ATTACHMENT 1:

GENERAL GUIDELINES FOR DATA COLLECTION AND REPORTING

General Guidelines for Data Collection and Reporting

SUMMARY OF CHANGES TO HEDIS 2010

- Removed the requirement that organizations must report the related quality measure when reporting an RRU measure from *General Guideline 12: How Rotation Works.*
- Revised PPO reporting requirements in *General Guideline 38: Data Collection Methods.*
- Added *General Guideline 48: Administrative Data Refresh.*
- Revised Table 1 to reflect changes in reduction of sample size based on the prior year's rate.
- Clarified how the eligible member population should be sorted.

HEDIS Reporting

1. Product-Line Reporting

HEDIS results must be collected and reported separately for populations covered by commercial insurance, Medicaid and Medicare.

2. Product-Specific Reporting

At the organization's discretion, HEDIS results may be reported separately by product (e.g., HMO, POS, PPO) or combined (HMO/POS). Organizations that would like to report a PPO product combined with the HMO or POS product must submit a written request to PCS at www.ncqa.org/pcs for approval. The request must specifically address all the elements contained in *General Guideline 3: HEDIS Submission for Organizations Seeking Accreditation*.

The organization must submit data for an entire product, including consumer-directed or high-deductible health plan (e.g., CDHP, HDHP) products that may be offered under an HMO or a PPO license. The organization must include all members—including administrative services only (ASO) members—except when the contract prohibits the organization from contacting members under any circumstances (a "no-touch" contractual agreement). The organization may exclude no-touch members from HEDIS/CAHPS results and from accreditation. Refer to *General Guideline 24: Self-Insured Members* for more information.

Definitions

HMO Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population.

An HMO is accountable for assessing access and ensuring quality and appropriate care. Practitioners affiliated with the health care system render health care services. In this type of organization, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.

A **practitioner** is a professional who provides health care services and is usually required to be licensed as defined by law.

POS Point of service. An HMO with an opt-out option. In this type of organization, members may choose to receive services either within the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner).

The level of benefits or reimbursement is generally determined by whether the member uses in-network or out-of-network services. Common uses of "POS" include references to products that enroll each member in both an HMO (or HMO-like) system and in an indemnity product. A POS product is also referred to as an "HMO swing-out organization," an "out-of-organization benefits rider to an HMO" or an "open-ended HMO."

PPO Preferred provider organization. PPOs take responsibility for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers, either by assuming insurance risk or by providing only administrative services.

3. HEDIS Submission for Organizations Seeking Accreditation

HEDIS results must correspond with the product line/product combination for which the organization seeks accreditation. NCQA defines the organization for accreditation and HEDIS reporting as part of the accreditation application process.

How NCQA Defines an Organization for Accreditation

NCQA defines the accreditable organization (also called the "accreditable entity") based on the legal entity and management structure and delivery system that support the product lines/products NCQA accredits. NCQA's goal is to arrive at accreditation decisions that reflect the organization that is legally accountable for services provided to its members and represents an organizational and delivery structure that is meaningful to members. NCQA considers the following structural factors when defining the entity NCQA evaluates for purposes of accreditation and HEDIS scoring.

Legal entity The first factor that NCQA considers when defining an organization is its legal structure. The goal is to identify the legal entity that issues a contract for insurance for a defined population or contracts with an employer to provide managed care services to a self-insured population.

For HMO and POS organizations only, if the organization consists of multiple legal entities within a state, but otherwise operates as a single, statewide organization (i.e., same management structure; a single practitioner/provider network for the entire state; centralized key functions, including quality improvement [QI], credentialing [CR] and utilization management [UM]), NCQA awards accreditation decisions for each legal entity, but the organization may submit one statewide HEDIS submission that is applied to each legal entity.

Practitioner and provider network The organization must have a single practitioner or provider network. If there are separate and distinct practitioner/provider networks, NCQA may consider each network and accompanying management structure a separate organization. NCQA recognizes that organizations sometimes market individual products with practitioner/provider networks that are subsets of a larger network. In this case, NCQA may define the organization at the level of the broader network.

Organizations that want to submit a request to report PPO/HMO/POS products in combination must have HMO/POS and PPO practitioner and provider networks that are at least 80 percent the same. If more than 20 percent of practitioners and providers do not participate in networks for both the HMO/POS and PPO products, NCQA requires separate HEDIS reporting for PPO and HMO/POS.

Centralization

NCQA considers the degree of centralization of key functions assessed by the accreditation standards. The organization should have a single QI program and a single set of UM, CR, Member Rights and Responsibilities (RR) and Member Connections (MEM) policies and procedures for the functions evaluated by the standards, including disease and complex case management, utilization management, credentialing, managing members complaints and appeals and developing member materials. If key functions are decentralized, with distinct policies and procedures, NCQA may determine that there is more than one accreditable entity.

Licensure

NCQA takes licensure into account when defining an organization. The organization may have multiple licenses, especially if its service area crosses state lines.

HEDIS/CAHPS reporting unit

The organization's HEDIS/CAHPS reporting unit is a key consideration in determining the accreditable entity (see "HEDIS Reporting for Accreditation", below for the definition of the HEDIS/CAHPS reporting unit). In general, because evaluation of HEDIS/CAHPS results is a component of the Accreditation score and NCQA issues a unique status for each HEDIS/CAHPS reporting unit, the accreditable entity is the same as the HEDIS CAHPS reporting unit.

HEDIS Reporting for Accreditation

NCQA combines Accreditation Survey results with specified HEDIS results for the product lines/products defined below, and issues accreditation decisions by product line/product.

HEDIS/CAHPS reporting unit

Organizations annually submit HEDIS/CAHPS results for a defined set of measures. NCQA evaluates an organization's results at the time of its Accreditation Survey and annually, between surveys, based on its performance on the measures. NCQA uses the following criteria to define a HEDIS/CAHPS reporting unit.

- Product line and product (refer to *General Guideline 1: Product-Line Reporting* and *General Guideline 2: Product-Specific Reporting*)
- Geographic unit

Geographic unit

HEDIS performance varies geographically throughout the United States. Results must reflect geographic variation to be meaningful to consumers and purchasers. For HMO and POS plans—which are generally incorporated locally and regulated individually by states—the size of the geographic unit is limited by the legal entity. Plans must report HEDIS/CAHPS for HMO and POS products at a reporting unit no larger than each legal entity, except as noted below under *Minimum enrollment thresholds.*

For PPO products, which may have a service area that is larger than a single state, the plan is required to report HEDIS/CAHPS results for geographic regions no larger than a state, except as noted below under *Minimum enrollment thresholds.* Current NCQA policies that allow HEDIS/CAHPS reporting across state lines in large metropolitan areas or when the organization has a small population out of state remain unchanged.

Minimum enrollment thresholds

NCQA's goal is to maximize an organization's ability to produce HEDIS/CAHPS results. A HEDIS/CAHPS reporting unit (accreditable entity) must have a sufficient number of members to calculate rates. NCQA recognizes that producing HEDIS/CAHPS results can be resource intensive, and has established a minimum membership threshold for requiring HEDIS reporting. A geographic unit with 15,000 or more members in a product/product line must submit audited HEDIS/CAHPS results to NCQA to be scored as part of accreditation.

If the reporting unit has fewer than 15,000 members, NCQA has established alternative accreditation policies for combining HEDIS/CAHPS reporting units, or accrediting an organization on standards, or standards and CAHPS only.

Combining reporting units with <15,000 members

Entities may be combined when, based solely on geographic reporting policy, a single legal entity is considered to have multiple HEDIS/CAHPS reporting units and, therefore, has multiple accreditable entities, one or more of which does not meet the minimum membership threshold. Refer to *Combining accreditable entities and HEDIS/CAHPS reporting units*. A reporting unit with less than 15,000 members that cannot meet the criteria for combining results must follow the alternative policies described below.

Reporting units with <15,000 members

A HEDIS/CAHPS reporting unit (accreditable entity) with less than 15,000 members may choose one of the following options for reporting:

- Submit a unique set of audited HEDIS/CAHPS results to NCQA to be scored as part of accreditation. If the results submitted have too many audit results of Small Denominator (SD) or No Benefit (NB), the reporting unit may be scored on standards and CAHPS only or on standards only.
- Combine its membership with another reporting unit in accordance with the policies described below, if applicable, to submit audited HEDIS/CAHPS results.
- Submit a unique set of CAHPS results only and be scored on standards and CAHPS only or on standards only.
- Not submit HEDIS/CAHPS or CAHPS results and be scored on standards only.

When accrediting an organization on standards and CAHPS only or standards only, NCQA will award a status no higher than *Commendable*.

Combining accreditable entities and HEDIS/CAHPS reporting units

The organization may combine two or more HEDIS/CAHPS reporting units (accreditable entities) into a single unit in order to achieve the minimum reporting threshold if they meet the following criteria.

- Reporting units are part of a single legal entity
- When combined, reporting units meet all other NCQA criteria for being defined as a single accreditable entity (e.g., licensure, centralization, provider network)
- Reporting units share contiguous geographic borders (e.g., side-by-side or corner-to-corner states) and are within the same CMS region

The organization may not combine reporting for product lines (commercial, Medicare, Medicaid), and must combine the fewest number of reporting units necessary to meet the threshold, allowing all reporting units to be able to report HEDIS/CAHPS for accreditation. The organization must submit HEDIS/CAHPS results for all reporting units within a CMS region when combining results.

Combining

Reporting units may combine membership for bordering states that cross CMS

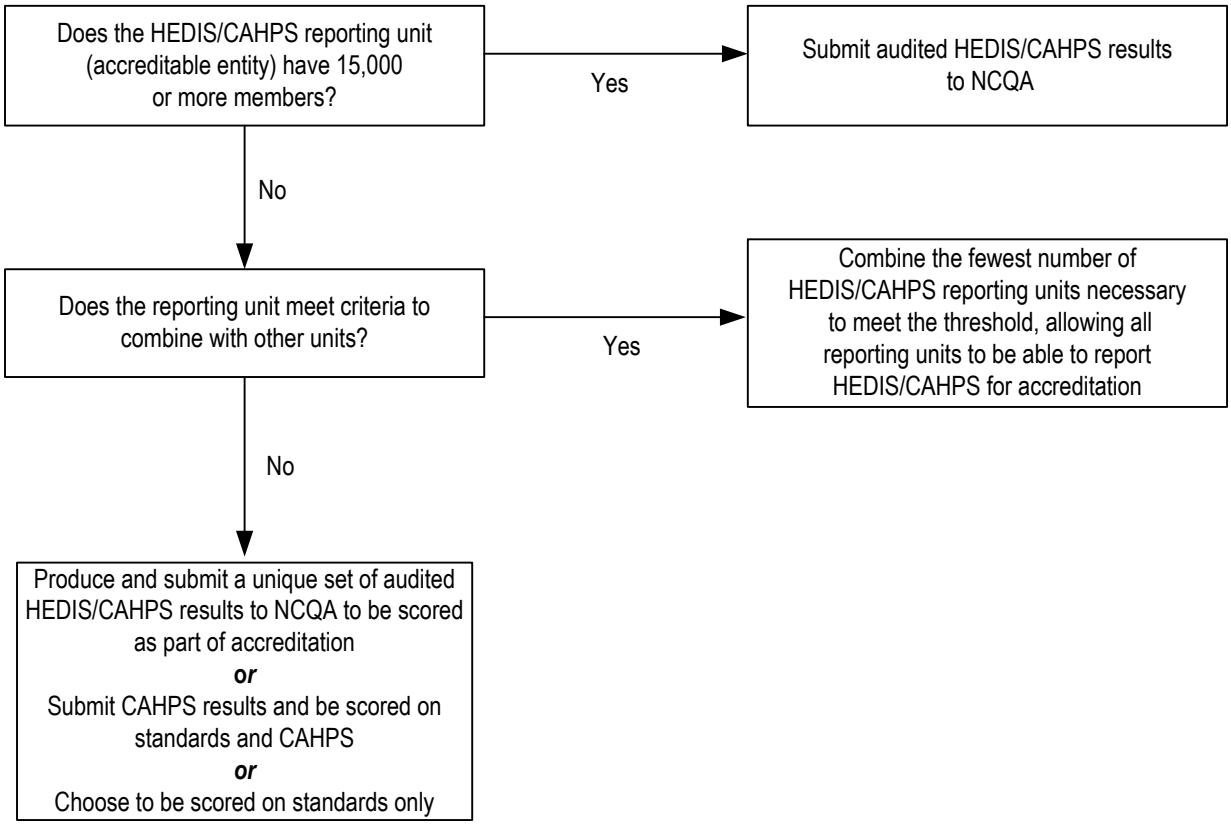
across CMS regions in limited situations

regions if all other conditions for combining are met, and the organization is not "licensed" or "selling" in the adjacent state, but has membership across the border because of commuting or residency reasons.

Approval process for all HEDIS state combining requests

All organizations that want to combine states for HEDIS reporting must submit a request to NCQA for review and approval each year, even if NCQA has approved combining in a prior year. Organizations must submit requests annually by December 31 of the year prior to reporting through the NCQA Policy Clarification Support (PCS) System; must include membership by state as of July 1 of the HEDIS measurement year and by applicable product or product line; and must document how the policies for combining are met. NCQA will respond to the request within 20 business days.

The following flow chart illustrates the combining policy.



Example 1 Under NCQA's definition of accreditable entity, Plan A and Plan B are each a distinct accreditable entity and HEDIS/CAHPS reporting unit. Each is a PPO plan that shares contiguous geographic borders; each has a membership of 8,000. They meet all the criteria above to combine membership, including being part of a single legal entity and sharing borders. Plan A and Plan B may combine into a single accreditable entity and HEDIS/CAHPS reporting unit.

Example 2 Under NCQA's definition of accreditable entity, Plan A, Plan B and Plan C are considered distinct accreditable entities and HEDIS/CAHPS reporting units. Each is a PPO plan that shares contiguous geographic borders; each has a membership of 8,000. All organizations meet all the criteria above to combine membership, including being part of a single legal entity and sharing borders.

If Plan A and Plan B combine, the resulting accreditable entity/reporting unit meets the threshold and leaves Plan C unable to report HEDIS/CAHPS for accreditation. Therefore, all three plans may combine into a single accreditable entity and HEDIS/CAHPS reporting unit.

Example 3 Under NCQA's definition of accreditable entity, Plan A, Plan B, Plan C and Plan D are each a distinct accreditable entity and HEDIS/CAHPS reporting unit. Each is a PPO plan that shares contiguous geographic borders. Plans A and B have 7,000 members each. Plans C and D have 8,000 members each. All plans meet all the criteria above to combine membership, including being part of a single legal entity and sharing borders.

Under the policy, Plans A and B could combine, and because they will be short of the minimum threshold requirement of 15,000 members, they may add Plan C. This would leave Plan D unable to report and require all four plans to combine. But the intent of the policy is for the *fewest entities* to combine to meet the minimum, and therefore, Plan A should combine with Plan C, and Plan B should combine with Plan D, creating two reporting units with 15,000 members each.

4. HEDIS Submission for Organizations Not Seeking Accreditation

To determine how many HEDIS reports to produce, the organization must define itself using the criteria specified by NCQA. An organization unable to determine the HEDIS reporting entity should submit written documentation relating to the criteria described in *General Guideline 3: HEDIS Submission for Organizations Seeking Accreditation* to the NCQA Policy Department via the PCS System at www.ncqa.org/pcs or by fax to 202-955-3599. NCQA staff review the organization's structure and make the final determination.

5. Model Type and Mixed-Model Type Organizations

Model type is the type of structure the organization uses to provide members with care (e.g., Staff, Group, IPA, Direct Contract, Mixed, Network).

Mixed-model organizations (e.g., an organization with an IPA and a group model) should report data for all model types combined.

6. Reporting HEDIS for Medicaid

Separate Medicaid HEDIS reports should be produced for each state with which the organization has a Medicaid contract.

If the organization contracts with a local entity (e.g., a county) rather than a state and contracts with each locality in which it provides service, the state and organization should discuss providing one comprehensive Medicaid HEDIS report by each organization to encompass all geographic areas served by the organization in that state.

7. Reporting HEDIS for Medicare

HEDIS reporting is required for the following.

