Effectiveness of Care

Specific Guidelines for Effectiveness of Care Measures

Which services count?

For Effectiveness of Care measures, report all services whether or not the MCO paid for them. For example, report services paid for by a third party, such as a community center, or services for which payment was denied because they were not properly authorized.

The MCO must include all paid, suspended, pending and denied claims and is ultimately responsible for the quality of care it provides to members. The MCO must also ensure certain services have been provided, even if another community provider provides them.

Optional exclusions

Some measures in the Effectiveness of Care domain allow the MCO to exclude certain members from the denominator identified as having a certain procedure or comorbidity (e.g., exclude women who have had bilateral mastectomies from the *Breast Cancer Screening* measure). The MCO is not required to make these exclusions, but may choose to do so to improve accuracy of the rates.

For each measure that includes optional exclusions, technical specifications indicate instructions the plan should follow; however, as a general rule, look for exclusions only for individuals where administrative data indicate that the specified numerator service/procedure did not occur. The MCO must first use the eligible population to identify members for whom administrative data shows that the numerator service/procedure was rendered within the time frame specified in the measure, and must count the members as having satisfied the measure (i.e., count these members in the numerator).

The MCO must verify that the exclusion occurred by the time specified in the measure. For hybrid measures, new members must replace members who met the exclusion criteria and have been excluded from the sample. (Refer to the *Guidelines for Calculations and Sampling* for more information on how to identify exclusions and substitute medical records.)

Effectiveness of Care measure format

There are 10 possible sections in each measure specification in this domain.

- Summary of Changes
- Description
- Calculation
- Definitions
- Eligible Population
- Administrative Specification
- Hybrid Specification
- Exclusion (optional)
- Note
- Data Elements for Reporting

Eligible population criteria

The **eligible population** includes all members who meet the specified criteria. Seven criteria define the eligible population for a specific measure.

- **Product line** specifies the product lines (commercial, Medicaid, Medicare) for which the measure should be reported.
- **Age** specifies any age group and gender requirement (e.g., *Breast Cancer Screening* is only collected for women 40–69 years of age).
- **Continuous enrollment** specifies the continuous enrollment criteria for the measure.
- **Allowable gap** specifies any allowable gaps during the continuous enrollment period. There are different allowable gap criteria for the Medicaid product line.
- **Anchor date** specifies any enrollment date requirement for the eligible population (e.g., children must be enrolled in the MCO on their second birthday for inclusion in the *Childhood Immunization Status* measure).
- **Benefit** specifies the type of benefits a member must have to be included in the eligible population (e.g., members must have medical, pharmacy and mental health benefits for inclusion in the *Antidepressant Medication Management* measure).
- **Event/diagnosis** specifies the medical event or diagnosis requirements for the eligible population (e.g., members must have a diagnosis of AMI for inclusion in the *Beta-Blocker Treatment After a Heart Attack* measure).

Administrative Specification

The **Administrative Specification** outlines the collection and calculation of a measure using only administrative data, including a description of the entire eligible population, the numerator requirements (i.e., the indicated treatment or procedure) and any optional exclusion allowed for the measure.

Hybrid Specification

The **Hybrid Specification** includes sampling requirements for the denominator population, medical record documentation requirements for the numerator and any optional exclusion allowed for the measure.

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO HEDIS 2007

- Deleted DTP, as the use of this vaccine was discontinued prior to the look-back period for the measure.
- Clarified that a history of disease and a seropositive test result cannot be used toward the pneumococcal conjugate vaccine rate.
- Deleted CPT codes 90701, 90720 from Table CIS-A.
- Added HCPCS codes to Table CIS-A.
- Added ICD-9-CM Diagnosis code 138 to Table CIS-A.

Description

The percentage of children two years of age who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	Children who turn two years of age during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator

The eligible population.

Numerators

For pneumococcal conjugate the MCO must find evidence of the antigen or vaccine. For all other antigens, the MCO may count any of the following.

- Evidence of the antigen or combination vaccine, ***or***
- Documented history of the illness, ***or***
- A seropositive test result.

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the MCO must find evidence of all the antigens.

DTaP/DT An initial DTaP vaccination followed by at least three DTaP, DT or individual diphtheria and tetanus shots, with different dates of service on or before the child's second birthday. Do not count any vaccination administered prior to 42 days after birth.

In states where the law allows an exception for a child who receives a pertussis vaccination, a child who has four diphtheria and four tetanus vaccinations is compliant.

IPV At least three polio vaccinations (IPV) with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted.

MMR At least one measles, mumps and rubella (MMR) vaccination, with a date of service falling on or before the child's second birthday.

HiB Three H influenza type B (HiB) vaccinations, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted.

Note: *Because one particular type of HiB vaccine requires only three doses, the HEDIS measure requires the MCO to meet the minimum possible standard of three doses, rather than the recommended four doses.*

Hepatitis B Three hepatitis B vaccinations, with different dates of service on or before the child's second birthday.

VZV At least one chicken pox vaccination (VZV), with a date of service falling on or before the child's second birthday.

Pneumococcal conjugate At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday.

Combination 2 (DTaP, IPV, MMR, HiB, hepatitis B, VZV) Children who received four DTaP/DT vaccinations; three IPV vaccinations; one MMR vaccination; three HiB vaccinations; three hepatitis B vaccinations; and one VZV vaccination on or before the child's second birthday.

Combination 3 (DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal conjugate) Children who received all antigens listed in Combination 2 and four pneumococcal conjugate vaccinations on or before the child's second birthday.

Table CIS-A: Codes to Identify Childhood Immunizations

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
DTaP	90698, 90700, 90721, 90723			99.39
Diphtheria and tetanus	90702			
Diphtheria	90719		032, V02.4	99.36
Tetanus	90703		037	99.38
Pertussis			033	99.37
IPV	90698, 90713, 90723		045, 138, V12.02	99.41
MMR	90707, 90710			99.48
Measles and rubella	90708			
Mumps and rubella	90709			
Measles	90705		055	99.45
Mumps	90704		072	99.46
Rubella	90706		056	99.47
HiB	90645-90648, 90698, 90721, 90748		038.41, 041.5, 320.0, 482.2	
Hepatitis B**	90723, 90740, 90744, 90747, 90748	G0010, Q3021 Q3023	070.2, 070.3, V02.61	
VZV	90710, 90716		052, 053	
Pneumococcal conjugate	90669	G0009		

***** ICD-9-CM Diagnosis codes indicate evidence of disease.

****** The two-dose hepatitis B antigen Recombivax is recommended for children between 11 and 14 years of age only and is not included in this table.

Exclusion *(optional)*

Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. An MCO that excludes contraindicated children may do so only if the administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the second birthday.

The MCO should look for exclusions as far back as possible in the member's history and use the codes in Table CIS-B to identify allowable exclusions.

Table CIS-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.4
DTaP	Encephalopathy	323.5 ***with*** (E948.4 or E948.5 or E948.6)
IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin	
MMR and VZV	Immunodeficiency, including genetic (congenital) immunodeficiency syndromes	279
MMR and VZV	HIV disease; asymptomatic HIV	042, V08
MMR and VZV	Cancer of lymphoreticular or histiocytic tissue	200-202
MMR and VZV	Multiple myeloma	203

Table CIS-B: Codes to Identify Exclusions **(continued)**

Immunization	Description	ICD-9-CM Diagnosis
MMR and VZV	Leukemia	204-208
MMR and VZV	Anaphylactic reaction to neomycin	
HiB	None	
Hepatitis B	Anaphylactic reaction to common baker's yeast	
Pneumococcal conjugate	None	

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line. The MCO may reduce the sample size using the current year's administrative rate for combination 3 or the prior year's audited, product-line specific results for combination 3. For information on reducing sample size, refer to the *Guidelines for Calculations and Sampling*.

Numerators

For pneumococcal conjugate, the MCO must find evidence of the antigen or vaccine. For all other antigens, the MCO may count any of the following.

- Evidence of the antigen or combination vaccine, ***or***
- Documented history of the illness, ***or***
- A seropositive test result.

