M E D D I C – M S S S I

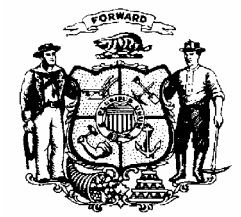
2007 TECHNICAL SPECIFICATIONS

Medicaid Encounter Data Driven Improvement Core Measure Set for SSI-eligible populations

Official clinical quality performance measures

SSI Managed Care Program

S t a t e o f W i s c o n s i n



DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING
BUREAU OF MANAGED HEALTH CARE PROGRAMS

October 2006

Quality Assessment and Performance Improvement

M E D D I C – M S S S I

2007 TECHNICAL SPECIFICATIONS

SSI managed care program

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MEDDIC-MS SSI PROJECT DEVELOPMENT LEAD

Quality Assessment and Performance Improvement

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MEDDIC-MS SSI 2006 REVISION LOG			
DATE	**PAGE**	**MEASURE**	**REVISION DESCRIPTION**
3/23/06	10	Preventive dental	Add codes D0160, D1204, D4355, and D 4910. Obsolete code D2220 deleted and D1201 deleted (inapplicable-child).
8/11/06	10	Preventive dental	Delete: "…both a clinical oral evaluation and prophylaxis…"
8/11/06	25	General dental	Add "certified dental hygienist" and "outpatient hospital" to provider types.
8/15 (EFF. 1/1/06)	22	MH/SA evaluation	Add HCPCS H0049 AODA evaluation
8/15 (EFF. 1/1/06)	23	Substance abuse treatment	Add HCPCS H0050 AODA brief intervention
9/18/06 (EFF. 1/1/07)	23	MH/SA eval and outpt treatment	Add ICD-9-CM: V79.1 Special screening for alcoholism to numerator #1.
9/18/06 (EFF. 1/1/07)	25	MH/SA eval and outpt treatment	Add V65.42 Counseling on substance use and abuse to numerator #3.
9/18/06 (EFF. 1/1/07)	25	MH/SA eval and outpt treatment	Add: HCPCS codes H0004, H0016 to numerator #3.
9/18/06 (EFF. 1/1/07)	28	General/specialty care inpatient.	Add: CPT: 90816 - 90822 (inpatient individual psychotherapy) to inpatient psychiatric care
9/22/06	18	Mammography and Pap testing	Move both measures intact from "monitoring measure" status to "Targeted Performance Improvement Measure"

M E D D I C-M S S S I 2 0 0 7

MEDICAID ENCOUNTER DATA DRIVEN IMPROVEMENT CORE MEASURE SET FOR SSI MANAGED CARE

INTRODUCTION

MEDDIC-MS SSI 2007 is the standardized performance measurement system specified by the state of Wisconsin for its SSI managed care program (*i*Care). Standardized performance measures must be specified by the State in its contracts for all Medicaid managed care programs under 42 CFR §438.240(c)(1-2). The measures address selected outcomes, prevalent clinical topics or are otherwise significant in the population of individuals with permanent disabilities eligible for SSI.

MEDDIC-MS SSI 2007 consists of two subsets of measures: Targeted Performance Improvement Measures (TPIM), which focus on high priority areas identified by stakeholders and the Department of Health and Family Services. The TPIMs are subject to goal-setting procedures developed by the DHFS. "Monitoring measures," are also used, most of which are utilization measures.

The measures automated, designed to operate with encounter data generated and reported as part of routine health care operations. No special operations such as field medical record review are necessary for the measures to operate accurately. However, medical record review remains a part of Wisconsin's overall quality assessment strategy for function such as data validity audits, ambulatory/inpatient quality of care reviews, focused quality reviews and other similar activities.

The Wisconsin Department of Health and Family Services publishes performance results on the measures in an on-line report called the MEDDIC-MS SSI Data Book. The MEDDIC-MS SSI Data Book may be viewed on-line at: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm

MEDDIC-MS SSI is a nationally recognized measure set. The federal Agency for Healthcare Research and Quality (AHRQ) has recognized MEDDIC-MS SSI for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

URAC® (Utilization Review Accreditation Commission) is one of the major health plan accrediting bodies in the nation and is recognized by CMS for health plan deeming. MEDDIC-MS and MEDDIC-MS SSI performance measures have been approved for health plan accreditation by URAC® (Utilization Review Accreditation Commission).

The Center for Health Transformation has recognized MEDDIC-MS and MEDDIC-MS SSI as "Transforming Examples" of innovation in health care and features information about them in its *Transforming Examples Resource Center*.

In 2005, MEDDIC-MS and MEDDIC-MS SSI were finalists for the Innovations Award by the Council of State Governments and were semi-finalists for the Innovations in American Government award sponsored by the John F. Kennedy School of Government at Harvard University.

These technical specifications incorporate updates and revisions as of October 2006, for measure calculation based on CY 2006 encounter data. For further information on the measures and on the goal-setting methodology contact:

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NOTE: The performance measures contained in this manual are not clinical practice guidelines and do not establish a standard of medical care. The measures are designed to assist the Wisconsin Department of Health and Family Services in assessing and improving quality of care delivered to SSI managed care program enrollees. The performance measures in this manual are subject to review and may be revised or rescinded at any time by the Wisconsin Department of Health and Family Services.

