean section of unspecified type
ICD-9-CM Diagnosis Codes
640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.x1, 646.x1, 646.x2, 647.x1, 647.x2, 648.x1, 648.x2, 649.x1, 649.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.02, 654.12, 654.32, 654.x2, 655.x1, 656.x1, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.01, 665.x1, 665.x2, 666.x2, 667.x2, 668.x1, 668.x2, 669.x1, 669.x2, 670.02, 671.x1, 671.x2, 672.02, 673.x1, 673.x2, 674.x1, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2, 678.x1, 679.x1, 679.x2
CPT Codes
59400 Routine obstetrical care including antepartum and postpartum care and vaginal delivery
59409 Vaginal delivery (with or without episiotomy and/or forceps)
59410 Obstetrical care for vaginal delivery only, including postpartum care
59510 Cesarean delivery
59514 Cesarean delivery only
59515 Cesarean delivery only; including postpartum care
59610 VBAC delivery
59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614 VBAC care after delivery; vaginal delivery only, after previous cesarean delivery, including postpartum care
59618 Attempted VBAC delivery
59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622 Attempted VBAC after care, cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

Step 3: For members identified in Step 2, use Table LBW-C to exclude members that have a delivery claim not resulting in a live birth.

Table LBW-C: Codes Used To Verify Live Births

Exclude Deliveries Not Resulting in a Live Birth
630-637 Other abnormal product of conception, hydatidiform mole, ectopic or abdominal pregnancy, missed or spontaneous abortion, legally/illegally induced abortion, legally unspecified abortion
639 Complications following abortion or ectopic and molar pregnancies
656.4 Intrauterine death affecting management of mother
768.0 Fetal death from asphyxia or anoxia before onset of labor or at unspecified time
768.1 Fetal death from asphyxia or anoxia during labor
V27.1 Outcome of delivery, single stillborn
V27.4 Outcome of delivery, twins, both stillborn
V27.7 Outcome of delivery, other multiple birth, all stillborn

Step 4: Attach member’s demographic information for all live births identified in steps 1 and 3.

Step 5: For any claims identified as mother’s claims (where the member’s date of birth is not the reporting year), attach possible infant demographics to each claim.

Step 6: Attach demographic information from the name and address file provided by the Ohio Department of Health (ODH) to the vital statistics file by matching unique certificate numbers in each file. The resulting file should contain the data elements listed in Table LBW-D.

Table LBW-D: Vital Stats File Data Elements

Vital Stats File Data Elements			
Certificate Number	Mother’s First Name	Mother’s Date of Birth	Birth weight
Child’s First Name	Mother’s Middle Initial	Child’s Date of Birth	Plural Birth Indicator
Child’s Middle Initial	Mother’s Last Name	Child’s Gender	Birth Order
Child’s Last Name	Mother’s Race	County of Birth	Indicator of Live Birth

Step 7: Common unique identifiers derived from ODM’s demographic data and encounter data (i.e., birthfile), and the vital statistics data (i.e., vital stats file) are used to match infants and mothers to the birth weight information recorded in the vital statistics data.

Step 8: Calculate rates using the birth weight listed in the vital statistics file.

Timeliness of Prenatal Care (PPC1)

Note: This measure will only be reported annually.

The percentage of deliveries who had their first prenatal visit within 42 days of Health Home enrollment or by the end of the first trimester for those women who were enrolled in the Health Home during the early stage of pregnancy.

Numerator: One (or more) prenatal care visit(s) within 42 days of enrollment in the Health Home or within the first trimester if the member was already enrolled in the Health Home.

Denominator: The eligible population.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013

Denominator:

Step 1: Identify all women enrolled in a Health Home with a live birth between November 6 of the year prior to the report year, and November 5 of the report year. Women who are identified through the codes listed in Table PPC-A are automatically included in the eligible population and require no further verification of the outcome.

Women who were not identified through the codes listed in Table PPC-A may be identified through any of the codes listed in the Table PPC-B. Deliveries not resulting in a live birth should be excluded.