For combination vaccinations that require more than one antigen (DTaP/DT and MMR), the MCO must find evidence of all the antigens.

Administrative

Refer to the *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

For immunization information obtained from the medical record, the MCO may count members where there is evidence that the antigen was rendered from:

- A note indicating the name of the specific antigen and the date of the immunization, ***or***
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, the MCO must find a note indicating the date of the event. The event must have occurred by the member's second birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth).

A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Note*: DTP vaccinations are no longer manufactured; however, notations of DTP in medical records count toward the numerator.*

Exclusion *(optional)*

Refer to the *Administrative Specification* for exclusion criteria. The exclusion must have occurred by the member's second birthday.

Note

- *NCQA follows the Centers for Disease Control and Prevention (CDC) and the Advisory Council on Immunization Practices (ACIP) guidelines for immunizations. HEDIS implements any changes to the guidelines (e.g., new vaccine recommendations) after three years to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CIS-1/2: Data Elements for Childhood Immunization Status

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 9 rates*
Current year's administrative rate (before exclusions)		*Each of the 9 rates*
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		*Each of the 9 rates*
Administrative rate on FSS		*Each of the 9 rates*
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 9 rates*	*Each of the 9 rates*
Numerator events by medical records		*Each of the 9 rates*
Reported rate	*Each of the 9 rates*	*Each of the 9 rates*
Lower 95% confidence interval	*Each of the 9 rates*	*Each of the 9 rates*
Upper 95% confidence interval	*Each of the 9 rates*	*Each of the 9 rates*

Adolescent Immunization Status (AIS)

SUMMARY OF CHANGES TO HEDIS 2007

- Added HCPCS codes to Table AIS-A.

Description

The percentage of adolescents 13 years of age who had a second dose of MMR, three hepatitis B and one chicken pox vaccine (VZV) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Age Adolescents who turn 13 years of age during the measurement year.

Continuous enrollment 12 months prior to the member's 13th birthday.

Allowable gap No more than 1 gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).

Anchor date Enrolled on the member's 13th birthday.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator The eligible population.

Numerators For all antigens, the MCO may count any of the following.

- Evidence of the antigen or combination vaccine, ***or***
- Documented history of the illness, ***or***
- A seropositive test result.

For combination vaccinations that require more than one antigen (i.e., MMR), the MCO must find evidence of all of the antigens.

MMR A second dose of MMR on or before the member's 13th birthday. To be compliant, a member must have received either:

- One MMR on or between the 4th and 13th birthdays, ***or***
- Two MMRs with different dates of service on or between the 1st and 4th birthdays.

Hepatitis B Three hepatitis B vaccinations with different dates of service on or before the member's 13th birthday. The MCO may count a member compliant if the member received the complete two-dose hepatitis B regimen identified by CPT code 90743. Members are also compliant if they receive one dose of the two-dose regimen (90743) and two other doses of hepatitis B.

VZV One VZV on or before the member's 13th birthday.

Combination 2 (MMR, hepatitis B, VZV) Adolescents who received the second MMR; three hepatitis B vaccinations; and one VZV on or before the member's 13th birthday.

Table AIS-A: Codes to Identify Adolescent Immunizations

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
MMR	90707, 90710			99.48
Measles and rubella	90708			
Mumps and rubella	90709			
Measles	90705		055	99.45
Mumps	90704		072	99.46
Rubella	90706		056	99.47
Hepatitis B	90723, 90731, 90740, 90743**-90748	G0010, Q3021, Q3023	070.2, 070.3, V02.61	
VZV	90710, 90716		052, 053	

* ICD-9-CM Diagnosis codes indicate evidence of disease.

** CPT code 90743 identifies the two-dose regimen for hepatitis B. The two-dose hepatitis B antigen Recombivax is only recommended for children between 11 and 14 years of age.

Exclusion *(optional)*

Adolescents who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. An MCO that excludes contraindicated adolescents may do so only for adolescents where the administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the 13th birthday.

The MCO should look for exclusions as far back as possible in the member's history and use the codes in Table AIS-B to identify exclusions.

Table AIS-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.4
MMR and VZV	Immunodeficiency, including genetic (congenital) immunodeficiency syndromes	279
MMR and VZV	HIV disease; asymptomatic HIV	042, V08
MMR and VZV	Cancer of lymphoreticular or histiocytic tissue	200-202
MMR and VZV	Multiple myeloma	203
MMR and VZV	Leukemia	204-208
MMR and VZV	Anaphylactic reaction to neomycin	
MMR and VZV	Pregnancy*	630-677, V22, V23, V28
Hepatitis B	Anaphylactic reaction to common baker's yeast	

*Pregnancy is a contraindication only if it occurs during the measurement year and prior to the member's 13th birthday.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line. The MCO may reduce the sample size using the current year's administrative result for combination 2 or the prior year's audited, product line-specific result for combination 2. For information on reducing the sample size, refer to the *Guidelines for Calculations and Sampling.*

Numerators

For all antigens, count any of the following.

- Evidence of the antigen or combination vaccine, ***or***
- Documented history of the illness, ***or***
- A seropositive test result.

For combination vaccinations that require more than one antigen (i.e., MMR), the MCO must find evidence of all antigens.

Administrative

Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record

For immunization information obtained from the medical record, the MCO may count members where there is evidence that the antigen was rendered from:

- A note indicating the name of the specific antigen and the date of the immunization, ***or***
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or seropositive test result, the MCO must find a note indicating the date of the event. The event must have occurred by the 13th birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not

constitute sufficient evidence of immunization for HEDIS reporting.

The MCO may count toward this measure evidence that the member received the two-dose regimen for hepatitis B only if the medical record clearly indicates that the two-dose regimen requirements were followed (e.g., Recombivax HB).

Exclusion *(optional)*

Refer to the *Administrative Specification* above for exclusion criteria. The exclusion must have occurred by the 13th birthday.

Note

- *NCQA follows CDC/ACIP guidelines for immunizations. HEDIS implements the guidelines after three years to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table AIS-1/2: Data Elements for Adolescent Immunization Status

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 4 rates*
Current year's administrative rate (before exclusions)		*Each of the 4 rates*
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		*Each of the 4 rates*
Administrative rate on FSS		*Each of the 4 rates*
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 4 rates*	*Each of the 4 rates*
Numerator events by medical records		*Each of the 4 rates*
Reported rate	*Each of the 4 rates*	*Each of the 4 rates*
Lower 95% confidence interval	*Each of the 4 rates*	*Each of the 4 rates*
Upper 95% confidence interval	*Each of the 4 rates*	*Each of the 4 rates*

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO HEDIS 2007

- Added CPT codes 99401–99404, 99411, 99412, 99420, 99429, 99499 to Table URI-B.
- Deleted CPT codes 99271–99275 from Table URI-B.
- Added UB-92 Revenue code 077x to Table URI-B.
- Moved UB-92 Revenue code 0456 from Table URI-B to Table URI-C.
- Deleted UB-92 Type of Bill code 43x from Table URI-C.
- Added Cefazolin, Cephradine, Lomefloxacin to Table URI-D.
- Deleted Dirithromycin, Flomefloxacin from Table URI-D.

Description

The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the Episode Date.

Calculation

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

Definitions

Episode Date

The date of service for any outpatient claim/encounter during the Intake Period with only a diagnosis of URI (Table URI-A). Exclude claims/encounters with more than one diagnosis. Use Tables URI-B and URI-C to identify outpatient visits.

First Eligible Episode

The *first* episode during the Intake Period that meets all of the following criteria is the first eligible episode.

- The outpatient claim/encounter during the Intake Period (Tables URI-B and URI-C) has only a diagnosis of URI (Table URI-A).
- There was a 30-day Negative Medication History prior to the Episode Date.
- The member was continuously enrolled 30 days prior to through 3 days after the Episode Date.

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 is used to capture eligible episodes of treatment.

Negative Medication History

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

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

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

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Ages Children 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.

Continuous enrollment 30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date Episode Date.

Benefits Medical and pharmacy.