M E D D I C - M S S S I 2 0 0 7

Notes on measure calculations

Measure end date: This is the last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins. Typically, the *measure end date* is December 31 if a calendar year is to be measured, but it may be any date specified by the DHFS according to program needs. This criterion will be specified in the measure calculation directive.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.* This criterion will be specified in the measure calculation directive.

Measure look-back period*:* Typically, this is 365 days immediately prior to the *measure end date*. The measure look-back period may vary as specified by the DHFS according to program needs. This criterion will be specified in the measure calculation directive.

Unduplicated enrollees*:* Denominators for all measures include unduplicated enrollees only, unless otherwise specified.

Medicare/Medicaid dual eligible enrollees: Exclude from the denominator dually eligible enrollees for measures involving services that are covered under Medicare.

Numerators: Include denied encounter records in calculations unless otherwise noted.

Denominators*:* Report only on SSI eligibles' MedStat code in any of these measures. Do not include in any denominators MedStat codes for AFDC/TANF Medicaid enrollees or BadgerCare (SCHIP) enrollees.

Very small denominator: When a denominator for a measure is <30 enrollees, the measure will not be reported, however, the data is available to the managed care organization upon request.

Encounter data quality & completeness: The DHFS will run an encounter data report as of the measure data extraction date to assure that encounter data submissions for all the months in the look-back period have been received, edited and uploaded as complete. Measure calculation will <u>not</u> proceed if more than 5 percent of submitted encounter records are not uploaded to the data warehouse due to non-corrected errors or known missing records. The Department will notify the data contractor of data status prior to proceeding with calculation of the measures.

TECHNICAL SPECIFICATIONS
TARGETED PERFORMANCE IMPROVEMENT MEASURES

1. Ambulatory care management of diabetes

Rationale: This targeted performance improvement measure is designed to measure and improve performance of outpatient management services for people with Type I or Type 2 diabetes. Diabetes is known to be a major predisposing factor for numerous potentially serious health problems later in life, particularly blindness, kidney disease and cardiovascular disease. The risk for these complications increases greatly when the disease is poorly managed.

Diabetes is the 7th most prevalent diagnosis in the SSI population, affecting over 15 percent of individuals, and its prevalence is increasing.

The measure tracks the delivery of the following important clinical management services for enrollees known to be diabetic, reported as *separate numerators*:

- Hemoglobin Alc (HbAlc) testing; and
- Lipid profile testing.

Technical specifications:

Denominator:

Age cohorts: enrollees age 18-75 years as of the measure end date. The age cohort begins at the eighteenth birthday and ends on the 75th birthday.

Enrollment criteria: Must be continuously enrolled for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the look-back period.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date.* Services provided prior to enrollment or during gaps in enrollment are counted in the numerator if identified in MCO encounter data, previous MCO encounter data, DPH data or FFS data.

Clinical criteria: Enrollees dispensed insulin and/or oral hypoglycemics/ antihyperglycemics , based on AHFS therapeutic codes 682092, 682020, or 682008 during the measure look-back period on an ambulatory basis, or had at least two encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one encounter in an acute inpatient or emergency room setting during the

measure look-back period, with diagnosis of diabetes identified by the following diagnosis codes: ICD9-CM 250, 357.2, 362.0, 648.0 or 366.41.

Acute Inpatient /ER Codes

UB-92 revenue codes: 1OX, 11X, 12X, 13X, 14X, 15X, 16X, 20X, 21X, 22X, 45X, 72X, 80X, 981, 987.

CPT: Inpatient-99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99291-99292. ER: 99281-99288. Prolonged physician services: 99356-99357.

Or, place of service codes:

Inpatient/ER: 21 Inpatient Hospital, 23 Emergency Room - Hospital
Outpatient/Non-Acute Inpatient Codes:

11 Office
12 Patient's Home
22 Outpatient Hospital
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Facility

Outpatient/Non-Acute Inpatient Codes

UB-92 revenue codes: 49X, 50X, 51X, 52X, 53X, 55X, 56X, 57X, 58X, 59X, 65X, 66X, 76X, 82X, 83X, 84X, 85X, 88X, 92X, 94X, 96X, 972, 973, 974, 975, 976, 977, 978, 979, 982, 983, 984, 985, 986, 988, 989.

CPT: Office, other outpatient: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275. Prolonged physician service: 99354-99355. Preventive services: 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420-99429. Home Services: 99341-99355. Other evaluation/management, 99499. Nursing facility examinations: 99301-99303. Nursing facility care: 99311-99313. Home or custodial care: 99321-99323, 99331-99333.

Numerators:

Hemoglobin A1c: At least one HbAlc test conducted in the measure *look-back period*. CPT code 83036.

Lipid Profile: At least one LDL test in the lookback period. Encounter data will be used to identify services. CPT codes 80061, 83721, 83715, 83716, 83718, 83719.

2. Dental Preventive Care, Age 18+ years

This measure applies only if dental care is a covered benefit under the MCO contract.

Technical Specifications:

Dental Services Measure:

The percent of enrollees who have had at least one preventive dental service *look-back period*.

Calculation of the measure:

The measure uses MCO enrollee data to identify the denominator and current and previous (if applicable) HMO claims/encounter data, FFS MEDS data to determine the numerator.

Denominator:

Age cohorts: Enrollees age 18+ years of age enrolled as of the *measure end date*.

