

# **ODJFS Methods for Clinical Performance Measures**

**Provider Agreement Effective July 1, 2005 to June 30, 2006**

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These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in NCQA HEDIS 2005 Technical Specifications manual. The main difference between the ODJFS methods and the HEDIS methods is that, in some cases, it has been necessary to include additional codes that are not listed in the HEDIS methods. Codes that are not listed in HEDIS, but have been added are identified with the symbol '+’.

The source of the data is as follows:

- (1) MCP submitted encounter data to obtain encounters.
- (2) ODJFS provider master file to identify primary care practitioners.
- (3) ODJFS recipient master file to obtain recipient demographic and eligibility information.

## Initiation of Prenatal Care

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

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

**Denominator:** The eligible population.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005 - December 31, 2005

The last menstrual period (LMP) field is used to determine the end date of the first trimester. If no last menstrual period date is provided, as required, or the date is invalid, then the length of the pregnancy is set at 38.5 weeks except if an encounter is found for the newborn indicating a pre-term birth. The length of the pregnancy is set at 28 weeks where the diagnosis was 7650.x (Extreme immaturity). If there was a diagnosis of 7651.x (Other preterm infants) then the length of the pregnancy is set at 33 weeks.

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

**Codes to Identify Live Births**

ICD-9-CM Diagnosis Codes

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

ICD-9-CM Diagnosis Codes\*

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

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

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



<b>CODES USED TO IDENTIFY DELIVERIES</b>
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ICD-9 Procedure Codes:

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

ICD-9 Diagnosis Codes:

- 650 Normal Delivery
- V27.x Outcome of Delivery

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

- 640-648; Complications mainly related to pregnancy
- 651-659; Normal delivery and other indications for care in pregnancy, labor, and delivery
- 660-669; Complications occurring mainly during the course of labor and delivery
- 670-676; Complications of the puerperium.

CPT Codes:

- 59409 Vaginal delivery (with or without episiotomy and/or forceps)
- 59514 Cesarean delivery only
- 59612 Vaginal delivery only, after previous cesarean delivery (with or with our episiotomy and/or forceps)
- 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

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

### **Methods for Matching Infants and Mothers Encounters**

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

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

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

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

**Prenatal Care Visit Codes**

HEDIS 2005 outlines four decision rules for identifying prenatal visits. The first decision rule includes using codes specific to antepartum care such as CPT-4 code 59425. The second rule requires a visit to a midwife or OB provider with procedure or diagnosis based evidence of prenatal care. The third decision rule requires a visit to a family practitioner or other primary care provider with diagnostic and procedure based evidence of prenatal care. The fourth decision rule uses CPT-4 codes in conjunction with a plan’s internal codes.

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

**Decision Rule 1:**

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

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

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

**Decision Rule 2:**

CPT-4 = 99201-99205 (office visit) or 99211-99215 or Revenue code 514 (OB/GYN Clinic)

**with either**

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

**OR**

ICD-9-CM = (640.0x-648.9x or 651.0x-659.9x) where x (fifth digit) = 3;

V code = V22-V23 or V28; or Occurrence code=10.

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

## **Frequency of Ongoing Prenatal Care**

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

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

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

**Data Source:** Encounter Data

**Report Period:** January 1, 2005 -December 31, 2005

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

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

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

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

## Cesarean Section Rate

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

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

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

**Data Source:** Encounter Data

**Report Period:** January 1, 2005 -December 31, 2005

<b>Codes to Identify C-Sections</b>
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<u>ICD-9-CM</u>
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74.0-74.2, 74.4 or 74.99
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<u>CPT Codes</u>
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59510, 59514, 59515, 59618, 59620, 59622
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## **Low Birth Weight Measure**

