

# Puget Sound Health Alliance

## Technical Specification Document

<b>About the Technical Specifications</b> .....	<b>2</b>
<b>Attribution Methodology</b> .....	<b>2</b>
<b>Diabetes</b> .....	<b>6</b>
HbA1c Testing .....	8
Eye Exam.....	8
LDL-C Screening .....	8
Medical Attention for Nephropathy.....	9
<b>Depression</b> .....	<b>11</b>
Effective Acute Phase Treatment.....	14
Effective Continuation Phase Treatment.....	15
<b>Appropriate Use of Services</b> .....	<b>16</b>
Use of Imaging Studies for Low Back Pain (LBP).....	16
Appropriate Testing for Children With Pharyngitis (CWP) .....	18
Appropriate Treatment for Children With Upper Respiratory Infection (URI) .....	22
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB).....	25
<b>Cardiovascular</b> .....	<b>29</b>
Cholesterol Management for Patients With Cardiovascular Conditions (CMC) .....	29
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) .....	31
Patients with Coronary Artery Disease who are prescribed a lipid lowering therapy .....	33
<b>Generic Prescribing</b> .....	<b>35</b>
Percentage of Generic Prescriptions for Statins .....	35
Percentage of Generic Prescriptions for SSRIs and other Second Generation Antidepressants .....	36
Percentage of Generic Prescriptions for PPIs.....	37
Percentage of Generic Prescriptions for NSAIDs .....	38
<b>Prevention</b> .....	<b>40</b>
Breast Cancer Screening (BCS) .....	40
Cervical Cancer Screening (CCS) .....	41
Colorectal Cancer Screening (COL) .....	43
Chlamydia Screening in Women (CHL) .....	44
<b>Asthma</b> .....	<b>47</b>
Use of Appropriate Medications for People With Asthma (ASM) .....	47
<b>Access to Care</b> .....	<b>50</b>
Adults' Access to Preventive/Ambulatory Health Services (AAP).....	50
Children and Adolescents' Access to Primary Care Practitioners (CAP).....	51

## About the Technical Specifications

The medical group and clinic measures used by the Puget Sound Health Alliance (the Alliance) for the Community Checkup report are based primarily on the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) specifications developed by the National Committee for Quality Assurance (NCQA). These measures include detailed specifications for calculating the results, including eligibility definitions, age ranges, procedure codes, specified dates of service, exclusions and continuous eligibility requirements. The measure for the use of cholesterol-lowering medication for heart disease was developed by the American College of Cardiology and the American Heart Association. The four generic prescribing measures were developed by the Alliance in response to the significant potential for cost savings associated with filling prescriptions using generic rather than brand name drugs. NCQA updates HEDIS technical specifications annually to incorporate clarifications, coding updates and changes. Any deviation from HEDIS 2008 technical specifications is noted at the beginning of each measure section.

## Attribution Methodology

To report performance results at the clinic level, the Alliance assigns or attributes the care of a patient to a clinician. If every patient saw only one doctor every year, attribution would be straightforward. However, many patients have several visits to different clinicians over the course of a year. Therefore, the Alliance employs two methods of attribution to ensure consistent assignment of patients to clinicians across services of interest.

During the selection process, the Alliance worked with clinics to test several different attribution methods. The final methods selected are the Primary Care Provider (PCP) Attribution and the PCP and Specialist Team Attribution. Each of these methods is described in the following section.

### Primary Care Provider (PCP) Attribution:

---

PCP Attribution is applied to prevention-related measures based on the concept that the PCP is the clinician that is primarily responsible for a patient's preventive care management.

***Note:** In addition to the prevention measures, medical groups will see that generic drug measures also use PCP attribution. Due to current limitations in our ability to capture prescribing clinician information across all prescriptions, the public report will only show county and regional-level summary results for generic drug measures. The clinic summaries of these measures are only presented to medical groups so they can view generic drug utilization among their patients.*

The PCP Attribution method assigns each patient to a **single** primary care provider (see [Specialties of Interest](#) for primary care related specialties) who provided the most Evaluation and Management visits (see [Evaluation and Management \(E&M\) visit codes](#) for a list of eligible service codes) over the most recent 24 month period covered in the report. To receive clinician attribution, patients must have a minimum of one service during the 24 month period.

The following is the ranking hierarchy to be used in selecting the single attributed primary care provider for each patient:

---

<sup>®</sup> HEDIS is a registered trademark of the National Association for Quality Assurance. Current Procedure Terminology © 2005 American Medical Association. All rights reserved.

1. Most number of E&M visits as defined in "[Evaluation and Management \(E&M\) visit codes](#)"
2. Highest sum of RVUs (the "relative value units" associated with the services based on the E&M visits in #1 above. The RVU assigns a weight for the intensity of the service -e.g. A service of 99211 would have a lower RVU than 99214 )
3. Most recent service date

## PCP and Specialist Team Attribution:

The "Team" method is applied to measures related to specific health conditions, as it is believed that patients benefit most when their entire medical team works together to ensure that they receive appropriate care.

This method assigns each patient to every measure-appropriate primary care provider and/or specialist (see [Specialties of Interest](#)) with *any* E&M visits over the most recent 24 months covered in the report. To receive clinician attribution, patients must have a minimum of one service during the 24 month period.

## Specialties of Interest

The below table shows which specialties are used by each type of measure:

Measures	Attribution Method	Primary Care Specialties													Non-Primary Care Specialties									
		Adult Medicine	Family Medicine	General Practice	Homeopathy	Internal Medicine	Naturopathy	Nurse Practitioner	Obstetrics & Gynecology	Osteopathy	Pediatrics	Physician Assistant	Preventive Medicine	Women's Health	Allergy & Immunology	Cardiovascular Disease	Chiropractor	Endocrinology	Gastroenterology	Orthopaedic Surgery	Physiatry	Psychiatry & Neurology	Pulmonology	Rheumatology
Appropriate Testing for Children With Pharyngitis	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Appropriate Treatment for Children with URI	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Breast Cancer Screening, age 42-69	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Cervical Cancer Screening	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Chlamydia Screening in Women, ages 16 to 25	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Colorectal Cancer Screening	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Percentage of Generic Prescriptions for NSAIDs	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Percentage of Generic Prescriptions for PPIs	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Percentage of Generic Prescriptions for SSRIs	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Percentage of Generic Prescriptions for Statins	PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓										
Antidepressant Medication Management measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓			
Asthma Measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							✓		
Beta Blocker treatment after a heart attack	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									
Comprehensive Diabetes Care measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓							
Coronary Artery Disease	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									
Cardiovascular Condition measures	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									
Low Back Pain	Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓			

## Evaluation and Management (E&M) visit codes

CPT codes	Explanation
99201	Office/outpatient evaluation and management visit, new patient. Level 1
99202	Office/outpatient evaluation and management visit, new patient. Level 2
99203	Office/outpatient evaluation and management visit, new patient. Level 3
99204	Office/outpatient evaluation and management visit, new patient. Level 4
99205	Office/outpatient evaluation and management visit, new patient. Level 5
99211	Office/outpatient evaluation and management visit, established patient. Level 1
99212	Office/outpatient evaluation and management visit, established patient. Level 2
99213	Office/outpatient evaluation and management visit, established patient. Level 3
99214	Office/outpatient evaluation and management visit, established patient. Level 4
99215	Office/outpatient evaluation and management visit, established patient. Level 5
99241	Office consultation for a new or established patient. Level 1
99242	Office consultation for a new or established patient. Level 2
99243	Office consultation for a new or established patient. Level 3
99244	Office consultation for a new or established patient. Level 4
99245	Office consultation for a new or established patient. Level 5
99341	Home visit for the evaluation and management of a new patient. Level 1
99342	Home visit for the evaluation and management of a new patient. Level 2
99343	Home visit for the evaluation and management of a new patient. Level 3
99344	Home visit for the evaluation and management of a new patient. Level 4
99345	Home visit for the evaluation and management of a new patient. Level 5
99347	Home visit for the evaluation and management of an established patient. Level 1
99348	Home visit for the evaluation and management of an established patient. Level 2
99349	Home visit for the evaluation and management of an established patient. Level 3
99350	Home visit for the evaluation and management of an established patient. Level 4
99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service.
99355	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service.
99358	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care.
99359	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care.
99382	Initial comprehensive preventive medicine evaluation and management of an individual (Age 1-4).
99383	Initial comprehensive preventive medicine evaluation and management of an individual (Age 5-11).
99384	Initial comprehensive preventive medicine evaluation and management of an individual (Age 12-17).
99385	Initial comprehensive preventive medicine evaluation and management of an individual (Age 18-39).
99386	Initial comprehensive preventive medicine evaluation and management of an individual (Age 40-64).
99387	Initial comprehensive preventive medicine evaluation and management of an individual (Age 65 and older).
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual (Age 1-4).
99393	Periodic comprehensive preventive medicine reevaluation and management of an

	individual (Age 5-11).
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual (Age 12-17).
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual (Age 18-39).
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual (Age 40-64).
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual (Age 65 and older).
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99420	Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)
99429	Unlisted preventive medicine service
99499	Unlisted evaluation and management service

