

**ODJFS Methods for  
Clinical Performance Measures**

**For the  
Aged, Blind, or Disabled (ABD)  
Managed Care Program**

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**For the Provider Agreement effective through June 30, 2010**

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## Overview

### Methodology

These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in NCQA HEDIS 2009 Technical Specifications manual. Measures that are not based on HEDIS methodology are:

- All disease-specific and composite inpatient hospital discharge rates
- All disease-specific and composite emergency department visit rates
- All disease-specific and composite hospital readmissions
- Comprehensive Diabetes Care (CDC)—Nephropathy Screening (does not include LOINC codes due to these codes not being collected by ODJFS)

### Data Source

The source of the data for calculating the measures are as follows:

- (1) MCP-submitted encounter data and Medicaid fee-for-service (FFS) claims data.
- (2) ODJFS recipient master file to obtain recipient demographic and eligibility information.
- (3) ODJFS provider master file.

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period, with the exception of inclusion of Ohio Department of Mental Health (ODMH) CMHC data for the “Follow-Up After Hospitalization for Mental Illness” measure. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period, with the exception of inclusion of ODMH CMHC data for the “Follow-Up After Hospitalization for Mental Illness” measure. For the CY 2008 look back period, only encounter data will be used.

### Report Period

The applicable reporting year for the methods included in this document is January 1, 2009 – December 31, 2009.

### Prior Reporting Year

Certain measures include claims, encounters, and/or enrollment data from the ‘year prior to the reporting year.’ The initial ‘year prior to the reporting year’ will be CY 2008 (i.e., the initial reporting period is CY 2009). For the initial ‘year prior to the reporting year,’ CY 2008 FFS and managed care claims/encounter data and FFS enrollment data will be used, as applicable, to calculate the measures. **Example:** the CHF – Inpatient Hospital Discharge Rate calculates the number of CHF-related discharges in the reporting year, per 1,000 member months, for members with a primary or secondary diagnosis of CHF in the year prior to the reporting year. FFS and managed care claims/encounter data in the year prior to the reporting year (i.e., CY 2008) will be used to identify those members (who were enrolled in the ABD managed care program in the reporting year CY 2009) who had a diagnosis of CHF.

### ABD Performance Measurement

HEDIS methods and specifications will be applied to the prior reporting year to determine baseline reporting results, and will then be applied to the current reporting year to determine results for evaluation. Example: For HEDIS 2009 methods and specifications, the baseline reporting year will be CY 2008 and the reporting year for evaluation will be CY 2009.

## Code Tables

Methods for selected measures will reference the following code tables.

**Table INP-1: Codes to Identify Acute Inpatient Discharges**

|                           |
|---------------------------|
| <b>UB-92 Type of Bill</b> |
| 111, 121, 411, 421        |

**Table CLMS-1: List of Applicable Provider Types**

|  |  |
|--|--|
| <b>Claims and encounters submitted by the following provider types will be used to identify members with specific diagnoses for the following measures, as applicable.</b> |  |
| <b>01 – General Hospital</b>   | <b>23 – Physician (DO), Group</b>            |
| <b>04 – Outpatient Health Facility</b>   | <b>50 – Comprehensive Clinic</b>             |
| <b>05 – Rural Health Facility</b>  | <b>52 – Public Health Dept. Clinic</b>       |
| <b>12 – Federally Qualified Health Center</b>  | <b>53 – Clinic, Rehabilitation</b>           |
| <b>20 – Physician (MD), Individual</b>   | <b>84 – Ohio Department of Mental Health</b> |
| <b>21 – Physician (MD), Group</b>  | <b>86 – Skilled Nursing Facility</b>         |
| <b>22 – Physician (DO), Individual</b>   |  |

**Table ED-1: Codes to Identify Emergency Department Visits**

|                      |            |                           |
|----------------------|------------|---------------------------|
| <b>UB-92 Revenue</b> |            | <b>UB-92 Type of Bill</b> |
| <b>045x, 0981</b>    | <b>AND</b> | <b>13x</b>                |
| <i>OR</i>            |            |                           |
| <b>CPT</b>           |            | <b>POS</b>                |
| <b>10040 – 69979</b> | <b>AND</b> | <b>23</b>                 |
| <i>OR</i>            |            |                           |
| <b>CPT</b>           |            |                           |
| <b>99281 – 99285</b> |            |                           |

# Congestive Heart Failure (CHF)

**Table CHF-1: Codes to Identify Congestive Heart Failure**

| ICD-9-CM Diagnosis |                                      |
|--------------------|--------------------------------------|
| 428.xx             | Heart failure                        |
| 398.91             | Rheumatic heart failure (congestive) |

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## **CHF – Inpatient Hospital Discharge Rate**

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*The number of CHF-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of CHF in the year prior to the reporting year.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was CHF (Table CHF-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of CHF (Table CHF-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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## **CHF – Emergency Department (ED) Visit Rate**

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*The number of CHF-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of CHF in the year prior to the reporting year.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was CHF (Table CHF-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of CHF (Table CHF-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

# Congestive Heart Failure (CHF)

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## Cardiac Related Hospital Readmission

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*This measure calculates the cardiac-related inpatient readmission rate.*

**Numerator:** Number of readmissions with a cardiac-related principal diagnosis (Table CHF-2) for members in the denominator. A readmission is defined as an admission with a cardiac-related principal diagnosis that occurs within 30 days of a prior admission with a cardiac-related principal diagnosis.

**Denominator:** Number of cardiac-related admissions identified by principal diagnosis code (Table CHF-2) during the reporting year for members who were enrolled for at least 11 months in the reporting year, who were enrolled during the last month of the reporting year, and who have a primary or secondary diagnosis of CHF (Table CHF-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

**Table CHF-2: Codes to Identify Cardiac-Related Admissions/Readmissions**

| ICD-9-CM Primary Diagnosis   |             | UB-92 Type of Bill |
|--|-------------|--------------------|
| 393.xx – 398.xx, 401.xx – 405.xx,<br>410.xx – 414.xx, 415.xx – 417.xx,<br>420.xx – 429.xx, 440.xx – 448.xx,<br>451.xx – 459.xx | <i>with</i> | 11x, 12x, 41x, 42x |