Enrollment criteria: Enrolled continuously for 304 days immediately prior to the *measure end date*. No more than one break of up to 45 days in enrollment. Enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the look-back period begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*.

Numerator:

Enrollees who had a dental visit during the *look-back period*. Count claims/encounters that include the following Current Dental Terminology (CDT) codes.

D1110 Prophylaxis, adult
D0120 Periodic oral evaluation
D0150 Comprehensive exam-new or established
D0160 Detailed and extensive oral evaluation
D1204 Topical fluoride adult without prophylaxis
D1205 Prophylaxis with fluoride adult, 13-20
D1351 Sealant
D4355 Mouth debridement, removal of subgingival/supragingival plaque and calculus
D4910 Periodontal maintenance procedure/maintenance following active therapy.

3. Post-hospitalization ambulatory care for mental illness within 7 and 30 days

Rationale: Psychiatric disorders are the second most prevalent diagnosis among individuals eligible for SSI, affecting approximately 32 percent of the population. Substance abuse is the 12th most prevalent diagnosis, affecting approximately 7 percent of the population. Therefore, access to both inpatient and ambulatory mental health and substance abuse care is very important. Follow-up ambulatory care for these disorders has been proven to be effective in preventing relapse and re-hospitalization. One recent

study found the relapse rate for individuals seen within 30 days was only 13.5 percent compared to a relapse rate of 25.1 percent when follow-up care was not provided.[1]

Technical specifications:

Calculation of measure:

This measure uses current and previous (if applicable) MCO claims/encounter data to identify enrollees discharged from inpatient care with a selected mental health diagnosis to identify those who have received ambulatory follow-up care. Count discharges for enrollees who have been hospitalized with a discharge date occurring during the *look-back period* and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified below. Do not count enrollees discharged from residential care or rehabilitation programs.

Denominator:

Age cohorts: Enrollees age 18+ years at the time of discharge.

Enrollment criteria: Continuously enrolled without breaks for at least 30 days *prior* to the date of discharge and for at least 30 days after discharge.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the look-back period begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date* but include in the denominator only those discharges occurring within the first 335 days of the look-back period.

Denominator clinical criteria—principle diagnosis:

Mental health:

DRG: 424-432, 701-878.

UB-92 revenue codes: 114, 124, 134, 144, 154, 204.

ICD-9-CM diagnosis codes 290.0-290.9, 293-302.9, 306-316, 295.xx, schizophrenic disorders; 296.xx, affective psychosis; 297.x, paranoid states; 298.x, other non-organic psychoses; 299.xx, psychoses with origin specific to childhood; 300.x, neurotic disorders; 301.x, personality disorders; 308.x, acute reaction to stress; 309.xx, adjustment reaction; 311, depressive disorder, NEC; 312.xx, disturbance of conduct, NEC; 313.xx, disturbance of emotions specific to childhood and adolescence; 314.00 - 314.01, attention deficit disorder.

[1] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs,* "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Substance abuse:

DRG: 433-437

UB-92 revenue codes: 116, 126, 136, 146, 156.

ICD-9-CM diagnosis codes 291.0 - 292.9, Alcoholic and drug psychosis; 303.00 - 305.9, Alcohol and drug dependence in conjunction with ICD-9-CM procedure codes 94.61, Alcohol rehabilitation; 94.63, Alcohol rehabilitation and detoxification; 94.64, Drug rehabilitation; 94.66, Drug rehabilitation and detoxification; 94.67, Combined alcohol and drug rehabilitation; 94.69, Combined alcohol and drug rehabilitation and detoxification; or UB-92 revenue codes 944, Drug rehabilitation (inpatient, non-residential setting); or 945, Alcohol rehabilitation (inpatient, non-residential setting).

If a member has more than one discharge during the *look-back period* with a principal diagnosis of one of the selected mental health/substance abuse disorders listed above, those discharges are each included in the denominator. However, if a discharge for one of the selected MH/SA disorders is followed by a readmission or a direct transfer to an acute or non-acute facility for any MH/SA principal diagnosis within the 30-day follow-up period, only the readmission discharge or the discharge from the facility to which the member was transferred should be counted, provided it meets the clinical criteria.

Numerators:

The number of discharges in the denominator that were followed by an ambulatory mental health or substance abuse encounter or day/night treatment within 7 and 30 days of hospital discharge reporting separate rates for each. Count enrollees with an encounter at 7 days only once in the numerator for 30 day follow-up, in addition to those enrollees with no encounter by 7 days but with an encounter by 30 days.

NOTE on HIPAA Procedure Code Modifiers: Use the following procedure codes with or without HIPAA procedure code modifiers, unless otherwise specified. See table below:

HIPAA Procedure Code Modifiers for Mental Health and Substance Abuse Services	
Modifier	**Description**
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
UA	Psychiatrist--MD
UB	Advanced Practice Nurse Practitioner
UC	Service provided in home or community setting
U7	Paraprofessional
U8	PA-C (physician assistant)

Numerator#1: Specialist follow-up care clinical criteria:

The follow-up visit must be with a mental health/substance abuse provider and can be for any mental health/substance abuse diagnosis. To identify ambulatory mental health follow-up encounters, use the CPT codes listed below or the UB-92 revenue codes: 900 psychiatric/psychological treatments; 901 electroshock treatment; 909 other psychiatric treatment; 910 general psychiatric services; 911 rehabilitation; 912 psychiatric/ psychological partial hospitalization, less intense; 913 psychiatric/ psychological partial hospitalization, intensive; 914 individual therapy; 915 group therapy; 916 family therapy, 961 psychiatric professional service; or 513, clinic-psychiatric.