Step 2: For women identified in Step 1, determine if enrollment in the Health Home was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

Table PPC-A: Codes to Identify Live Births

ICD-9-CM Diagnosis Codes	ICD-9-CM Diagnosis Codes (must have a matching delivery encounter)
650 -Normal Delivery	V30 - Single liveborn
V27.0 - Single liveborn	V31 - Twin, mate liveborn
V27.2 - Twins, both liveborn	V32 - Twin, mate stillborn
V27.3 - Twins, one liveborn and one stillborn	V33 - Twin, unspecified
V27.5 - Other multiple birth, all liveborn	V34 - Other multiple, mates all liveborn
V27.6 - Other multiple birth, some liveborn	V35 - Other multiple, mates all stillborn
	V36 - Other multiple, mates live- and stillborn
	V37 - Other multiple, unspecified
	V39 - Unspecified

Table PPC-B: Codes Used To Identify Deliveries and Verify Live Births

Identify Deliveries
<p><u>ICD-9-CM Procedure Codes:</u></p> <p>72.x Forceps, vacuum, and breech delivery</p> <p>73.x Other procedures inducing or assisting delivery</p> <p>74.0 Cesarean section and removal of fetus; Classical cesarean section</p> <p>74.1 Cesarean section and removal of fetus; Low cervical cesarean section</p> <p>74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section</p> <p>74.4 Cesarean section and removal of fetus; Cesarean section of other specified type</p> <p>74.99 Cesarean section of unspecified type</p> <p><u>ICD-9-CM Diagnosis Codes:</u></p> <p>640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.x1, 646.x1, 646.x2, 647.x1, 647.x2, 648.x1, 648.x2, 649.x1, 649.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.x2, 655.x1, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.x1, 665.x2, 666.x2, 667.x2, 668.x1, 668.x2, 669.x1, 669.x2, 670.02, 671.x1, 671.x2, 672.02, 673.x1, 673.x2, 674.x1, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2, 678.x1, 679.x1, 679.x2</p>

Identify Deliveries (Continued)

CPT Codes:

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

Exclude Deliveries Not Resulting in a Live Birth:

ICD-9-CM Diagnosis Codes:

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

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

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

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

Table PPC-C: Methods for Matching Infants and Mothers

Methods for Matching Infants and Mothers Encounters

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

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

OR

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

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

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

Numerator Specifications:

Only include visits that occur while member was enrolled.

Step 3: Determine if women identified in step 2 were enrolled on or before 280 days prior to delivery. For these women, go to step 4. For women not enrolled on or before 280 days prior to delivery, go to step 5.

Step 4: Determine if women identified in step 3 were continuously enrolled during the first trimester (176-280 days prior to delivery) with no gaps in enrollment. For these women, use one of the three decision rules to determine if there was a prenatal visit during the first trimester. For women not continuously enrolled during the first trimester (e.g., had a gap between 176-280 days prior to delivery), go to step 5.

Step 5: For women identified in steps 3 and 5, determine the last enrollment start date (i.e., the enrollment start date during the pregnancy that is closest to the delivery date).

For women whose last enrollment started on or between 219-279 days prior to delivery, go to step 6. For women whose last enrollment started less than 219 days prior to delivery, go to step 7.

Step 6: If the last enrollment segment started on or between 219-279 days prior to delivery, determine numerator compliance using the Table PPC-I and find a visit between the last enrollment start date and 176 days prior to delivery.

Step 7: If the last enrollment segment started less than 219 days prior to delivery, determine numerator compliance using the Table PPC-I and find a visit within 42 days after enrollment.

Prenatal Care Visit Codes

There are **three** decision rules for identifying prenatal visits.

Decision Rule 1: Either of the following during the first trimester, where the practitioner type is an OB practitioner, a midwife or family practitioner or other PCP (Table PPC-D):

- A bundled service (Table PPC-E) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Table PPC-F).