- Medicare Advantage (MA) contracts
- Section 1876 cost contracts with active enrollment
- Special Needs Plans (SNP)
- Certain demonstration projects

All members covered under these contracts are included in Medicare HEDIS reporting.

CMS communicates directly with all contracted organizations on additional reporting requirements (e.g., market area reporting, patient identifier information). Refer to the *Medicare Managed Care Manual, Chapter 5: Quality Assessment* on the CMS Web site (www.cms.gov).

SNPs are required to submit a subset of HEDIS measures. These plans include the dual-eligible, chronic care and institutional benefit packages. For more information on SNP reporting requirements, go to www.ncqa.org/snp.aspx.

8. Reporting HEDIS for the Children's Health Insurance Program (CHIP)

CHIP

States may contract with an organization to provide care to Children's Health Insurance Programs (CHIP) members as part of the organization's Medicaid product line, the commercial product line, or separate from both the Medicaid and commercial product lines. A state that contracts with an organization to care for CHIP members should enable the contracting organization to identify CHIP members, when possible.

Reporting guidelines

Reporting performance measures for CHIP members should be consistent with the organization's Medicaid contracting status and the direction of the state.

If the state has identified CHIP members to a contracting organization and the contracting organization is also collecting and reporting Medicaid HEDIS results, the organization should perform one of the following, as directed by the state.

- Report required HEDIS measures separately for CHIP members, ***or***
- Include CHIP members in its Medicaid product-line reports

The organization must exclude CHIP members from its commercial product-line reports, because including CHIP members in HEDIS reports for commercially enrolled populations may affect organization-to-organization comparison.
In addition, an organization with a small number of eligible CHIP members should follow *General Guideline 37: Small Numbers.* The organization should consult with its respective states to determine specific CHIP HEDIS reporting requirements.

NCQA will continue to work with CMS, the Agency for Healthcare Research and Quality (AHRQ), states and organizations to gain additional experience with issues and opportunities for future reporting on children covered by CHIP.

Continuous enrollment requirements

Whether the CHIP population is reported separately or included in the Medicaid HEDIS report, the organization should follow the Medicaid product line specifications and continuous enrollment requirements.

The HEDIS Compliance Audit

The HEDIS Compliance Audit™ is a process that runs concurrent with HEDIS Data Collection. The audit allows comparability across organizations and ensures validity and integrity of HEDIS data. It is required for organizations seeking NCQA Accreditation or for reporting in NCQA public reporting products, including Quality Compass®. The audit is required by many states and employer groups.

9. Audit Preparation

Contracting with an audit firm

The organization should request an application for a HEDIS Audit from an NCQA Licensed Organization (www.ncqa.org/audit.aspx) and is responsible for determining fees and entering into contracts. The first activity in audit preparation is contract execution. The organization should contact the NCQA Licensed Organization for bids and select a firm to conduct the HEDIS audit.

The contracting phase includes assessing measures to report, executing the contract with all the necessary ancillary agreements (e.g., confidentiality and conflict of interest) and negotiating a timeline. All Licensed Organizations employ or contract with Certified Auditors and select an audit team for the organization.

HEDIS Roadmap

The HEDIS Record of Administration, Data Management and Processes (formerly known as the "BAT") is a comprehensive instrument that must be completed by each organization. Auditors use the HEDIS Roadmap to review information about the organization's systems for collecting and processing data to produce HEDIS reports. The HEDIS Roadmap also describes the operational and organizational structure of the organization. It includes detailed questions about all audit standards and is used by auditors to organize the site visit.

10. Reporting

Audit results

HEDIS Compliance Audits result in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. All measures selected for public reporting must have a final, audited result. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below.

…for HEDIS measures

- A rate or numeric result. The organization followed the specifications and produced a reportable rate or result for the measure.
- *Small Denominator (NA).* The organization followed the specifications but the denominator was too small (<30) to report a valid rate.
- *Benefit Not Offered (NB).* The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
- *Not Reportable (NR).* The organization calculated the measure but the rate was materially biased or the organization chose not to report the measure.

…for survey sample frames

- *Reportable (R).* The survey sample frame was reviewed and approved.
- *Not Reportable (NR).* Indicates the survey sample frame was incomplete or materially biased, or an NCQA-Certified Survey Vendor did not administer the survey.

Material bias The organization cannot report a rate for a measure that the auditor determines is biased. Bias is based on the degree of data completeness for the data collection method used and differs according to measure and domain. Three assessments of bias are used. Refer to *Appendix 8: Bias Determination* in *Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures* for a description of the assessments and a list of measures to which they apply.

11. Marketing

Release by the organization of HEDIS Audit results must be in accordance with the *HEDIS Compliance Audit Guidelines for Advertising and Marketing* (*Appendix 5* of this volume). The organization may release the entire Final Audit Report without prior authorization from NCQA; however, it must obtain written authorization from NCQA before releasing any information abridged, summarized or quoted from the Final Audit Report.

Measure Rotation

12. How Rotation Works

To reduce the overall HEDIS reporting burden and allow the organization to allocate resources to improvement activities, NCQA instituted a measure rotation strategy where the organization may rotate select commercial and Medicaid measures and surveys on a biennial basis. Measure rotation allows the organization to use the audited and *reportable* Hybrid Method rate or survey from the prior year's data collection in lieu of collecting the measure for the measurement year. Each year NCQA specifies a list of measures eligible for rotation. Measures are rotated on a structured schedule and are eligible for rotation every other year. Measures may not be rotated in a year when they are not eligible for rotation.

13. Criteria for Eligibility

The following criteria must be satisfied in order for the organization to rotate a measure.

- The measure is on the list of those eligible for rotation in 2010
- The organization has an audited and reportable rate produced using the Hybrid Method from the prior year
- The organization's reporting entity has remained constant since the preceding year
- The organization had a *reportable small denominator* audit result (NA for HEDIS 2009) and that result still applies (NA audit result for HEDIS 2010)

Note: *The HEDIS Compliance Audit may include selecting a core set of measures for source code review. Even if the organization chooses the rotation option, the certified auditor can select an appropriate core set (excluding rotated measures) and conduct the audit.*

14. Measures Eligible for Rotation

Measure rotation applies to the commercial and Medicaid product lines only, but the organization should defer to state regulatory agencies about individual state decisions regarding the rotation strategy. The following measures are eligible for rotation for HEDIS 2010.

- *Cervical Cancer Screening (Medicaid only)*
- *Controlling High Blood Pressure*
- *Frequency of Ongoing Prenatal Care*
- *Prenatal and Postpartum Care*
- *Weeks of Pregnancy at Time of Enrollment*
- *CAHPS Health Plan Survey—4.0H, Child Version*
- *Children With Chronic Conditions*

15. Rotation and HEDIS Scoring for Accreditation

A number of measures eligible for rotation are used for accreditation scoring. NCQA holds thresholds constant for rotated measures. The organization may rotate measures and retain its HEDIS results and accreditation scores; it may also collect and report rotated measures and update HEDIS results to increase the accreditation score, or for other reasons. When deciding to rotate a measure, an organization in the NCQA Accreditation process should consider whether its accreditation score on the measure was satisfactory.

16. Measure Rotation and Data Submission

The organization must use the Interactive Data Submission System (IDSS) to indicate rotated measures. The organization retains responsibility for submitting data to NCQA through the IDSS by the HEDIS reporting deadline. NCQA provides instructions for completing the IDSS in the *IDSS Users Guide.*

In Which Reports Should HEDIS Members Remain?

17. Eligible Population

The **eligible population** for any measure is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event or anchor date enrollment requirement. The organization must include all members (regardless of benefit level) in the appropriate HEDIS report, with the exception of self-insured members that meet the criteria outlined in *General Guideline 24*.

- *For the Administrative Method,* the rate is calculated using the eligible population after any exclusions are removed
- *For the Hybrid Method,* the rate is calculated using the denominator (i.e., the systematic sample drawn from the eligible population) after any exclusions are removed

Note: *Refer to the measurement specifications for the criteria of* eligible population *for a specific measure.*

18. Commercial Members

Members enrolled through an employer group policy or through an individual or family policy should be included in the commercial HEDIS report.

19. Employer-Specific HEDIS Reports

NCQA does not recommend calculating employer-specific HEDIS reports because of confidentiality concerns, statistical concerns arising from small numbers and the medical record review burden for measures collected using the Hybrid Method.

20. The "Working Aged" and Retirees

Include employees 65 years of age and older and retirees in the product line that provides their primary coverage (Medicare or commercial).

21. Medicaid/Medicare-Eligible Members

Include these members in *both* the organization's Medicaid and Medicare HEDIS report *only* if the members are enrolled in the organization's MA contract or a Section 1876 Cost Contract *and* its Medicaid managed-care contract. An organization with a dual-eligible SNP benefit package should also include these members in its SNP submission.

Members who have Medicare fee-for-service (FFS) or unknown Medicare coverage as their primary insurer may be excluded from the organization's Medicaid report.

22. Members With Dual Coverage in Different Organizations

The organization should not try to account for coordination of benefits with other insurance carriers. NCQA recommends that for members with coverage in different organizations, both organizations include the members in their HEDIS reports, regardless of primary insurer. For example, dependent children who are enrolled in one organization's commercial product line under the mother's insurance, and enrolled in another organization's commercial product line under the father's insurance, should be included in both HEDIS reports.

23. Members With Dual Coverage in the Same Organization

For members with dual coverage in the organization (e.g., children enrolled under each parent), the organization must adhere to the following criteria.

- If members are enrolled twice in an HMO product, include them only once in the HMO report
- If the organization reports the HMO and POS products separately, include members with dual coverage in the HMO and POS products in both HEDIS reports
- If the organization reports the HMO and POS products combined or the HMO/POS/PPO products combined, include members in each product only once in the HMO/POS or HMO/POS/PPO combined report

24. Self-Insured Members

Administrative services only

Include self-insured ASO members in the organization's HEDIS reports. Self-insured members may be excluded from the HEDIS reports in either one of the following circumstances.

- The contract prohibits the organization from contacting members under any circumstances (no-touch policy). ASO members can only be excluded due to "no touch" contractual agreements with identified purchasers. A **no-touch contractual agreement** is a contract or other written agreement between the organization (i.e., HMO or PPO) and the ASO specifically stating that the organization cannot contact these members under any circumstances. The organization may exclude no-touch members from HEDIS/CAHPS results and from accreditation because they are not managed in the same way as other members.
- The organization is not responsible for administering both in-network and out-of-network claims for members (i.e., employer carve-out). If claims are administered through a third party on behalf of the organization, the organization is considered to be responsible for administering claims.

Membership Changes

25. Members Who Switch Organizations

The organization may count members who switch organizations as continuously enrolled, provided the members joined an organization that assumes ownership of or responsibility for the member's administrative data and medical records for the entire period of continuous enrollment specified in the measure.

An organization that chooses to report these members as continuously enrolled must follow the same definition of continuous enrollment as described in *General Guideline 29: Continuous Enrollment*, and must follow all other guidelines affecting continuous enrollment (i.e., allow switching between products [HMO, POS, PPO] or product lines [Medicaid, commercial, Medicare]). An organization that adopts this guideline must do so consistently across all measures.

26. Members Who Switch Organizations as a Result of a Merger or Acquisition

Measures with a continuous enrollment period

The organization has the option of counting as continuously enrolled members who switch organizations because of a merger that occurred during the measurement year. An organization that adopts this guideline must do so consistently across all measures.

Measures without a continuous enrollment period

The surviving organization has the option of including in the eligible population members from the nonsurviving entity starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization should exclude the members acquired from the nonsurviving entity from the eligible population for January and February. An organization that exercises this option must do so consistently across all measures.

27. Members Who Switch Product Lines

Measures with a continuous enrollment requirement

Members enrolled in different product lines (commercial, Medicaid, Medicare) at different times during the measurement year should be reported in the product line to which they belonged at the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the commercial product line during the continuous enrollment period is reported in the commercial HEDIS report.

Members who "age in" to a Medicare product line that began mid-year are considered continuously enrolled, provided that they were members of the organization through another product line (e.g., commercial) during the continuous enrollment period and their enrollment did not exceed any allowable gaps.

Measures without a continuous enrollment requirement

Assign members to a category based on the product line in which they were enrolled on the date of service (outpatient services) or date of discharge (inpatient services).

28. Members Who Switch Products

Measures with a continuous enrollment requirement

If the organization reports separately by product, members who switch from the commercial HMO product to the commercial POS product (or vice versa) in the time specified for continuous enrollment for a measure are continuously enrolled and should be included in the product-specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. For HMO or POS HEDIS reporting, count enrollment in a PPO product in the same manner as a gap in continuous enrollment.

For PPO HEDIS reporting, count enrollment in an HMO or POS product as a gap in continuous enrollment. For NCQA-approved combined HMO/POS/PPO reporting, members are considered continuously enrolled.

An organization must use claims data from all products, even when there is a gap in enrollment.

Enrollment in a Medicare Private Fee-for-Service (PFFS) plan is considered a gap in HMO/POS and PPO enrollment.

Measures without a continuous enrollment requirement

If the organization reports commercial HEDIS separately by product (e.g., HMO, POS, PPO), members who switch between products during the measurement year should be reported in the product to which they were enrolled on the date of service (outpatient services) or date of discharge (inpatient services).

Required Enrollment Periods and Benefits

29. Continuous Enrollment

Continuous enrollment specifies the minimum amount of time that a member must be enrolled in the organization before becoming eligible for a measure. One of several criteria used to identify the eligible population, it ensures that the organization has a sufficient amount of time to render services to its members. The continuous enrollment period and any allowable gaps for the period are specified in each measure. The member must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gaps, to be considered continuously enrolled.

A **gap** is the time during which a member is not covered by the organization (i.e., the time between disenrollment and re-enrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member is covered by the organization on both June 30 and July 1. If the member disenrolls on June 30 and re-enrolls on July 2, there is a 1-day gap because the member is without coverage on July 1.

An allowable gap can occur any time during continuous enrollment. For example, the *Comprehensive Diabetes Care* measure requires continuous enrollment throughout the measurement year (i.e., January 1–December 31) and allows one gap in enrollment of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is considered to be continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year. The member has one 38-day gap (January 1–February 7).

30. Medicaid Continuous Enrollment

For an organization that applies a full-month eligibility criterion to Medicaid beneficiaries and verifies enrollment prospectively in monthly intervals (in 1-month increments), the one gap in enrollment during the continuous enrollment period may not exceed 45 days. A member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

If the organization is prospectively notified of member enrollment, use the actual date of enrollment to calculate continuous enrollment, not the notification date.

Retroactive eligibility	The elapsed time between the actual date on which the organization became financially responsible for the Medicaid member and the date on which it received notification of the new member. For measures with a continuous enrollment requirement, the organization has the option to exclude a member if the retroactive eligibility period exceeds the allowable gap requirement. If the organization excludes Medicaid members with retroactive eligibility gaps, it must do so consistently across all measures.

31. Continuous Enrollment Over Multiple Years

Unless otherwise specified, for measures that span more than 1 year, members are allowed one gap in enrollment of up to 45 days during each year of continuous enrollment. A gap in enrollment that extends over multiple years of a continuous enrollment period may exceed 45 days. For example, in the *Breast Cancer Screening* measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and re-enrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member is considered to have one gap of 31 days (December 1–31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

32. Anchor Dates

If a measure requires a member to be enrolled and to have a specified benefit on a particular date, the specified allowable gap must not include that particular date; the member must also have the benefit on that date. For example, a 30-year-old woman who has only one gap in enrollment from November 30 of the measurement year throughout the remainder of the year is not eligible for the *Cervical Cancer Screening* measure. Although the member meets the continuous enrollment criteria, she does not meet the anchor date criteria, which requires her to be enrolled as of December 31 of the measurement year.

33. Required Benefits

…at the organization level

The organization is responsible for reporting HEDIS measures requiring a specific benefit that it provides to members, either directly or through a contractor.

The organization is not responsible for reporting HEDIS measures requiring a specific benefit that it does not offer.

…at the member level

Members who do not have a benefit that is specified in the measure should not be counted in that measure. For example, exclude members who do not have a pharmacy benefit from the *Outpatient Drug Utilization* measure.