Event/diagnosis Outpatient visit with only a diagnosis of URI during the Intake Period.

Follow the steps below to identify the eligible population:

Step 1 Identify all members in the specified age range who, during the 12-month Intake Period, had an outpatient or ED visit (Tables URI-B and URI-C) with only a diagnosis of URI (Table URI-A). Exclude claims/encounters with more than one diagnosis.

Table URI-A: Codes to Identify URI

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

Table URI-B: Codes to Identify Outpatient Visits

CPT	UB-92 Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 052x, 077x, 0982, 0983

Table URI-C: Codes to Identify Emergency Department Visits*

UB-92 Revenue		UB-92 Type of Bill
045x, 0981	*AND*	13x

OR

CPT
99281-99285

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

Step 2 Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient Episode Dates.

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

Note: *If the episode occurred on July 1 of the year prior to the measurement year, the MCO should look 30 days prior to the start of the Intake Period (June 1–30) to check for the member's negative medication history.*

Step 4 Calculate continuous enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 5 Select the first eligible episode. This measure examines one eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator

Antibiotic prescription Dispensed prescription for antibiotic medication (Table URI-D) on or three days after the Episode Date.

Table URI-D: Antibiotic Medications

Prescriptions			
• Amoxicillin	• Ceftitoren	• Clindamycin	• Minocycline
• Amoxicillin/Clavulanate	• Ceftibuten	• Dicloxacillin	• Ofloxacin
• Ampicillin	• Cefpodoxime proxetil	• Doxycycline	• Penicillin VK
• Azithromycin	• Cefprozil	• Erythromycin	• Penicillin G
• Cefaclor	• Ceftriaxone	• Ery E-Succ/Sulfisoxazole	• Sparfloxacin
• Cefadroxil hydrate	• Cefuroxime	• Gatifloxacin	• Sulfisoxazole
• Cefazolin	• Cephalexin	• Levofloxacin	• Tetracycline
• Cefdinir	• Cephradine	• Lomefloxacin	• Trimethoprim
• Cefixime	• Ciprofloxacin	• Loracarbef	• Trimethoprim-Sulfamethoxazole

Note: *NCQA will provide a list of NDC codes for antibiotic medications on its Web site at www.ncqa.org by November 15, 2006.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table URI-1/2: Data Elements for Appropriate Treatment for Children With Upper Respiratory Infection

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Appropriate Testing for Children With Pharyngitis (CWP)

SUMMARY OF CHANGES TO HEDIS 2007

- Added CPT codes 99401-99404, 99411, 99412, 99420, 99429, 99499 to Table CWP-B.
- Deleted CPT codes 99271-99275, 99381, 99391 from Table CWP-B.
- Added UB-92 Revenue code 077x to Table CWP-B.
- Moved UB-92 Revenue code 0456 from Table CWP-B to Table CWP-C.
- Deleted UB-92 Type of Bill code 43x from Table CWP-C.
- Added Cefazolin, Cephradine, Lomefloxacin to Table CWP-D.
- Deleted Dirithromycin, Flomefloxacin from Table CWP-D.

Description

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

Definitions

Episode Date — The date of service for any outpatient claim/encounter during the Intake Period with only a diagnosis of pharyngitis (Table CWP-A). Exclude claims/encounters with more than one diagnosis. Use Tables CWP-B and CWP-C to identify outpatient visits.

First Eligible Episode — The *first* episode during the Intake Period that meets all of the following criteria is the first eligible episode.

- The outpatient claim/encounter with only a diagnosis of pharyngitis is linked to a dispensed antibiotic prescription on or during the three days after the Episode Date.
- There was a 30-day Negative Medication History prior to the Episode Date.
- The member was continuously enrolled during the 30 days prior through 3 days after the Episode Date.

Group A streptococcus test — A strep test (Table CWP-E) administered in the seven-day period, beginning three days prior through three days after the First Eligible Episode Date.

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 is used to capture eligible episodes of treatment.

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

- A period of 30 days prior to the Episode Date during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions filled more than 30 days prior to the Episode Date that

are active on the Episode Date (Table CWP-D).

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

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Ages Children 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.

Continuous enrollment 30 days prior to the Episode Date to 3 days after the Episode Date (inclusive).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date None.

Benefits Medical and pharmacy.

Event/diagnosis Outpatient visit with only a diagnosis of pharyngitis during the Intake Period and prescribed an antibiotic for that episode of care.

Follow the steps below to identify the eligible population:

Step 1 Identify all members in the specified age range who during the 12-month Intake Period had an outpatient or ED visit (Tables CWP-B and CWP-C) with only a diagnosis of pharyngitis (Table CWP-A). Exclude claims/encounters with more than one diagnosis.

Table CWP-A: Codes to Identify Pharyngitis

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

Table CWP-B: Codes to Identify Outpatient Visits

CPT	UB-92 Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 052x, 077x, 0982, 0983

Table CWP-C: Codes to Identify Emergency Department Visits*

UB-92 Revenue		UB-92 Type of Bill
045x, 0981	*ND*	13x

OR

CPT
99281-99285

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

Step 2 Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient Episode Dates.

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

Table CWP-D: Antibiotic Medications

Prescriptions			
• Amoxicillin	• Ceftibuten	• Doxycycline	• Penicillin G
• Amox/Clavulanate	• Cefpodoxime proxetil	• Erythromycin	• Sparfloxacin
• Ampicillin	• Cefprozil	• Ery E-Succ/Sulfisoxazole	• Sulfisoxazole
• Azithromycin	• Ceftriaxone	• Gatifloxacin	• Tetracycline
• Cefaclor	• Cefuroxime	• Levofloxacin	• Trimethoprim
• Cefadroxil hydrate	• Cephalexin	• Lomefloxacin	• Trimethoprim-Sulfamethoxazole
• Cefazolin	• Cephradine	• Loracarbef	
• Cefdinir	• Ciprofloxacin	• Minocycline	
• Cefixime	• Clindamycin	• Ofloxacin	
• Ceftitoren	• Dicloxacillin	• Penicillin VK	

Note: *NCQA will provide a list of NDC codes for antibiotic medications on its Web site at www.ncqa.org by November 15, 2006.*

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.

Note: *If the episode occurred on July 1 of the year prior to the measurement year, the MCO should look back 30 days prior to the start of the Intake Period (i.e., June 1–30) to check for the member's medication history.*

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6 Select the first eligible episode. This measure examines one eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator

Group A strep test A strep test (Table CWP-E) in the seven-day period from three days prior through three days after the First Eligible Episode Date.

Table CWP-E: Codes to Identify Group A Streptococcus Tests

CPT	LOINC
87070, 87071, 87081, 87430, 87650-87652, 87880	626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 11475-1, 17656-0, 18481-2, 31971-5

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CWP-1/2: Data Elements for Appropriate Testing for Children With Pharyngitis

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis (AAB)

SUMMARY OF CHANGES TO HEDIS 2007

- Added CPT codes 99386, 99396, 99401–99404, 99411, 99412, 99420, 99429, 99499 to Table AAB-B.
- Deleted CPT codes 99271–99275, 99381–99384, 99391–99394 from Table AAB-B.
- Added UB-92 Revenue code 077x to Table AAB-B.
- Moved UB-92 Revenue code 0456 from Table AAB-B to Table AAB-C.
- Deleted UB-92 Type of Bill code 43x from Table AAB-C.
- Added Aztreonam, Cefixime, Cephradine, Piperacillin-Tazobactam, Ticarcillin-Clavulanate to Table AAB-F.
- Deleted Cloxacillin, Dirithromycin, Enoxacin, Flomefloxacin, Fusidic Acid, Methicillin, Mezlocillin, Netilmicin, Pefloxacin, Sulfamethizole, Teicoplanin from Table AAB-F.

Description

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were dispensed an antibiotic prescription on or within three days after the Episode Date.

This misuse measure assesses if antibiotics were inappropriately prescribed for healthy adults with acute bronchitis. A lower rate represents better performance.

Definitions

Episode Date

The date of service for any outpatient claim/encounter during the Intake Period with any diagnosis of acute bronchitis (Table AAB-A). Use Tables AAB-B and AAB-C to identify outpatient visits.