Table PPC-D: Codes to Identify Primary Care Practitioners (PCPs)

Provider Type	Physician Specialty Code	Other
01 (General Hospital) 04 (Outpatient Health Facility) 05 (Rural Health Facility) 09 (Maternal/Child Health Clinic - 9 mo.) 12 (Federally Qualified Health Center) 50 (Comprehensive Clinic) 52 (Public Health Dept. Clinic) 65 (Certified Nurse, Specialist) 71 (Certified Nurse, Midwife) 72 (Certified Nurse, Practitioner)	201, 203, 205, 206, 207, 208, 209, 210, 212, 213, 214, 215, 219, 229, 233, 234, 235, 263, 264, 274, 275, 290, 297, 320, 321, 324, 325, 326, 327, 328, 329, 330, 331, 333, 335, 337, 341, 342, 363, 721	Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where specialty code is 362 (unspecified) or is not indicated.

Table PPC-E: Codes to Identify Prenatal Bundled Services

CPT	Description
59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care, 7 or more visits
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
HCPCS	
H1005	

Table PPC-F: Codes to Identify Prenatal Visit

CPT	Description
99500	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring
CPT	Description
Category II	Description
0500F	Initial prenatal care visit
0501F	Prenatal flow sheet
0502F	Subsequent prenatal care
HCPCS	
H1000-H1004	

Decision Rule 2: Any visit to an OB practitioner or midwife (Table PPC-D) with a prenatal visit (Table PPC-F) and one of the following (Table PPC-H):

- An obstetric panel.
- An ultrasound (echocardiography) of the pregnant uterus.
- A pregnancy-related diagnosis code.
- All of the following:
 - Toxoplasma.
 - Rubella.
 - Cytomegalovirus.
 - Herpes simplex.
- Rubella and ABO.
- Rubella and Rh.

*Note: A visit to a midwife must include Provider Type = 71 or 72, **OR** Physician Specialty Code = 212, 219, 275, or 290.*

Table PPC-G: Codes to Identify Prenatal Visit

CPT Codes	UB Revenue Codes
99201-99205, 99211-99215, 99241-99245	0514

Table PPC-H: Codes to Identify Obstetric Panel, Ultrasound, and Pregnancy-Related Diagnosis

CPT Codes	Description
80055	Obstetric Panel
76801, 76805, 76811, 76813, 76815-76821, 76825-76828	Prenatal Ultrasound
86644	Cytomegalovirus
86694, 86695, 86696	Herpes simplex
86762	Rubella
86777	Toxoplasma
86900	ABO
86901	Rh
ICD-9-CM Procedure Codes	
88.78	Prenatal Ultrasound
ICD-9-CM Diagnosis Codes	
640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28	Pregnancy Diagnosis

Decision Rule 3: Any of the following during the first trimester, where the practitioner type is a family practitioner or other PCP (Table PPC-D) with a pregnancy related ICD-9-CM Diagnosis code (Table PPC-H) and a prenatal visit (Table PPC-F) AND one of the following:

- An obstetric panel (Table PPC-H)
- An ultrasound (echocardiography) of the pregnant uterus. (Table PPC-H)
- All of the following: (Table PPC-H)
 - Toxoplasma.
 - Rubella.
 - Cytomegalovirus.
 - Herpes simplex.
- Rubella and ABO. (Table PPC-H)
- Rubella and Rh. (Table PPC-H)

OR

Any of the following during the first trimester, where the practitioner type is a family practitioner or other PCP (Table PPC-D) and a prenatal visit (Table PPC-F) AND one of the following:

- Any internal organization code for LMP with an obstetrical history.
- Any internal organization code for LMP with risk assessment and counseling/education.

Note: For Decision Rule 3 criteria that require a prenatal visit code **and** a pregnancy-related diagnosis code, codes must be on the same claim.

Table PPC-I: Markers for Prenatal Care

Markers for Prenatal Care: The member must meet criteria in Part A <i>or</i> (Part B <i>and</i> Part C).		
PART A: Any one code.		
CPT Codes	HCPCS Codes	CPT Category II Codes
59400, 59425, 59426, 59510, 59610, 59618, 99500	H1000-H1004, H1005	0500F, 0501F, 0502F
PART B: Any one code.		
CPT Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes
76801, 76805, 76811, 76813, 76815-76821, 76825-76828	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28	88.78
PART C: Any one code.		
CPT Codes	UB Revenue Codes	
99201-99205, 99211-99215, 99241-99245	0514	

Note: ICD-9-CM Diagnosis code for pregnancy must be a Principal Diagnosis Code.