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

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

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

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

**Report Period:** January 1, 2005 -December 31, 2005

## **Very Low Birth Weight Measure**

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

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

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

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

**Report Period:** January 1, 2005 -December 31, 2005

## **Postpartum Care**

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

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

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

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

Codes to Identify Postpartum Visits	
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<u>ICD-9 Codes</u>	
91.46	Microscopic exam of specimen from female genital tract
V24.1	Lactating mother
V24.2	Routine postpartum follow-up
V25.1	Insertion of intrauterine contraceptive device
V72.3	Gynecologic al exam
V76.2	Special screening for malignant neoplasm (cervix)
<u>Revenue Codes</u>	
923	Pap Smear
<u>CPT-4</u>	
	<u>Description</u>
57170	Diaphragm cervical cap fitting
58300	Insertion of intrauterine device
59400	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care
59410	Vaginal delivery, including postpartum care
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only, including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care after previous cesarean delivery
59614	Vaginal delivery only, after previous cesarean delivery, including postpartum care
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
88141-88145	Cytopathology, cervical or vaginal
88147-88148	Cytopathology smears
88150-88155	Cytopathology slides
88164-88167	Cytopathology slides
88174-88175	Cytopathology, cervical or vaginal

## Well Child Visits in the First 15 Months of Life

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

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

**Denominator:** The eligible population.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

Codes to Identify Well-Child Visits
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CPT-4 Codes

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

ICD-9-CM Codes

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

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

<b>Codes to Identify Primary Care Practitioners</b>
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**Provider Type**

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

or

**Physician Specialty Code**

- 01 (General Practice)
- 15 (Internal Medicine)
- 16 (Pediatrics)
- 18 (Preventive Medicine)
- 53 (Obstetrics & Gynecology)
- 71 (Obstetrics & Gynecology - Osteopath)

or

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

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

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

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

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

**Denominator:** The eligible population.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

Codes to Identify Well-Child Visits
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CPT-4 Codes

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

ICD-9-CM Codes

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

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

## Adolescent Well-Care Visits

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

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

**Denominator:** The eligible population.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

Codes to Identify Adolescent Well-Care Visits
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<p><u>CPT-4 Codes</u></p> <p>99383 Initial preventive medicine - New patient (Age Group 5 through 11)</p> <p>99384 Initial preventive medicine - New patient (Age Group 12 through 17)</p> <p>99385 Initial preventive medicine - New patient (Age Group 18 through 39)</p> <p>99393 Periodic preventive medicine - Established Patient (Age Group 5 through 11)</p> <p>99394 Periodic preventive medicine - Established Patient (Age Group 12 through 17)</p> <p>99395 Periodic preventive medicine - Established Patient (Age Group 18 through 39)</p> <p><u>ICD-9-CM Codes</u></p> <p>V20.2 Routine Infant or Child Health Check</p> <p>V70.0 Routine General Medical Examination at a Health Care Facility (Health Checkup)</p> <p>V70.3 Other Medical Examination for Administrative Purposes</p> <p>V70.5 Health examination of defined subpopulation</p> <p>V70.6 Health examination in population surveys</p> <p>V70.8 Other specified general medical examinations</p> <p>V70.9 Unspecified general medical examinations</p>
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See method for identifying primary care practitioners under 'Well Child Visits in the First 15 Months of Life' performance measure.

## **Childhood Immunization Status**

*The percentage of enrolled children who turned two years old during the reporting year, who were enrolled for 12 months immediately preceding their second birthday (allowing for one month gap in MCP enrollment), who were enrolled during the last month of the reporting year, and who were identified as having four DTP/DTaP, three IPV/OPV, one MMR, two H influenza b, and two hepatitis B vaccines by the second birthday. The measure also calculates individual rates.*

**Numerator:** Children who received four DTP or DTaP vaccinations and three OPV or IPV vaccinations and one MMR and two HiB vaccinations and two hepatitis B vaccinations.

**Denominator:** The eligible population.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

Codes to Select Immunizations

<b>Immunization</b>	<b>CPT Codes</b>	<b>ICD-9-CM Codes</b>
<b>DTP/DTaP</b>	90698, 90700, 90701, 90702*, 90703*, ,90719*, 90720, 90721, 90723	V02.4*, V03.5*+, V03.6*+, V03.7*+, V06.1+, V06.2+, V06.3+, V06.5*+, 032*, 033*, 037*, 99.36*, 99.37*, 99.38*, 99.39
<b>IPV/OPV</b>	90698, 90712, 90713, 90723	V04.0+, V06.3+, V12.02, 045, 99.41
<b>MMR</b>	90704 (Mumps vaccine) with 90708 ( Measles & rubella vaccine)  90705 (Measles vaccine) with 90709 (Rubella & mumps vaccine)  90706 (Rubella vaccine) with 90704 (Mumps vaccine) and 90705 (Measles vaccine)  90707 (Measles, mumps, & rubella vaccine)  90710 (Measles, mumps, rubella, & varicella vaccine)	V04.2*+, V04.3*+, V04.6*+, V06.4+, 055*, 056*, 072*, 99.45*, 99.46*, 99.47*, 99.48
<b>HiB</b>	90645, 90646, 90647, 90648, 90698, 90720, 90721, 90737, 90748	041.5, 038.41, 320.0, 482.2, V03.81+
<b>Hepatitis B</b>	90723, 90740, 90744, 90746, 90747, 90748	V02.61, 070.2, 070.3, V05.3+
<b>VZV</b>	90710, 90716	052, 053, V05.4+