# Diabetes

## Changes from HEDIS 2008 specifications to Alliance specific measures:

- 30 day gap in enrollment (HEDIS allows 45)
- No Medicare data collected
- Measures are based on a specified measurement year (HEDIS based on a calendar year)
- Eye Exam measure uses a two-year measurement period (HEDIS uses one-year)

## Comprehensive Diabetes Care (CDC)

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

- Hemoglobin A1c (HbA1c) testing
- Eye exam (retinal) performed
- LDL-C screening
- Medical attention for nephropathy

## Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	18–75 years as of the last day of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 30 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	Last day of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	Two methods identify members with diabetes: pharmacy data and claim/encounter data. Both methods are used to identify the eligible population, but a member only needs to be identified in one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.  <i>Pharmacy data.</i> Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A).

**Table CDC-A: Prescriptions to Identify Members with Diabetes**

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

**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 coding only.*

*Claim/encounter data.* Members who had *two* face-to-face encounters with a diagnosis of diabetes (Table CDC-B) on different dates of service in an outpatient setting or nonacute inpatient setting, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table CDC-C for codes to identify visit type.

**Table CDC-B: Codes to Identify Diabetes**

Description	ICD-9-CM Diagnosis	DRG
Diabetes	250, 357.2, 362.0, 366.41, 648.0	294, 295

**Table CDC-C: Codes to Identify Visit Type**

Description	CPT	UB Revenue
Outpatient	92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

## HbA1c Testing

### Administrative Specification

**Denominator** The eligible population.

#### Numerators

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

**Table CDC-D: Codes to Identify HbA1c Tests**

CPT
83036, 83037

## Eye Exam

**Eye exam** An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following.

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the two-year measurement period, **or**

Refer to Table CDC-G for codes to identify eye exams.

**Table CDC-G: Codes to Identify Eye Exams\***

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

\*Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.

## LDL-C Screening

**Denominator** The eligible population.

#### Numerators

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

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

CPT
80061, 83700, 83701, 83704, 83715, 83716, 83721

**Medical Attention for Nephropathy**

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

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

**Table CDC-J: Codes to Identify Nephropathy Screening Tests**

Description	CPT
Nephropathy screening test	82042, 82043, 82044, 84156

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

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

**Table CDC-K: Codes to Identify Evidence of Nephropathy**

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	DRG
Urine macroalbumin test	81000-81003, 81005					
Evidence of treatment for nephropathy	36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925,	G0257, G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6	0367, 080x, 082x-085x, 088x	316, 317

	90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512					
--	--------------------------------------------------------------------------------------------	--	--	--	--	--

**Table CDC-L: ACE Inhibitors/ARBs**

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

### Exclusions

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

**Table CDC-O: Codes to Identify Exclusions**

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

# Depression

## Changes from HEDIS 2008 specifications to Alliance specific measures:

- Measures are based on a specified measurement year (HEDIS is on a calendar year basis)
- 18 years of age and older as of the 30<sup>th</sup> day of the fourth month in the measurement year (HEDIS uses April 30 specifically)
- 30 day gap in enrollment (HEDIS allows 45)
- No Medicare data collected

## Antidepressant Medication Management (AMM)

### Description

The following components of this measure assess different facets of the successful pharmacological management of major depression.

- *Effective Acute Phase Treatment.* The percentage of members 18 years of age and older as of the 30<sup>th</sup> of the fourth month in the measurement year who were diagnosed with a new episode of major depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.
- *Effective Continuation Phase Treatment.* The percentage of members 18 years of age and older as of the 30<sup>th</sup> of the fourth month in the measurement year who were diagnosed with a new episode of major depression and treated with anti-depressant medication and who remained on an antidepressant drug for at least 180 days.

### Definitions

<b>Intake Period</b>	The 12-month window starting on the first day of the fifth month of the year prior to the measurement year and ending on the 30 <sup>th</sup> of the fourth month of the measurement year.
<b>IESD</b>	Index Episode Start Date. The earliest encounter during the Intake Period with a qualifying diagnosis of major depression.
<b>Index Prescription Date</b>	The earliest prescription for antidepressants filled within a 44-day period, defined as 30 days prior to through 14 days on or after the IESD.
<b>Negative Diagnosis History</b>	A period of 120 days (4 months) prior to the IESD, during which time the member had no claims/encounters containing either a principal or secondary diagnosis of major depression (Table AMM-A).
<b>Negative Medication History</b>	A period of 90 days (3 months) prior to the Index Prescription Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antidepressant drug (refer to the medication listing at the end of this measure specification).
<b>New Episode</b>	To qualify as a New Episode, the following criteria must be met.

- A 120-day (4 months) Negative Diagnosis History prior to the IESD, and
- A 90-day (3 months) Negative Medication History prior to the Index Prescription Date

**Treatment days** The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days supply dispensed on the 100th day will have 80 days counted in the 180-day interval.

## Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	18 years and older as of the 30 of the fourth month of the measurement year.
<b>Continuous enrollment</b>	120 days prior to the IESD through 245 days after the IESD.
<b>Allowable gap</b>	One gap in enrollment of up to 30 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled).
<b>Anchor date</b>	IESD.
<b>Benefits</b>	Medical, pharmacy and mental health (inpatient and outpatient).
<b>Event/diagnosis</b>	Diagnosed with a New Episode of major depressive disorder during the Intake Period and treated with antidepressant medication.

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

**Step 1** Identify all members with a diagnosis of major depression who had at least one of the following during the 12-month Intake Period.

- At least one principal diagnosis of major depression (Table AMM-A) in any setting (e.g., outpatient or ED visits, inpatient discharges or partial hospitalizations), **or**
- At least two secondary diagnoses of major depression (Table AMM-A) on different dates of service in any outpatient setting (e.g., outpatient or ED visits), **or**
- At least one secondary diagnosis of major depression (Table AMM-A) associated with any inpatient discharge.

**Note:** Do not include lab claims when identifying members with major depression.

**Table AMM-A: Codes to Identify Major Depression**

Description	ICD-9-CM Diagnosis	DRG
Major depression*	296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311	426**

Prior depressive episodes	296.2-296.9, 298.0, 300.4, 309.0, 309.1, 309.28, 311	426**
---------------------------	------------------------------------------------------	-------

\* Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of that code). Additionally, other possible codes that could indicate a depression diagnosis (296.4–296.9, 309.0, 309.28) are not included in this list because these codes are less specific in identifying eligible members.

\*\* The organization must *exclude* members with this code if the principal diagnosis is ICD-9-CM code 301.12.

**Step 2** Determine the IESD and test for Negative Diagnosis History. For each member identified in step 1, determine the IESD by finding the date of the member's earliest encounter during the Intake Period (i.e., outpatient or ED visit date, inpatient discharge date, partial hospitalization visit date) with a qualifying major depression diagnosis (Table AMM-A).

Identify members who were diagnosed with a New Episode of major depression. The range of ICD-9-CM Diagnosis codes for prior depressive episodes in Table AMM-A is more comprehensive to exclude members diagnosed with any type of depression.