Exhausted benefits *(optional)*

For measures without a continuous enrollment criteria, only services or procedures that occurred while the member had a benefit should be included. For a member whose benefit is lost or exhausted during the time specified in the measure, the organization should include services or procedures that occurred while the member had the benefit. For example, for a member whose pharmacy benefit is exhausted on November 1 of the measurement year, only the outpatient drug expenses that occurred from January 1–October 31 should be reported.

For measures with a continuous enrollment criteria, the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. The organization has the option to exclude the member if the period when the benefit is exhausted exceeds any allowable gap or anchor date. For example, the *Use of Appropriate Medications for People With Asthma* measure requires a pharmacy benefit during the measurement year. The organization may elect to exclude a member whose pharmacy benefit is exhausted in September of the measurement year, since this exceeds the 45-day allowable gap period. If the organization chooses to implement this guideline, they must do so consistently across measures.

Carved-out benefits *(optional)* Some organizations can obtain the necessary information from a carved-out entity and may include these members in their measures. For example, an employer contracts directly with a pharmacy benefit manager (PBM), which shares pharmacy information with the organization. The organization may include the employer's members in the measure.

34. Accessing Medical Records Prior to Enrollment

An organization that can access data from a complete medical record should use the data to calculate a measure, but an organization that cannot access data from a medical record, because the data were updated before the member was enrolled, should calculate the measure with only the data available.

HEDIS Data Submission and Reporting

35. HEDIS Reporting Date

The previous calendar year is the standard measurement year for HEDIS data. For HEDIS 2010, the organization should submit data to NCQA on or before June 15, 2010.

State Medicaid agencies will notify a Medicaid-contracting organization of the submission date for Medicaid HEDIS 2010 data, but an organization with a Medicaid product in the accreditation process must meet the submission deadline of June 15, 2010.

CMS will notify a Medicare-contracting organization of the submission date for Medicare HEDIS 2010 data, but an organization with a Medicare product in the accreditation process must meet the submission deadline of June 30, 2010.

36. Required Data Elements

An organization that submits HEDIS data to NCQA must report the data elements identified in each measure specification. Data elements are standard for hybrid measures and administrative measures. Refer to *Appendix 4: Data Element Definitions.* Data elements with an asterisk (*) are optional and are used by NCQA as part of first-year analysis; they are included only for the first two years of data collection.

37. Small Numbers

Effectiveness of Care and Access/ Availability of Care domains

If during the entire measurement year fewer than 100 members are in the eligible population for a reported measure, include in the denominator all members who meet the criteria and report a 95 percent confidence interval. Reporting a confidence interval is required because the small denominator leads to a rate that is not as precise as a rate based on a larger denominator. If the denominator used to calculate a measure is smaller than 30 using either the Administrative or Hybrid Method, the organization is not required to report the rate but must provide all other information, including the following.

- A count of all members eligible for the measure, as defined by the measure specification (the **eligible population/denominator**)
- A count of all members who received the treatment or service as indicated (the **numerator**)

Separate reporting of numerator and eligible population/denominator information allows CMS and states to aggregate the data with those of other organizations to

produce national or statewide data or to calculate a rate. It also serves as a reminder of the threat of small numbers to the credibility of performance measures. The *Guidelines for Calculations and Sampling* contain more information on sample size and selection and confidence interval calculation.

Tabular Use of Services measures

The organization should not suppress reporting for any particular cell in the table (Discharges; Discharges/1,000 Member Months; Procedures; Days/1,000 Member Months), regardless of the total member months or member years for the particular age or sex cohort or the number of measured events (visits, days, discharges, stays, procedures).

Use of Services measures that request a percentage

For Use of Services measures that request a percentage (*Frequency of Ongoing Prenatal Care*, *Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life;* and *Adolescent Well-Care Visits)* follow the instructions for Effectiveness of Care measures described above.

Data Collection Methods and Data Sources

38. Data Collection Methods

HEDIS measures are specified for one or more of three data collection methods.

- Administrative Method
- Hybrid Method
- Survey Method

The organization must use the data collection methods specified in a measure for reporting. If the measure includes both the Administrative and Hybrid Methods, the organization may choose which method to use.

Administrative Method

Requires the organization to identify the eligible population and numerator using transaction data or other administrative databases. The organization reports a rate based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found through administrative data to have received the service required for the numerator.

Hybrid Method

Requires the organization to look for numerator compliance in both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. The organization reports a rate based on members in the sample who are found through either administrative or medical record data to have received the service required for the numerator.

Survey Method

Requires the organization to collect data through a survey. Specifications for survey measures are included in *HEDIS Volume 3: Specifications for Survey Measures; HEDIS Volume 3 (PPO Version): Specifications for Survey Measures;* and *HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey.*

PPO reporting for HEDIS 2010

Beginning with HEDIS 2010, NCQA allows PPOs to report HEDIS using the Hybrid Method for all measures, with the exception of the *Colorectal Cancer Screening* measure. Because this measure is scored for accreditation using administrative benchmarks and thresholds, all PPOs must continue to report the measure using the Administrative Method.

39. Supplemental Electronic Data

Definitions

Standard files Supplemental electronic files have a standard format that is well documented and remains stable from year to year.

- Laboratory data in HL-7 format
- Immunization data in state registries (may vary from state to state, but are consistent for all records in each state's registry)
- Encounter data from behavioral health vendors

Nonstandard files Supplemental electronic data sources might not follow a standard layout and formats might differ from source to source.

- Electronic files from electronic medical records (EMR)
- Electronic files from disease management (DM) or case management systems
- Electronic files from measure-exclusion databases

External data Any automated data supplied by contracted practitioners, vendors or public agencies (e.g., pharmacies, labs, hospitals, schools, state public health agencies). External data may also come from EMR. An EMR system is typically developed and maintained at the hospital or physician office and may be integrated (or linked) to the organization's system. External data files can be standard or nonstandard.

Internal data An automated data file created by the organization that supplements the claim/encounter data in the HEDIS repository. Data may come from internal systems such as DM programs. Internal files are nonstandard.

Required data elements All supplemental electronic data files must include all the data elements specified in the measure (e.g., date and place of service, procedure, prescription, practitioner type). Services must have been rendered within the period specified in the measure. For data obtained from an EMR, the organization must be able to distinguish between ordered and completed visits, procedures, lab and radiology orders; only completed events count toward compliance.

Data collection timing

…for external data External data, including lab data or data files from hospitals and providers, can be collected throughout the year and during the HEDIS reporting year period, allowing a reasonable lag for end-of-the-year services.

The organization may send a request for supplemental data to external sources during the measurement year or early in the reporting year. A request may be for services for the entire eligible population, for noncompliant members in the full population or for noncompliant members in the systematic sample, for hybrid measures.

…for internal data

The organization may load supplemental data from internal sources during the measurement year or early in the reporting year. Data may be for services for the entire eligible population; for noncompliant members in the full population; or for noncompliant members in the systematic sample, for hybrid measures.

Note: *For hybrid measures, only* ***electronic*** *files may be loaded and used like administrative data to calculate compliance for members in the systematic sample; all other data for members in the sample come from chart review and must follow the hybrid measure chart review specifications described in* General Guideline 41: Obtaining Information From Medical Records and EMRs.

Audit requirements

…for standard files

All supplemental electronic data are subject to audit review and differ only in the degree of review required.

For standard files, the auditor is not required to conduct primary source verification to check the accuracy and validity of data obtained from standard files such as laboratory data, but the auditor must request documentation to ensure that the agency or organization responsible for the data has reasonable processes in place for data collection and accuracy.

…for non-standard files

For nonstandard files, internal or external, the auditor is required to perform primary source verification that involves the following tasks.

- Create a randomly selected sample using acceptable methods (e.g., the sample feature in Excel).
- Create a sample with a minimum number of records equal to 5 percent of the total or 25 records (whichever is less). If the number of records in the database is fewer than the minimum required sample, the auditor must perform primary source verification for all records.
- Review the original paper chart or electronic record (e.g., EMR screen) for each member in the sample.

…for all files

For each supplemental electronic file, the organization must provide the auditor with the following documentation.

- How the supplemental data file was created
- Quality assurance or oversight used
- Data quality controls in place
- Data security in place
- Ongoing maintenance
- How the supplemental data file was transmitted

The auditor will further evaluate the policies and procedures for collecting and managing, mapping, importing and reporting the data.

40. Supplemental Paper Data

Definitions

Medical record data The organization may create data files using information from one or more of the member's medical records.

Note: *Data pulled from medical records as a result of chart review for a hybrid measure may be added to a database and used in subsequent HEDIS reporting years, but the elements must comply with the guidelines concerning data element requirements and audit review.*

Provider-reported data The organization may create internal files containing information from provider-reported results.

Note: *The organization should not create records or an ongoing database of exclusions for clinical conditions that can change.*

Member-reported data The *only* member-reported information that the organization may use is information obtained by a provider or clinician in the following circumstances.

- While taking a patient's history, orally or from a questionnaire completed by the patient and presented to the provider, if the following criteria are met.
  - The information is in the medical record by the deadline established for the measure, ***and***
  - The medical record includes a note indicating the date of service and the result (for measures requiring a result)
- While taking the patient's history or experience and recording it in a DM system

Notes

- *Electronic results from DM systems should be treated as electronic supplemental data.*
- *Data from DM systems can be used if the system is related to the disease being managed, the reported value was measured by a health care provider, and the DM system information is either in the patient's medical record or if the physician has the ability to access the DM system information during a visit.*
- *Member-reported biometric values (e.g., blood pressure [BP] readings, HbA1c levels, LDL-C levels, body mass index [BMI]) from self-administered tests are not acceptable for HEDIS reporting purposes.*

Member survey data Organizations and providers *may not* use information obtained from member surveys.

Note: *Organizations and providers may continue to use existing supplemental databases collected from patient surveys before HEDIS 2008 and approved by a certified auditor.*

Required data elements All supplemental paper data must include all the data elements specified in the measure, such as date and place of service, procedure, prescription and practitioner type. Services must have been rendered within the period specified in the measure. For data obtained from an EMR, the organization must be able to distinguish between ordered and completed visits, procedures, lab and radiology orders; only completed events count toward compliance. Provider forms should resemble provider abstraction tools and include all data elements required for the measure. They may not be simple attestations (i.e., a "yes or no" response to the members' compliance or exclusion); they must have all necessary data and should be signed by the provider.

Data collection timing Provider-reported data can be collected throughout the year and during the HEDIS reporting year collection period. Requests for data may be sent to the provider during

the measurement year or early in the reporting year. A form may be sent for the entire eligible population or the noncompliant members in the full population.

Note: *Provider forms may not be sent for noncompliant members in the systematic sample for hybrid measures. All paper reviews for members in the sample must follow the hybrid measures' chart review specifications described in* General Guideline 41.

Audit requirements

All supplemental paper data are subject to audit review. For provider forms, the organization must ensure the following.

- Providers were selected appropriately
- Forms contain all information necessary to meet the measure requirements

Auditors must review the forms (preferably before mailing), approve the list of members and selected providers and validate that the organization imported, evaluated and reported the data properly. The auditor is also required to perform primary source verification, which includes the following tasks.

- Create a randomly selected sample using acceptable methods (e.g., the sample feature in Excel).
- Create a sample with a minimum number of records equal to 5 percent of the total or 25 records (whichever is less). If the number of paper records is fewer than the minimum required sample, the auditor must do primary source verification for all records.
- Review of the original paper chart or the electronic record (e.g., EMR screen) for each member in the sample.

41. Obtaining Information From Medical Records and EMRs

An organization (and its contractors) using the Hybrid Method is responsible for determining compliance with HEDIS measurement specifications. Information from the medical record or EMR may be abstracted by one of the following groups.

- The organization
- Contractors hired to conduct a chart audit
- Practitioners of care

Processes used to determine the validity and integrity of abstracted data, including interrater reliability, quality control and rater-to-standard tests, are subject to review by the HEDIS Compliance Auditor. The organization must include these records in the HEDIS Compliance Audit medical record review validation. The organization should not use practitioner attestation forms because they do not require the practitioner to verify services using the medical record.

Organization or contractor abstraction

The organization may count a service if the medical record or EMR contains the following information.

- The date and the result, ***or***
- A consultation, laboratory or imaging report

All services must be rendered by the deadline for delivery of the service established in the measure (e.g., by the child's second birthday, for the *Childhood Immunization Status* measure).

EMR abstraction

The organization may review EMR screens at the practitioner's office or review printed records (including printed copies of screen-shots) containing the patient's name, the practitioner's name and the date. The organization should develop and implement confidentiality guidelines consistent with EMR abstraction.

When reviewing an EMR, the organization must be able to distinguish between ordered and completed visits, procedures, lab and radiology tests; only completed events count toward HEDIS compliance. Some EMRs record CPT codes when the practitioner enters a service order in the "order" screen. A CPT code found on the "order" list alone does not comply with the numerator criteria.

Practitioner abstraction

The organization may review a copy of the record mailed from the practitioner's office, containing the patient's name, the practitioner's name and the date. Although faxing relevant portions from the medical record is acceptable, it is not a preferred method because of patient confidentiality issues. Regardless of the method used, the organization should develop and implement confidentiality guidelines.

Guidelines for practitioner abstraction

An organization for which a practitioner supplies measure-specific information from a medical record must use an abstraction tool to perform the following functions.

- Provide guidelines for abstraction
- Complete quality control processes, such as interrater reliability or rater-to-standard reliability validation

The organization must provide guidelines for practitioner abstraction. Verbal or written guidance should include clear instructions for applying the technical specifications to medical record review. Instructions are subject to review by the HEDIS Compliance Auditor. The organization does not need to use the same tool for practitioner chart abstraction that it uses for the chart abstractions its contracted vendors perform, but all abstraction tools are required to have all necessary data elements and are subject to review by the HEDIS Compliance Auditor.

42. Measures That Require Use of Results From the Most Recent Test

For measures that require the use of results from the *most recent* test, the organization should search for medical record documentation that indicates a test was *performed* and not merely ordered. Medical record documentation that only indicates a test was ordered (and not performed) should not be included when identifying the most recent test. For example, documentation that the patient was sent to the lab or that labs were ordered may indicate the test was ordered, but it does not mean the test was actually performed. These situations should not be included when identifying the most recent test.

Medical record evidence indicating that a test was performed (and which, therefore, should be included when identifying the most recent test) includes documentation of a numeric value, interpretation of a numeric value (e.g., within normal limits, average, high) or documentation that a test was performed but results could not be calculated (e.g., LDL could not be calculated due to high triglycerides). To determine numerator compliance for rates that require results to be at a certain level, documentation of a numeric result is required. For example, documentation that a result is "within normal limits" or "under control" should be included when identifying the most recent test; its result would be considered "missing."

Additionally, if the organization uses both administrative and medical record data, the most recent test must be used even if it is found administratively and does not contain a result.

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43. Date Specificity

HEDIS requires that a date be specific enough to determine that an event occurred during the time established in the measure. For example, in the *Childhood Immunization Status* measure, members should receive three hepatitis B vaccines. Assume a member was born on February 5, 2007. Documentation in the medical record that the first hepatitis B vaccine was given "at birth" is specific enough to determine that it was given prior to the deadline for this measure (i.e., the child's second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2009, the organization cannot count the immunization because the date is not specific enough to confirm that it occurred prior to the member's second birthday.

There are instances when documentation of the year alone is adequate; these include most optional exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent" or "at a prior visit" are not acceptable.

For documented history of an event (e.g., documented history of a disease), undated documentation may be used as long as it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the *Childhood Immunization Status* measure, undated documentation on an immunization chart stating "chicken pox at age 1" is specific enough to determine that it occurred prior to the child's second birthday. Similarly, for the *Breast Cancer Screening* measure, undated documentation on a problem list stating "bilateral mastectomy in 1999" is specific enough to determine that this exclusion occurred prior to December 31 of the measurement year.

44. Indicators That Require the Same Data Collection Method

The organization must use the same data collection method (Administrative or Hybrid) for reporting the following indicators within each measure.

- *Cholesterol Management for Patients With Cardiovascular Conditions*
  - LDL-C screening
  - LDL-C control <100 mg/dL
- *Comprehensive Diabetes Care*
  - HbA1c testing
  - HbA1c poor control >9%
  - HbA1c control <8%
  - HbA1c control <7%
- *Comprehensive Diabetes Care*
  - LDL-C screening
  - LDL-C control <100
- *Comprehensive Diabetes Care*
  - BP control <130/80 mm Hg
  - BP control <140/90 mm Hg

45. Using the Hybrid Method to Collect Measures With Multiple Numerator Events

The following measures can be collected using the Hybrid Method and require more than one event to satisfy the numerator.