The following mental health procedure codes are included in this measure: 90801, diagnostic assessment; 90802 interactive psychiatric diagnostic interview; 90804-90809, individual psychotherapy; 90810-90815, interactive' psychotherapy; 90816-90822, individual psychotherapy; 90823-90829, interactive psychotherapy***(exclude services coded 90816-90829 from count in numerator if provided during an acute care inpatient stay or residential care facility. Count in numerator if provided during partial hospitalization only)***; 90804-90809 and 90816-90819 and 90821, 90822); 90845, psychoanalysis; 90847, family psychotherapy; 90849, multifamily group therapy; 90853, group psychotherapy; 90810-90815 and 90823-90829***)***; 90857, interactive group psychotherapy; 90862, pharmacology management; 90870-90871 electro-convulsive therapy; 99201-99205, problem-focused new patient office visit, 99211-09215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

Substance abuse:

To identify ambulatory substance abuse follow-up encounters, use CPT codes 90857, Interactive group psychotherapy; 90862, Pharmacologic management with no more than minimal medical psychotherapy; 90865, Narcosynthesis for psychiatric diagnostic and therapeutic purposes; 90870 - 90871, Electroconvulsive therapy; 90887, Interpretation of tests or exams; 99201-99205, problem-focused new patient office visit, 99211-09215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

HCPCS codes H0002, individual or group AODA treatment; H0005, group AODA treatment; T1006, family AODA treatment; individual/family or group AODA therapy; H2012HF, AODA day treatment. Count these codes only if they appear with ICD-9-CM codes 291.0 - 291.9, (alcoholic psychosis), 303.00 - 305.90 (alcohol dependence syndrome, drug dependence, and nondependent abuse of drugs).

Numerator #2: Primary care provider follow-up clinical criteria:

The same diagnosis codes must be applied as for specialist follow-up care. The same clinical criteria used to identify ambulatory follow-up encounters with a mental health/substance abuse provider, only the services must be provided by a primary care provider. ***Do not count procedures with the following code modifiers for the PCP numerator: HN, HO, or HP.***

Numerator #3: Other or unspecified provider follow-up clinical criteria:

The same diagnosis codes must be applied as for specialist follow-up care. The same clinical criteria used to identify ambulatory follow-up encounters with a mental health/substance abuse provider apply, only the provider is neither a specialist nor a PCP or is unspecified.

Mental health provider criteria:

Follow-up care encounters provided by MCO intervention specialists, case managers and/or counselors will be accepted for inclusion in the numerator, provided the individual meets at least one of the qualifying criteria below, or such qualified individual participates in the encounter.

A doctor of medicine (MD) or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board.of Neurology and Psychiatry or, if not certified, has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.

An individual who is licensed as a psychologist in his/her state of practice.

An individual who is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work or is listed on the National Association of Social Worker's Clinical Register or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.

A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist or has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience, and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.

An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or certified to do so by the state of practice or, if licensure or certification is not required by the state of practice, is eligible for clinical membership in the American Association for Marriage and Family Therapy.

An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and is licensed or certified to do so by the state of practice or, if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty

Certification in Clinical Mental Health Counseling from the National Board of Certified Counselors (NBCC).

Certified Professional Counselor and State Certified Psychotherapists

Certified Professional Counselor (CPC) must have one of the following degrees, MS, MA, M.ED, MSN, have passed the National Counselor Exam or the Clinical Rehabilitation Counselor Exam and be hold a valid Wisconsin license. A qualified CPC may perform counseling through various means of applying a combination of human development, rehabilitation and either psychosocial or psychotherapeutic principles, procedures or services that integrate a wellness, pathology and multicultural model of human behavior in order to assist an individual, couple, family, group of individuals, organization, institution or community to achieve mental, emotional, physical social, moral, educational, spiritual, vocational or career development and adjustment through the life span of the individual, couple, family, group of individuals, organization, institution or community.

Please see:
http://www.drl.state.wi.us/agencies/drl/Regulation/applicant_information/dod1044.html
Please see: http://www.wisconsin.gov/state/app/license

To be considered a **State Certified Psychotherapist**, the CPC must have completed 3000 hours of supervised experience in a Mental Health Setting after which time they are certified to bill third parties for their services in psychotherapy.

NOTE on HIPAA Procedure Code Modifiers: Use the following procedure codes with or without HIPAA procedure code modifiers, unless otherwise specified. See table below:

HIPAA Procedure Code Modifiers for Mental Health and Substance Abuse Services	
Modifier	**Description**
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
UA	Psychiatrist--MD
UB	Advanced Practice Nurse Practitioner
UC	Service provided in home or community setting
U7	Paraprofessional
U8	PA-C (physician assistant)

4. Post-hospitalization care for substance abuse within 7 and 30 days

Technical specifications:

Calculation of measure:

This measure uses current and previous (if applicable) MCO claims/encounter data, FFS MEDS data to identify enrollees discharged with a selected substance abuse diagnosis to identify those who have received appropriate follow-up care. Count discharges for enrollees who have been hospitalized with a discharge date occurring during the *look-back period* and a principal ICD-9-CM substance abuse diagnosis code specified below. Do not count enrollees discharged from residential care, partial hospitalization or residential rehabilitation programs in the denominator.