First Eligible Episode

The *first* episode during the Intake Period that meets all of the following criteria is the first eligible episode.

- The outpatient claim/encounter during the Intake Period (Tables AAB-B and AAB-C) has a diagnosis of acute bronchitis (Table AAB-A).
- There was a 30-day Negative Medication History prior to the Episode Date for any active antibiotic prescription (Table AAB-F).
- There was a 12-month Negative Comorbid Condition History prior to or on the Episode Date (Table AAB-D).
- There was a Negative Competing Diagnosis History during the 30 days prior to through 7 days after the Episode Date (Table AAB-E).
- The member was continuously enrolled one year prior to through seven days after the Episode Date.

Intake Period

The Intake Period is from January 1–December 24 of the measurement year.

Negative Medication History

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

- A period of 30 days prior to the Episode Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions filled more than 30 days prior to the Episode Date that

are active on the Episode Date (Table AAB-F).

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

Negative Comorbid Condition History	A period of 12 months prior to and including the Episode Date, during which time the member had no claims/encounters containing either a principal or secondary diagnosis for a comorbid condition (Table AAB-D).
Negative Competing Diagnosis History	A period of 30 days prior to through 7 days after the Episode Date (inclusive), during which time the member had no claims/encounters containing either a principal or secondary diagnosis for a competing diagnosis (Table AAB-E).

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Adults 18 years as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year.
Continuous enrollment	One year prior to the Episode Date through seven days after the Episode Date (inclusive).
Allowable gap	No more than one gap of 45 days is permitted from 365 days prior to the Episode Date through 7 days after the Episode Date. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Episode Date.
Benefits	Medical and pharmacy.
Event/diagnosis	Outpatient visit with any diagnosis of acute bronchitis during the Intake Period. Follow the steps below to identify the eligible population:
Step 1	Identify all members in the specified age range who during the Intake Period had an outpatient or ED visit (Tables AAB-B and AAB-C) with any diagnosis of acute bronchitis (Table AAB-A).

Table AAB-A: Codes to Identify Acute Bronchitis

Description	ICD-9-CM Diagnosis
Acute bronchitis	466.0

Table AAB-B: Codes to Identify Outpatient Visits

CPT	UB-92 Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 052x, 077x, 0982, 0983

Table AAB-C: Codes to Identify Emergency Department Visits*

UB-92 Revenue		UB-92 Type of Bill
045x, 0981	*AND*	13x

OR

CPT
99281-99285

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

Step 2 Determine all acute bronchitis Episode Dates. For each member identified in step 1, determine all outpatient Episode Dates.

Step 3 Test for Negative Comorbid Condition History. Exclude Episode Dates for which the member had a claim/encounter with a diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date (Table AAB-D).

Note: *If the acute bronchitis episode occurred on January 1 of the measurement year, look 12 months prior to the start of the measurement year to check for the member's comorbid condition history.*

Table AAB-D: Codes to Identify Comorbid Conditions

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

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date (Table AAB-F).

Note: *If the acute bronchitis episode occurred on January 1 of the measurement year, the MCO should look 30 days prior to the start of the measurement year to check for the member's negative medication history.*

Step 5 Test for Negative Competing Diagnosis History. Exclude Episode Dates where during the period 30 days prior through 7 days after the Episode Date (inclusive) the member had a claim/encounter with a competing diagnosis (Table AAB-E).

Note: *If the episode occurred on January 1 of the measurement year, look 30 days prior to the start of the measurement year to check for the member's competing diagnosis history.*

Table AAB-E: Codes to Identify Competing Diagnoses

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

Step 6 Calculate Continuous Enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days prior to the Episode Date through 7 days after the Episode Date.

Step 7 Select the first eligible episode. This measure examines one eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator

Antibiotic prescription Dispensed prescription for antibiotic medication (Table AAB-F) on or within three days after the Episode Date.

Table AAB-F: Antibiotic Medications

- Amikacin
- Amoxicillin
- Amoxicillin/Clavulanate
- Ampicillin
- Ampicillin-Sulbactam
- Azithromycin
- Aztreonam
- Benzathine penicillin
- Cefaclor
- Cefadroxil
- Cefadroxil hydrate
- Cefazolin
- Cefixime
- Cefotetan
- Cefoxitin
- Cefdinir
- Ceftitoren
- Cefepime
- Cefoperzone
- Cefotaxime
- Cefpodoxime proxetil
- Cefprozil
- Ceftazidime
- Ceftibuten
- Ceftizoxime
- Ceftriaxone
- Cefuroxime
- Cephradine
- Cephalexin
- Chloramphenical
- Ciprofloxacin
- Clarithromycin
- Clindamycin
- Daptomycin
- Dicloxacillin
- Doxycycline
- Erythromycin
- Ery E-Succ/Sulfisoxazole
- Fosfomycin
- Gatifloxacin
- Gentamicin
- Gemifloxacin
- Kanamycin
- Levofloxacin
- Lincomycin
- Linezolid
- Lomefloxacin
- Loracarbef
- Metronidazole
- Moxifloxacin
- Minocycline
- Nafcillin
- Neomycin
- Nitrofurantoin
- Norfloxacin
- Ofloxacin
- Oxacillin
- Penicillin VK
- Penicillin G
- Piperacillin
- Piperacillin-Tazobactam
- Procaine penicillin
- Rifampin
- Quinupristin/Dalfopristin
- Sparfloxacin
- Streptomycin
- Sulfisoxazole
- Sulfadiazine
- Sulfamethoxazole
- Sulfasalzine
- Telithromycin
- Tetracycline
- Ticarcillin-Clavulanate
- Ticarcillin
- Trimethoprim
- Trimethoprim-Sulfamethoxazole
- Vancomycin

Note: *NCQA will provide a list of NDC codes for antibiotic medications on its Web site at www.ncqa.org by November 15, 2006.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table AAB-1/2: Data Elements for Inappropriate Treatment for Adults With Acute Bronchitis

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Eligible population by non-ER/urgent care visits*	✓
Eligible population by ER/urgent care visits*	✓
Total exclusions	✓
Exclusions for comorbid conditions*	✓
Exclusions for competing diagnosis*	✓
Exclusions for Medication History*	✓
Numerator by non-ER/urgent care visits*	✓
Numerator by ER/urgent care visits*	✓
Total numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

*Reporting these additional data elements will be optional in the data submission tool (DST).

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO HEDIS 2007

- Added HCPCS codes to Tables COL-A and COL-B.
- Moved ICD-9-CM Diagnosis code V76.51 from colonoscopy description to FOBT description in Table COL-A.
- Deleted optional data elements from Table COL-2/3.

Description

The percentage of adults 50–80 years of age who had appropriate screening for colorectal cancer (CRC). The hybrid method is recommended to calculate this measure.

Eligible Population

Product lines	Commercial, Medicare (report each product line separately).
Ages	51–80 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than 1 gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerator One or more screenings for CRC. Appropriate screenings are defined by any one of the four criteria below.

- Fecal occult blood test (FOBT) during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

A member had an appropriate screening if a submitted claim/encounter contains any one of the codes in Table COL-A.

Table COL-A: Codes to Identify Colorectal Cancer Screening

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	LOINC
FOBT	82270, 82274	G0107, G0328	V76.51		2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104		45.24, 45.42	
DCBE	74280				
Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121		45.22, 45.23, 45.25, 45.43	

Exclusion *(optional)*

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

Table COL-B: Codes to Identify Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Colorectal cancer		G0213-G0215, G0231	153, 154.0, 154.1, 197.5, V10.05	
Total colectomy	44150-44153, 44155-44156, 44210-44212			45.8

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. The MCO may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. For information on reducing the sample size, refer to the *Guidelines for Calculations and Sampling.*

Numerator One or more screenings for CRC. Appropriate screenings must meet one of four criteria.

- FOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- DCBE during the measurement year or the four years prior to the measurement year. Air contrast enema is a clinical synonym.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

Administrative Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include *both* of the following.