Members with any diagnosis of major depression within the previous 120 days (4 months) of the IESD should be dropped from this denominator.

**Step 3** Identify members receiving antidepressant medication therapy. Among members identified in step 2, find those who filled a prescription for an antidepressant medication within 30 days before the IESD to 14 days on or after the IESD.

**Step 4** Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days prior to the IESD to 245 days (180 medication days + 51 potential gap days + 14 days for filling the prescription) after the IESD.

**Step 5** Identify the Index Prescription Date. Identify the earliest prescription up to 30 days before the IESD to 14 days on or after the IESD. Prescriptions may be up to 30 days before the IESD to account for members having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit.

Similarly, prescriptions may be 14 days on or after the IESD to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication or for member delay in filling the initial prescription.

**Step 6** From the resulting members from step 5, confirm the New Episode by testing for a Negative Medication History. Members who have antidepressant prescriptions filled during the Negative Medication History period do not represent new treatment episodes and must be excluded.

**Step 7** Exclude members who had an acute inpatient stay with a principal diagnosis of mental health (Table MPT-A) or substance abuse (Table AMM-B) during the 245 days after the IESD treatment period.

**Table AMM-B: Codes to Identify Substance Abuse**

ICD-9-CM Diagnosis	DRG
291-292, 303-305, 960-979 with a secondary diagnosis of chemical dependency	433, 521-523

### Administrative Specification

**Denominator** The eligible population.

**Numerators**

## Effective Acute Phase Treatment

### **Effective Acute Phase treatment**

An 84-day (12-week) acute treatment with antidepressant medication.

Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment (Table AMM-D) to provide continuous treatment for at least 84 days in the 114-day period. Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Allowable medication changes or gaps include the following.

- “Washout” period gaps to change medication
- “Treatment” gaps to refill the same medication

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

To determine continuity of treatment during the 114-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e., 84 treatment days + 30 gap days = 114 days).

For all prescriptions filled within 114 days of the Index Prescription Date, the organization should count treatment days on the Index Prescription Date and continue to count until a total of 84 treatment days has been established. Members whose gap days exceed 30 or who do not have 84 treatment days within 114 days after the Index Prescription Date are not counted in the numerator.

**Table AMM-D: Antidepressant Medications**

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

## Effective Continuation Phase Treatment

**Effective Continuation Phase treatment** A 180-day treatment with antidepressant medication. Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment (Table AMM-D) to provide continuous treatment for at least 180 days in the 231-day period.

The continuous treatment definition allows gaps in medication treatment up to a total of 51 days during the 231-day period. Allowable medication changes or gaps include the following.

- Washout period gap to change medication
- Treatment gaps to refill the same medication

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

To determine continuity of treatment during the 231-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 231 days (i.e., 180 treatment days + 51 gap days = 231 days); identify all prescriptions filled within the 231 days of the Index Prescription Date.

The organization should count treatment days on the Index Prescription Date and continue to count until a total of 180 treatment days has been established. Members whose gap days exceed 51 or who do not have 180 treatment days within 231 days after the Index Prescription Date are not counted in the numerator.

### Note

---

- *If the member has a mental health or pharmacy benefit with the organization (or if the organization contracts with the mental health or pharmacy benefit with a separate vendor) and the claim for major depression treatment or antidepressant medication is denied (e.g., the member failed to get proper authorization), the member should be included in the denominator of this measure.*
- *A member with a mental health benefit whose claim for follow-up visits is denied is included in the denominator of this measure but must also meet all other eligibility requirements for inclusion.*

# Appropriate Use of Services

## Changes from HEDIS 2008 specifications to Alliance specific measures:

- LBP Intake period: The first day of the measurement period through the 3<sup>rd</sup> day of the twelfth month of the measurement year (HEDIS uses January 1–December 3 specifically)
- CWP Intake period: A 12-month window that begins six months prior to the measurement year and ends on the 30<sup>th</sup> day of the sixth month in the measurement period (HEDIS uses July 1 and June 30 specifically)
- URI Intake period: A 12-month window that begins six months prior to the measurement year and ends on the 30<sup>th</sup> day of the sixth month of the measurement year (HEDIS uses July 1 and June 30 specifically)
- AAB Intake period: Beginning of the measurement period through the 24<sup>th</sup> day of the twelfth month of the measurement year (HEDIS uses January 1-December 24 specifically)
- 30 day gap in enrollment (HEDIS allows 45)
- Measures are based on a specified measurement year (HEDIS is on a calendar year basis)

## Use of Imaging Studies for Low Back Pain (LBP)

### Description

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

### Calculation

The measure is reported as an inverted rate [ $1 - (\text{numerator}/\text{eligible population})$ ]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

### Definitions

<b>Intake Period</b>	The first day of the measurement period thru the 3 <sup>rd</sup> day of the twelfth month of the measurement year. The Intake Period is used to identify the first outpatient or ED encounter with a primary diagnosis of low back pain.
<b>IESD</b>	Index Episode Start Date. The earliest date of service for any outpatient or ED encounter (Table LBP-B) during the Intake Period with a primary diagnosis of low back pain (Table LBP-A).
<b>Negative Diagnosis History</b>	A period of 180 days (6 months) prior to the IESD during which time the member had no claims/encounters with any diagnosis of low back pain (Table LBP-A).

## Eligible Population

<b>Product line</b>	Commercial, Medicaid.
<b>Ages</b>	18 years as of the first day of the measurement year to 50 years as of last day of the measurement year.
<b>Continuous enrollment</b>	180 days prior to the IESD through 28 days after the IESD.
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Anchor date</b>	IESD.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	Outpatient or ED visit with a primary diagnosis of low back pain. Follow the steps below to identify the eligible population.
<b>Step 1</b>	Identify all members in the specified age range who had an outpatient or ED encounter (Table LBP-B) with a primary diagnosis of low back pain (Table LBP-A) during the Intake Period.

**Table LBP-A: Codes to Identify Low Back Pain**

ICD-9-CM Diagnosis
721.3, 722.10, 722.32, 722.52, 722.93, 724.02, 724.2, 724.3, 724.5, 724.6, 724.70, 724.71, 724.79, 738.5, 739.3, 739.4, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

**Table LBP-B: Codes to Identify Visit Type**

Description	CPT	UB Revenue
Outpatient	98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
ED	99281-99285	045x, 0981

- Step 2** Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.
- Step 3** Test for Negative Diagnosis History. Exclude members with any low back pain diagnosis during the 180 days (6 months) prior to the IESD.
- Step 4** Test for clinically appropriate imaging studies. Refer to Table LBP-C to identify members who have a diagnosis for which an imaging study in the presence of low back pain is clinically indicated.
- **Cancer.** Exclude members who have a diagnosis of cancer. Organizations should look as far back as possible in the member's history through the end of the continuous enrollment period.
  - **Recent trauma, intravenous drug abuse, neurological impairment.** Exclude members who have any of these diagnoses in the 12 months prior to the IESD through the end of the continuous enrollment period.

**Table LBP-C: Codes to Identify Exclusions (Clinically Appropriate Indications for Low Back Imaging)**

Description	ICD-9-CM Diagnosis
Cancer	140-208, 230-239
Trauma	800-839, 850-854, 860-869, 905-909, 926.11, 926.12, 929, 952, 958-959
IV drug abuse	304.0, 304.1x, 304.2x, 304.4x, 305.4x, 305.5x, 305.6x, 305.7x
Neurologic impairment	344.60, 729.2

**Step 5** Calculate continuous enrollment. Members must be continuously enrolled for 180 days prior to the IESD through 28 days after the IESD.

### Administrative Specification

**Denominator** The eligible population.

**Numerator** An imaging study conducted on the IESD or in the 28 days following the IESD. Refer to Table LBP-D in order to identify imaging studies. A diagnosis code from Table LBP-A must be in conjunction with an imaging study code in Table LBP-D.