- *Childhood Immunization Status*
- *Well-Child Visits in the First 15 Months of Life*

For example, three separate antigens are collected to report the IPV rate for *Childhood Immunization Status.* For all measures listed above, the organization may use a combination of administrative and medical record data for a member in the denominator, if the events across medical record and administrative data are at least 14 days apart. The organization may count two IPV vaccines identified through administrative and the third IPV identified through medical record review for a member in the denominator, if the medical record date of service is not within 14 days of either administrative date of service. The organization may also count three IPVs identified through administrative and four DTaPs identified through medical record data for the same individual. An organization that has one event from the medical record and one from administrative data and is unable to determine if the dates are at least 14 days apart must use only the medical record event.

46. Measures That Use Pharmacy Data

Some measures require the use of pharmacy data. The specifications include medication tables that should be referenced in conjunction with the National Drug Code (NDC) lists posted to NCQA's Web site. The tables include a *Description* column that indicates the therapeutic category, and a *Prescription* column that includes all appropriate medications in their generic form. The organization is required to use the NDC lists for each pharmacy-dependent measure. Final NDC lists for pharmacy-related measures will be posted to the NCQA Web site on November 16, 2009.

47. Identifying Events/Diagnoses Using Laboratory Data

Laboratory data may not be used to identify an event, disease or condition (e.g., acute myocardial infarction [AMI], diabetes) unless listed in a code table that contains LOINC codes. Many organizations find a high rate of false positives when they use laboratory data to identify members with a disease or condition. Diagnosis codes are frequently reported on laboratory tests in cases where the condition is being ruled out; therefore, organizations should not use laboratory data or claims when identifying the following criteria.

- Eligible Population Event/Diagnosis
- Negative Diagnosis History
- Negative Competing Diagnosis
- Negative Comorbid Condition History
- Exclusions

Laboratory claims and data may be used for any code tables that contain LOINC codes.

48. Administrative Data Refresh

The organization has the option of refreshing administrative data after the hybrid sample is drawn. If an organization elects to refresh administrative data, it must only use the refresh to identify additional numerator hits. It should not use the refresh to identify additional exclusions or adjust the eligible population or sample denominator. Members found to be numerator compliant prior to the data refresh remain so regardless of what is found during the claims refresh. The organization can apply the data refresh on an indicator-by-indicator basis, but cannot apply it on a member-by-member basis. Data refreshes should be used consistently across screening and control indicators for *Cholesterol Management for Patients With Cardiovascular Conditions* and *Comprehensive Diabetes Care*.

HEDIS Coding Conventions

49. Coding Systems Included in HEDIS

HEDIS includes codes from the following coding systems.

- CMS Place of Service (POS)
- Current Procedural Terminology (CPT)
- Diagnosis-Related Group (DRG)
- Healthcare Common Procedure Coding System (HCPCS) Level II
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
- Logical Observation Identifiers Names and Codes (LOINC)
- Uniform Bill (UB) revenue and type of bill

50. Presentation of Codes

Unless otherwise noted, codes in HEDIS are stated to the minimum specificity required. For example, if a code is presented to the third digit, any valid fourth or fifth digits may be used for HEDIS reporting. When necessary, a code may be specified with an "x," which represents a required digit; for example, ICD-9-CM Diagnosis code 640.0x indicates a fifth digit is required, but the fifth digit could be any number allowed by the coding manual. All coding systems in the HEDIS specifications use this presentation format. The table below contains examples of codes and the included ranges.

ICD-9-CM Diagnosis Code	Included Ranges
299	299, 299.0-299.9 and 299.00-299.99
299.x	299.0-299.9 and 299.00-299.99
299.xx	299.00-299.99
299.0x	299.00-299.09
299.05	299.05 only

When reading HEDIS coding tables, assume there is an "or" in between each column unless otherwise noted; each code set is not dependent on another code set unless otherwise noted.

51. Principal vs. Secondary Diagnoses

Principal and secondary diagnoses are mentioned throughout HEDIS. Generally, a **principal diagnosis** or **primary diagnosis** is the diagnosis given at discharge and the one that is listed in the first position on a claim form. A **secondary diagnosis** is a diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis. A claim form may contain several secondary diagnoses. The organization should follow the specifications stated within each particular measure to determine whether a diagnosis must be principal or may be secondary.

Some measures require a specific principal diagnosis for eligibility; other measures allow any diagnosis (principal or secondary). For example, the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure specifies that any diagnosis of an initial AMI is eligible. If a member's claim lists the principal diagnosis as "severe head injury trauma," but an initial AMI is listed as a second, third, fourth or fifth diagnosis on the same claim form, the member would still be included in the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure.

On a UB-04 claim form, the principal diagnosis is listed in Form Locator 67, *Principal Diagnosis Code,* and secondary diagnoses are listed in Form Locators 67A–Q, *Other Diagnosis Codes*. Data in Form Locators 69, *Admitting Diagnosis Code,* and 70a–c, *Patient's Reason for Visit,* should not be included in HEDIS reporting.

On a CMS1500 claim form, the principal diagnosis is listed in Item Number 21, line 1, and secondary diagnoses are listed in Item Number 21, lines 2–4.

52. CPT Code Modifiers

CPT modifiers are two- or five-digit extensions that, when added to CPT codes, provide additional information about a service or procedure. With the exception of myringotomies and mastectomies in the *Frequency of Selected Procedures* measure, the same procedure should never be counted twice for the same date of service. The organization should follow the guidelines below when procedure codes in its databases have modifiers (**xxxxx** denotes the five-digit CPT code).

- **xxxxx-26** indicates the professional component of a service (**xxxxx-TC** is used by some organizations to indicate the technical component of the same service). For a given procedure, the organization should count one or the other of these codes, but not both.
- **xxxxx-54** denotes surgical care only; **xxxxx-55** denotes postoperative management only; **xxxxx-56** denotes preoperative management only. For a given procedure, the organization should count only one of these codes.
- **xxxxx-80** and **xxxxx-82** indicate charges for surgical assistant services; **xxxxx-81** indicates a charge for minimum surgical assistant services. If the primary surgeon does not submit a claim for a given procedure, the organization should count only one of these codes. If a primary surgeon submits a claim, the organization should not count any of these codes.

Unless otherwise specified, if a CPT code specified in HEDIS appears in the organization's database with any modifier other than those specified above, the code may be counted in the HEDIS measure.

53. Uniform Bill Code Specificity

Uniform Bill (UB) codes, primarily type of bill and revenue codes, are used to identify services. As with the ICD-9-CM codes, an "x" may be used in place of a digit.

HEDIS specifies UB type of bill codes using three digits. The organization may also use the equivalent four-digit version of the code (which consists of the three-digit code plus a leading zero); for example, to identify skilled nursing facility (SNF) encounters, it may use 21x or 021x.

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54. Mapping Proprietary or Other Codes

For all HEDIS measures, an organization that does not use the coding systems specified (e.g., CPT or ICD-9-CM) must "map" the codes it uses to the codes specified in HEDIS. Organizations may map proprietary codes, Level III and state-specific Level II HCPCS codes and NDC codes; they may not map standard codes or deleted codes to the codes used in the measures. When mapping codes, it is important that the organization match the clinical specificity required for HEDIS. NDC code mapping should be linked to the generic name, strength/dose and route indicated in the HEDIS NDC lists posted on the NCQA Web site (www.ncqa.org).

For audit purposes, the organization should document the method used to map codes. At a minimum, documentation should include a crosswalk containing the relevant codes, descriptions and clinical information. The organization must document the policies and procedures used to implement codes. For Level III and state-specific Level II HCPCS mapping, the organization must provide the state's instructions for using state-specific codes. Auditors may request additional information.

55. Retirement of Codes

NCQA annually tracks billing, diagnostic and procedure codes designated obsolete. NCQA does not remove codes in the year in which they receive the designation because of the look-back period in many HEDIS measures. Obsolete codes are deleted from the HEDIS specifications one year after the look-back period is exhausted. For example, since the *Breast Cancer Screening* measure counts a mammogram in the measurement year or the year prior to the measurement year, mammography codes have a two-year look-back period. A mammogram code that is designated obsolete effective January 1, 2008, is deleted from the specifications in HEDIS 2011 after the two-year look-back period (2009, 2010) plus one additional year (2008) is exhausted.

NCQA uses the NDC system. Obsolete NDC codes are phased out of the specifications three years after the look-back period to allow pharmacies and organizations to use their inventory and change their systems. NCQA encourages organizations to update their information systems and to ensure that complete, accurate and consistent coding is used for all encounters and claims so that HEDIS specifications can be followed. This will help the industry move toward a uniform system of performance measurement.

56. Table Names

Measure specifications contain two types of tables: one to present specification requirements and one used by organizations to submit data. A standardized naming system is used to refer to the tables. Table names begin with the three-character abbreviation for the measure; for example, *Comprehensive Diabetes Care* tables begin with "CDC."

Specification tables Tables that are part of the specifications (i.e., coding and pharmaceutical tables) begin with the measure abbreviation and end with a hyphen (**-**) and a capital letter to distinguish its order in the measure's specifications. For example, the first table in the *Comprehensive Diabetes Care* measure is CDC-A.

Reporting tables

Data element tables begin with the measure abbreviation. Each product line (commercial, Medicaid, Medicare) is assigned a number.

- **CDC-1** (Medicaid)
- **CDC-2** (commercial)
- **CDC-3** (Medicare)

If there is more than one table to be reported for a product line, it is assigned a lowercase letter. For example, the Medicaid tables for *Enrollment by Product Line* are ENP-1a (Total Medicaid) and ENP-1b (Medicaid/Medicare Dual-Eligibles).

Measures Reportable With a Partial Year of Data

If an organization has a new product or product line licensed during the measurement period, a number of HEDIS measures may be reported with a partial year of data. In general, a measure without a continuous enrollment requirement is reportable with less than a full measurement period of data. Organizations that want to submit HEDIS measures using data from a portion of the measurement period must present a written request for approval to the PCS System at www.ncqa.org/pcs.

Guidelines for Calculations and Sampling

Guidelines for Calculations and Sampling

This section contains guidelines relating to calculating rates based on the Administrative and Hybrid Methods, as well as specifications for sampling when using the Hybrid Method. An organization using this method must follow the systematic sampling methodology described in this chapter or must receive written authorization from NCQA for an alternative sort or sampling method. Proper utilization and implementation of these methods is assessed as part of NCQA's HEDIS Compliance Audit™.

How to Use the Administrative Method

An organization that uses the Administrative Method to collect and report measures must complete the following steps.

Step 1 Identify the eligible population.

Step 2 Search administrative systems to identify numerator events for all members in the eligible population.

Step 3 If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured.

Note: *This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.*

Step 4 Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.

Step 5 Calculate the rate.

Guidelines for the Hybrid Method

Measures that can be collected using the Hybrid Method are listed in Table 1. Each hybrid measure can be classified into one of the following categories:

- *Membership-dependent denominator*—Defined by membership data only (e.g., women between 24 and 64 years of age for *Cervical Cancer Screening*), ***or***
- *Claims-dependent denominator*—Defined by membership and claims data (e.g., members who were diagnosed with hypertension for *Controlling High Blood Pressure*)

Drawing the sample prior to the reporting year

The organization is strongly encouraged to draw samples no earlier than January 2010 for the 2009 measurement year. This increases the accuracy and completeness of the eligible population from which the sample is drawn.

The organization must adhere to the following guidelines if it draws samples prior to January 2010.

Membership-dependent denominators

For measures where the eligible population is determined through membership-data (the bulleted list below), do not draw the sample prior to December 1 of the measurement year.

- *Childhood Immunization Status*
- *Lead Screening in Children*
- *Cervical Cancer Screening*
- *Colorectal Cancer Screening*
- *Care for Older Adults*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- *Adolescent Well-Care Visits*

An organization that draws its sample on or between December 1 and December 31 of the measurement year must perform the following tasks.

- Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.
- On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. For any member who does not meet all the denominator criteria, another record must be substituted.
  - For example, for the *Childhood Immunization Status* measure, on December 5 of the measurement year, an organization draws a sample of children who turn 2 years of age during the measurement year. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure (e.g., meet the continuous enrollment criteria and were members of the organization as of their second birthday). Any ineligible member (i.e., does not meet one or more of the denominator criteria) must be excluded and replaced by an eligible member from the oversample group.

Claim-dependent denominators

For measures where the eligible population is determined through membership data and claims data (the bulleted list below), do not draw the sample before the end of the measurement year.

- *Adult BMI Assessment*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Controlling High Blood Pressure*
- *Cholesterol Management for Patients With Cardiovascular Conditions*
- *Comprehensive Diabetes Care*
- *Medication Reconciliation Post-Discharge*
- *Prenatal and Postpartum Care*
- *Frequency of Ongoing Prenatal Care*
- *Weeks of Pregnancy at Time of Enrollment*

To be drawn from a complete eligible population, the sample must be selected no earlier than January of the reporting year. The organization should allow claims incurred through December 31 to be captured on its administrative systems before identifying the eligible population and drawing the sample.

Determining the required sample size

Using the Hybrid Method to collect and report a measure requires the organization to draw a sample from the eligible population. Use Table 1 to determine the appropriate sample size for measures. For hybrid measures reported in the prior year, use the last column of Table 1 to determine whether the prior year's audited result can be used to reduce the current year's sample size.

Use Table 2 if the organization uses the prior year's rate to determine the current year's sample. The organization may use the product line-specific rate derived from administrative data for the current measurement year and Table 2 to reduce the required sample size. The required sample size decreases as the organization's rate improves; for example, the organization calculates a 77 percent administrative rate for the commercial product line for a new measure and decides to implement the Hybrid Method.

Instead of using a sample size of 411, the organization reduces the sample size for this measure for its commercial product line by using the 77 percent administrative rate and Table 2. According to Table 2, the minimum required sample size is 296.

Population definition

In some cases, the size of the eligible population for a measure may be smaller than the required sample size. In this case, the organization must use its entire eligible population and report the data with a 95 percent confidence interval.

Why should a 95 percent confidence interval be used when the entire eligible population is included? When these data are used for decision-making, an inference is made to expected future performance or to a group of potential members. In either case, the user is interested in the "process of care," which goes beyond organization performance in a single year for a static product line.

It is therefore appropriate to consider the organization's entire eligible population for a measure as a sample from the universe of "all years" or "all populations."

Finite population correction

When calculating the sample size for the Hybrid Method, the organization may be interested in applying a finite population correction (FPC) factor to reduce the sample size; however, since HEDIS views organization enrollment as a sample from a larger potential population (see above), and the use of the FPC decreases the power to detect differences between organizations, it is *not appropriate* to use the FPC for public reporting of HEDIS measures.

Calculating the 95 percent confidence interval

The formula for calculating the 95 percent confidence interval around an organization's HEDIS rate is:

$$lower = p - 1.96 \sqrt{\frac{p(1-p)}{n} - \frac{1}{2n}}$$

$$upper = p + 1.96 \sqrt{\frac{p(1-p)}{n} + \frac{1}{2n}}$$

where p = the organization's rate and n = the sample size.

For example, suppose the organization has a sample size of 96 eligible women for its *Cervical Cancer Screening* rate. Of these, 50 received a Pap Test during the year. The calculation would proceed as follows:

$$p = \frac{50}{96} = 52\%$$

$$lower = .52 - 1.96 \sqrt{\frac{.52(1-.52)}{96} - \frac{1}{192}} = 41.5\%$$

$$upper = .52 + 1.96 \sqrt{\frac{.52(1-.52)}{96} + \frac{1}{192}} = 62.5\%$$

Thus, the user can be 95 percent certain that the organization's true Pap test rate is between 41.5 percent and 62.5 percent.