Postpartum Care (PPC2)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

The percentage of deliveries that had a postpartum visit on or between 21 days and 56 days after delivery.

Numerator: A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Postpartum visits may be identified using the codes listed in Table PPC-J. Any of the following meet criteria:

- A postpartum visit.
- Cervical cytology.
- A bundled service where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Denominator: The same denominator as outlined in the Timeliness of Prenatal Care measure.

Annual Report Period: January 1, 2013 – December 31, 2013

Table PPC-J: Codes to Identify Postpartum Visits

Code	Description
ICD-9-CM Diagnosis and Procedure Codes	
89.26	Gynecological examination
V24.1	Lactating mother
V24.2	Routine postpartum follow-up
V25.1	Insertion of intrauterine contraceptive device
V72.3	Gynecological exam
V76.2	Special screening for malignant neoplasm (cervix)
UB Revenue Codes	
0923	Pap Smear
CPT	
57170	Diaphragm cervical cap fitting
58300	Insertion of intrauterine device
59400	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care
59410	Vaginal delivery, including postpartum care
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only, including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care after previous cesarean delivery
59614	Vaginal delivery only, after previous cesarean delivery, including postpartum care
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
88141-88143	Cytopathology, cervical or vaginal
88147-88148	Cytopathology smears
88150	Cytopathology slides
88152-88154	Cytopathology slides
88164-88167	Cytopathology slides
88174-88175	Cytopathology, cervical or vaginal
99501	Home visit for postnatal assessment and follow-up care
CPT Category II Codes	
0503F	Postpartum care visit
HCPCS Codes	
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
G0123-G0124	Screening cytopathology, cervical or vaginal (any reporting system)
G0141	Screening cytopathology smears, cervical or vaginal
G0143-G0145	Screening cytopathology smears, cervical or vaginal
G0147-G0148	Screening cytopathology smears, cervical or vaginal
P3000-P3001	Screening Papanicolaou smear, cervical or vaginal
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Adult BMI Assessment (ABA)*

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

Numerator: The number of members meeting denominator criteria who had a BMI assessment during the report period or the year prior to the report period. For members younger than 19 years of age on the date of service, BMI percentile (Table ABA-C) also meets criteria.

Denominator (Annual Reporting): The number of members 18 to 74 years of age who had 11 or more months of enrollment in the Health Home during the reporting period, had 11 or more months of enrollment in Medicaid during the year prior to the reporting period, and had an outpatient visit (Table ABA-A) during the report period or the year prior to the report period.

Denominator (Quarterly Reporting): The number of members 18 to 74 years of age who were enrolled in a Health Home during the last month of the reporting period and had an outpatient visit (Table ABA-A) during the report period or the year prior to the report period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table ABA-A: Codes to Identify Outpatient Visits

CPT Codes	HCPCS Codes	UB Revenue Codes
99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0402, G0438, G0439	051x, 0520-0523, 0526-0529, 0982, 0983

Table ABA-B: Codes to Identify BMI/Weight Assessments

CPT Codes	CPT Category II Codes	ICD-9-CM Diagnosis Codes
G8417-G8420	3008F, 2001F	V85.0-V85.4

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table ABA-C: BMI Percentiles

Description	ICD-9-CM Diagnosis Codes
BMI Percentiles	V85.51-V85.54

Exclusion: Exclude members who had a diagnosis of pregnancy during the report period or the year prior to the report period (Table ABA-D).

Table ABA-D: Codes to Identify Pregnancies

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

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the report period.

- *BMI percentile documentation*
- *Counseling for nutrition*
- *Counseling for physical activity*

Numerator: The number of members in the denominator that had each of the three following numerators: 1) BMI percentile documentation, 2) counseling for nutrition, and 3) counseling for physical activity. For adolescents 16-17 years of age on the date of service, a BMI value also meets criteria (Table WCC-B).

Denominator: Members ages 3-17 who had 11 or more months of enrollment in a Health Home during the reporting period and who had an outpatient visit (Table WCC-A) with a PCP or OB/GYN (Table WCC-C) during the report period.