**Table LBP-D: Codes to Identify Imaging Studies**

Description	CPT	UB Revenue
Imaging studies	72010, 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220	0320, 0329, 0350, 0352, 0359, 0610, 0612, 0614, 0619, 0972

## Appropriate Testing for Children With Pharyngitis (CWP)

### Description

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

### Definitions

- Intake Period** A 12-month window that begins six months prior to the measurement year and ends on the 30<sup>th</sup> day of the sixth month of the measurement year. The Intake Period captures eligible episodes of treatment.
- Episode Date** The date of service for any outpatient or ED visit (Table CWP-B) during the Intake Period with only a diagnosis of pharyngitis (Table CWP-A). Exclude claims/ encounters with more than one diagnosis.
- IESD** Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria.
- Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date

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

### Negative Medication History

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

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

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

## Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	Children 2 years of age six months prior to the measurement year to 18 years as of the 30 <sup>th</sup> day of the sixth month in the measurement year.
<b>Continuous enrollment</b>	30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Anchor date</b>	None.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/ diagnosis</b>	Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period.

Follow the steps below to identify the eligible population:

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

**Table CWP-A: Codes to Identify Pharyngitis**

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

**Table CWP-B: Codes to Identify Visit Type**

Description	CPT	UB Revenue
<b>IESD</b>	Index Episode Start Date. The earliest Episode Date during the Intake Period	

that meets all of the following criteria.

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

### Negative Medication History

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

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

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

## Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	Children 2 years of age six months prior to the measurement year to 18 years as of the 30 <sup>th</sup> day of the sixth month in the measurement year.
<b>Continuous enrollment</b>	30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Anchor date</b>	None.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/ diagnosis</b>	Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period.

Follow the steps below to identify the eligible population:

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

**Table CWP-A: Codes to Identify Pharyngitis**

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

**Table CWP-B: Codes to Identify Visit Type**

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 0520-0523, 0526-0529, 077x, 0982, 0983
ED*	99281-99285	045x, 0981

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

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

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

**Table CWP-C: Antibiotic Medications**

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

- Step 4** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.
- Step 5** Calculate continuous enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to through 3 days after the Episode Date.
- Step 6** Select the IESD. This measure examines the earliest eligible episode per member.

### Administrative Specification

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

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

CPT
87070, 87071, 87081, 87430, 87650-87652, 87880

## Appropriate Treatment for Children With Upper Respiratory Infection (URI)

### Description

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

### Calculation

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

### Definitions

- Intake Period** A 12-month window that begins six months prior to the measurement year and ends on the 30<sup>th</sup> day of the sixth month of the measurement year. The Intake Period captures eligible episodes of treatment.
- Episode Date** The date of service for any outpatient or ED visit (Table URI-B) during the Intake Period with only a diagnosis of URI (Table URI-A). Exclude claims/encounters with more than one diagnosis.
- IESD** Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria.
- A 30-day Negative Medication History prior to the Episode Date

- A Negative Competing Diagnosis during the 3 days after the Episode Date
- The member was continuously enrolled 30 days prior to through 3 days after the Episode Date

### Negative Medication History

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

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

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

### Negative Competing Diagnosis

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

## Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	Children 3 months of age six months prior to the measurement year to 18 years as of the 30 <sup>th</sup> day of the sixth month of the measurement year.
<b>Continuous enrollment</b>	30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Anchor date</b>	Episode Date.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/diagnosis</b>	Outpatient or ED visit with only a diagnosis of URI during the Intake Period.

Follow the steps below to identify the eligible population:

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

**Table URI-A: Codes to Identify URI**

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

**Table URI-B: Codes to Identify Visit Type**

Description	CPT	UB Revenue
-------------	-----	------------

Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 0520-0523, 0526-0529, 077x, 0982, 0983
ED*	99281-99285	045x, 0981

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

- Step 2** Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with a URI diagnosis.
- Step 3** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date (Table CWP-C).
- Step 4** Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis (Table URI-C) on or 3 days after the Episode Date.

**Table URI-C: Codes to Identify Competing Diagnoses**

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

- Step 5** Calculate continuous enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.
- Step 6** Select the IESD. This measure examines the earliest eligible episode per member.

## Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	Dispensed prescription for antibiotic medication (Table CWP-C) on or three days after the IESD.

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

### **Description**

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

### **Calculation**

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

### **Definitions**

<b>Intake Period</b>	Beginning of the measurement period through the 24 <sup>th</sup> day of the twelfth month of the measurement year. The Intake Period captures eligible episodes of treatment.
<b>Episode Date</b>	The date of service for any outpatient or ED visit (Table AAB-B) during the Intake Period with any diagnosis of acute bronchitis (Table AAB-A).
<b>IESD</b>	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria. <ul style="list-style-type: none"> <li>• A 30-day Negative Medication History prior to the Episode Date (Table AAB-D)</li> <li>• A 12-month Negative Comorbid Condition History prior to the Episode Date (Table AAB-C)</li> <li>• A Negative Competing Diagnosis during the 30 days prior to through 7 days after the Episode Date (Table URI-C)</li> <li>• The member was continuously enrolled one year prior to through 7 days after the Episode Date</li> </ul>
<b>Negative Medication History</b>	To qualify for Negative Medication History, the following criteria must be met. <ul style="list-style-type: none"> <li>• A period of 30 days prior to the Episode Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug</li> <li>• No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date (Table AAB-D)</li> </ul>

A prescription is considered **active** if the “days supply” indicated on the date

the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

**Negative Comorbid Condition History**

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

**Negative Competing Diagnosis**

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

## Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	Adults 18 years of age twelve months prior to the measurement year to 64 years as the day prior to the measurement year.
<b>Continuous enrollment</b>	One year prior to the Episode Date through 7 days after the Episode Date (inclusive).
<b>Allowable gap</b>	No more than one gap of 30 days is permitted from 365 days prior to through 7 days after the Episode Date. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
<b>Anchor date</b>	Episode Date.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/diagnosis</b>	Outpatient or ED visit with any diagnosis of acute bronchitis during the Intake Period. Follow the steps below to identify the eligible population:
<b>Step 1</b>	Identify all members in the specified age range who during the Intake Period had an outpatient or ED visit (Table AAB-B) with any diagnosis of acute bronchitis (Table AAB-A).

**Table AAB-A: Codes to Identify Acute Bronchitis**

Description	ICD-9-CM Diagnosis
Acute bronchitis	466.0

**Table AAB-B: Codes to Identify Visit Type**

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 0520-0523, 0526-0529, 077x, 0982, 0983
ED*	99281-99285	045x, 0981

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

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

**Step 3** Test for Negative Comorbid Condition History. Exclude Episode Dates for

which the member had a claim/encounter with a diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date (Table AAB-C).

**Table AAB-C: Codes to Identify Comorbid Conditions**

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

- Step 4** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date (Table AAB-D).
- Step 5** Test for Negative Competing Diagnosis. Exclude Episode Dates where during the period 30 days prior to 7 days after the Episode Date (inclusive) the member had a claim/ encounter with any competing diagnosis (Table URI-C).
- Step 6** Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days prior to the Episode Date through 7 days after the Episode Date.
- Step 7** Select the IESD. This measure examines the earliest eligible episode per member.