Note

- *For rates near 0 percent, the lower limit may be negative. If this occurs, replace the lower limit with 0 percent. For rates near 100 percent, the upper limit may exceed 100 percent. If this occurs, replace the upper limit with 100 percent. The IDSS automatically calculates these percentages.*
- *There are more complex confidence interval calculations with better properties at extreme values. This formula is provided because it performs adequately over a wide range of percentages and is simple to compute.*

Statistical assumptions for sample size

Sample size is calculated assuming a two-tailed test of significance between two proportions (α = .05, 80 percent power, two-tailed test of significance). A normal approximation to the binomial with a continuity correction was employed in the sample size calculation. The worst-case assumption of a 50 percent expected value was assumed.

The detectable difference for most measures is 10 percentage points. This was chosen because it is a big enough difference to be actionable, it is not unduly burdensome for data collection and it is not so small as to be "swamped" by nonsampling error.

Table 1: Sample Size Information for Hybrid Measures

Measure	Medicaid	Commercial	Medicare	Prior Year's Rate May Be Used to Reduce MY 2009 Sample Size[1]
Domain 1: Effectiveness of Care				
Adult BMI Assessment	411	411	411	Y
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411	411	NA	Y[2]
Childhood Immunization Status	411	411	NA	N[3]
Immunizations for Adolescents	411	411	NA	N
Lead Screening in Children	411	NA	NA	Y[4]
Cervical Cancer Screening	411	411	NA	Y
Colorectal Cancer Screening	NA	411	411	Y
Care for Older Adults	NA	NA	411	Y[2]
Cholesterol Management for Patients With Cardio-vascular Conditions	411	411	411	Y[2]
Controlling High Blood Pressure	411	411	411	Y
Comprehensive Diabetes Care	548	548	548	Y[5]
Medication Reconciliation Post-Discharge	NA	NA	411	Y
Domain 2: Access/Availability of Care				
Prenatal and Postpartum Care	411	411	NA	Y[6]
Domain 5: Use of Services				
Frequency of Ongoing Prenatal Care	411	NA	NA	Y[6]
Well-Child Visits in the First 15 Months of Life	411	411	NA	Y[7]
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	411	411	NA	Y
Adolescent Well-Care Visits	411	411	NA	Y
Domain 8: Health Plan Descriptive Information				
Weeks of Pregnancy at Time of Enrollment	411	NA	NA	N

[1] Refer to *Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured* in this section to determine the minimum required sample size.

[2] If reducing the sample size based on the current year's administrative rate or the prior year's product line-specific rate for this measure, the lowest rate from all the indicators must be used.

[3] If reducing the sample based on the current year's administrative rate for the *Childhood Immunization Status* measure, the lowest rate must be used.

[4] If a separate sample from the *Childhood Immunization Status* measure is used for *Lead Screening in Children*, the organization can reduce the sample based on the product-line specific current measurement year's administrative rate or the prior year's reported rate for *Lead Screening in Children*.

[5] If reducing the sample size based on the product-line-specific rate for *Comprehensive Diabetes Care*, the organization should first take the inverse of the HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) and then reduce using the lowest rate among all the reported CDC indicators.

[6] If reducing the sample size based on the product-line-specific current measurement year's administrative rate or the prior year's reported rate, the lowest of the three rates for *Timeliness of Prenatal Care, Postpartum Care* and the rate for women who received 81 percent or more of expected prenatal care visits must be used for both *Prenatal and Postpartum Care* and *Frequency of Ongoing Prenatal Care*.

[7] If reducing the sample size based on the product-line-specific current measurement year's administrative rate or the prior year's reported rate for *Well-Child Visits in the First 15 Months of Life*, the rate for children who received six or more well-child visits must be used.

Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured

The organization may use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the sample size. *Table 1: Sample Size Information for Hybrid Measures* must be used first to determine if a prior year's rate can be used to reduce the sample size for a particular measure.

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Sample Size Is	If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Sample Size Is
≤50%	411	73%	328
51%	411	74%	321
52%	410	75%	313
53%	410	76%	305
54%	409	77%	296
55%	407	78%	288
56%	405	79%	279
57%	403	80%	270
58%	401	81%	260
59%	398	82%	250
60%	395	83%	240
61%	392	84%	229
62%	388	85%	219
63%	384	86%	207
64%	380	87%	196
65%	376	88%	184
66%	371	89%	172
67%	366	90%	159
68%	360	91%	147
69%	354	92%	134
70%	348	93%	120
71%	342	94%	106
72%	335	≥95%	100

Note: *Truncate the decimal portion of the rate to obtain a whole number.*

Systematic Sampling Methodology

NCQA implemented a systematic sampling scheme for the Hybrid Method. Proper utilization and implementation of this method ensures ongoing integrity of HEDIS data and supports increasing requests for audited data. For each hybrid measure, the organization should complete the following steps.

Step 1 Determine the eligible member (EM) population. Develop a list of EMs, including full name (last, first), date of birth and event (if applicable). An organization that chooses to report on combined HMO/POS or HMO/POS/PPO products must include all EMs from all products.

Step 2 Determine the minimum required sample size (MRSS) from Table 1 or Table 2. This becomes the denominator for the measure. Use either Table 1 or Table 2, as appropriate, to determine the MRSS. (Refer to *Determining the required sample size* for instructions.) If the EM is ≤MRSS, proceed to step 4.

Note: *The MRSS can only be the appropriate value from Table 1 or Table 2.*

Step 3 Determine the final sample size (FSS). The FSS includes the MRSS (from step 2) plus an adequate number of additional records to make substitutions. The organization should attempt to oversample only enough to guarantee that the MRSS is met. Keep substitution criteria in mind when making this decision.

The following oversampling rates are acceptable.

- 5 percent
- 10 percent
- 15 percent
- 20 percent

An organization that wants to use oversample rates larger than 20 percent must obtain written approval from NCQA. Refer to *Oversample requests to NCQA* for further details.

The FSS is calculated by the following formula:

$$FSS = MRSS + (MRSS \times \text{oversampling rate})$$

(round *up* to the next whole number), where MRSS = the minimum required sample size (step 2).

For example, if the MRSS is 411 and a 10 percent oversample is needed,

$$FSS = 411 + (411 \times 0.10) = 453.$$

Step 4 If EM >FSS, go to step 5. If EM ≤MRSS, all eligible members are included in the sample. If MRSS <EM ≤FSS, proceed to step 8.

Step 5 Sort the list of EMs in alphabetical order by the last name, first name, date of birth and event (if applicable). An organization that reports on combined products (e.g., HMO/POS or HMO/POS/PPO) must alphabetize the combined EM population from both products.

The organization may sort the list of EMs in reverse alphabetical order (from Z to A) after it obtains written approval from NCQA.

Step 6 Calculate N = EM/FSS. Round *down* to a whole number.

Determine N, which is used in the formula to determine which member will start your sample. N is calculated using the equation:

$$N = EM/FSS$$

where EM = the eligible member population (step 1) and FSS = the final sample size (step 3).

Step 7 Calculate START = (RAND $\times$ N). Before choosing members, determine the member to start with (START). It is important that the sample be selected from a single pass through the member list. START can have many values and still allow only one pass.

In October 2009, NCQA will release a Random Number (RAND) table that lists a value between 0 and 1 for each measure where the Hybrid Method is applicable. Refer to this table to determine the RAND to be used when determining START. The random number for each respective measure should be used to calculate the starting point from which to draw the final sample.

Calculate the number from which to start drawing the final sample as follows:

$$START = (RAND \times N)$$

(round per the .5 rule to the nearest whole number greater than 0), where RAND = the random number for each respective measure identified from Volume 2 *Technical Update,* released in October 2009.

Step 8 Select the sample, choosing every i^{th} member using the formula:

$$i^{th} \text{ member} = START + [(i-1) \times (EM/FSS)]$$

(rounding [(i-1) x (EM/FSS)] per the .5 rule to the nearest whole number greater than 0).

For i = 2,3,4, …, FSS where EM = the eligible member population (step 1). FSS = the final sample size (step 3).

Starting with the member corresponding to the number START, choose every i^{th} member until the MRSS is met. This becomes the primary list of sampled members.

Continue choosing every i^{th} member until the FSS is met. This set of members becomes the auxiliary list of sampled members (i.e., the oversample).

The organization can stop once the FSS is achieved, or use all members in the primary and auxiliary list.

Note: *From step 4, if MRSS <EM ≤FSS, sort the EMs in alphabetical order by the last name, first name, date of birth and event (if applicable). Choose the first MRSS EMs as the primary sample and the remaining EMs as the auxiliary sample.*

If the oversample was calculated correctly, the majority of members in the auxiliary list should ultimately be used to replace exclusions.

The organization must document all exclusions because they may be subject to audit.

Oversample requests to NCQA

Oversample rates larger than 20 percent must be approved annually by NCQA. The organization must submit a formal request with its rationale to NCQA for approval, through the PCS System at www.ncqa.org/pcs, or fax to the attention of HEDIS Policy at 202-955-3599.

NCQA provides the organization with written notification of approval or disapproval within seven business days. The organization must maintain the documentation for the HEDIS Compliance Audit™.

Oversampling methodology

For hybrid measures, the starting sample size should be higher than the designated sample size because medical records must be substituted if a member is ineligible for the measure; for example, if a member was incorrectly identified as a diabetic through administrative data or meets exclusion criteria for the measure.

To adjust for this, divide the sample size by the percentage of charts expected to be inappropriate for review. Suppose 10 percent of charts are expected to be inappropriate for the measure.

FSS (rounded *up* to the next whole number) = 411 + (411 × 0.10) = 452.1 (rounded *up* to 453).

The recommended methodology for carrying out substitution is:

- Replace the member's chart with that of the first member in the auxiliary list
- Continue replacing each ineligible member with the next consecutive member of the auxiliary list.

An organization that underestimates the oversample and exhausts all members from the auxiliary list without satisfying the MRSS must achieve MRSS and select another systematic sample from the remaining alphabetized list of eligible members. The organization should also use its prior year's data and HEDIS results to determine how large an oversample is needed.

Some organizations may calculate rates on their sample and oversample combined. These organizations will have no substitutions because the oversample is included in the denominator. An organization that chooses to use this type of reporting must include the entire oversample, regardless of its numerator compliance.

An organization that reports measures using the oversample and the sample must do so consistently across all measures.

Example 1

The eligible population for the commercial product line for *Cervical Cancer Screening* is 9,000. Reduce the minimum required sample size using the commercial rate from the prior year's HEDIS submission, which was 77 percent. Based on experience, estimate a 5 percent oversample rate. Follow the systematic sampling scheme.

Step 1 EM = 9,000.

Step 2 From Table 2, the MRSS is 296.

Step 3 FSS = 296 + (296 × .05) = 310.8 (the next whole number *above* is 311, so FSS = 311).

Step 4 Since 9,000 > 311, go to step 5.

Step 5 Sort the list alphabetically and in this order: last name, first name and date of birth.

Step 6 N = 9,000/311 = 28.

Step 7 For this example, assume that RAND = 0.66, so START = 0.66 x 28 = 18.48.

- Rounding using the .5 rule, START = 18
- The 18th sorted member is chosen *first*
- The 2nd member chosen is the 18 + [(2-1) x 28.93] = 18 + 29 = 47th sorted member, after rounding the term [(2-1) x 28.93] to 29, using the .5 rule
- The 3rd member chosen is the 18 + [(3-1) x 28.93] = 18 + 58 = 76th sorted member
- The 296th member (the last one in the primary list) is the 18 + [(296-1) x 28.93] = 18 + 8,534 = 8,555th sorted member
- The last member in the auxiliary sample is the 18 + [(311-1) x 28.93] = 18 + 8,968 = 8,986th sorted member

Example 2

The eligible member population for *Cholesterol Screening for Members With Acute Cardiovascular Events* is 389. This measure was not collected last year, nor will the administrative rate from this year be used to reduce the sample size. Follow the systematic sampling scheme.

Step 1 EM = 389.

Step 2 From Table 1, the MRSS is 411. Since 389 <411, skip to step 4.

Step 3 *Skip this step.*

Step 4 Include all 389 members in your primary list.

Example 3

The eligible member population for *Childhood Immunization Status* is 436. The sample size will not be adjusted using this year's administrative rate. Based on experience with this population, about 10 percent of the members from the primary sample will have to be excluded. Follow the systematic sampling scheme.

Step 1 EM = 436.

Step 2 From Table 1, the MRSS is 411.

Step 3 FSS = 411 + (411 $\times$ .10) = 452.1 (the next whole number *above* is 453, so FSS = 453).

Step 4 Since 411 <436, skip to step 6.

Step 5 *Skip this step.*

Step 6 Sort the list and choose the first 411 as the primary list. The remaining 25 members become the auxiliary list.

Complex Probability Sampling

Organization responsibility

Properly applied, other techniques such as stratified sampling, cluster sampling and other complex probability approaches can improve precision and increase sampling efficiency. An organization that uses a probability sampling approach different from the one specified must provide written rationale and documentation of the approach to NCQA, through the PCS System (www.ncqa.org/pcs) or by fax at 202-955-3599, to the attention of HEDIS Policy. The organization must demonstrate that the sampling approach is auditable and that it does not introduce bias against particular members being chosen. A committee of statisticians and health policy experts staffed by NCQA reviews the approach. Written notification of NCQA approval or disapproval is provided within 10 business days.

If complex sampling methods are used, the estimated rate should be reported, in addition to any information required to perform a valid test of significance between that rate and another organization's rate.

The organization should also report the sample size (if different from the HEDIS recommendation) and document the method used in the calculation (including software used, if applicable). The organization should consult a statistician before implementing a complex sampling methodology.

Substituting Medical Records

Acceptable circumstances for substitution:

The organization should specify the number of records it substitutes. The organization may not substitute members who are noncompliant because they refused the service or because the organization is unable to locate their chart. Unless otherwise noted in the specifications for a particular measure, the organization should not drop members from the sample or make substitutions, except under the three circumstances described below.

1. Errors in sampling data

Chart review reveals that a member does not meet the eligibility criteria for inclusion in the sample. Data errors can be due to incorrect member or clinical information. The following are examples of valid data errors.

- A member selected for the *Childhood Immunization Status* sample is found to be 22 years old
- A member in the *Comprehensive Diabetes Care* sample has a diagnosis in the chart that shows a prescription for oral hypoglycemics was not due to diabetes
- A member in the *Cholesterol Management for Patients With Cardiovascular Conditions* sample because of a diagnosis of ischemic vascular disease (IVD) is ruled out by a negative test result
- A member in the sample for any measure has a notation, entered by the deadline established for the measure, explaining the reason for the erroneous inclusion or stating the member does not have the condition

The medical record must have evidence that a member does not meet the criteria for the measure; a chart without any notation either substantiating or refuting the diagnosis is not evidence that the member does not have the condition being measured.

2. *Exclusion to treatment being measured* A member has a valid exclusion to the treatment being measured; for example, a member with a diagnosis of colorectal cancer or total colectomy is a valid exclusion in the denominator for the *Colorectal Cancer Screening* measure.

Valid exclusions are included in the measure specifications. An organization that removes members based on exclusions may do so only for members in the denominator for whom administrative data or medical record data do not show that the service/procedure was rendered within the appropriate period specified. The organization must verify that the exclusion occurred by the deadline established for the measure.

3. *Selecting an employee/ dependent for the sample* An employee of the organization or the vendor, or the employee's dependent, was selected for the sample, and the employee or dependent's medical record must be reviewed to determine compliance with the measure. The organization or vendor may exclude employees and their dependents in this situation *only*.

Hybrid Method: Three Approaches

There are three approaches to conducting the Hybrid Method; they differ only in the timing for identifying individuals in the denominator who have a valid exclusion. The first two approaches allow the organization to first select the sample and then search for valid exclusions. The third allows the organization to search for valid exclusions on the entire eligible population prior to selecting the sample. The organization may use any of the three approaches.

Approach 1

Step 1 Search the administrative systems for numerator events for the sampled members. Starting with the primary list, follow the administrative specification to search administrative systems for numerator events.

Step 2 Search the administrative systems for an exclusion. For members for whom administrative data does not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured, if applicable.

Note: *This step applies only to measures for which optional exclusions are specified and in which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.*

Step 3 From the oversampled population, substitute for the excluded records.

Step 4 Search the medical records for numerator events for the sampled population. Review the medical records of members in the sample for whom a numerator event or exclusion to the service/procedure being measured was not identified using administrative data.