Report period:

- Annual Report Period: January 1, 2013 – December 31, 2013

Table WCC-A: Codes to Identify Outpatient Visits

CPT Codes	UB Revenue Codes	HCPCS Codes
99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 0982, 0983	G0402, G0438, G0439

Table WCC-B: Codes to Determine Weight Assessment and Counseling for Nutrition and Physical Activity

Description	CPT Codes	CPT Category II Codes	ICD-9-CM Diagnosis Codes	HCPCS Codes
BMI percentile (all ages)	G8417-G8420	3008F, 2001F	V85.51-85.54	
BMI (for ages 16-17)			V85.0-V85.4	
Counseling for nutrition	97802-97804		V65.3	G0270, G0271, G0447, S9449, S9452, S9470
Counseling for physical activity			V65.41	G0447, S9451

Table WCC-C: Codes to Identify PCPs and OB/GYNs

Provider Type	Physician Specialty Code	Other
01 (General Hospital) 04 (Outpatient Health Facility) 05 (Rural Health Facility) 09 (Maternal/Child Health Clinic - 9 mo.) 12 (Federally Qualified Health Center) 50 (Comprehensive Clinic) 52 (Public Health Dept. Clinic) 65 (Certified Nurse, Specialist) 71 (Certified Nurse, Midwife) 72 (Certified Nurse, Practitioner)	201, 203, 205, 206, 207, 208, 209, 210, 212, 213, 214, 215, 219, 229, 233, 234, 235, 263, 264, 274, 275, 290, 297, 320, 321, 324, 325, 326, 327, 328, 329, 330, 331, 333, 335, 337, 341, 342, 363, 721	Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where specialty code is 362 (unspecified) or is not indicated.

Adolescent Well-Care Visits (AWC)

The percentage of members 12–21 years of age who received at least one comprehensive well-care visit with a PCP or OB/GYN during the report year.

Numerator: Members with at least one comprehensive well-child visit (Table AWC-A) with a PCP or OB/GYN (Table AWC-B) practitioner during the report year.

Denominator (Annual Reporting): Members age 12-21 who had 11 or more months of enrollment in a Health Home during the reporting period.

Denominator (Quarterly Reporting): Members age 12-21 who were enrolled in a Health Home during the last month of the reporting period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table AWC-A: Codes to Identify Adolescent Well-Care Visits

CPT	HCPCS Codes	ICD-9-CM Diagnosis Codes
99381-99385, 99391-99395, 99461	G0438, G0439	V20.2, V20.3, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Table AWC-B: Codes to Identify PCPs and OB/GYNs

Provider Type	Physician Specialty Code	Other
01 (General Hospital) 04 (Outpatient Health Facility) 05 (Rural Health Facility) 09 (Maternal/Child Health Clinic - 9 mo.) 12 (Federally Qualified Health Center) 50 (Comprehensive Clinic) 52 (Public Health Dept. Clinic) 65 (Certified Nurse, Specialist) 71 (Certified Nurse, Midwife) 72 (Certified Nurse, Practitioner)	201, 203, 205, 206, 207, 208, 209, 210, 212, 213, 214, 215, 219, 229, 233, 234, 235, 263, 264, 274, 275, 290, 297, 320, 321, 324, 325, 326, 327, 328, 329, 330, 331, 333, 335, 337, 341, 342, 363, 721	Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where specialty code is 362 (unspecified) or is not indicated.

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The percentage of members 20 years and older who had an ambulatory or preventive care visit.

Numerator: The number of members who meet the denominator criteria and had an ambulatory or preventive care visit (Table AAP-A) during the report period.

Denominator (Annual Reporting): The number of members 20 year of age and older who had 11 or more months of enrollment in a Health Home during the reporting period.

Denominator (Quarterly Reporting): The number of members 20 year of age and older who were enrolled in a Health Home during the last month of the reporting period.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

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

Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	UB Revenue Codes
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	
Routine infant or child check			V20.2	

Appropriate Treatment for Children with Upper Respiratory Infections (URI)

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

Numerator: The number of members in the denominator who were dispensed an antibiotic prescription (Table URI-D) within three days of the episode date.