### Administrative Specification

**Denominator** The eligible population.

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

**Table AAB-D: Antibiotic Medications**

Description	Prescription
5-aminosalicylates	● sulfasalazine
Amebicides	● metronidazole
Aminoglycosides	● amikacin                      ● kanamycin                      ● streptomycin ● gentamicin                      ● neomycin                      ● tobramycin
Aminopenicillins	● amoxicillin                      ● ampicillin
Antipseudomonal penicillins	● piperacillin                      ● ticarcillin
Beta-lactamase inhibitors	● amoxicillin-clavulanate                      ● piperacillin-                      ● ticarcillin-clavulanate

	● ampicillin-sulbactam	tazobactam	
First generation cephalosporins	● cefadroxil ● cefazolin	● cephalixin ● cephradine	
Fourth generation cephalosporins	● cefepime		
Ketolides	● telithromycin		
Lincomycin derivatives	● clindamycin	● lincomycin	
Macrolides	● azithromycin ● clarithromycin	● erythromycin ● erythromycin ethylsuccinate	● erythromycin lactobionate ● erythromycin stearate
Miscellaneous antibiotics	● aztreonam ● chloramphenicol ● dalbopristin-quinupristin	● daptomycin ● erythromycin-sulfisoxazole ● linezolid	● metronidazole
Sulfamethoxazole-trimethoprim DS	● doxycycline	● sulfamethoxazole-trimethoprim	● vancomycin
Natural penicillins	● penicillin G benzathine-procaine ● penicillin G potassium	● penicillin G procaine ● penicillin G sodium	● penicillin V potassium
Penicillinase resistant penicillins	● dicloxacillin	● nafcillin	● oxacillin
Quinolones	● ciprofloxacin ● gatifloxacin ● gemifloxacin	● levofloxacin ● lomefloxacin ● moxifloxacin	● Norfloxacin ● ofloxacin ● sparfloxacin
Rifamycin derivatives	● rifampin		
Second generation cephalosporin	● cefaclor ● cefotetan	● cefoxitin ● cefprozil	● cefuroxime ● loracarbef
Sulfonamides	● sulfadiazine ● sulfamethoxazole-trimethoprim		● sulfisoxazole
Tetracyclines	● doxycycline	● minocycline	● tetracycline
Third generation cephalosporins	● cefdinir ● cefixime ● cefoperazone	● cefotaxime ● ceftazidime	● ceftibuten ● ceftriaxone
Urinary anti-infectives	● fosfomycin ● nitrofurantoin ● nitrofurantoin macrocrystals	● nitrofurantoin macrocrystals-monohydrate ● trimethoprim	

# Cardiovascular

## Changes from HEDIS 2008 specifications to Alliance specific measures:

- Measures are based on a specified measurement year (HEDIS is on a calendar year basis)
- 30 day gap in enrollment (HEDIS allows 45)
- CMC Description: 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 transluminal coronary angioplasty (PTCA) two to twelve months prior to the measurement year (HEDIS uses January 1–November 1 specifically)
- PBH Description: The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive six months prior to the measurement year to the 30<sup>th</sup> day of the sixth month of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge (HEDIS uses July 1 of the year prior to June 30 specifically)
- No Medicare data collected

## ***Cholesterol Management for Patients With Cardiovascular Conditions (CMC)***

### Description

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 transluminal coronary angioplasty (PTCA) two to twelve months prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had an LDL-C screen in the measurement year.

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid
<b>Ages</b>	18–75 years as of the last day of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 30 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	Last day of the measurement year.
<b>Benefit</b>	Medical.

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

Both methods are used to identify the eligible population, but a member only needs to be identified in one to be included in the measure.

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

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

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	DRG
AMI (inpatient only)			410.x1		121, 122, 516
CABG (inpatient only)	33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572	S2205-S2209		36.1, 36.2	106, 107, 109, 547-550
PTCA	33140, 92980-92982, 92984, 92995, 92996			00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09	516, 517, 526, 527, 555-558

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

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

**Table CMC-B: Codes to Identify IVD**

Description	ICD-9-CM Diagnosis	DRG
IVD	411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445	140, 559

**Table CMC-C: Codes to Identify Visit Type**

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987

## Administrative Specification

**Denominator** The eligible population.

## Numerators

**LDL-C screening** An LDL-C test performed any time during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in Table CMC-D.

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

**Table CMC-D: Codes to Identify LDL-C Screening**

CPT
80061, 83700, 83701, 83704, 83715, 83716, 83721

## Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

### Description

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive six months prior to the measurement year to the 30<sup>th</sup> day of the sixth month of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

### Definition

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

### Eligible Population

**Product lines** Commercial, Medicaid.

**Ages** 18 years and older as of the last day of the measurement year.

**Continuous enrollment** Discharge date through 180 days after discharge.

**Allowable gap** No more than one gap in enrollment of up to 30 days within the 180 days of the event. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).

**Anchor date** Discharge date.

**Benefit** Medical and pharmacy.

**Event/diagnosis** Discharged alive from an acute inpatient setting with an AMI six months prior to the measurement year through the 30<sup>th</sup> day of the sixth month of the

measurement year.

If a member has more than one episode of AMI six months prior to the measurement year through the 30<sup>th</sup> day of the sixth month of the measurement year, the organization should only include the first discharge and must use the codes listed in Table PBH-A to identify AMIs.

**Table PBH-A: Codes to Identify AMI**

Description	ICD-9-CM Diagnosis	DRG
AMI	410.x1*	121, 122, 516, 526

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

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

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

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

## Administrative Specification

**Denominator** The eligible population.

**Numerator** A 180-day course of treatment with beta-blockers.

Identify all members in the denominator population whose dispensed days supply is  $\geq 150$  days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days supply filled.

To determine continuity of treatment during the 180-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 150 treatment days + 30 gap days = 180 days); identify all prescriptions filled within 180 days of the Discharge Date.

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

**Table PBH-B: Beta-Blocker Medications**

Description	Prescription		
Noncardioselective beta-blockers	<ul style="list-style-type: none"> <li>● carteolol</li> <li>● carvedilol</li> <li>● labetalol</li> </ul>	<ul style="list-style-type: none"> <li>● nadolol</li> <li>● penbutolol</li> <li>● pindolol</li> </ul>	<ul style="list-style-type: none"> <li>● propranolol</li> <li>● timolol</li> <li>● sotalol</li> </ul>
Cardioselective beta-blockers	<ul style="list-style-type: none"> <li>● acebutolol</li> <li>● atenolol</li> </ul>	<ul style="list-style-type: none"> <li>● betaxolol</li> <li>● bisoprolol</li> </ul>	<ul style="list-style-type: none"> <li>● metoprolol</li> </ul>
Antihypertensive combinations	<ul style="list-style-type: none"> <li>● atenolol-chlorthalidone</li> <li>● bendroflumethiazide-nadolol</li> <li>● bisoprolol-hydrochlorothiazide</li> </ul>	<ul style="list-style-type: none"> <li>● hydrochlorothiazide-metoprolol</li> <li>● hydrochlorothiazide-propranolol</li> <li>● hydrochlorothiazide-timolol</li> </ul>	

## Exclusion

Exclude from the denominator members identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy. Use administrative data to look as far back as possible in the member's history through the end of the continuous enrollment period for evidence of a contraindication to beta-blocker therapy. Refer to Table PBH-C for codes for contraindications to beta-blocker therapy.

**Table PBH-C: Codes to Identify Exclusions**

Description	Prescription	ICD-9-CM Diagnosis
History of asthma	Inhaled corticosteroids*	493
Hypotension		458
Heart block >1 degree		426.0, 426.12, 426.13, 426.2-426.4, 426.51-426.54, 426.7
Sinus bradycardia		427.81
COPD		491.2, 496, 506.4

## Patients with Coronary Artery Disease who are prescribed a lipid lowering therapy

### Measure Description

The percentage of patients age 18 to 75 with coronary artery disease (CAD) who had a prescription filled for a lipid lowering medication.

### Population Definition

**Population:** Patients with coronary artery disease (CAD), who are 18-75 years old in the 12-month measurement period.

Patients are identified for the denominator in one of two ways: procedure or diagnosis. Both criteria must be used to identify the eligible population.

**Continuous enrollment:** The 12-month measurement period.

**Allowable gap:** No more than 30 days per 12-month measurement period.

*Procedure.* Discharged alive for procedures related to CAD in the past 24 months. Use the codes below to identify CAD procedures.

*Diagnosis.* At least one outpatient, nonacute inpatient, acute inpatient or emergency department (ED) visit with any diagnosis of coronary artery disease (CAD) on or between the first day of the first month and the first day of the eleventh month of the year prior to the measurement.

### Codes to Identify Coronary Artery Disease (CAD) and Related Procedures

Description	CPT Codes	ICD-9CM Diagnosis Codes	DRG
CAD	92980-92982, 92984, 92995, 92996, 33140,	414.00-414.07, 414.8, 414.9, 410.00-410.92,	106-109, 121, 122, 124, 125, 516-518,

	33510-33514, 33516-33519, 33521-33523, 33533-33536	411.0-411.89, 412, 413.0-413.9, V45.81, V45.82	547-550
--	----------------------------------------------------	------------------------------------------------	---------

### Administrative Specification

**Denominator:** The defined population.

**Numerator:** Patients within the denominator population are numerator compliant if they had at least one prescription filled for a lipid lowering medication during the measurement year.