### NOTE

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

## Coronary Artery Disease (CAD)

**Table CAD-1: Codes to Identify Coronary Artery Disease**

| ICD-9-CM Diagnosis |   |
|--------------------|---|
| 410.xx             | Acute Myocardial Infarction                                     |
| 411.xx             | Other acute/subacute forms of ischemic heart disease            |
| 412.xx             | Old myocardial infarction                                       |
| 413.xx             | Angina pectoris   |
| 414.0x             | Coronary atherosclerosis  |
| 414.8              | Other specified forms of ischemic heart disease                 |
| 414.9              | Chronic ischemic heart disease, unspecified                     |
| 429.2              | Cardiovascular disease, unspecified                             |
| 996.03             | Mechanical complication of cardiac device/coronary bypass graft |
| V45.81             | Aortocoronary bypass status                                     |

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### **CAD – Inpatient Hospital Discharge Rate**

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*The number of acute CAD-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of CAD in the year prior to the reporting year.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was CAD (Table CAD-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of CAD (Table CAD-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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### **CAD – Emergency Department (ED) Visit Rate**

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*The number of CAD-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of CAD in the year prior to the reporting year.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was CAD (Table CAD-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of CAD (Table CAD-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

# Coronary Artery Disease (CAD)

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## Cardiac Related Hospital Readmission

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*This measure calculates the cardiac-related inpatient readmission rate.*

**Numerator:** Number of readmissions with a cardiac-related principal diagnosis (Table CAD-2) for members in the denominator. A readmission is defined as an admission with a cardiac-related principal diagnosis that occurs within 30 days of a prior admission with a cardiac-related principal diagnosis.

**Denominator:** Number of cardiac-related admissions identified by principal diagnosis (Table CAD-2) during the reporting year for members who were enrolled for at least 11 months in the reporting, who were enrolled during the last month of the reporting year, and who have a primary or secondary diagnosis of CAD (Table CAD-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims data

**Table CAD-2: Codes to Identify Cardiac Related Admissions**

| ICD-9-CM Primary Diagnosis   |             | UB-92 Type of Bill |
|--|-------------|--------------------|
| 393.xx – 398.xx, 401.xx – 405.xx,<br>410.xx – 414.xx, 415.xx – 417.xx,<br>420.xx – 429.xx, 440.xx – 448.xx,<br>451.xx – 459.xx | <i>with</i> | 11x, 12x, 41x, 42x |

### NOTE

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

## Persistence of Beta-Blocker Treatment after a Heart Attack

*This measure calculates the percentage of members 21 years and older during the reporting year who were hospitalized and discharged alive from July 1 of the year prior to the reporting year to June 30 of the reporting year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.*

**Numerator:** Number of members in the denominator who received a beta-blocker prescription for at least 135 days supply within 180 days after discharge (135 treatment days plus 45 gap days). The list of drugs included in the numerator can be found at [www.ncqa.org](http://www.ncqa.org). Members who are on beta-blocker prescriptions that are active at the time of admission can also be included in the numerator if the “days supply” indicated on the pharmacy encounter claim is the number of days or more between the date the prescription was filled and the relevant admission date.

**Denominator:** Number of members 21 years of age and older as of December 31 of the reporting year who were hospitalized and discharged alive from July 1 of the year prior to the reporting year to June 30 of the reporting year with a diagnosis of AMI (Table CAD-3) and who were enrolled at least six months after discharge.

**Exclusions:** If a member had a prescription for one of the drugs listed in NCQA’s “beta-blocker treatment after a heart attack - exclusions” list, the member is excluded from the measure. Members with an encounter or a claim with a primary diagnosis listed in Table CAD-5 in the reporting year or the year prior to the reporting year will be excluded from the denominator.

**Notes:** If a member has more than one episode of AMI from July 1 of the year prior to the reporting year to June 30 of the reporting year, then only the first discharge will be included in the measure.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

**Table CAD-3: Codes to Identify AMI**

| Description | ICD-9-CM Code |
|-------------|---------------|
| AMI         | 410.x1        |

**Table CAD-4: Beta-Blocker Medications**

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

*NCQA provides a comprehensive list of medications and NDC codes on its Web site ([www.ncqa.org](http://www.ncqa.org)).*

## Persistence of Beta-Blocker Treatment after a Heart Attack (continued)

**Table CAD-5: Exclusions**

| Description           | ICD-9-CM Diagnosis  |
|-----------------------|---|
| History of asthma     | 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   |

**Table CAD-6: Medications to Identify Exclusions (History of Asthma)**

| Description                 | Prescription  |
|-----------------------------|---|
| Bronchodilator combinations | <ul style="list-style-type: none"> <li>• budesonide-formoterol</li> <li>• fluticasone-salmeterol</li> </ul>   |
| Inhaled corticosteroids     | <ul style="list-style-type: none"> <li style="width: 50%;">• beclomethasone</li> <li style="width: 50%;">• fluticasone</li> <li style="width: 50%;">• budesonide</li> <li style="width: 50%;">• mometasone</li> <li style="width: 50%;">• flunisolide</li> <li style="width: 50%;">• triamcinolone</li> </ul> |

NCQA provides a comprehensive list of medications and NDC codes on its Web site ([www.ncqa.org](http://www.ncqa.org)).

*Transfers to acute facilities.* Include hospitalizations in which the member was transferred directly to another acute care facility for any diagnosis (discharge status codes 02, 43, 61, 65, or 66). The discharge date from the facility to which the member was transferred must occur on or before June 30 of the measurement year. The subsequent, not the initial, acute inpatient facility discharge will be used as this measure's discharge date. The subsequent discharge date must occur on or before June 30 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 (discharge status code 03, 04, 05, 41, 62, 63, or 64).

*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.

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

## **Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed**

*The percentage of members between the ages of 21 and 75 who had a cardiovascular condition in the year prior to the reporting year, who were enrolled for at least 11 months in the reporting year and the year prior to the reporting year and enrolled in the last month of the reporting year, and who received a lipid profile during the reporting year.*

**Numerator:** Members in the denominator who received a lipid profile (Table CAD-7) during the reporting period.

**Denominator:** Members discharged alive between the ages of 21 and 75 for AMI, CABG, or PTCA on or between January 1 and November 1 of the year prior to the reporting year (Table CAD-8) or members with at least one outpatient or acute inpatient visit with any diagnosis of IVD (Table CAD-9) during the measurement year and the year prior to the measurement year (members must meet the outpatient or inpatient visit criteria during both the measurement year and the year prior to the measurement year – criteria need not be the same across years). AMI and CABG should be from inpatient claims/encounters only. All cases of PTCA should be included, regardless of setting.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