- A note indicating the date the colorectal cancer screening was performed.
- For a notation in the progress notes, the result or finding (this ensures that the screening was performed and not merely ordered).

A result is not required for a notation in the medical history because it pertains to screenings that occurred in the past and it is assumed that the result was negative (a positive result would have been noted as such). A notation in the medical history must include a date reference that meets the timeline outlined in the specifications.

Exclusion *(optional)*

Refer to the *Administrative Specification* above for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of CRC or total colectomy. The diagnosis of colorectal cancer or total colectomy must have occurred by December 31 of the measurement year. The MCO may use the description of the codes listed in Table COL-B as synonyms for a diagnosis of CRC or total colectomy.

Note

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

  If the medical record indicates that fewer than three samples were returned and does not indicate the type of test (guaiac or immunochemical), the member does not meet the screening criteria for inclusion in the numerator. If the medical record indicates that fewer than three samples were returned and an iFOBT was done, the member meets the screening criteria for inclusion in the numerator.

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table COL-2/3: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO HEDIS 2007

- Decreased the lower age limit to women 40 years of age.
- Added HCPCS code to Table BCS-A.
- Deleted UB-92 Revenue code 0401 from Table BCS-A.

Description

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

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages Women 42–69 years as of December 31 of the measurement year. Report two age stratifications and an overall rate.

- 42–51 years
- 52–69 years
- Total

The total rate is the sum of the two numerators divided by the sum of the two denominators.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than 1 gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator The eligible population.

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

Table BCS-A: Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB-92 Revenue
76083, 76090-76092	G0202	87.36, 87.37, V76.11, V76.12	0403

Exclusion *(optional)*

Exclude women who had a bilateral mastectomy and for whom administrative data do not indicate that a mammogram was performed. The MCO should look for evidence of a bilateral mastectomy as far back as possible in the member's history. If the MCO finds evidence of two separate mastectomies, it may exclude the member from the measure. The bilateral mastectomy must have occurred by December 31 of the measurement year. The codes in Table BCS-B identify exclusions.

Table BCS-B: Codes to Identify Exclusions

Description	CPT	ICD-9-CM Procedure
Bilateral mastectomy	19180.50 ***or*** (19180 with modifier code 09950*) 19200.50 ***or*** (19200 with modifier code 09950*) 19220.50 ***or*** (19220 with modifier code 09950**)** 19240.50 ***or*** (19240 with modifier code 09950**)**	85.42, 85.44, 85.46, 85.48
Unilateral mastectomy (members must have 2 separate occurrences on 2 different dates of service)	19180, 19200, 19220, 19240	85.41, 85.43, 85.45, 85.47

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

Note

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

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table BCS-1/2/3: Data Elements for Breast Cancer Screening

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO HEDIS 2007

- Raised the lower age limit to 21 years of age.
- Added HCPCS codes to Table CCS-A.

Description

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

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	*Commercial:* The measurement year and the two years prior to the measurement year. *Medicaid:* The measurement year.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

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

Table CCS-A: Codes to Identify Cervical Cancer Screening

CPT Codes	HCPCS	ICD-9-CM Procedure	UB-92 Revenue	LOINC
88141-88145, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	91.46, V72.32, V76.2	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0

Exclusion *(optional)*

Women who had a hysterectomy with no residual cervix and for whom the administrative data do not indicate that a Pap test was performed. The MCO should look through administrative data for evidence of a hysterectomy as far back as possible in the member's history. The hysterectomy must have occurred by December 31 of the measurement year. The MCO should use codes in Table CCS-B to identify a hysterectomy.

Table CCS-B: Codes to Identify Exclusions

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

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line.

Numerator One or more Pap tests during the measurement year or the two years prior to the measurement year as documented through either administrative data or medical record review.

Administrative Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include *both* of the following.

- A note indicating the date on which the test was performed.
- The result or finding.

Exclusion *(optional)*

Refer to the *Administrative Specification* above for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix. Documentation of "complete hysterectomy," "total hysterectomy," "total abdominal hysterectomy" or "radical hysterectomy" meets the criteria for hysterectomy with no residual cervix. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria. However, documentation of "hysterectomy" alone does not meet the criteria because it does not indicate the cervix has been removed. The hysterectomy must have occurred by December 31 of the measurement year. The MCO may use the descriptions of the codes listed in Table CCS-B as synonyms for a hysterectomy with no residual cervix.

Note

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

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CCS-1/2: Data Elements for Cervical Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO HEDIS 2007

- Added CPT code 84163 to Table CHL-A.
- Deleted CPT codes 88144, 88145 from Table CHL-A.
- Added HCPCS codes to Table CHL-A.
- Added ICD-9-CM Diagnosis codes V61.6, V61.7 to Table CHL-A.
- Replaced ICD-9-CM Diagnosis code 131.00 with 131 (to include any valid fourth or fifth digit) in Table CHL-A.
- Added ICD-9-CM Procedure codes 72-75 to Table CHL-A.
- Added UB-92 Revenue Codes 0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729 to Table CHL-A.
- Added LOINC codes 42316-0, 42481-2, 42931-6 to Table CHL-A.
- Added LOINC code 42931-6 to Table CHL-B.
- Deleted LOINC codes 561-1, 6343-8, 6345-3, 6346-1, 6347-9, 16593-6, 31765-1, 32001-0, 32003-6, 32004-4, 32671-0, 32774-2, 34708-8, 35713-7, 35714-5, 35715-2, 35716-0, 35717-8, 35722-8, 35726-9, 35727-7, 35728-5, 35729-3, 35730-1 from Tables CHL-A and CHL-B.

Description

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

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Ages Women 16–25 years as of December 31 of the measurement year. Report two age stratifications and an overall rate.

- 16–20 years
- 21–25 years
- Total

The total rate is the sum of the two numerators divided by the sum of the two denominators.

Continuous enrollment The measurement year.

Allowable gap No more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis *Sexually active.* Two methods identify sexually active women: pharmacy data and claim/encounter data. The MCO must use *both* methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.

Pharmacy data Members dispensed prescription contraceptives (e.g., oral contraceptive, IUD, diaphragm or other prescribed contraceptive) during the measurement year. NCQA will provide a complete list of pharmaceutical contraceptives with NDC codes on its Web site at www.ncqa.org by November 15, 2006. The MCO must use this list to identify the required prescriptions.

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

Table CHL-A: Codes to Identify Sexually Active Women

Description	Codes
CPT	11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76802, 76805, 76810-76812, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84703, 86592-86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87800, 87801, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269
HCPCS	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091, S0199, S8055
ICD-9-CM Diagnosis	042, 054.10, 054.11, 054.12, 054.19, 078.1, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131 ,614-616, 622.3, 623.4, 626.7, 628, 630-677, 795.0**,** V01.6, V02.7, V02.8, V08, V22-V28, V45.5, V61.5-V61.7, V72.3, V72.4, V73.88, V73.98, V74.5, V76.2
ICD-9-CM Procedure	72-75
UB-92 Revenue	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925
LOINC	557-9, 560-3, 660-1, 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 1832-5, 1834-1, 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9,2114-7, 2115-4, 2118-8, 2119-6, 4993-2, 5028-6, 5291-0, 5292-8, 5392-6, 5393-4, 5394-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 6487-3, 6488-1, 6489-9, 6510-2, 6511-0, 6514-4, 6516-9, 6561-5, 6562-3, 7975-6, 8041-6, 10524-7, 10705-2, 11083-3, 11084-1, 11481-9, 11597-2, 12222-6, 12223-4, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 14509-4, 14510-2, 14513-6, 15019-3, 16280-0, 16600-9, 16601-7, 16602-5, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 18500-9, 19080-1, 19171-8, 19176-7, 19177-5, 19180-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 20403-2, 20404-0, 20415-6, 20507-0, 20508-8, 20993-2, 20994-0, 21189-6, 21190-4, 21191-2, 21192-0, 21198-7, 21414-8, 21415-5, 21416-3, 21440-3, 21441-1, 21613-5, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 23838-6, 23908-7, 24110-9, 24111-7, 24312-1, 24364-2, 25372-4, 25373-2, 26009-1, 29311-8, 30167-1, 31147-2, 31771-9, 31772-7, 31775-0, 31777-6, 31905-3, 31906-1, 31993-9, 32198-4, 32199-2, 32705-6, 33717-0, 33773-3, 34382-2, 34493-7, 34656-9, 34670-0, 34718-7, 35457-1, 36902-5, 36903-3, 38372-9, 42316-0, 42481-2, 42931-6

Administrative Specification

Denominator The eligible population.