#### Numerator Qualifying Codes:

Lipid Lowering Medications			
Abitrate	Fenofibrate Micronized	Niacor	Simvastatin
Advicor	Gemcor	Niacor B3	Slo-Niacin
Altocor	Gemfibrozil	Niaspan	Tricor
Altoprev	Lescol	Niaspan ER	Triglide
Antara	Lescol XL	Niaspan ER Starter Pack	Vytorin
Atromid-S	Lipitor	Nico-400	Welchol
B-3-50	Locholest	Nicobid Tempules	Zetia
B-3-500-GR	Locholest Light	Nicolar	Zocor
Caduet	Lofibra	Nicotinex	
Cholestyramine	Lopid	Nicotinic Acid	
Cholestyramine Light	Lovastatin	Pravachol	
Clofibrate	Mevacor	Pravastatin	
Colesevelam	Niacin	Pravastatin-aspirin	
Colestid	Niacin ER Starter Pack	Pravigard PAC	
Colestid Flavored	Niacin Extended Release	Prevalite	
Colestipol	Niacin SR	Prevalite Powder	
Crestor	Niacin TD	Questran	
Fenofibrate	Niacin TR	Questran Light	

# Generic Prescribing

## Percentage of Generic Prescriptions for Statins

### Measure Description

The measure determines the percentage of generic statin (cholesterol lowering agents) prescriptions used by patients compared to all statin prescriptions in the measurement period.

### Population Definition

**Population:** Patients taking prescribed statins in the 12-month measurement period.

### Technical Specifications

**Denominator:** Number of prescribing events for all statins both brand and generic. A prescribing event is defined as a 30-day supply.

Statin Drugs	
• Altacor	• Lovastatin
• Altoprev	• Mevacor
• Crestor	• Pravachol
• Fluvastatin	• Pravastatin Sodium
• Lescol	• Simvastatin
• Lescol XL	• Vytorin
• Lipitor	• Zocor

**Numerator:** Number of prescribing events for statins identified as generic.

### Analytic Notes

1. In order to normalize the count of prescriptions in calculating the percentage of generic prescriptions the Alliance, through Milliman, researched how NCQA represents drug counts and also sought input from the Milliman pharmacy consulting staff. Milliman recommends using the count of days prescription as the primary way of calculating the percentage. This is one of the approaches used by NCQA in HEDIS reporting. The Milliman pharmacy staff recommended defaulting to tablet count if days are not available. Milliman confirmed that days and tablets are an optional field on the Alliance data requirements. Given this the decision is to see what data elements are provided by the participants and based on that determine the best approach to calculating percentage of generics.
2. This measure requires that the population have a drug benefit and drug claim data is submitted.
3. The Alliance will be reporting this measure at no lower than the county level.

## Percentage of Generic Prescriptions for SSRIs and other Second Generation Antidepressants

### Measure Description

The measure determines the percentage of generic second generation antidepressant prescriptions compared to all second generation antidepressant prescriptions for patients in the measurement period.

### Population Definition

**Population:** Patients taking any prescribed second generation antidepressants in the 12-month measurement period.

### Technical Specifications

**Denominator:** Number of second generation antidepressant prescribing events, both brand and generic. A prescribing event is defined as a 30-day supply.

Second Generation Antidepressant Drugs	
• Bupropion Hydrochloride	• Mirtazapine
• Celexa	• Paroxetine
• Citalopram Hydrobromide	• Pexeva
• Cymbalta	• Prozac
• Effexor	• Prozac Weekly
• Effexor XR	• Rapiflux
• Fluoxetine Hydrochloride	• Remeron
• Fluvoxamine Maleate	• Sarafem
• Lexapro	• Sertraline Hydrochloride
• Luvox	• Venlafaxine Hydrochloride
• Paroxetine Hydrochloride	• Wellbutrin
• Paxil	• Zoloft
• Paxil CR	• Nefazodone Hydrochloride
• Budeprion SR	• Budeprion XL
• Bupropion XL	

**Numerator:** Number of prescribing events for second generation antidepressant prescriptions identified as generic

### Analytic Notes

1. In order to normalize the count of prescriptions in calculating the percentage of generic prescriptions the Alliance, through Milliman, researched how NCQA represents drug counts and

also sought input from the Milliman pharmacy consulting staff. Milliman recommends using the count of days prescription as the primary way of calculating the percentage. This is one of the approaches used by NCQA in HEDIS reporting. The Milliman pharmacy staff recommended defaulting to tablet count if days are not available. Milliman confirmed that days and tablets are an optional field on the Alliance data requirements. Given this the decision is to see what data elements are provided by the participants and based on that determine the best approach to calculating percentage of generics.

2. This measure requires that the population have a drug benefit and drug claim data is submitted.
3. The Alliance will be reporting this measure at no lower than the county level.

## Percentage of Generic Prescriptions for PPIs

### Measure Description

The measure determines the percentage of generic proton pump inhibitors (gastric acid secretion reduction) PPI prescriptions compared to all PPI prescriptions.

### Population Definition

**Population:** Patients taking any prescribed PPI –proton pump inhibitors (gastric acid secretion reduction) in the 12-month measurement period.

### Technical Specifications

**Denominator:** Number of prescribing events for both brand and generic PPIs. A prescribing event is defined as a 30-day supply.

**Numerator:** Count of PPI prescriptions identified as generic

PPI Drugs	
• Aciphex	• Prevpac
• Nexium	• Prilosec
• Omeprazole	• Prilosec Otc
• Prevacid	• Protonix
• Prevacid Solutab	• Zegerid

### Analytic Notes

1. For this measure, “prescriptions” includes over the counter (OTC) products when they are reimbursed by payers. These OTC products (e.g. Prilosec OTC) are counted as generic drugs, included in both the measure numerator and denominator.
2. In order to normalize the count of prescriptions in calculating the percentage of generic prescriptions the Alliance, through Milliman, researched how NCQA represents drug counts and also sought input from the Milliman pharmacy consulting staff. Milliman recommends using the count of days prescription as the primary way of calculating the percentage. This is one of the

approaches used by NCQA in HEDIS reporting. The Milliman pharmacy staff recommended defaulting to tablet count if days are not available. Milliman confirmed that days and tablets are an optional field on the Alliance data requirements. Given this the decision is to see what data elements are provided by the participants and based on that determine the best approach to calculating percentage of generics.

3. This measure requires that the population have a drug benefit and drug claim data is submitted.
4. The Alliance will be reporting this measure at no lower than the county level.

## ***Percentage of Generic Prescriptions for NSAIDs***

### **Measure Description**

The measure determines the percentage of non-steroidal anti-inflammatory drugs (NSAIDs) prescriptions compared to all NSAIDs prescriptions.

### **Population Definition**

**Population:** Patients ages taking any prescribed NSAIDs –non-steroidal anti-inflammatory drugs in the 12-month measurement period.