For measures in which more than one service is captured (e.g., four DTaPs are needed to satisfy the DTaP rate for *Childhood Immunization Status*), the organization may combine services identified through administrative and medical record data as long as the dates of service between the administrative and the medical record dates are at least 14 days apart.

Step 5 Search the record for an exclusion to the service/procedure being measured. For members for whom the medical record does not show a positive numerator event, search the record for an exclusion to the service/procedure being measured, if applicable.

Note: *This step applies only to measures for which optional exclusions are specified and in which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.*

Step 6 Remove members with medical-record identified exclusions. Remove from the denominator members for whom the medical record identified an exclusion.

Step 7 From the oversampled population, substitute for the excluded records. Refer to *Substituting Medical Records*.

Step 8 Use either administrative or medical record data to identify the numerator event for additional members used as replacements.

Step 9 Determine the numerator. Include only members in the sample who were identified through either administrative data or medical record review as having had received or experienced the numerator event.

Step 10 Calculate the rate. The organization may calculate a rate using the denominator (MRSS with substitutions) or the denominator plus the entire oversample (FSS), but should be consistent across measures.

Approach 2

Step 1 Search the administrative systems for numerator events for the sampled members. Starting with the primary list, follow the administrative specification to search administrative systems for numerator events.

Step 2 Search the medical records for numerator events for the sampled population. Starting with the primary list, review the medical records of members in the sample for whom a numerator event was not identified using administrative data. For measures in which more than one service is captured (e.g., four DTaPs are needed to satisfy the DTaP rate for *Childhood Immunization Status*), the organization may include services identified through administrative data and medical record review, provided that each date of service is at least 14 days apart.

Step 3 Search for administratively identified and medical record exclusions. For members for whom administrative data or the medical record does not show a positive numerator event, search administrative data or the medical record for an exclusion to the service/procedure being measured, if applicable.

Note: *This step applies only to measures for which optional exclusions are specified and in which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.*

Step 4 Remove members with exclusions identified in administrative data or in the medical record. Remove from the denominator members from step 3 for whom administrative data or the medical record identified an exclusion to the service/procedure being measured.

Step 5 From the oversampled population, substitute for the excluded records. Refer to *Substituting Medical Records*.

Step 6 Use either administrative or medical record data to identify the numerator event for additional members used as replacements.

Step 7 Determine the numerator. Include in the numerator for the measure only, members in the sample who were identified through either administrative data or medical record review as having had received or experienced the numerator event.

Step 8 Calculate the rate. The organization may calculate a rate using the denominator (MRSS with substitutions) or the denominator plus the entire oversample (FSS), but should be consistent across measures.

Approach 3

Step 1 Identify the EM population (members who satisfy all of the denominator criteria).

Step 2 Search the administrative systems for numerator events for the entire EM population. Follow the administrative specifications to search administrative systems for numerator events for the eligible member population identified in step 1.

Step 3 Search for administratively identified exclusions. For members for whom administrative data does not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured, if applicable.

Note: *This step applies only to measures for which optional exclusions are specified and in which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.*

Step 4 Exclude members with administratively identified exclusions. Remove from the eligible population members from step 3 for whom administrative data identified an exclusion to the service/procedure being measured.

Step 5 Determine the FSS, using the guidelines for *Systematic Sampling Methodology*.

Step 6 Search the administrative systems for numerator events for the sampled members. From the members identified as compliant for numerator events from step 2, pull the members included in the FSS.

Step 7 Search the medical records for numerator events for the sampled population. Review the medical records of members in the sample for whom a numerator event or exclusion to the service/procedure being measured was not identified using administrative data.

For measures in which more than one service is captured (e.g., four DTaPs are needed to satisfy the DTaP rate for *Childhood Immunization Status*), the organization may combine services identified through administrative and medical record data, provided that the dates of service are at least 14 days apart.

Step 8 Search for medical record exclusions. For members for whom administrative data or the medical record does not show a positive numerator event, search the medical record for an exclusion to the service/procedure being measured, if applicable.

Note: *This step applies only to measures for which optional exclusions are specified and in which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.*

Step 9 Exclude members with medical record identified exclusions. Remove from the denominator members for whom the medical record identified an exclusion.

Step 10 From the oversampled population, substitute for the excluded records. Refer to *Substituting Medical Records*.

Step 11 Use either administrative or medical record data to identify the numerator event for additional members used as replacements.

Step 12 Determine the numerator. Include in the numerator for the measure only members in the sample who were identified through either administrative data or medical record review as having had received or experienced the numerator event.

Step 13 Calculate the rate. The organization may calculate a rate using the denominator (MRSS with substitutions) or the denominator plus the entire oversample (FSS), but should be consistent across measures.

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Adult BMI Assessment (ABA)

SUMMARY OF CHANGES TO HEDIS 2010

Added CPT codes 99341–99345, 99347–99350 to Table ABA-A.

Added ICD-9-CM Diagnosis codes 678, 679 to Table ABA-C.

Description

The percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.

Definitions

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among those of the same sex and age.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years as of January 1 of the year prior to the measurement year to 74 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 one gap in continuous 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	None.
Benefit	Medical.
Event/diagnosis	Members who had an outpatient visit (Table ABA-A) during the measurement year or the year prior to the measurement year.

Table ABA-A: Codes to Identify Outpatient Visits

CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0344	V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	051x, 0520-0523, 0526-0529, 077x, 0982, 0983

Administrative Specification

Denominator The eligible population.

Numerator BMI (Table ABA-B) during the measurement year or year prior to the measurement year.

Table ABA-B: Codes to Identify BMI

HCPCS	ICD-9-CM Diagnosis
G8417-G8420	V85.0-V85.5

Exclusions *(optional)*

Members who have a diagnosis of pregnancy (Table ABA-C) during the measurement year or the year prior to the measurement year.

Table ABA-C: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Pregnancy	630-679, V22, V23, V28

Hybrid Specification

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

Numerator BMI during the measurement year or year prior to the measurement year as documented through either administrative data or medical record review.

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

Medical record Documentation in the medical record must indicate the date of the BMI and the BMI value.

For members younger than 19 years on the date of service, documentation of BMI percentile also meets criteria:

BMI percentile documented as a value (e.g., 85th percentile)

BMI percentile plotted on an age-growth chart.

Exclusions *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year or the year prior to the measurement year.

Note

The following notations or examples of documentation are considered "negative findings" and do not count as numerator compliant.

No BMI or BMI percentile documented in medical record or plotted on age-growth chart

Notation of height and weight only

BMI or BMI percentile noted before the look-back period or after the measurement year

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ABA-1/2/3: Data Elements for Adult BMI Assessment

	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 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 2010

No changes to this measure.

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.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one 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 code in Table BCS-A.

Table BCS-A: Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
76090-76092, 77055-77057	G0202, G0204, G0206	V76.11, V76.12	87.36, 87.37	0401, 0403

Exclusion *(optional)*

Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through December 31 of the measurement year. Exclude members for whom there is evidence of two unilateral mastectomies. Refer to Table BCS-B for codes to identify exclusions.

Table BCS-B: Codes to Identify Exclusions

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

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

Note

The purpose of this measure is to evaluate primary screening. Do not count biopsies, breast ultrasounds or MRIs for this measure because they are not appropriate methods for primary breast cancer screening.

Data Elements for Reporting

Organizations that submit 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	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO HEDIS 2010

Lowered the upper age limit from 80 to 75 years of age.

Removed double contrast barium enema (DCBE) from the numerator criteria.

Clarified requirements for medical record documentation for the FOBT.

Deleted HCPCS code G0107 from Table COL-A.

Deleted LOINC code 50196-5 from Table COL-A "FOBT" description.

Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product lines	Commercial, Medicare (report each product line separately).
Ages	51–75 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 one 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 colorectal cancer. Appropriate screenings are defined by any one of the following criteria.

- Fecal occult blood test (FOBT) during the measurement year. Regardless of FOBT type, guaiac (gFOBT) or immunochemical (iFOBT), assume that the required number of samples was returned.
- Flexible sigmoidoscopy 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 code 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	G0328, G0394	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	
Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121		45.22, 45.23, 45.25, 45.42, 45.43	

Exclusion *(optional)*

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

Table COL-B: Codes to Identify Exclusions

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

Hybrid Specification

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

Numerator One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria.

- FOBT during the measurement year
- Flexible sigmoidoscopy 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

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

Medical record Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record. If it is unclear whether the documentation is part of the medical history, then the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

If the medical record does not indicate the type of test and there is no indication as to how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.

If the medical record does not indicate the type of test and the number of returned samples is specified, the member would only meet the screening criteria if the number of samples specified is greater than or equal to three samples. If the number of samples is less than three, the member does not meet the screening criteria for inclusion in the numerator.

iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the member meets the screening criteria for inclusion in the numerator regardless of the number of returned samples.

If the medical record indicates that a gFOBT was done, follow the scenarios below.

If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.

If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.

If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.

Do not count *digital rectal exam* as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

Exclusion *(optional)*

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

Data Elements for Reporting

Organizations that submit 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 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	✓	✓

Glaucoma Screening in Older Adults (GSO)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The percentage of Medicare members 65 years and older, without a prior diagnosis of glaucoma or glaucoma suspect, who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.

Eligible Population

Product line	Medicare.
Age	67 years and older 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 one gap in 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 eye exams for glaucoma by an eye care professional (i.e., ophthalmologist, optometrist) during the measurement year or the year prior to the measurement year. A member is considered to have had an eye exam for glaucoma if a submitted claim/encounter contains any code in Table GSO-A.

Table GSO-A: Codes to Identify Glaucoma Screening Eye Exams

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
92002, 92004, 92012, 92014, 92081-92083, 92135, 92140, 99202-99205, 99213-99215, 99242-99245	G0117, G0118, S0620, S0621	V80.1	95.02, 95.03, 95.26

Exclusion *(optional)*

Members who had a prior diagnosis of glaucoma or glaucoma suspect. Look for evidence of glaucoma as far back as possible in the member's history through December 31 of the measurement year. Refer to Table GSO-B for codes to identify exclusions.

Table GSO-B: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Glaucoma suspect	365.0
Glaucoma	365.1-365.9

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table GSO-3: Data Elements for Glaucoma Screening in Older Adults

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

Care for Older Adults (COA)

SUMMARY OF CHANGES TO HEDIS 2010

Added HCPCS G8427, G8428 to Table COA-C.

Clarified that a complete physical functional status assessment is required.

Clarified that a comprehensive pain assessment is required.

Description

The percentage of adults 65 years and older who had each of the following during the measurement year.

- Advance care planning
- Medication review
- Functional status assessment
- Pain screening

Definitions

Medication list	A list of the member's medications in the medical record, which may include prescriptions, over-the-counter (OTC) medications and herbal or supplemental therapies.
Medication review	A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.

Eligible Population

Product line	Medicare SNP.
Ages	66 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	
Advance care planning	Evidence of advance care planning during the measurement year (Table COA-A).

Table COA-A: Codes to Identify Advance Care Planning

Description	CPT Category II	HCPCS
Advance care planning	1157F, 1158F	S0257

Medication review At least one medication review (Table COA-B) conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record (Table COA-C), as documented through administrative data.

The claim/encounter for a member's medication review and medication list must be on the same date of service.

Table COA-B: Codes to Identify Medication Review

Description	CPT	CPT Category II	HCPCS*
Medication review	90862, 99605, 99606	1160F	G8427, G8428

Table COA-C: Code to Identify Medication List

Description	CPT Category II	HCPCS*
Medication list	1159F	G8427, G8428

*The HCPCS codes meet criteria for both medication review and medication list.

Functional status assessment At least one functional status assessment during the measurement year (Table COA-D).

Table COA-D: Codes to Identify Functional Status Assessment

Description	CPT Category II	ICD-9-CM Procedure
Functional status assessment	1170F	
Functional evaluation		93.01

Pain screening At least one pain screening or pain management plan during the measurement year. A member had a pain screening if a submitted claim/encounter contains any code in Table COA-E.

Table COA-E: Codes to Identify Pain Screening

Description	CPT Category II
Pain screening	0521F, 1125F, 1126F

Hybrid Specification

Denominator

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

Numerators

Advance care Planning

Evidence of advance care planning as documented through either administrative data or medical record review.

Administrative

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

Medical record

Advanced care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Evidence of advance care planning must include either:

The presence of an advanced care plan in the medical record, ***or***

Documentation of an advance care planning discussion with the provider *and* the date on which it was discussed. The documentation of discussion must be notated in the measurement year. Notation that the member has previously executed an advance care plan meets criteria.

Examples of advance care plans include:

Advance directives. Directives pertaining to treatment preferences and the designation of a surrogate decision maker in the event that a person should become unable to make medical decisions on their own behalf. (e.g., living will, power of attorney, health care proxy).

Actionable medical orders. Written instructions regarding initiation, continuation, withholding or withdrawal of particular forms of life-sustaining treatment.

Living wills. Legal documents denoting preferences for life-sustaining treatment and end-of-life care.

Surrogate decision maker. A written document designating someone else to make future medical treatment choices.

Examples of an advance care planning discussion include either:

Notation in the medical record of a discussion with a provider or the initiation of a discussion by a provider during the measurement year, ***or***

Oral statements. Conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be noted in the medical record during the measurement year.

Medication Review

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through either administrative data or medical record review.

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

Medical record Documentation must come from the same medical record and must include the following.

- A medication list in the medical record, ***and*** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date on which it was performed
- Notation that the member is not taking any medication and the date on which it was noted

A review of side effects for a single medication at the time of prescription alone is not sufficient.

An outpatient visit is not required to meet criteria.

Functional Status Assessment At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.

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

Medical record Documentation in the medical record must include evidence of a complete physical functional status assessment and the date on which it was performed.

Notations for a complete physical functional status assessment may include the following.

- Functional independence
- Loss of independent performance, Activities of Daily Living (ADL), social activities, or Instrumental Activities of Daily Living (IADL)
- The level of assistance needed to accomplish daily activities
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®
  - ADL list
  - Assessment of Living Skills and Resources (ALSAR)
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
  - Bayer Activities of Daily Living (B-ADL) Scale
  - Barthel Index
  - Extended Activities of Daily Living (EADL) Scale
  - Independent Living Scale (ILS)
  - Katz Index of Independence in Activities of Daily Living
  - Kenny Self-Care Evaluation
  - Klein-Bell Activities of Daily Living Scale
  - Kohlman Evaluation of Living Skills (KELS)
  - Lawton & Brody's IADL scales

Pain Screening At least one pain screening or a pain management plan during the measurement year, as documented through either administrative data or medical record review.

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

Medical record Documentation in the medical record must include evidence of a comprehensive pain screening or a pain management plan and the date on which it was performed. Evidence of a comprehensive pain screening may include the following.

- Notation of a comprehensive pain assessment. Pain assessment associated with an acute event (e.g., toothache, earache, localized pain from trauma) does not meet criteria for a comprehensive pain assessment.
- Results of a screening using a standardized pain screening tool, as in but not limited to:
  - Multidimensional Pain Inventory
  - Faces Pain Scale
  - 0–10 Numeric Rating Scales, verbal or visual
  - Verbal Descriptor Scale
  - Brief Pain Inventory (Short Form)

Evidence of a pain management plan may include the following.

- Notation of no pain intervention and the rationale
- Notation of plan for treatment of pain, which may include use of pain medications, psychological support and patient/family education
- Notation of plan for reassessment of pain, including reassessment time interval

Note

Refer to Appendix 3 for the definition of clinical pharmacist*.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table COA-3: Data Elements for Care for Older Adults

	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 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*

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The percentage of members 40 years of age and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

Definitions

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 captures the first COPD diagnosis.

IESD — Index Episode Start Date. The earliest date of service for any encounter during the Intake Period with any diagnosis of COPD (Table SPR-A).

For an outpatient claim/encounter, the IESD is the date of service.

For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge.

For a transfer or readmission, the IESD is the discharge date of the original admission.

Negative Diagnosis History — A period of 730 days (2 years) prior to the IESD (inclusive), during which the member had no claims/encounters containing any diagnosis of COPD (Table SPR-A). For an *inpatient (acute or nonacute) IESD*, use the date of admission to determine the Negative Diagnosis History.

Eligible Population

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

Ages — 42 years or older as of December 31 of the measurement year.