Denominator (Annual Reporting): Children 3 months-18 years of age who were given a diagnosis of URI (Table URI-A), had a 30-day negative medication history prior to the episode date, and did not have a competing diagnosis (Table URI-C) on the same day as or for three days after the episode date. To be included in the measure, members must have been enrolled in the Health Home 30 days prior to the episode date through 3 days after the episode date (inclusive). Determine qualifying occurrences of URI as outlined below.

Denominator (Quarterly Reporting): Children 3 months-18 years of age who were given a diagnosis of URI (Table URI-A), had a 30-day negative medication history prior to the episode date, and did not have a competing diagnosis (Table URI-C) on the same day as or for three days after the episode date. To be included in the measure, members must be enrolled in the Health Home for the month the episode occurs, and have been enrolled in Medicaid 30 days prior to the episode date. Determine qualifying occurrences of URI as outlined below.

Step 1: Identify all members who had an outpatient, observation visit, or ED visit (Table URI-B) with only a diagnosis of URI (Table URI-A) during the 12 month window beginning 6 months prior to the start of the measurement year. Exclude claims/encounters with more than one diagnosis and 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 only a URI diagnosis.

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

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.

Step 5: Calculate continuous enrollment. The member must be continuously enrolled in the Health Home (annual reporting) and in Medicaid (quarterly reporting) without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6: Select the Index Episode Start Date. This measure examines the earliest eligible episode per member.

Calculation: The measure is reported as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
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- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table URI-A: Codes to Identify URI

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

Table URI-B: Codes to Identify Visit Type

Description	CPT Codes	UB Revenue Codes	HCPCS Codes
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455-99456	051x, 0520-0523, 0526-0529, 0982, 0983	G0402, G0438, G0439
ED*	99281-99285	045x, 0981	
Observation	99217-99220		

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

Table URI-C: Codes to Identify Competing Diagnoses

Description	ICD-9-CM Diagnosis Codes
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, 478.22, 478.24, 478.29, 478.71, 478.79, 478.9
Prostatitis	601
Cellulitis, mastoiditis, other bone infections	383, 681, 682, 730
Acute lymphadenitis	683

Description	ICD-9-CM Diagnosis Codes
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
Acne	706.0, 706.1

Table URI-D: Antibiotic Medications

Description	Prescription
Aminopenicillins	<ul style="list-style-type: none"> Amoxicillin Ampicillin
Beta-lactamase inhibitors	<ul style="list-style-type: none"> Amoxicillin-clavulanate
First generation cephalosporins	<ul style="list-style-type: none"> Cefadroxil Cephalexin Cefazolin
Folate antagonist	<ul style="list-style-type: none"> Trimethoprim
Lincomycin derivatives	<ul style="list-style-type: none"> Clindamycin
Macrolides	<ul style="list-style-type: none"> Azithromycin Clarithromycin Erythromycin Erythromycin ethylsuccinate Erythromycin lactobionate Erythromycin stearate
Miscellaneous antibiotics	<ul style="list-style-type: none"> Erythromycin-sulfisoxazole
Natural penicillins	<ul style="list-style-type: none"> Penicillin G potassium Penicillin V potassium Penicillin G sodium
Penicillinase-resistant penicillins	<ul style="list-style-type: none"> Dicloxacillin
Quinolones	<ul style="list-style-type: none"> Ciprofloxacin Moxifloxacin Levofloxacin Ofloxacin
Second generation cephalosporins	<ul style="list-style-type: none"> Cefaclor Cefuroxime Cefprozil
Sulfonamides	<ul style="list-style-type: none"> Sulfamethoxazole-trimethoprim Sulfisoxazole
Tetracyclines	<ul style="list-style-type: none"> Doxycycline Tetracycline Minocycline
Third generation cephalosporins	<ul style="list-style-type: none"> Cefdinir Ceftibuten Cefixime Cefditoren Cefpodoxime Ceftriaxone
<p><i>NCQA provides a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org).</i></p>	

Annual Dental Visit (ADV)

Note: This measure will be removed from Year 2 reporting (i.e., CY 2014).