**Table CAD-7: Codes to Identify LDL-C Screening**

| <b>CPT</b>                        | <b>CPT Category II</b> |
|-----------------------------------|------------------------|
| 80061, 83700, 83701, 83704, 83721 | 3048F, 3049F, 3050F    |

**Table CAD-8: Codes to Identify AMI, PTCA, and CABG**

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

**Table CAD-9: Codes to Identify IVD**

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

**Table CAD-10: Codes to Identify Visit Type**

| <b>Description</b> | <b>CPT</b>  | <b>UB-92 Revenue</b>   |
|--------------------|---|--|
| Outpatient         | 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 | 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983  |
| Acute inpatient    | 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291   | 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987 |

## **Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed** (continued)

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used. In order for a member to meet continuous enrollment in the look back period, ABD recipients must be enrolled in Ohio Medicaid for 11 out of 12 months AS WELL AS enrolled in the same managed care plan for six out of seven months.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

## Hypertension (Non-Mild)

**Table HYP-1: Codes to Identify Hypertension (Non-Mild)**

| ICD-9-CM Diagnosis |                                       |
|--------------------|---------------------------------------|
| 362.11             | Hypertensive retinopathy              |
| 401.0              | Essential hypertension, malignant     |
| 402.xx             | Hypertensive heart disease            |
| 403.xx             | Hypertensive kidney disease           |
| 404.xx             | Hypertensive heart and kidney disease |
| 437.2              | Hypertensive encephalopathy           |

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### **Hypertension (Non-Mild) – Inpatient Hospital Discharge Rate**

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*The number of acute non-mild hypertension-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of non-mild hypertension in the year prior to the reporting year.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was non-mild hypertension (Table HYP-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of non-mild hypertension (Table HYP-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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### **Hypertension (Non-Mild) – Emergency Department (ED) Visit Rate**

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*The number of non-mild hypertension-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of hypertension (non-mild) in the year prior to the reporting year.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was non-mild hypertension (Table HYP-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of non-mild hypertension (Table HYP-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

# Diabetes

**Table DIAB-1: Codes to Identify Diabetes**

| ICD-9-CM Diagnosis |                            |        |                   |
|--------------------|----------------------------|--------|-------------------|
| 250.x              | Diabetes mellitus          | 366.41 | Diabetic cataract |
| 357.2              | Polyneuropathy in diabetes | 648.0  | Diabetes mellitus |
| 362.0              | Diabetic retinopathy       |        |                   |

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## Diabetes – Inpatient Hospital Discharge Rate

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*The number of acute diabetes-related inpatient hospital discharges in the reporting year, per thousand member months, for members identified as diabetic in the year prior to the reporting year.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was diabetes (Table DIAB-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members identified as diabetic (Table DIAB-2) in the year prior to the reporting year.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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## Diabetes – Emergency Department (ED) Visit Rate

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*The number of diabetes-related emergency department (ED) visits in the reporting year, per thousand member months, for members identified as diabetic in the year prior to the reporting year.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was diabetes (Table DIAB-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members identified as diabetic (Table DIAB-2) in the year prior to the reporting year.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

# Diabetes

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## Comprehensive Diabetes Care (CDC)/Eye Exam

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*The percentage of diabetic members between the ages of 21 and 75 who received an applicable exam or screening (as specified in the numerator) during the reporting year.*

**Numerator:** Number of members in the denominator who received a retinal exam (Table DIAB-5) by an optometrist or ophthalmologist (Table DIAB-6). Note: the number of members in the denominator who received the following tests and screenings will also be reported as ‘informational only’ measures: HbA1c testing (Table DIAB-7), LDL-C screening (Table DIAB-8), and screening or treatment for nephropathy (Table DIAB-9 and Table DIAB-10).

**Denominator:** Number of members between the ages of 21 and 75 identified as diabetic (Table DIAB-2) in the reporting year or the year prior to the reporting year, who were enrolled for at least 11 months in the reporting year, and who were enrolled during the last month of the reporting year. Members with steroid-induced or gestational diabetes are excluded (Table DIAB-11).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

### Table DIAB-2: Methods to Identify Diabetic Members

- **Two methods identify diabetic members.**
- **To be included in the measure, a member needs to be identified in only one method.**

#### Method 1: Pharmacy

Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics (Table DIAB-3).

#### Method 2: Inpatient, Outpatient, & Emergency Department Visits

Members who had:

- Two (2) visits with different dates of service in an outpatient or nonacute inpatient setting (Table DIAB-4) with a primary or secondary diagnosis of diabetes (Table DIAB-1), **OR**
- One (1) visit in an acute inpatient or emergency department setting (Table DIAB-4) with a primary or secondary diagnosis of diabetes (Table DIAB-1)

## Comprehensive Diabetes Care (CDC)/Eye Exam (continued)

**Table DIAB-3: Prescriptions to Identify Members with Diabetes**

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

NCQA provides a comprehensive list of medications and NDC codes on its Web site ([www.ncqa.org](http://www.ncqa.org)).

**Table DIAB-4: Codes to Identify Visit Type**

| Description          | CPT  | UB-92 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 | 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983   |
| Nonacute Inpatient   | 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337   | 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x   |
| Acute Inpatient      | 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291  | 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987 |
| Emergency Department | 99281-99285  | 045x, 0981   |

**Table DIAB-5: Codes to Identify Eye Exams**

| CPT   | CPT Category II*           | HCPCS                       | ICD-9-CM Procedure and Diagnosis                         |
|---|----------------------------|-----------------------------|--|
| 67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 99203-99205, 99213-99215, 99242-99245 | 2022F, 2024F, 2026F, 3072F | S0620, S0621, S0625*, S3000 | 14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16, V72.0 |

\* CPT Category II Codes and HCPCS S0625 do not need to be billed by an optometrist or an ophthalmologist.