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

Table CHL-B: Codes to Identify Chlamydia Screening

CPT	LOINC
87110, 87270, 87320, 87490, 87491, 87492, 87810	557-9, 560-3, 4993-2, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 16602-5, 20993-2, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6

Exclusion *(optional)*

The MCO may exclude members who had a pregnancy test during the measurement year followed within seven days (inclusive) by *either* a prescription for Accutane (isotretinoin) ***or*** an x-ray. This exclusion does not apply to members who qualify for the denominator based on services other than the pregnancy test alone. The MCO should use the codes provided in Table CHL-C to identify exclusions.

Table CHL-C: Codes to Identify Exclusions

Description	CPT	UB-92 Revenue	LOINC
Pregnancy test	81025, 84702, 84703	0925	2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0
WITH			
Diagnostic radiology	70010-76499	032x	
Prescription for Accutane (isotretinoin)*****			

*****An NDC list for Accutane (isotretinoin) will be available on the NCQA Web site at www.ncqa.org by November 15, 2006.

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CHL-1/2: Data Elements for Chlamydia Screening

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Osteoporosis Management in Women Who Had a Fracture (OMW)

SUMMARY OF CHANGES TO HEDIS 2007

- Added CPT codes 22520, 22521, 22523, 22524 to Table OMW-A.
- Added HCPCS codes to Table OMW-A.
- Added ICD-9-CM Procedure codes 81.65, 81.66 to Table OMW-A.
- Added HCPCS code to Table OMW-B.
- Deleted fluoride, vitamin D, calcium products from Table OMW-C.

Description

The percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after date of the fracture.

Definitions

Index Episode Start Date (IESD)	The date of service for any outpatient claim/encounter during the Intake Period with a diagnosis of fracture (Table OMW-A). For fractures requiring hospitalization (inpatient), the date of service is the date of discharge from the inpatient setting.
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 is used to capture eligible episodes.
Negative Diagnosis History	A period of 60 days prior to the Index Episode Start Date, during which time the member had no diagnosis of fracture using Table OMW-A. For fractures requiring an inpatient stay, use the date of admission to determine Negative Diagnosis History.

Eligible Population

Product line	Medicare.
Age	Women 67 years and older as of December 31 of the measurement year.
Continuous enrollment	12 months prior to the initial eligible fracture through 6 months (180 days) post-fracture.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	The first fracture during the intake period.
	Follow the steps below to identify the eligible population.

Step 1 Identify members who, during the 12-month Intake Period, had a fracture (Table OMW-A). If the member had more than one fracture, include only the first fracture.

Table OMW-A: Codes to Identify Fractures*

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	DRG
21800-21825, 22305-22328, 22520, 22521, 22523, 22524, 23500-23515, 23570-23630, 23665-23680, 24500-24587, 24620, 24635, 24650-24685, 25500-25652, 25680, 25685, 27193-27248, 27254, 27500-27514, 27520-27540, 27750-27828	S2360, S2362	733.1, 805-806, 807.0-807.4, 808-815, 818-825, 827, 828	79.00-79.03, 79.05-79.07, 79.09, 79.10-79.13, 79.15-79.17, 79.19, 79.20-79.23, 79.25-79.27, 79.29, 79.30-79.33, 79.35-79.37, 79.39, 79.60-79.63, 79.65-79.67, 79.69, 81.65, 81.66	235, 236

*****Fractures of finger, toe, face and skull are not included in this measure.

Step 2 Test for Negative Diagnosis History. Exclude members with a fracture (Table OMW-A) during the 60 days prior to the Index Episode Start Date. For fractures requiring hospitalization, use the admission date to determine Negative Diagnosis History.

Step 3 Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in enrollment during the 12 months prior to the fracture through 6 months (180 days) post-fracture.

Step 4 Exclude members who have received osteoporosis screening or treatment in the prior year. Exclude members who had a BMD test (Table OMW-B) during the 365 days prior to the Index Episode Start Date.

Exclude members who received any medication listed in Table OMW-C during the 365 days prior to the Index Episode Start Date.

For members with an inpatient stay use the admission date to determine a negative screening and medication history.

Administrative Specification

Denominator The eligible population.

Numerator Members who were appropriately treated or tested for osteoporosis after the fracture. Appropriate treatment or testing is defined by any one of the following criteria.

- A BMD test (Table OMW-B) on the IESD or in the 180-day period after the IESD.
- A BMD test (Table OMW-B) during the acute care inpatient stay for the fracture (applies only to fractures requiring hospitalization).
- A dispensed prescription (Table OMW-C) to treat osteoporosis on or in the 180-day period after the IESD.

Table OMW-B: Codes to Identify Bone Mineral Density Test

CPT	HCPCS	ICD-9-CM Procedure
76070, 76071, 76075-76077, 76078, 76977, 78350-78351	G0130	88.98, V82.81

Table OMW-C: FDA-Approved Osteoporosis Therapies

Prescriptions and Therapies		
• Alendronate	• Estrogen	• Raloxifene
• Alendronate-Cholecalciferol	• Ibandronate	• Risedronate
• Calcitonin	• Injectable estrogens	• Teriparatide

Note

- *If the member had a direct transfer to another acute care facility, the discharge date from the second admission should be used to evaluate compliance with the measure.*
- *NCQA will provide a list of NDC codes for medications to treat osteoporosis on its Web site at www.ncqa.org by November 15, 2006.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table OMW-3: Data Elements for Osteoporosis Management in Women Who Had a Fracture

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS 2007

- Decreased the lower age limit to 18 years of age.
- Changed adequately controlled blood pressure from ≤140/90 to <140/90.
- Changed methodology for determining representative BP. The lowest BP is used as the representative BP regardless of posture.
- Clarified that the lowest systolic and lowest diastolic values can be utilized to fulfill the numerator criteria for the representative BP.
- Added Table CBP-A: Codes to Identify Hypertension.
- Added CPT codes 99384–99387, 99394–99397 to Table CBP-B.
- Added HCPCS codes to Table CBP-C.
- Added ICD-9-CM Diagnosis code 585.6 to Table CBP-C.
- Expanded ESRD optional exclusion to include evidence of dialysis and renal transplant; added appropriate codes to Table CBP-C.
- Added pregnancy to the optional exclusions; added appropriate codes to Table CBP-C.
- Added data element to capture false positive diagnoses.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. *Use the Hybrid Method for this measure.*

Definitions

Adequate control Adequate control is both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high normal range).

Representative BP Representative BP is the most recent BP reading during the measurement year (as long as the BP occurred after the diagnosis of HTN was made). If multiple BP measurements occur on the same date or are notated in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 18–85 years as of December 31 of the measurement year. Report two age stratifications and a total rate.

- 18–45 years
- 46–85 years
- Total

The total rate is the sum of the two numerators divided by the sum of the two

denominators.

Continuous enrollment — The measurement year.

Allowable gap — No more than 1 gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date — None.

Benefit — Medical.

Event/diagnosis — *Hypertensive.* A member is considered hypertensive if there is at least one outpatient encounter with a diagnosis of hypertension (Table CBP-A) during the first six months of the measurement year. Use the codes listed in Table CBP-B to identify outpatient visits.

Table CBP-A: Codes to Identify Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

Table CBP-B: Codes to Identify Outpatient Visits

Description	CPT
Outpatient visits	99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397

Hybrid Specification

Denominator — A systematic sample drawn from the eligible population for each product line whose diagnosis of hypertension is confirmed by chart review. To confirm the diagnosis of hypertension, the MCO must find notation of one of the following in the medical record on or before June 30 of the measurement year.