\* This code must be used in conjunction with codes that identify the remaining antigen requirements in order to satisfy the measure.

+ Code not in HEDIS methods.

Children who are identified as being immunocompromised for a specific vaccine are excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates is equal. As specified in HEDIS, immunocompromised children are excluded only if the encounter data does not indicate that the particular immunization for which the child was contraindicated was rendered.

**Codes to Identify Exclusions for Childhood Immunizations**

Immunization	Contraindication	ICD-9-CM Code
Any particular vaccine	anaphylactic reaction to the vaccine or its components	999.4
DTP/DTaP	encephalopathy within 7 days of previous dose of DTP/DTaP	323.5
OPV, VZV, and MMR	immunodeficiency, including genetic immunodeficiency syndromes	279
OPV, VZV, and MMR	HIV-infected or household contact with HIV infection	infection V08, symptomatic 042
OPV, VZV, and MMR	cancer of lymphoreticular or histiocytic tissue	200-202
OPV, VZV, and MMR	multiple myeloma	203.xx
OPV, VZV, and MMR	leukemia	204.xx-208.xx
IPV	anaphylactic reaction to streptomycin, polymixin B or neomycin	E9306, E9308, E9460, E9465, E9466
HiB	none	
VZV, MMR	anaphylactic reaction to neomycin	E9306

**Annual Dental Visit:**

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

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

**Denominator:** The eligible population.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

Codes to Identify Annual Dental Visits		
CPT Codes	ICD-9-CM Codes	HCPCS Codes
70300, 70310, 70320, 70350, 70355	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97	D0120-D0999, D1110-D1550, D2110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6199, D7110-D7999, D8010-D8999, D9110-D9999, T1015+ with a modifier of U2

+ Code not in HEDIS Methods.

## **Lead Testing For 1 Year Olds**

*The percentage of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 15th month of life, and who received a lead screening test.*

**Numerator:** The number of children in the denominator who received a lead screening test. CPT-4 codes of 83655 or 83660 are used to identify that the member had a lead screening test.

**Denominator:** The number of enrolled members who turned 15 months old during the reporting year, who were enrolled in the MCP from 9 months through 15 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 15th month of life.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

## **Lead Testing For 2 Year Olds**

*The percentage of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), who were enrolled in the MCP during their 27th month of life, and who received a lead screening test.*

**Numerator:** The number of children in the denominator who received a lead screening test. CPT-4 codes of 83655 or 83660 are used to identify that the member had a lead screening test.

**Denominator:** The number of enrolled members who turned 27 months old during the reporting year, who were enrolled in the MCP from 21 months through 27 months of age (allowing for a one month gap in MCP enrollment), and who were enrolled in the MCP during their 27th month of life.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

## Use of Appropriate Medications for People with Asthma

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

Members are identified as having persistent asthma by having ANY of the following in the year prior to the measurement year:

1. at least four asthma medication dispensing events\* (i.e., an asthma medication was dispensed on four occasions) OR
2. at least one Emergency Department (ED) visit based on the visit codes below with asthma (ICD-9 code 493) as the principal diagnosis OR
3. at least one hospitalization based on the visits codes below with asthma (ICD-9 code 493) as the principal diagnosis OR
4. at least four outpatient asthma visits based on the visit codes below with asthma (ICD-9 code 493) as one of the listed diagnoses AND at least two asthma medication dispensing events.\*