Continuous enrollment — 730 days (2 years) prior to the IESD through 180 days after the IESD.

Allowable gap — One gap in enrollment of up to 45 days is allowed in each of the 12-month periods prior to the IESD or in the 6-month period after the IESD, for a maximum of two gaps total. 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 — IESD.

Benefit — Medical.

Event/ diagnosis The first COPD diagnosis. Follow the steps below to identify the eligible population for the measure.

Step 1 Identify all members who had any diagnosis of COPD (Table SPR-A) during the Intake Period. If the member had more than one diagnosis of COPD, include only the first one.

Table SPR-A: Codes to Identify COPD

Description	ICD-9-CM Diagnosis
Chronic bronchitis	491
Emphysema	492
COPD	496

Step 2 Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a COPD diagnosis during the 730 days (2 years) prior to the IESD. For an inpatient (acute or nonacute) IESD, use the date of admission to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled in the organization 730 days (2 years) prior to the IESD through 180 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator At least one claim/encounter with any code listed in Table SPR-B for spirometry in the 730 days (2 years) before the IESD to 180 days after the IESD.

Table SPR-B: Codes to Identify Spirometry Testing

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

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SPR-1/2/3: Data Elements for Use of Spirometry Testing in the Assessment and Diagnosis of COPD

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

Pharmacotherapy Management of COPD Exacerbation (PCE)

SUMMARY OF CHANGES TO HEDIS 2010

Clarified in Step 2 that for ED visits resulting in an inpatient stay only the inpatient stay should be included.

Clarified that an ED visit for any diagnosis on or seven days after the Episode Date should be excluded in step 4.

Description

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported.

1. Dispensed a systemic corticosteroid within 14 days of the event
2. Dispensed a bronchodilator within 30 days of the event

Note: *The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.*

Definitions

Intake Period	An 11-month period that begins on January 1 of the measurement year and ends on November 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any acute inpatient discharge or ED claim/encounter during the Intake Period with a principal diagnosis of COPD. *For an acute inpatient claim/encounter,* the Episode Date is the date of discharge. *For an ED claim/encounter,* the Episode Date is the date of service.
Active prescription	A prescription is considered active if the "days supply" indicated on the date the member filled the prescription is the number of days or more between that date and the relevant Episode Date.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	40 years or older as of January 1 of the measurement year.
Continuous enrollment	Episode Date through 30 days after the Episode Date.
Allowable gap	None.
Anchor date	Episode Date.
Benefits	Medical and pharmacy.

Event/ diagnosis A COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.

Follow the steps below to identify the eligible population.

Step 1 Identify all members who during the Intake Period had an acute inpatient discharge or an ED visit with a primary diagnosis of COPD (Table PCE-A). Use Table PCE-B to identify acute inpatient discharges and ED visits.

Table PCE-A: Codes to Identify COPD

Description	ICD-9-CM Diagnosis
Chronic bronchitis	491
Emphysema	492
COPD	496

Table PCE-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Acute inpatient		010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987
ED*	99281-99285	045x, 0981

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

Step 2 Determine all COPD Episode Dates. For each member identified in step 1, identify all acute inpatient discharges and ED visits. Do not include ED visits that result in an inpatient admission.

Step 3 Test for transfers. Exclude Episode Dates on which the member was transferred directly to an acute or nonacute care facility for any diagnosis.

Step 4 Test for readmission and additional ED visits. Exclude Episode Dates for which the member was readmitted to an acute or nonacute care facility for any diagnosis on or within seven days after the Episode Date. Exclude Episode Dates for which the member had an ED visit for any diagnosis on or seven days after the Episode Date.

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

Note: *All Episode Dates that were not excluded should remain in the denominator. The denominator for this measure is based on acute inpatient discharges and ED visits, not members.*

Administrative Specification

Denominator The eligible population.

Numerators

Systemic corticosteroid Dispensed prescription for systemic corticosteroid (Table PCE-C) on or 14 days after the Episode Date. The organization may count systemic corticosteroids that are active on the Episode Date.

Table PCE-C: Systemic Corticosteroids

Description	Prescription			
Glucocorticoids	betamethasone dexamethasone	hydrocortisone methylprednisolone	prednisolone prednisone	triamcinolone

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Bronchodilator Dispensed prescription for a bronchodilator (Table PCE-D) on or 30 days after the Episode Date. The organization may count bronchodilators that are active on the Episode Date.

Table PCE-D: Bronchodilators

Description	Prescription		
Anticholinergic agents	albuterol-ipratropium	ipratropium	tiotropium
Beta 2-agonists	albuterol arformoterol budesonide-formoterol	fluticasone-salmeterol formoterol levalbuterol	metaproterenol pirbuterol salmeterol
Methylxanthines	dyphylline-guaifenesin guaifenesin-theophylline potassium iodide-theophylline	aminophylline dyphylline theophylline	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PCE-1/2/3: Data Elements for Pharmacotherapy Management of COPD Exacerbation

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Exclusions based on direct transfers to another facility*	✓
Exclusions based on readmissions*	✓
Numerator events by administrative data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

*Reporting this additional data element is optional in IDSS.

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

SUMMARY OF CHANGES TO HEDIS 2010

Clarified that a calculated or direct LDL may be used for LDL-C screening and control.

Deleted CPT codes 99261–99263 from Table CMC-C.

Deleted LOINC code 24331-1 from Table CMC-D.

Description

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

LDL-C screening

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 one 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 eligible population in two ways: by event or by diagnosis. The organization must use *both* to identify the eligible population, but a member only needs to be identified in one to be included in the measure. *Event*. Discharged alive for AMI, CABG or PTCA on or between January 1 and November 1 of the year prior to the measurement year. Refer to Table CMC-A for codes to identify AMI, PTCA and CABG. The organization should include AMI and CABG from inpatient claims/encounters only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, ED).

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

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

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

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

At least one acute inpatient claim/encounter (Table CMC-C) with any IVD diagnosis (Table CMC-B)

Table CMC-B: Codes to Identify IVD

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

Table CMC-C: Codes to Identify Visit Type

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

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4

LDL-C Level <100 mg/dL Using automated laboratory data, the member is numerator compliant if the most recent LDL-C level during the measurement year is <100 mg/dL. The member is noncompliant 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.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-I and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. The organization may reduce its sample size using the current year's lowest administrative rate or the prior year's audited, product line-specific results for the two rates. Refer to the *Guidelines for Calculations and Sampling* for information about sampling.

Numerators

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

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

Medical record Documentation in medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result.

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

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.

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

Medical record Documentation in medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result.

The organization may calculate LDL-C levels from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

$$(\text{LDL-C}) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5)$$

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

$$(\text{LDL-C}) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5) - 0.3[\text{lipoprotein (a)}]$$

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

Data Elements for Reporting

Organizations that submit 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 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*

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS 2010

Clarified that member-reported BP readings are not acceptable.

Added CPT codes 90957–90962, 90965, 90966, 90969, 90970 to Table CBP-C "Evidence of ESRD" description.

Added ICD-9-CM Diagnosis codes 678, 679 to Table CBP-C "Pregnancy" description.

Deleted CPT code 90939 from Table CBP-C.

Description

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

Definitions

Adequate control	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	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension 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.
Continuous enrollment	The measurement year.
Allowable gap	No more than one 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 one-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	*Hypertensive.* A member is considered hypertensive if there is at least one outpatient encounter (Table CBP-B) with a diagnosis of hypertension (Table CBP-A) during the first six months of the measurement year.

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. The organization may reduce the sample size using the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

To confirm the diagnosis of hypertension, the organization must find notation of one of the following in the medical record on or before June 30 of the measurement year.

HTN	History of HTN
High BP (HBP)	Hypertensive vascular disease (HVD)
Elevated BP (↑BP)	Hyperpiesia
Borderline HTN	Hyperpiesis
Intermittent 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 HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the *only* notations of hypertension in the medical record.

Identifying the medical record

The organization 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). If the organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

The organization 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 manages the hypertension, the organization may 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 organization may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.

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) manages the member's hypertension after June 30, the organization may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the organization may elect to use this chart for the most recent BP reading. If the member did not have any visits with the specialist prior to June 30 of the measurement year, the organization must go to another medical record to confirm the diagnosis.

Numerator

The number of members in the denominator whose most recent BP is adequately controlled during the measurement year. For a member's BP to be controlled, *both* the systolic and diastolic BP *must be* <140/90 (adequate control). To determine if a member's BP is adequately controlled, the organization 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 on which the diagnosis of hypertension was made or confirmed. Do not include BP readings that meet the following criteria.

BPs taken during an acute inpatient stay or an ED visit

BPs taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)

BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)

BP readings reported by or taken by the member

Step 2 Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

Exclusions *(optional)*

Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (Table CBP-C) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

Exclude from the eligible population all members with a diagnosis of pregnancy (Table CBP-C) during the measurement year.

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 FUH-B for codes to identify nonacute care.

Table CBP-C: Codes to Identify Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS
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, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0308-G0319, G0322, G0323, G0326, G0327, G0392, G0393, 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	72x	65
Pregnancy			630-679, V22, V23, V28				

Note

The organization 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.

Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of hypertension.

Data Elements for Reporting

Organizations that submit 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	✓
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 records excluded because of false-positive diagnoses	✓
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 2010

No changes to this measure.

Description

The percentage of members 18 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 AMI and who received persistent beta-blocker treatment for six months after discharge.

Definition

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

Eligible Population

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

Ages 18 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 one 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 (Table PBH-A) from 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 organization should only include the first discharge.

Table PBH-A: Codes to Identify AMI

Description	ICD-9-CM Diagnosis
AMI	410.x1*

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

Transfers to acute facilities. Include hospitalizations in which the member was transferred directly to another acute inpatient facility for any diagnosis. Count the discharge from the subsequent acute inpatient facility, not the initial discharge. The discharge date from the facility to which the member was transferred must occur on or before 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 dispensed days supply 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 organization should factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.

Table PBH-B: Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	carteolol carvedilol labetalol	nadolol penbutolol pindolol	propranolol timolol sotalol
Cardioselective beta-blockers	acebutolol atenolol	betaxolol bisoprolol	metoprolol nebivolol
Antihypertensive combinations	atenolol-chlorthalidone bendroflumethiazide-nadolol bisoprolol-hydrochlorothiazide		hydrochlorothiazide-metoprolol hydrochlorothiazide-propranolol hydrochlorothiazide-timolol

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Exclusion *(optional)*

Use administrative data to look as far back as possible in the member's history through the end of the continuous enrollment period for evidence of a contraindication to beta-blocker therapy. Refer to Table PBH-C and Table PBH-D for codes and medications representing contraindications to beta-blocker therapy.

Table PBH-C: Codes to Identify Exclusions

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

Table PBH-D: Medications to Identify Exclusions (History of Asthma)

Description	Prescription		
Bronchodilator combinations	budesonide-formoterol	fluticasone-salmeterol	
Inhaled corticosteroids	beclomethasone budesonide flunisolide	fluticasone mometasone triamcinolone	fluticasone CFC free

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Data Elements for Reporting

Organizations that submit 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	✓

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO HEDIS 2010

Clarified that HbA1c control (<7.0%) is only reported for the commercial and Medicaid product lines.

Deleted CPT codes 99261–99263, 99301–99303, 99311–99313, 99321–99323, 99331–99333 from Table CDC-C.

Deleted CPT Category II code 3047F from Tables CDC-D, CDC-E, CDC-F and CDC-Q.

Clarified that a calculated or direct LDL may be used for LDL-C screening and control.

Deleted LOINC code 24331-1 from Table CDC-H.

Deleted LOINC codes 34535-5, 50561-0, 53525-2 from Table CDC-J.

Added CPT codes 90957–90962, 90965, 90966, 90969, 90970 to Table CDC-K "Evidence of treatment for nephropathy" description.

Added LOINC code 53525-2 to Table CDC-K.

Deleted LOINC codes 24356-8, 24357-6, 50556-0, 50564-4 from Table CDC-K.

Deleted CPT code 90939 from Tables CDC-K, CDC-P.

Deleted CPT Category II code 3076F from Table CDC-N.

Clarified that member-reported BP readings are not acceptable.

Added ICD-9-CM Diagnosis code 249 to Table CDC-O "Steroid induced" description.

Added CPT codes 90957–90962, 90965, 90966, 90969, 90970 to Table CDC-P "ESRD" description.

Description

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

Hemoglobin A1c (HbA1c) testing	LDL-C screening
HbA1c poor control (>9.0%)	LDL-C control (<100 mg/dL)
HbA1c control (<8.0%)	Medical attention for nephropathy
HbA1c control (<7.0%) *****	BP control (<130/80 mm Hg)
Eye exam (retinal) performed	BP control (<140/90 mm Hg)

**Additional exclusion criteria are required for this indicator. This indicator is only reported for the commercial and Medicaid product lines.*

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.

Allowable gap No more than one 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 There are two ways to identify members with diabetes: by pharmacy data and by claim/ encounter data. The organization must use both to identify the eligible population, but a member only needs to be identified in one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A).

Table CDC-A: Prescriptions to Identify Members With Diabetes

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

Note: *Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

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

Table CDC-B: Codes to Identify Diabetes

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

Table CDC-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Administrative Specification

Denominator The eligible population.

Required exclusions for the HbA1c Control <7% indicator For the HbA1c control <7% indicator, exclude members who meet any of the following criteria.

65–75 years of age as of December 31 of the measurement year.

CABG or PTCA. Members discharged alive for CABG or PTCA in the measurement year or the year prior to the measurement year. Refer to Table CMC-A and use codes for PTCA and CABG only. CABG cases should be from inpatient claims/encounters only. Include all cases of PTCA, regardless of setting (e.g., inpatient, outpatient, ED).

IVD. Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

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

At least one acute inpatient claim/encounter (Table CMC-C) with an IVD diagnosis (Table CMC-B)

Chronic heart failure (CHF). Members who had at least one encounter, in any setting, with CHF. Refer to Table RCA-A and use codes for CHF only. Look as far back as possible in the member's history through December 31 of the measurement year.

Prior MI. Members who had at least one encounter, in any setting, with any code to identify MI (Table CDC-P). Look as far back as possible in the member's history through December 31 of the measurement year.

Chronic renal failure (CRF)/ESRD. Members who had at least one encounter, in any setting, with any code to identify CRF/ESRD (Table CDC-P). Look as far back as possible in the member's history through December 31 of the measurement year.

Dementia. Members who had at least one encounter, in any setting, with any code to identify dementia (Table DDE-E). Look as far back as possible in the member's history through December 31 of the measurement year.

Blindness. Members who had at least one encounter, in any setting, with any code to identify blindness (Table CDC-P). Look as far back as possible in the member's history through December 31 of the measurement year.

Amputation (lower extremity). Members who had at least one encounter, in any setting, with any code to identify lower extremity amputation (Table CDC-P). Look as far back as possible in the member's history through December 31 of the measurement year.

Table CDC-P: Codes to Identify Required Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS
MI			410, 412				
CRF/ESRD	36145, 36800-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0311-G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339	585.4, 585.5, 585.6, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98	080x, 082x-085x, 088x	72x	65
Blindness			369.0, 369.1, 369.2, 369.4, 369.6, 369.7				
Amputation (lower extremity)	27290, 27295, 27590-27592, 27594, 27596, 27598, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28800, 28805, 28810, 28820, 28825			84.1			

Numerators

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

Table CDC-D: Codes to Identify HbA1c Tests

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6

HbA1c Poor Control >9% Use automated laboratory data to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is >9.0% or is missing a result or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the automated result for the most recent HbA1c test during the measurement year is ≤9.0%.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-E and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Note: *For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).*

Table CDC-E: Codes to Identify HbA1c Levels >9%

Description	CPT Category II
Numerator compliant (HbA1c >9.0%)	3046F
Not numerator compliant (HbA1c ≤9.0%)	3044F, 3045F

HbA1c Control <8% Use automated laboratory data to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is <8.0%. The member is not numerator compliant if the automated result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-Q and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Table CDC-Q: Codes to Identify HbA1c Levels <8%

Description	CPT Category II
Numerator compliant (HbA1c <8.0%)	3044F
Not numerator compliant (HbA1c ≥8.0%)	3045F*, 3046F

*****CPT Category II code 3045F indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization may use other sources (laboratory data, hybrid reporting method) to determine if the HbA1c result was <8%.