Denominator:

Age cohorts: Enrollees age 18+ years.

Enrollment criteria: Continuously enrolled without breaks for at least 30 days *prior* to the date of discharge and for at least 30 days after discharge.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the look-back period begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date,* but include in the denominator only those discharges occurring within the first 335 days of the look-back period.

Denominator clinical criteria:

ICD-9-CM diagnosis codes 291.0 - 292.9, Alcoholic and drug psychosis; 303.00 - 305.9, Alcohol and drug dependence in conjunction with ICD-9-CM procedure codes 94.61, Alcohol rehabilitation; 94.63, Alcohol rehabilitation and detoxification; 94.64, Drug rehabilitation; 94.66, Drug rehabilitation and detoxification; 94.67, Combined alcohol and drug rehabilitation; 94.69, Combined alcohol and drug rehabilitation and detoxification; or UB-92 revenue codes 944, Drug rehabilitation (inpatient, non-residential setting); or 945, Alcohol rehabilitation (inpatient, non-residential setting).

Numerators:

Discharges in the denominator that were followed by an ambulatory substance abuse encounter within 7 and 30 days of discharge.

Numerator#1: Specialist follow-up care clinical criteria:

The follow-up visit *for numerator #1* must be with a mental health or substance abuse treatment provider and can be for any listed substance abuse diagnosis.

Numerator #2: Primary care provider follow-up clinical criteria:

The same diagnosis codes must be applied as for specialist follow-up care. The same clinical criteria are used to identify ambulatory follow-up encounters with a substance abuse provider, only the services must be provided by a primary care provider.

Numerator #3: Other or unspecified provider follow-up clinical criteria:

The same diagnosis codes must be applied as for specialist follow-up care. The same clinical criteria used to identify ambulatory follow-up encounters with a substance abuse provider apply, only the provider is neither a specialist nor a PCP or is unspecified.

Clinical criteria: To identify ambulatory follow-up encounters, use CPT codes 90857, Interactive group psychotherapy; 90862, Pharmacologic management with no more than minimal medical psychotherapy; 90865, Narcosynthesis for psychiatric diagnostic and therapeutic purposes; 90870 - 90871, Electroconvulsive therapy; 90887, Interpretation of tests or exams; 99201-99205, problem-focused new patient office visit, 99211-09215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

HCPCS codes H0022 individual AODA treatment; H0005, group AODA treatment; T1006, family AODA treatment; H0022, T1006, H0005, individual/family or group AODA therapy; H2012HF, AODA day treatment. Count these codes only if they appear with ICD-9-CM codes 291.0 - 291.9, (alcoholic psychosis), 303.00 - 305.90 (alcohol dependence syndrome, drug dependence, and nondependent abuse of drugs).

Provider criteria: The follow-up visit must be with a mental health or chemical dependency provider, primary care provider or other provider as defined above. The criteria for mental health provider is identified under the Mental health Follow-up Care Measure. ***Substance abuse Provider criteria****:* The follow-up visit must be with a mental health or chemical dependency provider, including CADC I, II, or III with appropriate clinical oversight.

WOMEN'S HEALTH

Technical specifications:

1. Breast cancer detection--screening mammography

a. Mammograms provided to women by age cohort.

Technical specifications:

Denominator

Age cohorts: Female enrollees (excluding those with history of bilateral radical mastectomy, CPT: 19180,19200-19220, 19240, or ICD-9-CM: 85.35-85.36, 85.44, 85.46, 85.48)--

i. 40-49 years of age.

ii. 50+ years of age.

Age cohort is determined by enrollee age at the measure end date.

Enrollment criteria:

Must be continuously enrolled for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the look-back period.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*.

Numerator:
Enrollees in the denominator who had at least one mammogram in the measure look-back period based on current and previous (if applicable) MCO claims/encounter data and FFS MEDS data.

Clinical criteria:

CPT codes: 76090-76092 (x-ray mammogram).

ICD-9-CM procedure codes: 87.36, 87.37;

Revenue codes 401 or 403;

Or, revenue codes 320 or 400 in conjunction with ICD-9-CM diagnosis codes 174.xx, 198.81, 217, 233.0, 238.3, 610.0, 610.1-2, 611.72, 793.8, V10.3, V76.1, V76.10-12 and V76.19.

b. Malignancies of the breast detected

The number of enrollees diagnosed with breast malignancy among those screened.

Technical specifications:

Denominator:

Unduplicated enrollees included in the numerator for measure (a) above.

Numerator:

Clinical criteria:

ICD-9-CM diagnosis codes: 174.xx, 198.81, or 233.0. Count malignancies detected on or after the mammogram date of service, but before the measure end date.

2. Cervical cancer detection-Pap tests

a. Pap tests provided to women in each age cohort.

Technical specifications:

Denominator

Age cohorts: Female enrollees (exclude enrollees with history of total abdominal or vaginal hysterectomy, ICD-9-CM 68.4, 68.5, 68.51, 68.59, or radical, 68.6,68.7, 68.8, 68.9; or CPT: 58210, 58150, 58152, 58200, 58285)—

i. 18-65 years of age.