*\* Note: A dispensing event is defined as one prescription of an amount lasting 30 days or less. Two different prescriptions dispensed on the same day are counted as two different dispensing events. To calculate dispensing events for prescriptions lasting longer than 30 days, ODJFS divided the drug quantity by 30 and rounded up to convert. For example, a 100-day prescription is equal to 4 dispensing events ( $100/30=3.33$ , rounded up to 4). Inhalers count as one dispensing event; for example, an inhaler with a 90-day supply is considered one dispensing event. In addition, multiple inhalers of the same medication filled on the same date of service are counted as one dispensing event; for example, a member may obtain two inhalers on the same date (one for home and one for work), but intend to use both during the same 30-day period.*

**Numerator:** For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the reporting year. The NDC list provided on NCQA's Web site at [http://www.ncqa.org/Programs/HEDIS/hedis\\_2005\\_volume\\_2\\_technical\\_sp.htm](http://www.ncqa.org/Programs/HEDIS/hedis_2005_volume_2_technical_sp.htm) is used to identify these medications.

**Denominator:** The eligible population.

**Data Source:** Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

Codes to Identify ED and Inpatient Asthma Encounters

Description	CPT Codes	UB-92 Revenue Codes
Acute Inpatient	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99291-99292, 99356, 99357	10X-16X, 20X-22X, 72X, 80X, 987
Emergency Department (ED) services	99281-99285	450, 451, 452, 459, 981
Outpatient Visit	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275	456, 510, 515, 516, 517, 520, 521, 523, 526, 76X, 770, 779, 982, 983, 988

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

## Comprehensive Diabetes Care

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

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

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

### Data Source: Encounter Data

**Report Period:** January 1, 2005-December 31, 2005

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

**Pharmacy Encounter Data:** Those who were dispensed insulin and/or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the reporting year or the year prior to the reporting year. A list of these medications and the corresponding NDC codes can be found at [http://www.ncqa.org/Programs/HEDIS/hedis\\_2005\\_volume\\_2\\_technical\\_sp.htm](http://www.ncqa.org/Programs/HEDIS/hedis_2005_volume_2_technical_sp.htm)

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

Codes to Identify Diabetics Using Encounter Data			
Description	ICD-9-CM Codes	UB-92 Revenue Codes	CPT Codes
Diabetes Diagnosis	250, 357.2, 362.0, 366.41, 648.0		
Outpatient/non-acute inpatient		19X, 456, 49X-53X, 55X-59X, 65X, 66X, 76X, 77X, 82X-85X, 88X, 92X, 94X, 96X, 972-979, 982-986, 988, 989	92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275, 99301-99303, 99311-99313, 99321-99323, 99331-99333, 99341-99355, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420-99429, 99499
Acute inpatient/ED		10X-16X, 20X-22X, 450, 451, 452, 459, 72X, 80X, 981, 987	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291-99292, 99356-99357

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

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

**Numerator(s):**

1. HBA1c Testing: One (or more) HBA1c test(s) conducted during the reporting year identified through encounter data. CPT code of 83036 (hemoglobin, glyated) is used to identify the test.
2. Eye Exam: An eye screening for diabetic retinal disease during the reporting year by an eye care professional (optometrist or ophthalmologist).

**Codes to Identify Eye Exams\***

CPT Codes	ICD-9-CM Codes
67101, 67105, 67107-67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 99203, 99204, 99205, 99213, 99214, 99215, 99242-99245	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16

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

**Codes to Identify Eye Care Professionals**

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

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

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

<b>Codes to Identify LDL-C Screening</b>
<b>CPT Codes</b>
80061, 83715, 83716, 83721

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

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

<b>Codes to Identify Microalbuminuria Test</b>
<b>CPT Codes</b>
82042, 82043, 82044, 84156, 84160*,84165* * Codes must be accompanied by CPT 81050 to indicate the test was urinalysis.

<b>Codes to Identify Diabetic Nephropathy</b>			
<b>Description</b>	<b>CPT Codes</b>	<b>ICD-9-CM Codes</b>	<b>Revenue Codes</b>
Evidence of diagnosis and/or treatment of nephropathy	36800, 36810, 36815, 36820, 36821, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90945, 90947, 90989, 90993, 90997, 90999, 99512	39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0, V42.0, V45.1, V56	800-804, 809, 820-825, 829-835, 839-845, 849-855, 859-882, 889