## Comprehensive Diabetes Care (CDC)/Eye Exam (continued)

**Table DIAB-6: Codes to Identify Eye Care Professionals**

| Provider Type   | Specialty Code                                       |
|---|--|
| 35—Optometrist, Individual<br>55—Professional School Clinic, Optometry<br>61—Optometrist, Group | 54—Ophthalmology<br>72—Ophthalmology, Otolaryngology |

**Table DIAB-7: Codes to Identify HbA1c Tests**

| CPT          | CPT Category II            |
|--------------|----------------------------|
| 83036, 83037 | 3044F, 3045F, 3046F, 3047F |

**Table DIAB-8: Codes to Identify LDL-C Screening**

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

**Table DIAB-9: Codes to Identify Nephropathy Screening Tests**

| CPT                        | CPT Category II |
|----------------------------|-----------------|
| 82042, 82043, 82044, 84156 | 3060F, 3061F    |

**Table DIAB-10: Codes to Identify Evidence of Nephropathy**

| Description   | CPT Codes   | CPT Category II Codes | HCPCS Codes   | ICD-9-CM Diagnosis and Procedure Codes   | Revenue Codes               |
|---|---|-----------------------|---|--|-----------------------------|
| Evidence of diagnosis and/or treatment of nephropathy | 36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512 | 3066F                 | G0257, G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339 | 38.95, 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, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1, V56 | 0367, 080x, 082x-085x, 088x |

**Table DIAB-11: Codes to Identify Steroid-Induced and Gestational Diabetes**

| Description          | ICD-9-CM Diagnosis |
|----------------------|--------------------|
| Polycystic Ovaries   | 256.4              |
| Steroid-Induced      | 251.8, 962.0       |
| Gestational Diabetes | 648.8              |

## **Comprehensive Diabetes Care (CDC)/Eye Exam** (continued)

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

# Chronic Obstructive Pulmonary Disease (COPD)

**Table COPD-1: Codes to Identify COPD**

| ICD-9-CM Diagnoses |  |
|--------------------|--|
| 491.XX             | Chronic bronchitis                                   |
| 492.XX             | Emphysema  |
| 496.XX             | Chronic airway obstruction, not elsewhere classified |

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## **COPD – Inpatient Hospital Discharge Rate**

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*The number of acute COPD-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of COPD in the year prior to the reporting year.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was COPD (Table COPD-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of COPD (Table COPD-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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## **COPD – Emergency Department (ED) Visit Rate**

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*The number of COPD-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of COPD in the year prior to the reporting year.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was COPD (Table COPD-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of COPD (Table COPD-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

# Chronic Obstructive Pulmonary Disease (COPD)

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## Use of Spirometry Testing in the Assessment and Diagnosis of COPD

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*The percentage of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis. Note: Initial report period will be CY 2010.*

**Numerator:** The number of members in the denominator with at least one claim/encounter with any of the codes listed in Table COPD-2 for spirometry 720 days before to 180 days after the episode start date.

**Denominator:** Members 42 years of age or older as of December 31 of the reporting year, continuously enrolled 730 days (2 years) prior to the index episode start date through 180 days after the index episode start date (IESD). One gap in enrollment is allowed in each of the 12-month periods prior to the index episode start date or in the 6-month period after the IESD.

Step 1: Identify all members who, during the intake period, had any diagnosis of COPD (Table COPD-1).

Step 2: Determine the COPD episode start date. For each member identified in step 1, identify the date of the earliest encounter during the intake period with a COPD diagnosis (Table COPD-1).

Step 3: Determine if the episode start date is a new episode. Members with a new episode of COPD must have a negative diagnosis history. Members with any encounter or claim during the 730 days (2 years) prior to the IESD should be excluded from the denominator. For an inpatient index episode, use the date of admission to determine the negative diagnosis history.

Step 4: Calculate continuous enrollment. Members must be continuously enrolled in the MCP 730 days (2 years) prior to the episode start date through 180 days after the episode start date.

**Table COPD-2: Codes to Identify Spirometry**

| Description | CPT  |
|-------------|--|
| Spirometry  | 94010, 94014-94016, 94060, 94070, 94375, 94620 |

**Index episode start date:** The earliest encounter during the intake period with a qualifying diagnosis of COPD (Table COPD-1). For an outpatient episode, the index episode start date is the date of service. For an inpatient episode, the index episode start date is the date of discharge. For a transfer or readmission, the index episode start date is the discharge date of original admission.

**Negative diagnosis history:** A period of 730 days (2 years) prior to the IESD, during which the member had no claims/encounters containing any principal or secondary diagnosis of COPD (Table COPD-1). For an inpatient index episode, use the date of admission to determine the negative diagnosis history.

**Intake Period:** A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The intake period issued to capture eligible episodes of treatment.

**New Episode:** To qualify as a new episode, two criteria must be met: 1) a 730-day negative diagnosis history on or before the IESD and 2) continuous enrollment.

# Asthma

**Table ASM-1: Codes to Identify Asthma**

| ICD-9-CM Diagnosis |        |
|--------------------|--------|
| 493.xx             | Asthma |

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## **Asthma – Inpatient Hospital Discharge Rate**

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*The number of acute asthma-related inpatient hospital discharges in the reporting year, per thousand member months, for members with persistent asthma.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was asthma (Table ASM-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members with persistent asthma (Table ASM-2).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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## **Asthma – Emergency Department (ED) Visit Rate**

---

*The number of asthma-related emergency department (ED) visits in the reporting year, per thousand member months, for members with persistent asthma.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was asthma, for members included in the denominator.

**Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members with persistent asthma (Table ASM-2).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

# Asthma

## Use of Appropriate Medications for People with Asthma

*The percentage of members ages 21 to 56 with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma.*

**Numerator:** The number of members in the denominator who received one or more prescriptions of the recommended medications (Table ASM-5) during the reporting year. A comprehensive list of the medications can be found at [www.ncqa.org](http://www.ncqa.org).

**Denominator:** The number of members 21 to 56 years of age, as of December 31 of the reporting year, identified as having persistent asthma, who had 11 or more months of enrollment in the reporting year and the year prior to the reporting year, and were enrolled as of December 31 of the reporting year.

### Table ASM-2: Methods to Identify Members with Persistent Asthma

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

- Group 1. Member has at least one emergency department visits (Table ASM-3) with asthma as the principal diagnosis (Table ASM-1).
- Group 2. Member has at least one acute inpatient discharge (Table ASM-3) with asthma as the principal diagnosis (Table ASM-1).
- Group 3. Member has at least four outpatient asthma visits (Table ASM-3) with asthma as one of the listed diagnoses (Table ASM-1) and at least two asthma medication dispensing events (Table ASM-4).
- Group 4. Member has at least four asthma medication dispensing events (i.e., an asthma medication dispensed on four occasions) (Table ASM-4).\*\*
- *A member with at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed will be excluded from the denominator unless the member also has at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier.*

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

*\*\* 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 down to convert. For example, a 100-day prescription is equal to 3 dispensing events ( $100/30=3.33$ , rounded down to 3).*

## Use of Appropriate Medications for People with Asthma (continued)

**Table ASM-3: Codes to Identify Asthma Visit Type**

| Description          | CPT   | UB-92 Revenue  |
|----------------------|---|--|
| Outpatient           | 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429 | 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983  |
| Acute Inpatient      | 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291   | 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987 |
| Emergency Department | 99281-99285   | 045x, 0981   |

**Table ASM-4: Asthma Medications**

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

NCQA provides a comprehensive list of medications and NDC codes on its Web site ([www.ncqa.org](http://www.ncqa.org)).