Age cohort is determined by enrollee age at the measure end date.

Enrollment criteria:

Must be continuously enrolled for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*. Exclude from the denominator enrollees with a Pap test encounter as defined in the clinical criteria in the 24 months prior to the *look-back period*, if enrolled throughout the 36 months prior to the *measure end date or if the service is identified in FFS claims data, previous HMO encounter data or other data source*. Services provided by non-network provider(s) are counted in the numerator if reported in encounter data.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*.

Numerator:
Enrollees in the denominator who had at least one Pap test in the measure look-back period, based on current and previous (if applicable) MCO claims/encounter data and FFS MEDS data.

Clinical criteria:

CPT codes: 88141, 88142-88145, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164-88167.

Revenue code 923.

ICD-9-CM diagnosis codes: 795.0. Procedure codes: 91.46, V76.2, V76.47, V67.01.

b. Malignancies of the cervix or uterus detected

The number of enrollees diagnosed with cervical/uterine malignancy among those screened.

Technical specifications:

Denominator:

Unduplicated enrollees included in the numerator for measure (a) above.

Numerator #1, malignant or pre-malignant lesions:

Clinical criteria:

ICD-9-CM diagnosis codes: 179, 180.x, 182.0-182.8, or 233.1-2.

Numerator #2, Human papillomavirus (HPV) detected:

Clinical criteria:

ICD-9-CM diagnosis codes: 079.4.

TECHNICAL SPECIFICATIONS
MONITORING MEASURES

CHRONIC CONDITIONS

1. Asthma care

a. Period prevalence of asthma:

Technical specifications:

Denominator

Age cohorts: 18+ years of age.

Enrollment criteria: Must be continuously enrolled for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of up to 45 days. The enrollee must have a total of not less than 259 enrolled days in the look-back period.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator. This is the date from which the *look-back period* begins.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator.

Numerator #1: Enrollees with a diagnosis of asthma

Clinical Criteria

Unduplicated enrollees in each age cohort with encounter primary diagnosis codes for asthma. ICD-9-CM 493.x.

b. Asthma inpatient care:

Denominator:

Enrollees in numerator #1 above.

Numerator:

Enrollees in the denominator with at least one inpatient discharge for the asthma diagnoses above.

c. Asthma ED (emergency department) care:

Denominator:

Enrollees in numerator #1 above.

Numerator:

Enrollees in the denominator with at least one ED encounter for the asthma diagnoses above.

Query for encounters including an emergency department visit with a principal diagnosis of asthma, ICD-9 CM 493.x. An emergency department visit is identified by a principal diagnosis of asthma (493.x) paired with one of the following procedure or revenue codes: CPT 99281-99285 or 99288; UB-92 45X or 981.

MENTAL HEALTH AND/OR SUBSTANCE ABUSE

1. Outpatient mental health and/or substance abuse evaluations

Technical specifications:

Denominator

Age cohort: 18+ years.

Enrollment criteria: Must be continuously enrolled with the same HMO for at least ten months (304 days) immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period.*

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator.

Numerators

Numerator #1, MH/AODA outpatient evaluation

Enrollees receiving at least one outpatient mental health or substance abuse evaluation. Include services provided by mental health or substance abuse specialty providers based on current and previous (if applicable) HMO claims/encounter data and FFS MEDS data..

Clinical criteria:

NOTE on HIPAA Procedure Code Modifiers:

Use the following procedure codes with or without HIPAA procedure code modifiers, unless otherwise specified. See table below:

HIPAA Procedure Code Modifiers for Mental Health and Substance Abuse	
Modifier	**Description**
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
UA	Psychiatrist--MD

HIPAA Procedure Code Modifiers for Mental Health and Substance Abuse	
Modifier	**Description**
UB	Advanced Practice Nurse Practitioner
UC	Service provided in home or community setting
U7	Paraprofessional
U8	PA-C (physician assistant)

CPT codes: 90801, 90802, 96100, 96115, 96117

HCPCS: H2012, H0046, H0047, H0049 or H0050 and/or revenue code 918 in place of service outpatient hospital.

ICD-9-CM: V79.1 Special screening for alcoholism.

Exclude place of service codes: 21, 31, 32, 51, 52, 54, 56.

Numerator #2, MH day/outpatient treatment

Enrollees diagnosed with non-organic, non-substance abuse mental health disorder receiving day/outpatient mental health treatment. Include services provided by mental health specialists, general and/or family practitioners, or general internal medicine physician based on current and previous (if applicable) HMO claims/encounter data and FFS MEDS data.

Clinical criteria:

To identify ambulatory encounters, use the CPT codes listed below or the UB-92 revenue codes: 900 psychiatric/psychological treatments; 901 electroshock treatment; 909 other psychiatric treatment; 910 general psychiatric services; 911 rehabilitation; 912 psychiatric/ psychological partial hospitalization, less intense; 913 psychiatric/ psychological partial hospitalization, intensive; 914 individual therapy; 915 group therapy; 916 family therapy, 961 psychiatric professional service ; or 513, clinic-psychiatric.