- HTN
- High blood pressure (HBP)
- Elevated blood pressure (↑BP)
- Borderline HTN
- Intermittent HTN
- History of HTN

The notation of hypertension may appear anytime on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents.

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see ***Note*** at the end of this section)
- Office note
- Subjective, objective, assessment, plan (SOAP) note
- Encounter form
- Telephone call record
- Diagnostic report
- Hospital discharge summary

Statements such as "rule out hypertension," "possible hypertension," "white-coat hypertension," "questionable hypertension" and "consistent with hypertension" are not sufficient to confirm the diagnosis of hypertension if such statements are the *only* notations of hypertension in the medical record.

Identifying the medical record

The MCO should use only the medical records of one practitioner or provider team for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the records from one practitioner or provider team (even if obtained by a different practitioner) should be considered (e.g., from a consultation note or other note relating to a BP reading from a health care practitioner or provider team). The MCO should use the following algorithm to find the appropriate medical record to review:

Step 1 Identify the member's primary care practitioner (PCP).

- If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.
- If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.
- If a practitioner other than the member's PCP is managing the hypertension, the MCO may elect to use the medical record of that practitioner, instead.

Step 2 Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the MCO may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading. The following two examples illustrate such circumstances.

- If a member sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and BP reading may be identified through two different medical records.
- If a member has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) actually manages the member's hypertension, the MCO may need to use more than one medical record. For example, if all recent claims coded with 401 came from the specialist, the MCO must use this chart for the most recent BP reading; however, if the member did not have any visits with the specialist prior to June 30 of the measurement year, the MCO must go to another medical record to confirm the diagnosis of hypertension.

Numerator The number of members in the denominator whose most recent blood pressure is adequately controlled during the measurement year.

For a member's BP to be controlled, *both* the systolic and diastolic BP *must be less than* 140/90 (adequate control). To determine if a member's BP is adequately controlled, the MCO must identify the representative BP.

Administrative None.

Medical record Follow the steps below to determine representative BP:

Step 1 Identify the most recent BP reading noted during the measurement year.

- The reading must occur after the date the diagnosis of hypertension was made.
- Do not include BP readings from outpatient visits which were for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Do not include BP readings obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) or at an emergency room visit.

Step 2 Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Exclusions *(optional)*

Exclude from the eligible population all members with evidence of end-stage renal disease (Table CBP-C) anytime on or prior to December 31 of the measurement year

Exclude from the eligible population all pregnant members (Table CBP-C) during the measurement year.

Table CBP-C: Codes to Identify Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB-92 Revenue	DRG
Evidence of ESRD	36145, 36800, 36810, 36815, 36818, 36819, 36820, 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	G0257, G0314-G0319, G0322, G0323, G0326, G0327, S9339	585.5, 585.6, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.6	0367, 080x, 082x-085x, 088x	317
Pregnancy			630-677, V22, V23, V28			

Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of ESRD, dialysis or renal transplant meets the criteria for evidence of end-stage renal disease.

The MCO may exclude from the eligible population all members who had an admission to a nonacute inpatient setting any time during the measurement year. Refer to Table NON-A for codes to identify nonacute care.

Note

- *The MCO may use an undated notation of hypertension on problem lists. Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator.*
- *If the MCO cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.*
- *The MCO generally requires an oversample of 10–15 percent to meet the minimum required sample size (MRSS) for confirmed cases of hypertension.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CBP-1/2/3: Data Elements for Controlling High Blood Pressure

	Hybrid
Measurement year	✓
Data collection methodology (hybrid)	✓
Eligible population	*For each age stratification and total*
Number of numerator events by administrative data in eligible population (before exclusions)	*For each age stratification and total*
Current year's administrative rate (before exclusions)	*For each age stratification and total*
Minimum required sample size (MRSS) or other sample size	*For each age stratification and total*
Oversampling rate	*For each age stratification and total*
Final sample size (FSS)	*For each age stratification and total*
Number of numerator events by administrative data in FSS	*For each age stratification and total*
Administrative rate on FSS	*For each age stratification and total*
Number of original sample records excluded because of valid data errors	*For each age stratification and total*
Number of records excluded because of false positive diagnoses	*For each age stratification and total*
Number of administrative data records excluded	*For each age stratification and total*
Number of medical record data records excluded	*For each age stratification and total*
Number of employee/dependent medical records excluded	*For each age stratification and total*
Records added from the oversample list	*For each age stratification and total*
Denominator	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Numerator events by medical records	*For each age stratification and total*
Reported rate	*For each age stratification and total*
Lower 95% confidence interval	*For each age stratification and total*
Upper 95% confidence interval	*For each age stratification and total*

Beta-Blocker Treatment After a Heart Attack (BBH)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

The percentage of members 35 years of age and older during the measurement year who were hospitalized and discharged alive from January 1–December 24 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received an ambulatory prescription for beta-blockers upon discharge.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	35 years and older as of December 31 of the measurement year.
Continuous enrollment	Discharge date and seven days after discharge (inclusive).
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical.
Event/diagnosis	*Discharged alive from an inpatient setting with an AMI from January 1–December 24 of the measurement year.* If a member has more than one episode of AMI from January 1–December 24 of the measurement year, only include the first discharge and use the codes listed in Table BBH-A to identify AMIs.

Table BBH-A: Codes to Identify AMI

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

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

Transfers to acute facilities. Include hospitalizations in which the member was transferred directly to another *acute care facility* for any diagnosis. The discharge date from the facility to which the member was transferred must occur on or before December 24 of the measurement year.

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

Readmissions. Exclude from the denominator hospitalizations in which the member was readmitted to an acute or nonacute care facility for any diagnosis within seven days after discharge, because tracking the member between admissions is not deemed feasible.

Administrative Specification

Denominator The eligible population.

Numerator Members who received an ambulatory prescription for beta-blockers within seven days (inclusive) after discharge as indicated by pharmacy or claims data. Table BBH-B lists the beta-blockers included in this measure. Prescriptions rendered on an *ambulatory basis* while a patient is hospitalized for AMI through the seventh day after discharge count toward this measure. If the MCO is unable to determine whether the prescription was rendered on an inpatient or ambulatory basis, it may only count prescriptions rendered after discharge. To account for members who are on beta-blockers prior to admission, the MCO may also count beta-blocker prescriptions that are active at the time of admission.

A prescription is considered **active** if the "days supply" indicated on the date the member filled the prescription is the number of days or more between the date the prescription was filled and the relevant admission date.

Transfers. If a member was directly transferred to another acute facility, identify that the prescription is active on the date of admission for the initial inpatient stay for AMI or that the member received a beta-blocker prescription within seven days after the discharge from the facility to which the member was transferred.

For claims data, a code from Table BBH-C on or between the discharge date and seven days after discharge indicates the member is numerator compliant.

Table BBH-B: Beta-Blocker Medications

Prescriptions			
• Acebutolol HCL	• Carteolol HCL	• Metoprolol tartrate	• Propranolol HCL
• Atenolol	• Carvedilol	• Nadolol	• Sotalol HCL
• Betaxolol HCL	• Labetalol HCL	• Penbutolol sulfate	• Timolol maleate
• Bisoprolol fumarate	• Metoprolol succinate	• Pindolol	

Note: *NCQA will provide a complete list of medications and the NDC codes that count toward this measure on its Web site at www.ncqa.org by November 15, 2006.*

Table BBH-C: Codes to Identify Beta Blocker Therapy Prescribed

Description	CPT Category II
Beta-blocker therapy prescribed	4006F

Exclusion *(optional)*

The MCO *is strongly encouraged* to exclude from the denominator members who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy. The MCO may use the codes from Table BBH-D for contraindications to beta-blocker therapy.

Table BBH-D: Codes to Identify Exclusions

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line. The MCO may reduce its sample size using the prior year's audited, product line specific reported rate or this year's administrative rate. For information on reducing sample size, refer to the *Guidelines for Calculations and Sampling.*

Numerator

Members who received an ambulatory prescription for beta-blockers rendered within seven days after discharge. Prescriptions filled on an *ambulatory basis* anytime while the patient is hospitalized for AMI through the seventh day after discharge count toward this measure. If the MCO is unable to determine if the prescription was rendered on an inpatient or ambulatory basis, it may count those prescriptions rendered after discharge.