**Table ASM-5: Preferred Asthma Therapy Medications**

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

NCQA provides a comprehensive list of medications and NDC codes on its Web site ([www.ncqa.org](http://www.ncqa.org)).

## Use of Appropriate Medications for People with Asthma (continued)

### **Exclusion**

Exclude from the eligible population all members diagnosed with emphysema or chronic obstructive pulmonary disease (COPD) any time on or prior to December 31 of the measurement year (i.e., in the measurement year or year prior to the measurement year), as identified by the following codes:

**Table ASM-6: Codes to Identify Exclusions**

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

Members in the eligible population (i.e., denominator) will be excluded if they meet the exclusion criteria and are numerator non-compliant.

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used. In order for a member to meet continuous enrollment in the look back period, ABD recipients must be enrolled in Ohio Medicaid for 11 out of 12 months AS WELL AS enrolled in the same managed care plan for six out of seven months.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

# Mental Health, Severely Mentally Disabled (SMD)

**Table SMD-1: Codes to Identify SMD**

| ICD-9-CM Principal Diagnosis |  |
|------------------------------|--|
| 293.xx                       | Transient mental disorders due to conditions classified elsewhere  |
| 294.xx                       | Persistent mental disorders due to conditions classified elsewhere |
| 295.xx                       | Schizophrenic disorders  |
| 296.xx                       | Episodic mood disorders  |
| 297.xx                       | Delusional disorders   |
| 298.xx                       | Other nonorganic disorders   |
| 299.xx                       | Pervasive developmental disorders                                  |

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## SMD – Inpatient Hospital Discharge Rate

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*The number of acute SMD-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of SMD in the year prior to the reporting year.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was SMD (Table SMD-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of SMD (Table SMD-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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## SMD – Emergency Department (ED) Visit Rate

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*The number of SMD-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of SMD in the year prior to the reporting year.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was SMD, for members included in the denominator.

**Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members with a primary or secondary diagnosis of SMD (Table SMD-1) in the year prior to the reporting year, as reported on claims and encounters submitted by the provider types listed in Table CLMS-1.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

## Mental Health, Severely Mentally Disabled (SMD)

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### **SMD – Inpatient Hospital Readmission Rate**

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*The number of readmissions with a principal diagnosis of SMD for members who had a diagnosis of SMD in the year prior to the reporting year. A readmission is defined as an admission with a principal diagnosis of SMD that occurs within 30 days of a prior SMD-related admission.*

**Numerator:** Number of readmissions with a principal diagnosis of SMD (Table SMD-1) and Type of Bill specified in Table INP-1 for members in the reporting year with a diagnosis of SMD (Table SMD-1) in the year prior to the reporting year. A readmission is defined as an admission with a principal diagnosis of SMD that occurs within 30 days of a prior admission with a principal diagnosis of SMD.

**Denominator:** Number of admissions with a principal diagnosis of SMD (Table SMD-1) and Type of Bill specified in Table INP-1 during the reporting year for members who were enrolled for at least 11 months in the reporting year, who were enrolled during the last month of the reporting year, and who have a primary or secondary diagnosis of SMD in the year prior to the reporting year.

**Data Source:** Encounter Data, Fee-for-Service Claims data

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Encounter data and ODMH CMHC data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Encounter data and ODMH CMHC data will be used for the CY 2009 report period and the CY 2008 look back period.

# Mental Health

## Follow-up After Hospitalization for Mental Illness

*The percentage of discharges for members who were hospitalized for treatment of selected mental health disorders and were enrolled from the date of discharge through 30 days after discharge, who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.*

**Numerator:** Note: Two separate measures will be calculated. Members in the denominator who had an outpatient visit, intensive outpatient encounter, or partial hospitalization (Table SMD-3a) up to:

- 1) 30 days after discharge, and
- 2) 7 days after discharge.

Include outpatient visits, intensive outpatient encounters, or partial hospitalizations that occur on the date of discharge.

**Denominator:** Members discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Table SMD-2) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. **Exclusions:** Discharges followed by a readmission or a direct transfer for any diagnosis within the 30-day follow-up period.

### Table SMD-2: Codes to Identify Mental Health Disorders

| ICD-9-CM Diagnosis                            |
|---|
| 295-299, 300.3, 300.4, 301, 308, 309, 311-314 |

### Table SMD-3a: Codes to Identify Visits

| CPT/HCPCS   |             |  |
|---|-------------|--|
| <b>Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner from Table SMD-3b.</b>   |             |  |
| 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485<br>Z1831 – Pharmacological Mgt., Z1832 – MH Assessment, non-MD, Z1833 – Counseling & Therapy, Indiv., Z1834 – Counseling & Therapy, Group, Z1837 – Crisis Intervention, Z1839 – Psychiatric Dx Interview, Z1840 – Community Psych. Support Tx, Individual, Z1841 – Community Psych. Support, Group |             |  |
| CPT   | POS         |  |
| <b>Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner from Table SMD-3b.</b>  |             |  |
| 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876   | <i>WITH</i> | 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72 |
| 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263  | <i>WITH</i> | 52, 53   |
| UB-92 Revenue   |             |  |
| <b>The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.</b>   |             |  |
| 0513, 0900-0905, 0907, 0911-0917, 0919  |             |  |
| <b>Visits identified by the following Revenue codes must be with a mental health practitioner from Table SMD-3b or in conjunction with any diagnosis code from Table SMD-2.</b>   |             |  |
| 0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983   |             |  |

## Follow-up After Hospitalization for Mental Illness (continued)

**Table SMD-3b: Methods to Identify Mental Health Practitioner**

| Method 1—Provider Type  | Method 2—Physician Specialty                | Method 3—Provider Type With Modifier   |
|---|---|--|
| <b>Provider Type</b><br>02-Mental Hospital<br>42-Psychologist, Individual<br>51-Clinic, Mental, Drug, Alcohol<br>67-Psychologist, Group<br>84-Mental Health Dept. | <b>Physician Specialty</b><br>23-Psychiatry | <b>Provider Type</b><br>20-Physician (MD), Individual<br>21-Physician (MD), Group<br>22-Physician (DO), Individual<br>23-Physician (DO), Group                                       |
|   |   | <i>WITH</i>  |
|   |   | <b>Modifier</b><br>AJ-clinical social worker<br>HP-doctoral level trained professional<br>HO-master's degree level trained professional<br>HN-bachelor's level clinical staff person |

If a discharge for a selected mental health disorder is followed by a readmission or direct transfer (discharge status code 02, 43, 61, 65, or 66) to an acute facility for any mental health principal diagnosis within the 30-day follow-up period, only the readmission discharge or the discharge from the facility to which the recipient was transferred will be counted.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer (discharge status code 03, 04, 05, 41, 62, 63, or 64) to a nonacute facility for any mental health principal diagnosis within the 30-day follow-up period. Refer to Table SMD-3c for codes to identify nonacute care.