The percentage of members who had at least one dental visit during the report period.

Numerator: One (or more) dental visits (Table ADV-A) with a dental practitioner during the report period.

Denominator: Members who had 11 or more months of enrollment in a Health Home during the reporting period.

Reporting Units: Report rates for two age categories: 2-21 years of age and 22 years and older.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013

Table ADV-A: Codes to Identify Annual Dental Visits

CPT Codes	HCPCS/CDT Codes*
70300, 70310, 70320, 70350, 70355	D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999
*CDT (Current Dental Terminology)	

UTILIZATION

Ambulatory Care—Sensitive Condition Admission (SCA)*

The acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per 100,000 population younger than 75 years of age.

Numerator: The total number of acute care hospitalizations for members under 75 years of age with an ambulatory care sensitive condition as a primary diagnosis (Table SCA-A).

Denominator: The total number of Health Home members under 75 years of age at the midpoint of the reporting period.

Exclusions: Deaths prior to discharge.

Formula: (Total number of acute care hospitalizations for ambulatory care sensitive conditions younger than 75 years of age / total mid-year population younger than 75 years of age) x 100,000.

Report Period:

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- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table SCA-A: Codes to Identify Sensitive Conditions

Description	Primary ICD-9-CM Diagnosis Codes		Secondary ICD-9-CM Diagnosis Codes
Grand mal status and other epileptic convulsions	345		
COPD	491, 492, 494, 496		
	466, 480–486, 487.0	<i>AND</i>	496
Asthma	493		
Diabetes	250.0, 250.1, 250.2, 250.8		
Heart failure and pulmonary edema	428, 518.4	<i>AND NOT</i>	336, 35xx, 36xx, 373x, 375x, 377x, 378x, 379.4–379.8
Hypertension	401.0, 401.9, 402.0, 402.1, 402.9		
Angina	411.1, 411.8, 413		

Inpatient & ED Utilization—Rates (UTL)

The number of inpatient, emergency department, AOD, and mental health inpatient discharges per 1,000 member months.

Numerators:

1. Total Inpatient Discharges (Table UTL-A) excluding discharges with a principal diagnosis of mental health or chemical dependency or live-born infant (Table UTL-B).
2. Total ED visits (Table UTL-C) excluding mental health and chemical dependency services (Table UTL-E). Any of the following meet criteria:
 - A principal diagnosis of mental health or chemical
 - Psychiatry
 - Electroconvulsive therapy
 - Alcohol or drug rehabilitation or detoxification

ED visits that result in an inpatient stay should not be counted toward this measure. In addition, only one ED visit should be counted per date of service.

3. Total AOD Inpatient Discharges, as determined by the following criterion.
 - a. An inpatient facility code (Table UTL-A) in conjunction with any diagnosis of chemical dependency (Table UTL-E).
4. Total Mental Health Discharges, as determined by the following criterion.
 - a. An inpatient facility code (Table UTL-A) in conjunction with a principal mental health diagnosis (Table UTL-F).

Denominator: The number of Health Home member months.

Report Period:

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- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table UTL-A: Codes to Identify Inpatient Discharges

UB Type of Bill		
11x, 12x, 41x, 84x	<i>OR</i>	Any acute inpatient facility code

Table UTL-B: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis Codes
V30-V37, V39, 290-316

Table UTL-C: Codes to Identify ED Visits

CPT Codes		UB Revenue Codes	
99281-99285		045x, 0981	
<i>OR</i>			
CPT Codes		POS Codes	
10040-69979	<i>WITH</i>	23	

Table UTL-D: Codes to Identify Exclusions for Emergency Department Visits

Principal ICD-9-CM Diagnosis Codes	
290-316	
<i>OR</i>	
CPT Codes	
90785, 90791, 90792, 90801-90802, 90804-90824, 90826-90829, 90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90857, 90862, 90863, 90865, 90867-90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899	

Table ULT-E: Codes to Identify Chemical Dependency Diagnosis

ICD-9-CM Diagnosis Codes
291-292, 303-304, 305.0, 305.2-305.9, 535.3, 571.1

Table UTL-F: Codes to Identify Mental Health Diagnosis

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

All-Cause Readmissions (ACR)*

For members 18 years of age and older, the number of acute inpatient stays during the report period that were followed by an acute readmission for any diagnosis within 30 days.