The following mental health procedure codes are included in this measure: 90801, diagnostic assessment; 90802 interactive psychiatric diagnostic interview; 90804-90809, individual psychotherapy; 90810-90815, interactive' psychotherapy; 90816-90822, individual psychotherapy; 90823-90829, interactive psychotherapy ***(exclude services coded 90816-90829 from count in numerator if provided during an acute care inpatient stay or residential care facility. Count in numerator if provided during partial hospitalization only)***; 90845 and 90804-90809 and 90816-90819 and 90821, 90822; 90845, psychoanalysis; 90847, family psychotherapy; 90849, multifamily group therapy; 90853, group psychotherapy; 90810-90815 and 90823-90829; 90857, interactive group psychotherapy; 90862, pharmacology management; 90870-90871 electro-convulsive therapy; 99201-99205, problem-focused new patient office visit, 99211-99215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive

exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

Exclude place of service codes: 21, 31, 32, 51, 52, 54, 56.

Numerator #3, Outpatient/day treatment for substance abuse specialty/non-specialty care.

Enrollees with substance abuse diagnosis receiving day/outpatient substance abuse treatment. Include services provided by substance abuse specialists, general and/or family practitioners, or general internal medicine physician.

Clinical criteria:

To identify ambulatory encounters, use CPT codes 90857, interactive group psychotherapy; 90862, pharmacologic management with no more than minimal medical psychotherapy; 90865, narcosynthesis for psychiatric diagnostic and therapeutic purposes; 90870 - 90871, electroconvulsive therapy; 90887, interpretation of tests or exams; 99201-99205, problem-focused new patient office visit, 99211-99215, problem-focused established patient office visit, 99241-99245, new or established patient problem-focused office consultation, 99341-99345, home visit, 99347-99350, home visit, established patient, 99383-99387 new patient, preventive services with comprehensive exam, age 5 and over; 99393-99397 established patient, preventive services with comprehensive exam, age 5 and over; 99401-99404 individual counseling, preventive medicine, risk reduction.

HCPCS codes H0004, H0016, H0022 individual or group AODA treatment; H0005, group AODA treatment; T1006, family AODA treatment; H2012HF, AODA day treatment, or H0050 brief SA intervention. Count these codes only if they appear with ICD-9-CM codes 291.0 - 291.9, (alcoholic psychosis), 303.00 - 305.90 (alcohol dependence syndrome, drug dependence, and nondependent abuse of drugs). V65.42 Counseling on substance use and abuse.

Exclude place of service codes: 21, 31, 32, 51, 52, 54, 56.

GENERAL AND SPECIALTY CARE

Technical specifications:

Denominator

Age cohorts: 18+ years.

Enrollment criteria: Must be continuously enrolled for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than 45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator.

Numerator #1, Emergency department (ED) visits without admission to inpatient care, by age cohort.

Clinical Criteria:

Enrollees in the denominator receiving care in an emergency department of an acute care provider facility without subsequent admission to an inpatient care facility as a direct result of the ED visit in the *measure look-back period*.

CPT codes: 10040-69979, or 99281-99285 with HCFA 1500 place of service code 23.

or

UB-92 revenue codes: 450, 451, 452, 456, 459 with encounter type "hospital outpatient."

Numerator #2, Primary care encounters.

Clinical Criteria:

Enrollees having one or more primary care encounters in the measure *look-back period*. Also calculate the total of all primary care encounters. Primary care encounters are ambulatory care encounters for any purpose provided by any provider type defined in the HMO contract that the enrollee may select for primary care.

CPT codes: 99201-99215, 99241-99245, 99341-99350, 99354-99357 (99354-99357 may not be counted if the code appears in conjunction with any of the other listed CPT codes on the same date of service), 59400, 59425, 59426, 59510, 59610, 59618, 99381-99387, 99391-99397, 99401-99404 preventive medicine, individual counseling, 99420 health risk assessment, 99429 unlisted preventive health services.

Numerator #3, Vision care encounters.

Clinical Criteria:

Enrollees in the denominator having one or more vision care encounters in the measure *look-back period*. Count only encounters with an ophthalmologist or optometrist.

CPT codes: 92002, 92004, 99201-99205, 99211-99215, 92499 or HCPCS codes W8004 or W8009.

Numerator #4, Audiology encounters.

Clinical Criteria:

Enrollees in the denominator having one or more audiology encounters in the measure *look-back period*. Count only encounters with an audiology specialist provider.

CPT codes: 92506-92508, 92541-92547, 92551-92569, 92571-92579, 92582-92584, 92590-92599.

Numerator #5, General Dental encounters. (Applies only to MCOs that have dental care included in their contract.)

Clinical Criteria:

Enrollees in the denominator having one or more dental care encounters in the measure *look-back period*. Count encounters with a dentist (DDS or DDM), dental hygienist or outpatient hospital.