**Table SMD-3c: Codes to Identify Nonacute Care**

| Description  | HCPCS              | UB Revenue   | UB Type of Bill | POS    |
|--|--------------------|--|-----------------|--------|
| Hospice  |                    | 0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659 | 81x, 82x        | 34     |
| SNF  |                    | 019x   | 21x, 22x        | 31, 32 |
| Hospital transitional care, swing bed or rehabilitation  |                    |  | 18x             |        |
| Rehabilitation   |                    | 0118, 0128, 0138, 0148, 0158                         |                 |        |
| Respite  |                    | 0655   |                 |        |
| Intermediate care facility   |                    |  |                 | 54     |
| Residential substance abuse treatment facility   |                    | 1002   |                 | 55     |
| Psychiatric residential treatment center   | T2048, H0017-H0019 | 1001   |                 | 56     |
| Comprehensive inpatient rehabilitation facility  |                    |  |                 | 61     |
| Other nonacute care facilities that do not use the UB Revenue or Type of Bill codes for billing (e.g., ICF, SNF) |                    |  |                 |        |

Exclude discharges in which the patient was transferred directly (discharge status code 02, 03, 04, 05, 20, 33, 61, 62, 63, 64, 65, or 66) or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis.

## **Follow-up After Hospitalization for Mental Illness** (continued)

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Encounter data and ODMH CMHC data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Encounter data and ODMH CMHC data will be used for the CY 2009 report period and the CY 2008 look back period.

# Mental Health

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## Antidepressant Medication Management

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*The percentage of members who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.*

**Note:** Initial report period will be CY 2009.

**Numerator:** Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment 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: 1) washout period gap to change medication or 2) treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 51 days. The MCP may count any combination of gaps. Total gap days may not exceed 51 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.

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.

### **Denominator:**

Step 1: Identify all members with a diagnosis of depression who, during the 12-month intake period, had:

At least one principal diagnosis of major depression (Table SMD-4) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges, or partial hospitalizations), or

At least two visits in any outpatient setting (e.g., outpatient or emergency room visits) on different dates of service with any diagnosis of major depression (Table SMD-4), or

At least one inpatient discharge with any diagnosis of major depression (Table SMD-4).

Step 2: Determine the index episode start date and test for negative diagnosis history. For each member identified in Step 1, determine the index episode start date by finding the date of the member's earliest encounter during the intake period (i.e., outpatient or emergency room visit date, inpatient discharge date, partial hospitalization visit date) with a qualifying major depression diagnosis (Table SMD-4).

Identify members who were diagnosed with a new episode of depression. The range of ICD-9-CM diagnosis codes for prior depressive episodes in Table SMD-4 is more comprehensive to exclude members diagnosed with any type of depression.

Members with any diagnosis of depression within the previous 120 days (4 months) of the index episode start date 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 index episode start date to 14 days on or after the index episode start date.

## Antidepressant Medication Management (continued)

Step 4: Calculate continuous enrollment. Members must be continuously enrolled in the MCP for 120 days prior to the index episode start date to 245 days (180 medication days plus 51 potential gap days plus 14 days for filling the prescription) after the index episode start date.

Step 5: Identify the index prescription date. Identify the earliest prescription up to 30 days before the index episode start date to 14 days on or after the index episode start date. Prescriptions may be up to 30 days before the index episode start date 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 index episode start date 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.

### Definitions

Intake period: the 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.

Index episode start date: The earliest encounter during the intake period with a qualifying diagnosis of major depressions.

Index prescription date: The earliest prescription for antidepressants filled within a 44-day period, defined as 30 days prior to through 14 days on or after the index episode start date.

Negative diagnosis history: A period of 120 days (4 months) prior to the index episode start date, during which time the member had no claims/encounters containing either a principal or secondary diagnosis of depression (Table SMD-4).

Negative medication history: 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 (*A list of NDC codes for this measure may be found at [www.ncqa.org](http://www.ncqa.org).*)

New episode: To qualify as a new episode, two criteria must be met: 1) a 120-day (4-month) negative diagnosis history prior to the index episode start date and 2) a 90-day (3-month) 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.

**Table SMD-4: Major Depression Diagnoses**

| Description               | ICD-9-CM Diagnosis                                     |
|---------------------------|--|
| Major depression          | 296.20-269.25, 296.30-296.35, 298.0, 300.4, 309.1, 311 |
| Prior depressive episodes | 296.26, 296.36, 296.4-296.9, 309.0, 309.28             |

## Antidepressant Medication Management (continued)

**Table SMD-5: Antidepressant Medications**

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

NCQA provides a comprehensive list of medications and NDC codes on its Web site ([www.ncqa.org](http://www.ncqa.org)).

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Encounter data and ODMH CMHC data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used. Continuous enrollment will be determined using both FFS eligibility and managed care enrollment data.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Encounter data and ODMH CMHC data will be used for the CY 2009 report period and the CY 2008 look back period.