To account for members who are on beta-blockers prior to admission, the MCO may also count prescriptions for beta-blockers that are active at the time of admission.

Administrative

Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record

Documentation in medical record must include, at a minimum, a note indicating that the member received a prescription for beta-blockers within the time frame specified.

Exclusion *(optional)*

Refer to the *Administrative Specification* above for exclusion criteria. Exclusionary evidence in the medical record must include a dated note indicating the contraindications. The MCO should look as far back as possible in the member's history through the end of the continuous enrollment period for evidence of a contraindication or a previous adverse reaction to beta-blocker therapy.

Note

- *Expired members are those with a patient status code (Form Locator 22) equal to 20–29.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table BBH-1/2/3: Data Elements for Beta-Blocker Treatment After a Heart Attack

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

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

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

The percentage of members 35 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Note: *Although similar in clinical logic to the* Beta-Blocker Treatment After a Heart Attack *measure, this measure has multiple differences with regard to the eligible population criteria and data collection methodology. The measure is administrative-only, due to the need for pharmacy claims confirmation to validate persistence of therapy for 135 of 180 days.*

Definition

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	35 years and older as of December 31 of the measurement year.
Continuous enrollment	Discharge date through 180 days after discharge.
Allowable gap	No more than 1 gap in enrollment of up to 45 days within the 180 days of the event. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Discharge date.
Benefit	Medical and pharmacy.
Event/diagnosis	*Discharged alive from an acute inpatient setting with an AMI between July 1 of the year prior to the measurement year through June 30 of the measurement year.* If a member has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year, the MCO should only include the first discharge and must use the codes listed in Table PBH-A to identify AMIs.

Table PBH-A: Codes to Identify AMI

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

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

Transfers to acute facilities. Include hospitalizations in which the member was transferred directly to another *acute care facility* for any diagnosis. Count the discharge from the subsequent, not the initial, acute inpatient facility. The discharge date from the facility to which the member was transferred 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.

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

Administrative Specification

Denominator The eligible population.

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

Identify all members in the denominator population whose days supply dispensed is ≥135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days supply filled.

To determine continuity of treatment during the 180-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days + 45 gap days = 180 days); identify all prescriptions filled within 180 days of the Discharge Date.

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

Table PBH-B: Beta-Blocker Medications

Prescriptions			
• Acebutolol HCL	• Carteolol HCL	• Metoprolol tartrate	• Propranolol HCL
• Atenolol	• Carvedilol	• Nadolol	• Sotalol HCL
• Betaxolol HCL	• Labetalol HCL	• Penbutolol sulfate	• Timolol maleate
• Bisoprolol fumarate	• Metoprolol succinate	• Pindolol	

Note: *NCQA will provide a list of medications and the NDC codes that count toward this measure on its Web site at www.ncqa.org by November 15, 2006.*

Exclusion *(optional)*

The MCO *is strongly encouraged* to exclude from the denominator members who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy. The MCO should look as far back as possible in the member's history through the end of the continuous enrollment period, in administrative data for evidence of a contraindication to beta-blocker therapy. The MCO may use the codes from Table PBH-C for contraindications to beta-blocker therapy.

Table PBH-C: Codes to Identify Exclusions

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

Note

- *Expired members are those with a patient status code (Form Locator 22) equal to 20–29.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table PBH-1/2/3: Data Elements for Persistence of Beta-Blocker Treatment After a Heart Attack

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

SUMMARY OF CHANGES TO HEDIS 2007

- Retired LDL-C control <130 mg/dL.
- Changed the timing requirement for reporting LDL-C control <100 mg/dL. The value must come from the most recent LDL-screening in the measurement year.
- Added HCPCS to table CMC-A.
- Added ICD-9-CM Procedure codes 00.66, 36.06, 36.07 to Table CMC-A.
- Added ICD-9-CM Diagnosis codes 414.8, 414.9 to Table CMC-B.
- Deleted ICD-9-CM Diagnosis codes 437.0, 437.1, 438, 441, 443.9 from Table CMC-B.
- Added CPT codes 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 99455, 99456 to Table CMC-C.
- Deleted CPT codes 92002-92014, 99271–99275, 99292, 99351–99357 from Table CMC-C.
- Deleted UB-92 Revenue codes 0115, 0125, 0135, 0145, 0155, 049x, 050x, 053x, 056x, 065x, 076x, 080x, 082x-085x, 088x, 092x, 094x, 096x, 0972–0979, 0984–0986, 0988, 0989 from Table CMC-C.
- Moved UB-92 Revenue code 0456 from outpatient/nonacute inpatient description to acute inpatient/ emergency department description in Table CMC-C.
- Added CPT codes 83700, 83701, 83704 to Table CMC-D.
- Added LOINC code 39469-2 to Table CMC-D.

Note: *NCQA will conduct a field test this summer to determine changes to the measure's denominator. Following the field test, NCQA will conduct a brief Public Comment period. Modifications to the denominator will be announced in the Volume 2 Technical Update in October. If a final decision is available before October, revised specifications will be sent to all stakeholders.*

Description

The percentage of members 18–75 years of age who, from January 1–November 1 of the year prior to the measurement year, were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA), *or* who had a diagnosis of ischemic vascular disease (IVD), who had each of the following during the measurement year.

- LDL-C screening performed
- LDL-C control (<100 mg/dL)

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year

Allowable gap No more than 1 gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis Members are identified for the denominator in one of two ways: event or diagnosis. The MCO must use both criteria to identify the eligible population.

Event. Discharged alive for AMI, CABG, or PTCA on or between January 1 and November 1 of the year prior to the measurement year. Use the codes listed in Table CMC-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, emergency room).

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

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

Diagnosis. At least one outpatient, nonacute inpatient, acute inpatient or ED visit with any diagnosis of IVD on or between January 1 and November 1 of the year prior to the measurement year. Use the codes in Table CMC-B to identify an IVD diagnosis and Table CMC-C to identify the visit type.

Table CMC-B: Codes to Identify IVD

Description	ICD-9-CM Diagnosis	DRG
IVD	411, 413, 414.0, 414.8, 414.9, 429.2, 433-435, 440.1, 440.2, 444, 445	140, 524, 559

Table CMC-C: Codes to Identify Visit Type

Description	CPT	UB-92 Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 052x, 057x-059x, 077x, 0982, 0983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	0118, 0128, 0138, 0148, 0158, 019x, 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, 0987
Emergency department	99281-99285	045x, 0981

Administrative Specification

Denominator The eligible population.

Numerator

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

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

CPT	LOINC
80061, 83700, 83701, 83704, 83715, 83716, 83721	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 24331-1, 39469-2

LDL-C level <100 mg/dL Using automated laboratory data, during the measurement year, the member is numerator compliant if the most recent LDL-C level is <100 mg/dL. If the automated result for the most recent LDL-C test is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the member is not compliant.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line.

Numerators

LDL-C screening An LDL-C test performed during the measurement year as determined by administrative data or medical record review.

LDL-C level <100 mg/dL The *most recent* LDL-C level performed during the measurement year is <100 mg/dL, as documented through automatic laboratory data or medical record review. If the result for the most recent LDL-C test is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the member is not compliant.

Administrative Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result. The MCO may calculate LDL-C levels from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5)

If lipoprotein (a) is measured, this calculation is:

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5) – 0.3[lipoprotein (a)]

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL.

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table CMC-1/2/3: Data Elements for Cholesterol Management for Patients With Cardiovascular Conditions

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 2 rates*
Current year's administrative rate (before exclusions)		*Each of the 2 rates*
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		*Each of the 2 rates*
Administrative rate on FSS		*Each of the 2 rates*
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 2 rates*	*Each of the 2 rates*
Numerator events by medical records		*Each of the 2 rates*
Reported rate	*Each of the 2 rates*	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*	*Each of the 2 rates*