CPT codes: 70300, 70310, 70320, 70355; or

CDT codes:

D0120, D0140, D0150, D0160, D0170, D0180, D0210-D0290, D0320-D0350, D0470, D0999, D1110-D1351, D1510-D1550, D2110-D2161, D2330- D2394, D2510-D25440, D2610-D26640, D2710-D2799, D2910-D2999, D3110, D3120, D3220-D3240, D3310-D3353, D3430-D3470, D3950-D3999, D4341-D4381, D4910-D4999, D5986, D5987, D6210-D6253, D6519, D6520-D6544, D6600-D6615, D6720-D6793, D7130, D7140, D7282-D7287, D7880-D7912, D8692-D9215, D9310-D9971, D9999

Level II HCPCS codes:

D0120001003, D0140001003, D0150001003, D0160001003, D0170001003, D0170002004, D0180001003, D0210001003-D0290001003, D0320001003-D0350001003, D0470001003, D0999001003, D1110001003- D1351001003, D1510001003- D1550001003, D2110001003-D2161001003, D2330001003-D2394001003, D2510001003-D2544001003, D2610001003- D2664001003, D2710001003-D2799001003, D2910001003- D2999001003, D3110001003, D3120001003, D3220001003-D3240002004, D3310001003- D3353002004, D3430001003- D3470001003, D3950001003- D3999001003, D4341001003-D4381002004, D4910001003- D4999001003, D5986001003, D5987001003, D6210001003-D6253001003, D6519001003, D6520001003- D6544001003, D6600001003-D6615001003, D6720001003-D6793001003, D7130001003, D7140001003, D7282001003-D7287001003, D7880001003- D7912001003, D8692001003-D9215001003, D9310001003- D9971001003, D9999001003

INPATIENT CARE

These monitoring measures track total discharges for selected inpatient services in the *look-back period*. Report denominator size, numerator/denominator percentage, total discharges, total inpatient days and average length of stay for each numerator, by applicable age cohort by HMO and as an aggregate total.

Technical specifications:

Denominator

Age cohorts: 18+ years.

Enrollment criteria: Must be continuously enrolled for at least 304 days immediately prior to the *measure end date* with no more than one gap in enrollment of not more than

45 days. The enrollee must have a total of not less than 259 enrolled days in the *look-back period*.

Measure end date: The last date by which measured services can be rendered to be included in the measure numerator.

Measure data extraction date: The date(s) determined by the department for extraction of data from the data warehouse for the purposes of reporting the measure. This will be at least 182 days after the *measure end date.*

Measure look-back period: 12 months (365 days) from the *measure end date*. Services provided prior to enrollment in the HMO are not counted in the numerator.

Numerator #1, Surgery

Clinical criteria:

Report all surgical stays with the following codes:

DRG: 1-3, 6-8, 36-42, 49-63, 75-77, 103-111, 113-120, 146-171, 191-201, 209-213, 216-220, 223-230, 232-234, 257- 270, 285-293, 302-315, 334-345, 353-365, 370-371, 374-375, 377, 381, 392-394, 401, 402, 406-408, 415, 424, 439-443, 461, 468, 471, 476-479, 482, 483-486, 488, 491, 493, 494, 496-504, 506, 507, 515-520, 525-543.

Or;

ICD-9-CM surgical codes with UB-92 revenue code 36X where "X" represents any third digit.

Numerator #2, Medical care.

Clinical criteria:

Report all inpatient medical stays—excluding maternity & MH/SA—with the following codes:

DRG: 9-35, 43-48, 64-74, 78-102, 121-145, 172-190, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 395-399, 403-405, 409-414, 416-423, 444-455, 460, 462-467, 470, 473, 475, 487, 489, 490, 492, 505, 508-511, 524,

Or;

ICD-9-CM diagnosis codes excluding codes for maternity, psychiatry, substance abuse, surgery, or other.

Numerator #3, Psychiatry.

Report all inpatient psychiatric stays with the following codes:

Mental health:

DRG: 424-432, 701-878.

UB-92 revenue codes: 114, 124, 134, 144, 154, 204.

CPT: 90816 - 90822 (inpatient individual psychotherapy).

ICD-9-CM diagnosis codes 290.0-290.9, 293-302.9, 306-316, 295.xx, schizophrenic disorders; 296.xx, affective psychosis; 297.x, paranoid states; 298.x, other non-organic psychoses; 299.xx, psychoses with origin specific to childhood; 300.x, neurotic disorders; 301.x, personality disorders; 308.x, acute reaction to stress; 309.xx, adjustment reaction; 311, depressive disorder, NEC; 312.xx, disturbance of conduct, NEC; 313.xx, disturbance of emotions specific to childhood and adolescence; 314.00 - 314.01, attention deficit disorder.

Numerator #4, Substance abuse.

Report all inpatient substance abuse stays with the following codes:

Substance abuse:

DRG: 433-437

UB-92 revenue codes: 116, 126, 136, 146, 156.

ICD-9-CM diagnosis codes 291.0 - 292.9, Alcoholic and drug psychosis; 303.00 - 305.9, Alcohol and drug dependence in conjunction with ICD-9-CM procedure codes 94.61, Alcohol rehabilitation; 94.63, Alcohol rehabilitation and detoxification; 94.64, Drug rehabilitation; 94.66, Drug rehabilitation and detoxification; 94.67, Combined alcohol and drug rehabilitation; 94.69, Combined alcohol and drug rehabilitation and detoxification; or UB-92 revenue codes 944, Drug rehabilitation (inpatient, non-residential setting); or 945, Alcohol rehabilitation (inpatient, non-residential setting).

Numerator #5, Other (hospice, rehabilitation, respite) inpatient care.

Report all other inpatient (including both hospital and non-hospital place of service codes) stays with the following UB-92 revenue codes:

Hospice: 115, 125, 135, 145, 155, 650, 659;

Rehabilitation: 118, 128, 138, 148, 158; Respite: 655.