## Alcohol or Other Drug Abuse or Dependence (AOD)

**Table AOD-1: Codes to Identify AOD**

| ICD-9-CM Diagnosis |                                  |
|--------------------|----------------------------------|
| 291.xx             | Alcohol induced mental disorders |
| 292.xx             | Drug induced mental disorders    |
| 303.xx             | Alcohol dependence syndrome      |
| 304.xx             | Drug dependence                  |
| 305.0x             | Alcohol abuse                    |
| 305.2x-305.9x      | Other drug abuse                 |
| 535.3              | Alcohol gastritis                |
| 571.1              | Acute alcohol hepatitis          |

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### **AOD – Inpatient Hospital Discharge Rate**

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*The number of acute alcohol and other drug abuse or dependence (AOD)-related inpatient hospital discharges in the reporting year, per thousand member months, for members who in the year prior to the reporting year, had one of the following: an AOD-related acute inpatient admission or two AOD-related emergency department (ED) visits*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was AOD (Table AOD-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members who in the year prior to the reporting year had one of the following: at least one AOD-related acute inpatient admission or at least two AOD-related ED visits. “AOD-related” includes acute inpatient admissions or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (Table AOD-1).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

**Note:** Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addictions Services will not be used in this measure.

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

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## **AOD – Emergency Department (ED) Visit Rate**

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*The number of AOD-related emergency department (ED) visits in the reporting year, per thousand member months, for members with AOD.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was AOD (Table AOD-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members who in the year prior to the reporting year had one of the following: at least one AOD-related acute inpatient admission or at least two AOD-related ED visits. “AOD-related” includes acute inpatient admissions or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (Table AOD-1).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

**Note:** Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addictions Services will not be used in this measure.

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## **AOD – Inpatient Hospital Readmission Rate**

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*The number of alcohol and other drug abuse or dependence (AOD)-related readmissions for members who had a diagnosis of AOD in the year prior to the reporting year. A readmission is defined as an AOD-related admission that occurs within 30 days of a prior AOD-related admission.*

**Numerator:** Number of readmissions with a principal diagnosis of AOD (Table AOD-1) for members in the denominator. A readmission is defined as an admission with a principal diagnosis of AOD (Table AOD-1) that occurs within 30 days of a prior admission with a principal diagnosis of AOD. Exclusions: readmissions that occur within 30 days of a prior admission for detoxification therapy. Admissions for detoxification therapy are identified using an AOD diagnosis (Table AOD-1) in conjunction with one of following ICD-9-CM procedure codes for detoxification therapy: 94.25, 94.62, 94.63, 94.65, 94.66, 94.68, and 94.69.

**Denominator:** Number of AOD-related admissions identified by principal diagnosis (Tables AOD-1 and INP-1) during the reporting year for members who were enrolled for at least 11 months in the reporting year and who in the year prior to the reporting year had one of the following: at least one AOD-related acute inpatient admission or at least two AOD-related ED visits. “AOD-related” includes acute inpatient admissions or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (Table AOD-1).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

**Note:** Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addictions Services will not be used in this measure.

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.

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## **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

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

**Engagement:** *The percentage of members who initiate treatment who have two or more AOD services within 30 days after the date of the initiation visit (inclusive).*

### **Numerator:**

#### Initiation of AOD treatment

Step 1: Identify all members in the denominator whose index episode start date was an inpatient discharge with any AOD diagnosis. This visit counts as the initiation event.

Step 2: Identify all members in the denominator whose index episode start date was an outpatient visit, detoxification visit, or emergency department visit.

Step 3: Use Table AOD-3 or Table AOD-6 to determine if the members in step 2 had an additional outpatient visit or inpatient admission with any AOD diagnosis within 14 days of the index episode start date (inclusive). To determine if the 14-day criterion is met for inpatient stays, use the admission date, not the discharge date.

Step 4: Exclude from the denominator members whose initiation service was an inpatient stay with a discharge date after December 1.

#### Engagement of AOD Treatment

Identify members who had an initiation of AOD treatment visit and two or more services with an AOD dependence diagnosis within 30 days after the date of the initiation visit (inclusive). Use Table AOD-3 or Table AOD-6 to identify engagement treatment. For members who initiated treatment via an inpatient stay, 30 days starts at the member's inpatient discharge. To determine if the 30-day criterion is met for engagement inpatient stays, use the admission date of the subsequent inpatient stay, not the discharge date.

### **Denominator:**

Step 1: Identify members who had:

- an outpatient claim or encounter (Table AOD-3) for AOD services between January 1 and November 15 of the measurement year, or
- a detoxification or emergency department (Table AOD-4 or Table AOD-5) claim or encounter between January 1 and November 15 of the measurement year, or
- an inpatient claim or encounter (Table AOD-6), with a discharge date between January 1 and November 15 of the measurement year.

Step 2: Determine the index episode start date. For each member identified in step 1, determine the index episode start date by identifying the date of the member's earliest encounter during the measurement year (e.g., outpatient, detoxification or emergency department visit date; inpatient discharge date) with any qualifying AOD dependence diagnosis (Table AOD-2).

Step 3: Determine if the index episode start date is a new episode. Members with a new episode of AOD dependence have a negative diagnosis history. Negative Diagnosis History: A period of 60 days prior to the Index Episode Start date, during which the member had no claims/encounters with any diagnosis of AOD dependence (Table AOD-2). For members with an inpatient visit, use the admission date to determine negative diagnosis history. For ED visits that result in an inpatient admission, use the ED date of service to determine the negative diagnosis history.

# Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (continued)

Step 4: Calculate continuous enrollment. The member must be continuously enrolled without any gaps for 60 days prior through 44 days after the index episode start date.

**Data Source:** Encounter Data, Fee-for-Service Claims Data

**Note:** Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addiction Services will not be used in this measure.

**Table AOD-2: Codes to Identify AOD Dependence**

| ICD-9-CM Diagnosis   |
|--|
| 291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1 |

**Table AOD-3: Outpatient Visit Codes  
Must Be Paired With Diagnosis of AOD from Table AOD-2**

| CPT   |           | HCPCS  |           | UB-92 Revenue   |
|---|-----------|--|-----------|---|
| 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510 | <b>or</b> | G0155, G0176, G0177, G0396, G0397, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012 | <b>or</b> | 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 077x, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983 |
| CPT   |           |  |           | POS   |
| 90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876  |           | <i>WITH</i>  |           | 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72                                  |
| 90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263   |           | <i>WITH</i>  |           | 52, 53  |

**Table AOD-4: Detoxification Services Codes**

| HCPCS         |           | ICD-9-CM Procedure                       |           | UB-92 Revenue                |
|---------------|-----------|--|-----------|------------------------------|
| H0008 – H0014 | <b>or</b> | 94.62, 94.63, 94.65, 94.66, 94.68, 94.69 | <b>or</b> | 0116, 0126, 0136, 0146, 0156 |

**Table AOD-5: Emergency Department Services Codes**

| CPT                                   |           | UB-92 Revenue |
|---------------------------------------|-----------|---------------|
| 99281-99285                           | <b>or</b> | 045x, 0981    |
| <i>WITH</i>                           |           |               |
| Any diagnosis of AOD from Table AOD-2 |           |               |

**Table AOD-6: Codes to Identify Inpatient Services**

|  |             |   |
|--|-------------|---|
| ICD-9-CM diagnosis code from Table AOD-2 | <i>WITH</i> | UB-92 bill Type: 11x, 12x, 18x, 21x, 22x, 41x, 42x, 84x |
|--|-------------|---|

## Inpatient Discharge & Emergency Department Visit Rates With Age Group Breakouts

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### **Inpatient Hospital Discharge Rate with Age Group Breakouts**

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The condition-specific and composite inpatient hospital discharge rates will be calculated by age group (Table AGE-1). For hospitalizations, the age of the member is the age as of the date of discharge. For member months, age is the age of the member as of the last day of the month.