### **Technical Specifications**

**Denominator:** Number of prescribing events for NSAIDs. A prescribing event is defined as a 30-day supply.

**Numerator:** Count of NSAID prescribing events identified as generic

<b>NSAID Drugs</b>			
• Aflaxen	• Butatab	• Dolgesic	• Ibifon 600
• Anaprox	• Cataflam	• Duract	• Ibren
• Anaprox-Ds	• Celebrex	• Ec Naprosyn	• Ibu-4
• Ansaid	• Clinoril	• Etodolac	• Ibu-6
• Arthrotec	• Cotylbutazone	• Feldene	• Ibu-8
	• Daypro	• Fenoprofen	• Ibuprofen
	• Diclofenac Potassium	• Flurbiprofen	

### NSAID Drugs

- |                        |                            |                         |
|------------------------|----------------------------|-------------------------|
| • Ibu-Tab              | • Naproxen                 | • Prevacid Naprapac 500 |
| • Indomethacin         | • Naproxen Delayed Release | • Piroxicam             |
| • Indomethacin Er      | • Naproxen Ec              | • Relafen               |
| • Indomethacin Sr      | • Naproxen Sodium          | • Rufen                 |
| • Ketoprofen           | • Naproxen Sodium Ds       | • Saletto               |
| • Lodine               | • Orudis                   | • Sulindac              |
| • Lodine XI            | • Oruvail                  | • Tolectin              |
| • Meclofenamate        | • Oxaprozin                | • Tolectin 600          |
| • Meclofenamate Sodium | • Phenylbutazone           | • Tolectin Ds           |
| • Meclomen             | • Phenylbutazone Alka      | • Tolmetin Sodium       |
| • Mefenamic Acid       | • Ponstel                  | • Toradol               |
| • Mobic                | • Ponstel Kapseals         | • Voltaren-Xr           |
| • Motrin               | • Prevacid Naprapac 375    |                         |
| • Motrin Pediatric     |                            |                         |
| • Nabumetone           |                            |                         |
| • Nalfon               |                            |                         |
| • Nalfon 200           |                            |                         |
| • Naprelan             |                            |                         |
| • Naprelan 500         |                            |                         |
| • Naprosyn             |                            |                         |

### Analytic Notes

1. In order to normalize the count of prescriptions in calculating the percentage of generic prescriptions the Alliance, through Milliman, researched how NCQA represents drug counts and also sought input from the Milliman pharmacy consulting staff. Milliman recommends using the count of days prescription as the primary way of calculating the percentage. This is one of the approaches used by NCQA in HEDIS reporting. The Milliman pharmacy staff recommended defaulting to tablet count if days are not available. Milliman confirmed that days and tablets are an optional field on the Alliance data requirements. Given this the decision is to see what data elements are provided by the participants and based on that determine the best approach to calculating percentage of generics.
2. This measure requires that the population have a drug benefit and drug claim data is submitted.
3. The Alliance will be reporting this measure at no lower than the county level.
4. This measure may be impacted by physicians appropriately advising patients to obtain an over-the-counter medication. A higher percentage of brand name used could reflect appropriate use of brand name drugs based on a patient's clinic

# Prevention

## Changes from HEDIS 2008 specifications to Alliance specific measures:

- 30 day gap in enrollment (HEDIS allows 45)
- No Medicare data collected
- Measures are based on a specified measurement year (HEDIS is based on a calendar year)
- COL: The eligible population is defined as the percentage of members 51-54 years of age who had appropriate screening for colorectal cancer (HEDIS uses 50-58 specifically)

## ***Breast Cancer Screening (BCS)***

### Description

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

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	Women 42–69 years as of the last day of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 30 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.
<b>Anchor date</b>	Last day of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	One or more mammograms during the measurement year or the year prior to the measurement year. A woman had a mammogram if a submitted claim/encounter contains any one of the codes in Table BCS-A.

**Table BCS-A: Codes to Identify Breast Cancer Screening**

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
76083, 76090-76092, 77055-77057	G0202	V76.11, V76.12	87.36, 87.37	0403

### Exclusion

The organization may exclude women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through June 30 of the measurement year. Exclude members for whom there is evidence of two separate mastectomies. Refer to Table BCS-B for codes to identify exclusions.

**Table BCS-B: Codes to Identify Exclusions**

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

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

### Note

- Do not count biopsies, breast ultrasounds or other diagnostic mammograms for this measure because they are not appropriate methods for primary breast cancer screening.

## Cervical Cancer Screening (CCS)

### Description

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

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	Women 24–64 years as of the last day of the measurement year.
<b>Continuous enrollment</b>	<i>Commercial:</i> The measurement year and the two years prior to the measurement year. <i>Medicaid:</i> The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 30 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	Last day of the measurement year.

<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

### Administrative Specification

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

**Table CCS-A: Codes to Identify Cervical Cancer Screening**

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V72.32, V76.2	91.46	0923

### Exclusion

Exclude women who had a hysterectomy with no residual cervix. Look as far back as possible in the member's history for evidence of hysterectomy through June 30 of the measurement year. Refer to Table CCS-B for codes to identify a hysterectomy.

**Table CCS-B: Codes to Identify Exclusions**

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

### Note

- *Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.*
- *Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.*

## Colorectal Cancer Screening (COL)

### Description

The percentage of members 51-54 years of age who had appropriate screening for colorectal cancer.

### Eligible Population

<b>Product lines</b>	Commercial, Medicare (report each product line separately).
<b>Ages</b>	51–54 years as of the last day of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 30 days during each year of continuous enrollment.
<b>Anchor date</b>	Last day of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	<p>One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria.</p> <ul style="list-style-type: none"> <li>• Fecal occult blood test (FOBT) during the measurement year</li> <li>• Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year</li> <li>• Double contrast barium enema (DCBE) or air contrast barium enema during the measurement year or the four years prior to the measurement year</li> <li>• Colonoscopy during the measurement year or the nine years prior to the measurement year</li> </ul>

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

**Table COL-A: Codes to Identify Colorectal Cancer Screening**

Description	CPT	HPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
FOBT	82270, 82274	G0107, G0328	V76.51	
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104		45.24
DCBE	74280			

Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121		45.22, 45.23, 45.25, 45.42, 45.43
-------------	------------------------------------------------------	--------------	--	-----------------------------------

## Exclusion

Organizations may exclude members with a diagnosis of colorectal cancer or total colectomy. Organizations should look for evidence of colorectal cancer or total colectomy as far back as possible in the member's history. The codes in Table COL-B identify exclusions.

**Table COL-B: Codes to Identify Exclusions**

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

## Note

- Do not count digital rectal exam toward this measure because it is not specific or comprehensive enough to screen for colorectal cancer.
- Do not count single contrast barium enema or a notation of barium enema toward this measure because they are not as specific or as comprehensive as the double contrast or air contrast barium enema.
- There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Immunochemical FOBT tests may require fewer than three samples. Regardless of test type, for administrative data assume that the required number of samples was returned.

## Chlamydia Screening in Women (CHL)

### Description

The percentage of women 16–25 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	Women 16–25 years as of the last day of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 30 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

<b>Anchor date</b>	Last day of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	<i>Sexually active.</i> Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use <i>both</i> methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.  <i>Pharmacy data.</i> Members who were dispensed prescription contraceptives during the measurement year (Table CHL-A).

**Table CHL-A: Prescriptions to Identify Contraceptives**

Description	Prescription
Contraceptives	<ul style="list-style-type: none"> <li>● desogestrel-ethinyl estradiol</li> <li>● drospirenone-ethinyl estradiol</li> <li>● ethinyl estradiol-ethynodiol</li> <li>● ethinyl estradiol-etonogestrel</li> <li>● ethinyl estradiol-levonorgestrel</li> <li>● ethinyl estradiol-norelgestromin</li> <li>● ethinyl estradiol-norethindrone</li> <li>● ethinyl estradiol-norgestimate</li> <li>● ethinyl estradiol-norgestrel</li> <li>● etonogestrel</li> <li>● levonorgestrel-medroxyprogesterone</li> <li>● mestranol-norethindrone</li> </ul>
Diaphragm	<ul style="list-style-type: none"> <li>● diaphragm</li> </ul>
Spermicide	<ul style="list-style-type: none"> <li>● nonxynol 9</li> <li>● octoxynol</li> </ul>

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

**Table CHL-B: Codes to Identify Sexually Active Women**

Description	Codes
CPT	11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84703, 86592-86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87660, 87800, 87801, 87808, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269
HCPCS	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0180, S0199, S4981, S8055
ICD-9-CM Diagnosis	042, 054.10, 054.11, 054.12, 054.19, 078.1, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 614-616, 622.3, 623.4, 626.7, 628, 630-677, 795.0, 996.32, V01.6, V02.7, V02.8, V08, V15.7, V22-V28, V45.5, V61.5-V61.7, V69.2, V72.3, V72.4, V73.88, V73.98, V74.5, V76.2
ICD-9-CM Procedure	69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 97.24, 97.71, 97.73
UB Revenue	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925
LOINC	557-9, 560-3, 660-1, 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 1832-5, 1834-1, 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 4993-2, 5028-6, 5291-0, 5292-8, 5392-6, 5393-4, 5394-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 6487-3, 6488-1, 6489-9, 6510-2, 6511-0, 6514-4, 6516-9, 6561-5, 6562-3, 7975-6, 8041-6, 10524-7, 10705-2, 11083-3, 11084-1, 11481-9, 11597-2, 12222-6, 12223-4, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 14509-4, 14510-2, 14513-6, 15019-3, 16280-0, 16600-9,