Numerator: The number of acute 30-day readmissions for any diagnosis.

Denominator (Annual Reporting): All Health Home member acute inpatient discharges that occur during the report period prior to the first day of the last month of the report period for members 18 years of age and older in which the member was enrolled in the Health Home through 30 days after discharge.

Denominator (Quarterly Reporting): All Health Home member acute inpatient discharges that occur during the report period prior to the first day of the last month of the report period for members 18 years of age and older in which the member is enrolled in a Health Home in the last month of the reporting period. In addition, the member had to be enrolled in Medicaid through 30 days after discharge.

Step 1: Using only institutional claims (Table ACR-A), identify all acute inpatient stays (Table ACR-B) with a discharge date during the report period prior to the first day of the last month of the report period. Include acute admissions to behavioral healthcare facilities. Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.

Step 2: Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3: Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Exclude any acute inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

Step 5: Exclude stays for the following reasons:

- Inpatient stays with discharges for death.
- Acute inpatient discharge with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period in Table ACR-C.

Step 6: Calculate continuous enrollment.

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Report Period:

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- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table ACR-A: Codes to Identify Institutional Claims

Type of Bill
0111, 0121, 0114, 0124

Table ACR-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987

Table ACR-C: Codes to Identify Maternity Related Inpatient Discharges

Description	ICD-9-CM Diagnosis Codes
Pregnancy	630-679, V22, V23, V28
Conditions originating in the perinatal period	760-779, V21, V29-V39

CARE COORDINATION

Timely Transmission of Transition Record (TTR)*

Percentage of members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the Health Home within 24 hours of discharge.

Numerator: Members for whom a transition record was transmitted to the Health Home within 24 hours of discharge for each discharge during the report period (Table TTR-C).

Denominator (Annual Reporting): All members, regardless of age, who were discharged from an inpatient facility to home/self-care or any other site of care, excluding members who died, left against medical advice, or discontinued care at discharge and one day past discharge and were enrolled in the Health Home.

Denominator (Quarterly Reporting): All members enrolled in a Health Home during the last month of the reporting period, regardless of age, who were discharged from an inpatient facility to home/self-care or any other site of care, excluding members who died, left against medical advice, or discontinued care.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
- Quarter 1 Report Period: April 1, 2013 – March 31, 2014
- Quarter 2 Report Period: July 1, 2013 – June 30, 2014
- Quarter 3 Report Period: October 1, 2013 – September 30, 2014
- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table TTR-A: Codes to Identify Members Discharged from an Inpatient Facility

Description	Type of Bill Codes		Discharge Status
Hospital inpatient	0111, 0121, 0114, 0124	AND	01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table TTR-B: Codes to Identify Denominator Exclusions

Description	Discharge Status
Left against medical advice	07
Expired	20
Expired at home	40
Expired in a medical facility	41
Expired—place unknown	42

Table TTR-C: Codes to Identify Transition Record Transmission

Description	CPT Category II Codes		Modifier
Discharge with transition record within 24 hours	1110F	AND	U3

Medication Reconciliation Post-Discharge (MPD)

Percentage of members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a reconciled medication list was transmitted to the Health Home within 24 hours.

Numerator: Number of members for whom a reconciled medication list was transmitted to the Health Home within 24 hours of discharge (Table MPD-A).

Denominator: All members, regardless of age, who were discharged from an inpatient facility to home/self-care or any other site of care (Table TTR-A), excluding members who died, left against medical advice, or discontinued care (Table TTR-B) and who were enrolled in the Health Home on the date of discharge and one day past discharge.

Report Period:

- Annual Report Period: January 1, 2013 – December 31, 2013
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- Quarter 4 Report Period: January 1, 2014 – December 31, 2014

Table MPD-A: Codes to Identify Discharge Medication Reconciled With Medication List

Description	CPT Category II Codes
Discharge medications reconciled with current medication list	1111F