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### **Emergency Department Visit Rate with Age Group Breakouts**

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The condition-specific and composite emergency department visit rates will be calculated by age group (Table AGE-1). For visits, the age of the member is the age as of the date of service. For member months, age is the age of the member as of the last day of the month.

**Table AGE-1**

| <b>Age</b> | <b>Discharges/Visits</b> | <b>Member Months</b> | <b>Discharges/Visits<br/>per 1,000 Member<br/>Months</b> |
|------------|--------------------------|----------------------|--|
| 20-44      | xx                       | xx                   | xx   |
| 45-64      | xx                       | xx                   | xx   |
| 65-74      | xx                       | xx                   | xx   |
| 75-84      | xx                       | xx                   | xx   |
| 85+        | xx                       | xx                   | xx   |
| Total      | xx                       | xx                   | xx   |

# Composite Utilization Rates

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## Inpatient Hospital Discharge Rate

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*The number of acute inpatient hospital discharges related to CHF, CAD, non-mild hypertension, diabetes, COPD, asthma, SMD, or AOD, per thousand member months, for members who had the same diagnosis in the year prior to the reporting year. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: an AOD-related acute inpatient admission or two AOD-related ED visits.*

**Numerator:** The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was CHF (Table CHF-1), CAD (Table CAD-1), non-mild hypertension (Table HYP-1), diabetes (Table DIAB-1), COPD (Table COPD-1), asthma (Table ASM-1), SMD (Table SMD-1), or AOD (Table AOD-1), for members included in the denominator.

**Denominator:** Member months in the reporting year for members in the year prior to the reporting year with a primary or secondary diagnosis of CHF (Table CHF-1), CAD (Table CAD-1), non-mild hypertension (Table HYP-1), COPD (Table COPD-1), or SMD (Table SMD-1) as reported on claims/encounters submitted by the provider types listed in Table CLMS-1; who are diabetic (Table DIAB-2); or who have persistent asthma (Table ASM-2). For AOD, members need to have had one of the following in the year prior to the reporting year: at least one AOD-related inpatient admissions or at least two AOD-related. “AOD-related” includes inpatient admission or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (Table AOD-1).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

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## Emergency Department (ED) Utilization Rate

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*The number of emergency department (ED) visits in the reporting year related to CHF, CAD, non-mild hypertension, diabetes, COPD, asthma, SMD, or AOD, per thousand member months, for members who had the same diagnosis in the year prior to the reporting year. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: an AOD-related acute inpatient admission or two AOD-related ED visits.*

**Numerator:** The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was CHF (Table CHF-1), CAD (Table CAD-1), mild hypertension (Table HYP-1), diabetes (Table DIAB-1), COPD (Table COPD-1), asthma (Table ASM-1), SMD (Table SMD-1), or AOD (Table AOD-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day as, the first day of an inpatient admission).

**Denominator:** Member months in the reporting year for members in the year prior to the reporting year with a primary or secondary diagnosis of CHF (Table CHF-1), CAD (Table CAD-1), non-mild hypertension (Table HYP-1), COPD (Table COPD-1), or SMD (Table SMD-1) as reported on claims/encounters submitted by the provider types listed in Table CLMS-1; who are diabetic (Table DIAB-2); or who have persistent asthma (Table ASM-2). For AOD, members need to have had one of the following in the year prior to the reporting year: at least one AOD-related inpatient admissions or at least two AOD-related. “AOD-related” includes inpatient admission or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (Table AOD-1).

**Data Source:** Encounter Data, Fee-for-Service Claims Data

# Composite Utilization Rates

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## **Inpatient Hospital Readmission Rate**

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*The number of CHF-, CAD-, SMD-, or AOD-related inpatient hospital readmissions for members who had the same diagnosis in the year prior to the reporting year. A readmission is defined as an admission that occurs within 30 days of a prior admission for the same diagnosis.*

**Numerator:** Number of readmissions with a cardiac-related (Table CHF-2 and Table CAD-2), SMD-related (Table SMD-1), or AOD-related (Table AOD-1) principal diagnosis for members included in the denominator. A readmission is defined as an admission that occurs within 30 days of a prior admission for the same diagnosis. **AOD Exclusions:** Readmissions that occur within 30 days of a prior admission for detoxification therapy. Admissions for detoxification therapy are identified using an AOD diagnosis (Table AOD-1) in conjunction with one of following ICD-9-CM procedure codes for detoxification therapy: 94.25, 94.62, 94.63, 94.65, 94.66, 94.68, and 94.69.

**Denominator:** Number of admissions with a cardiac-related (Table CHF-2 and Table CAD-2), SMD-related (Table SMD-1), or AOD-related (Table AOD-1) principal diagnosis admissions during the reporting year for members who were enrolled for at least 11 months in the reporting year, who were enrolled during the last month of the reporting year, and who had a primary or secondary diagnosis of CHF (Table CHF-1), CAD (Table CAD-1), or SMD (Table SMD-1). For AOD, members need to have had one of the following in the year prior to the reporting year: at least one AOD-related inpatient admissions or at least two AOD-related. "AOD-related" includes inpatient admission or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (Table AOD-1).

**Data Source:** Encounter Data, Fee-for-Service Claims data

### **NOTE**

**SFY 2010 Baseline report period (CY 2008):** For baseline reports, CY 2008 will be the report period and CY 2007 will be the look back period. Only encounter data will be used for the CY 2008 report period. For the CY 2007 look back period, both FFS claims and encounter data will be used.

**SFY 2010 Report period (CY 2009):** CY 2009 will be the report period and CY 2008 will be the look back period. Only encounter data will be used for the CY 2009 report period and the CY 2008 look back period.