	16601-7, 16602-5, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 18500-9, 19080-1, 19171-8, 19176-7, 19177-5, 19180-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 20403-2, 20404-0, 20415-6, 20507-0, 20508-8, 20993-2, 20994-0, 21189-6, 21190-4, 21191-2, 21192-0, 21198-7, 21414-8, 21415-5, 21416-3, 21440-3, 21441-1, 21613-5, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 23838-6, 23908-7, 24110-9, 24111-7, 24312-1, 24364-2, 25372-4, 25373-2, 26009-1, 29311-8, 30167-1, 31147-2, 31771-9, 31772-7, 31775-0, 31777-6, 31905-3, 31906-1, 31993-9, 32198-4, 32199-2, 32705-6, 33717-0, 33773-3, 34382-2, 34493-7, 34656-9, 34670-0, 34718-7, 35457-1, 36902-5, 36903-3, 38372-9, 42316-0, 42481-2, 42931-6, 43406-8
--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

## Administrative Specification

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

**Table CHL-C: Codes to Identify Chlamydia Screening**

CPT
87110, 87270, 87320, 87490, 87491, 87492, 87810

## Exclusion

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

**Table CHL-D: Codes to Identify Exclusions**

Description	CPT	UB Revenue	
Pregnancy test	81025, 84702, 84703	0925	
<i>WITH</i>			
Diagnostic radiology	70010-76499	032x	
Prescription for isotretinoin*			

# Asthma

## Changes from HEDIS 2008 specifications to Alliance specific measures:

- 30 day gap in enrollment (HEDIS allows 45)
- Measures are based on a specified measurement year (HEDIS based on a calendar year)

## *Use of Appropriate Medications for People With Asthma (ASM)*

### Description

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

### Definitions

<b>Dispensing event</b>	A <b>dispensing event</b> is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ( $100/30 = 3.33$ , rounded down to 3). In addition, two different prescriptions dispensed on the same day are counted as two different dispensing events.
<b>Inhaler dispensing event</b>	Inhalers count as one dispensing event; for example, an inhaler with a 90-day supply is considered one dispensing event. In addition, multiple inhalers of the same medication filled on the same date of service should be counted as one dispensing event; for example a member may obtain two inhalers on the same day (one for home and one for work), but intend to use both during the same 30-day period.

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid.
<b>Ages</b>	5–56 years by the last day of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 30 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment year.
<b>Anchor date</b>	Last day of the measurement year.
<b>Benefits</b>	Medical. Pharmacy during the measurement year.

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

- Step 1** Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
- At least one ED visit (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A)
  - At least one acute inpatient discharge (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A)
  - At least four outpatient asthma visits (Table ASM-B), with asthma as one of the listed diagnoses (Table ASM-A) and at least two asthma medication dispensing events (Table ASM-C)
  - At least four asthma medication dispensing events (Table ASM-C)

**Table ASM-A: Codes to Identify Asthma**

Description	ICD-9-CM Diagnosis
Asthma	493

**Table ASM-B: Codes to Identify Visit Type**

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 0520-0523, 0526-0529, 057x- 059x, 077x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987
ED	99281-99285	045x, 0981

**Table ASM-C: Asthma Medications**

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

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

- Meet any of the other three criteria in step 1 in the same year as the leukotriene

modifier, **or**

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

### Administrative Specification

**Denominator** The eligible population.

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

**Table ASM-D: Preferred Asthma Therapy Medications**

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

### Exclusion

Exclude from the eligible population all members diagnosed with emphysema or COPD (Table ASM-E) any time on or prior to the last day of the measurement year.

**Table ASM-E: Codes to Identify Exclusions**

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

### Note

- The definition used for “persistent” asthma is an approximation based on the previous two years’ service and medication use rather than a clinical measure of severity. This definitional approach was chosen for logistical and feasibility reasons so that an efficient, reasonably standardized and sufficiently large population that allows unbiased organization-to-organization comparison could be identified through administrative sources.
- The first four classes of medication in Table ASM-C count in the numerator because they are considered acceptable as primary therapy for long-term control of asthma. The last class (inhaled beta-2 agonists) does not count in the numerator because it is recommended as add-on rather than primary therapy for persistent asthma.
- The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

# Access to Care

## Changes from HEDIS 2008 specifications to Alliance specific measures:

- 30 day gap in enrollment (HEDIS allows 45)
- No Medicare data collected
- Measures are based on a specified measurement year (HEDIS based on a calendar year)

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

### Description

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

- *Medicaid members* who had an ambulatory or preventive care visit during the measurement year
- *Commercial members* who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid
<b>Ages</b>	20–65 years and older as of the last day of the measurement year. <ul style="list-style-type: none"> <li>• 20–44 years</li> <li>• 45–64 years</li> <li>• 65 years and older</li> </ul>
<b>Continuous enrollment</b>	<i>Medicaid:</i> The measurement year. <i>Commercial:</i> The measurement year and the two years prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 30 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	Last day of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

### Administrative Specification

<b>Denominator</b>	The eligible population (report each age stratification separately).
--------------------	----------------------------------------------------------------------

**Numerator**      *Medicaid:* One or more ambulatory or preventive care visits during the measurement year.

*Commercial:* One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.

To identify visits, count each member with an occurrence of one of the CPT codes or UB Revenue codes listed in Table AAP-A.

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

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			
Home services	99341-99350			
Nursing facility care	99301-99303, 99304-99310, 99311-99313, 99318			
Domiciliary, rest home or custodial care services	99321-99323, 99324-99328, 99331-99333, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420, 99429	G0344		0770, 0771, 0779
Ophthalmology and optometry	92002, 92004, 92012, 92014			
Clinic				051x
Freestanding clinic				052x
Professional fees, outpatient services				0982
Professional fees, clinic				0983
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

## ***Children and Adolescents' Access to Primary Care Practitioners (CAP)***

### **Description**

The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

### **Eligible Population**

**Product lines**      Commercial, Medicaid.

<b>Ages</b>	12 months–19 years as of the last day of the measurement year. Report four age stratifications. <ul style="list-style-type: none"> <li>• 12–24 months as of the last day of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 31, 2006 and December 1, 2005).</li> <li>• 25 months–6 years as of the last day of the measurement year. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between November 30, 2005, and January 1, 2001).</li> <li>• 7–11 years as of the last day of the measurement year.</li> <li>• 12–19 years as of the last day of the measurement year.</li> </ul>
<b>Continuous enrollment</b>	<i>For 12–24 months, 25 months–6 years:</i> The measurement year. <i>For 7–11 years, 12–19 years:</i> The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	<i>For 12–24 months, 25 months–6 years:</i> No more than one gap in enrollment of up to 30 days during the measurement year. <i>For 7–11 years, 12–19 years:</i> No more than one gap in enrollment of up to 30 days during each year of continuous enrollment.  To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.
<b>Anchor date</b>	Last day of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	<i>For 12–24 months, 25 months–6 years:</i> One or more visits with a PCP during the measurement year.  <i>For 7–11 years, 12–19 years:</i> One or more visits with a PCP during the measurement year or the year prior to the measurement year.  The organization should count all members who had an ambulatory or preventive care visit to <i>any</i> PCP, as defined by the organization, with an occurrence of one of the CPT or ICD-9-CM codes listed in Table CAP-A. Exclude specialist visits.

**Table CAP-A: Codes to Identify Ambulatory or Preventive Care Visits**

Description	CPT	ICD-9-CM Diagnosis
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	

Home services	99341-99350	
Preventive medicine	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429	
General medical examination		V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9