HbA1c Control <7% Use automated laboratory data to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is <7.0%. The member is not numerator compliant if the automated result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-F and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Note: *This indicator uses the eligible population with additional eligible population criteria (e.g., removing members with required exclusions).*

Table CDC-F: Codes to Identify HbA1c Levels <7%

Description	CPT Category II
Numerator compliant (HbA1c <7.0%)	3044F
Not numerator compliant (HbA1c ≥7.0%)	3045F, 3046F

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

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

A *negative* retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Refer to Table CDC-G for codes to identify eye exams. For exams performed in the year prior to the measurement year, a result must be available.

Table CDC-G: Codes to Identify Eye Exams*

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

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

** The organization does not need to limit CPT Category II codes or HCPCS S0625 to an optometrist or an ophthalmologist. These codes indicate an eye exam was performed by an eye care professional.

*** CPT Category II code 3072F can only be used if the claim/encounter was during the measurement year because it indicates the member had "no evidence of retinopathy in the prior year." Additionally, because the code definition itself indicates results were negative, an automated result is not required.

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

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

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

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4

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

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-I and use the most recent code during the measurement year to evaluate whether the member is numerator compliant. Use Table CDC-I to determine compliance.

Table CDC-I: Codes to Identify LDL-C Levels

Description	CPT Category II
Numerator compliant (LDL-C <100 mg/dL)	3048F
Not numerator compliant (LDL-C ≥100 mg/dL)	3049F, 3050F

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

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

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

Table CDC-J: Codes to Identify Nephropathy Screening Tests

Description	CPT	CPT Category II	LOINC
Nephropathy screening test	82042, 82043, 82044, 84156	3060F, 3061F	1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13801-6, 14956-7, 14957-5, 14958-3, 14959-1, 13705-9, 14585-4, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8

Evidence of nephropathy

Any of the following meet criteria for evidence of nephropathy.

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

Table CDC-K: Codes to Identify Evidence of Nephropathy

Description	CPT	CPT Category II*	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS	LOINC
Urine macroalbumin test*	81000-81003, 81005	3062F							5804-0, 20454-5, 50561-0, 53525-2
Evidence of treatment for nephropathy	36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	3066F	G0257, G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6	0367, 080x, 082x-085x, 088x	72x	65	
ACE inhibitor/ ARB therapy		4009F							

*A CPT Category II code indicates a positive result for urine macroalbumin; the organization must use automated laboratory data to confirm a positive result for tests identified by CPT or LOINC codes.

Table CDC-L: ACE Inhibitors/ARBs

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

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

BP Control <130/80 mm Hg

Use automated data to identify the most recent BP reading during the measurement year.

The member is numerator compliant if the BP is <130/80 mm Hg. The member is not compliant if the BP is ≥130/80 mm Hg or if there is no automated BP reading during the measurement year. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-M and use the most recent codes during the measurement year to evaluate whether the member is numerator compliant for both systolic and diastolic levels.

Table CDC-M: Codes to Identify Systolic and Diastolic BP Levels <130/80

Description	CPT Category II	
	Systolic	Diastolic
Numerator compliant (BP <130/80 mm Hg)	3074F	3078F
Not numerator compliant (BP ≥130/80 mm Hg)	3075F, 3077F	3079F, 3080F

BP Control <140/90 mm Hg

Use automated data to identify the most recent BP reading during the measurement year. Refer to Table CDC-N and use the most recent code to evaluate whether the member is numerator compliant.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg or if there is no automated BP reading during the measurement year. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in Table CDC-N and use the most recent codes during the measurement year to evaluate whether the member is numerator compliant for both systolic and diastolic levels.

Table CDC-N: Codes to Identify Systolic and Diastolic BP Levels <140/90

Description	CPT Category II	
	Systolic	Diastolic
Numerator compliant (BP <140/90 mm Hg)	3074F, 3075F	3078F, 3079F
Not numerator compliant (BP ≥140/90 mm Hg)	3077F	3080F

Hybrid Specification

Denominator

A systematic sample of 548 drawn from the eligible population for each product line. A sample size of 548 is based on the goal of achieving a sample of at least 411 for the HbA1c <7% denominator after required exclusions.

Members who meet the required exclusion criteria for the HbA1c <7% indicator should not be substituted with members from the oversample. These members will only be excluded when reporting the denominator for the HbA1c <7% indicator. In other words, organizations should report the FSS for the HbA1c <7% indicator as 548 minus the required exclusions.

Required exclusions for HbA1c Good Control <7%

Administrative

Refer to *Administrative Specification* to identify required exclusions from administrative data.

Medical record

Exclude members who meet any of the following criteria.

65–75 years of age as of December 31 of the measurement year.

CABG or PTCA. Dated documentation of CABG or PTCA in the measurement year or the year prior to the measurement year.

IVD. Documentation of an IVD diagnosis. Look as far back as possible in the member's history through December 31 of the measurement year. Appropriate diagnoses include:

IVD

Ischemic heart disease

Angina

Coronary atherosclerosis

Coronary artery occlusion

Cardiovascular disease

Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries)

Atherosclerosis of renal artery

Atherosclerosis of native arteries of the extremities

Chronic total occlusion of artery of the extremities

Arterial embolism and thrombosis

Atheroembolism

CHF. Documentation of CHF diagnosis. Look as far back as possible in the member's history through December 31 of the measurement year.

Prior MI. Documentation of prior MI. Look as far back as possible in the member's history through December 31 of the measurement year.

CRF/ESRD. Documentation of Stage 4 or 5 CRF or ESRD. Look as far back as possible in the member's history through December 31 of the measurement year.

Dementia. Documentation of dementia. Look as far back as possible in the member's history through December 31 of the measurement year.

Blindness. Documentation of blindness in one or both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.

Amputation (lower extremity). Documentation of lower extremity amputation. Look as far back as possible in the member's history through December 31 of the measurement year.

Note: *The organization must search the medical record for required exclusions before it searches for a numerator hit.*

Numerators

HbA1c Testing An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result. The organization may count notation of the following in the medical record.

A1c	Hemoglobin A1c	HgbA1c
HbA1c	Glycohemoglobin A1c	

HbA1c Poor Control >9% The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing or was not done during the measurement year, as documented through automated laboratory data or medical record review.

Note: *For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).*

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result.

HbA1c Control <8% The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.

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

Medical record At a minimum, documentation in medical record must include a note indicating the date on which the HbA1c test was performed and the result.

HbA1c Good Control <7% The *most recent* HbA1c level (performed during the measurement year) is <7.0% as identified by automated laboratory data or medical record review.

Note: *This indicator uses the eligible population with additional eligible population criteria (i.e., removing members with comorbid conditions.)*

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

Medical record At a minimum, documentation in medical record must include a note indicating the date on which the HbA1c test was performed and the result.

Eye Exam An eye screening for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following.

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, ***or***
- A *negative* retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

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

Medical record At a minimum, documentation in the medical record must include one of the following.

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date on which the procedure was performed and the results, ***or***
- A chart or photograph of retinal abnormalities indicating the date on which the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

LDL-C Screening An LDL-C test performed during the measurement year as identified by claim/ encounter or automated laboratory data or medical record review.

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. The organization may use a calculated LDL for LDL-C screening and control indicators.

LDL-C Control <100 mg/dL The *most recent* LDL-C level performed during the measurement year is <100 mg/dL, as documented through automated laboratory data or medical record review.

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

Medical record Documentation in medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result.

The organization 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, use the following calculation.

(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.

Medical Attention for Nephropathy

A nephropathy screening test during the measurement year ***or*** evidence of nephropathy during the measurement year as documented through either administrative data or medical record review.

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

Administrative

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

Medical record

Nephropathy screening test. At a minimum, documentation must include a note indicating the date on which a urine microalbumin test was performed, and the result. Any of the following meet the criteria for a urine microalbumin test.

- 24-hour urine for microalbumin
- Timed urine for microalbumin
- Spot urine for microalbumin
- Urine for microalbumin/creatinine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio

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

- Documentation of a visit to a nephrologist.
- Documentation of medical attention for any of the following (no restriction on provider type).
  - Diabetic nephropathy
  - ESRD
  - CRF
  - Chronic kidney disease (CKD)
  - Renal insufficiency
  - Proteinuria
  - Albuminuria
  - Renal dysfunction
  - Acute renal failure (ARF)
  - Dialysis, hemodialysis or peritoneal dialysis
- A positive urine macroalbumin test. At a minimum, documentation in the medical record must include a note indicating the date on which the test was performed, and a positive result. Any of the following meet the criteria for a positive urine macroalbumin test.
  - Positive urinalysis (random, spot or timed) for protein
  - Positive urine (random, spot or timed) for protein
  - Positive urine dipstick for protein
  - Positive tablet reagent for urine protein
  - Positive result for albuminuria
  - Positive result for macroalbuminuria
  - Positive result for proteinuria
  - Positive result for gross proteinuria

Note: *"Trace" urine macroalbumin test results are not considered numerator compliant.*

Evidence of ACE inhibitor/ARB therapy. Documentation in medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs within the measurement year.

BP Control <130/80 mm Hg The *most recent* BP level (taken during the measurement year) is <130/80 mm Hg, as documented through administrative data or medical record review.

BP Control <140/90 mm Hg The *most recent* BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.

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

Medical record To determine if BP is adequately controlled, the organization must identify the representative BP following the steps below.

Identifying the medical record The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from which the member receives care.

Step 1 Identify the most recent BP reading notated during the measurement year. Do not include BP readings that meet the following criteria.

- BPs taken during an acute inpatient stay or an ED visit
- BPs taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)
- BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)
- BP readings reported by or taken by the member

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. The systolic and diastolic results do not need to be from the same reading.

Exclusions *(optional)*

Members with a diagnosis of polycystic ovaries (Table CDC-O) who did not have any face-to-face encounters with a diagnosis of diabetes (CDC-B), in any setting, during the measurement year or the year prior to the measurement year. Diagnosis can occur at any time in the member's history, but must have occurred by December 31 of the measurement year.

Members with gestational or steroid-induced diabetes (CDC-O) who did not have any face-to-face encounters with a diagnosis of diabetes (CDC-B), in any setting, during the measurement year or the year prior to the measurement year. Diagnosis can occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year.

Table CDC-O: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis

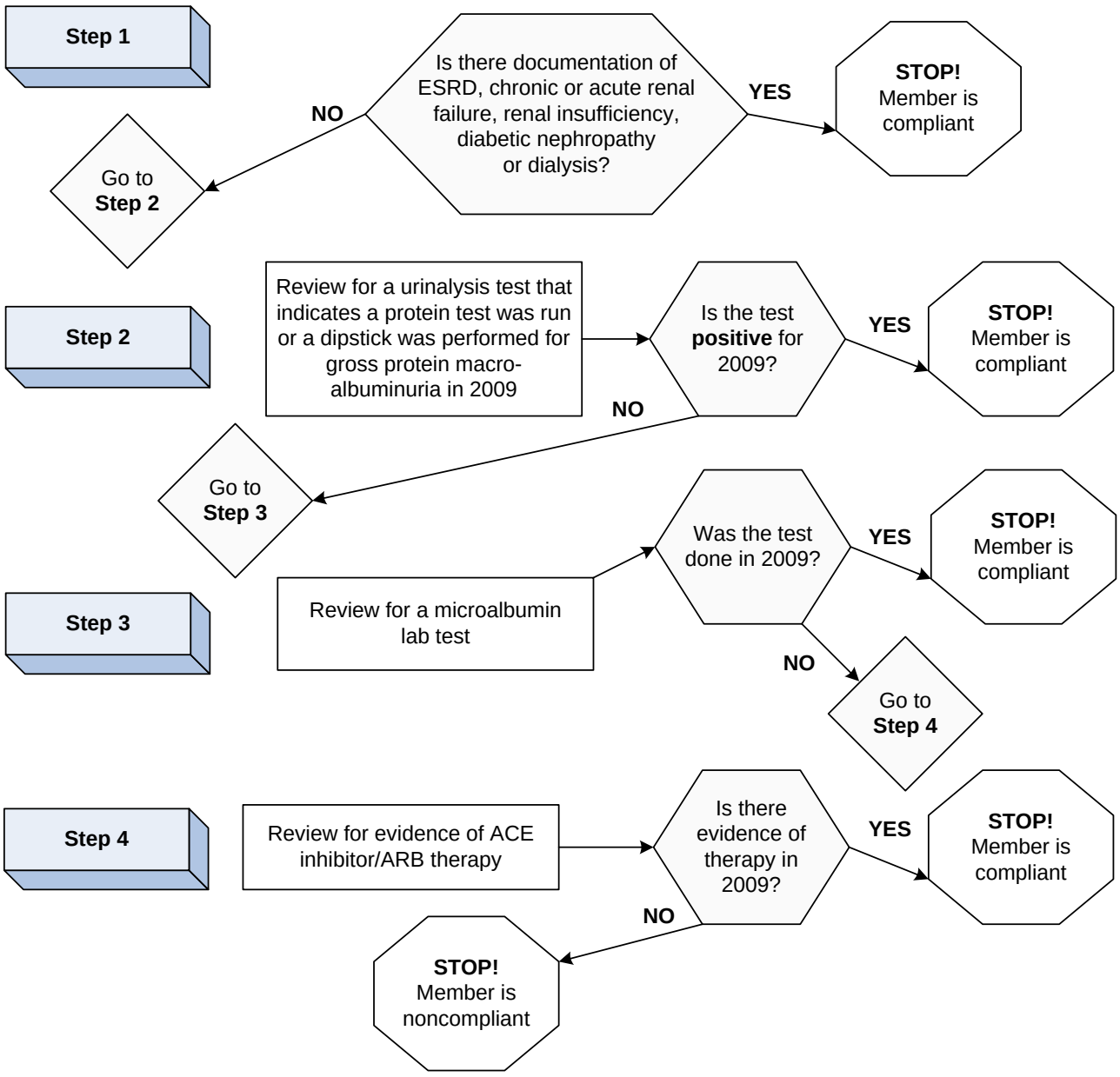
Polycystic ovaries	256.4
Steroid induced	249, 251.8, 962.0
Gestational diabetes	648.8

Note

The organization may select data collection method (Administrative vs. Hybrid) at the indicator level, but the method for screening and control rates must be consistent, as must the methodology for BP control indicators.

Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

Monitoring for Diabetic Nephropathy



Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CDC-1/2/3: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	*Each of the 10 rates*	*Each of the 10 rates*
Data collection methodology (Administrative or Hybrid)	*Each of the 10 rates*	*Each of the 10 rates*
Eligible population	*Each of the 10 rates*	*Each of the 10 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 10 rates*
Current year's administrative rate (before exclusions)		*Each of the 10 rates*
Minimum required sample size (MRSS) or other sample size		*Each of the 10 rates*
Oversampling rate		*Each of the 10 rates*
Final sample size (FSS)		*Each of the 10 rates*
Number of numerator events by administrative data in FSS		*Each of the 10 rates*
Administrative rate on FSS		*Each of the 10 rates*
Number of original sample records excluded because of valid data errors		*Each of the 10 rates*
Number of administrative data records excluded		*Each of the 10 rates*
Number of medical records excluded		*Each of the 10 rates*
Number of employee/dependent medical records excluded		*Each of the 10 rates*
Number of HbA1c <7 required exclusions		*Each of the 10 rates*
Records added from the oversample list		*Each of the 10 rates*
Denominator		*Each of the 10 rates*
Numerator events by administrative data	*Each of the 10 rates*	*Each of the 10 rates*
Numerator events by medical records		*Each of the 10 rates*
Reported rate	*Each of the 10 rates*	*Each of the 10 rates*
Lower 95% confidence interval	*Each of the 10 rates*	*Each of the 10 rates*
Upper 95% confidence interval	*Each of the 10 rates*	*Each of the 10 rates*

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

SUMMARY OF CHANGES TO HEDIS 2010

Deleted CPT codes 99301–99303, 99311–99313, 99321–99323, 99331–99333 from Table ART-B.

Added J codes J2910 "Anti-rheumatics" description and J9310 "Immunomodulators" description.

Added ICD-9-CM Diagnosis codes 678, 679 to Table ART-D "Pregnancy" description.

Description

The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/diagnosis	Two face-to-face physician encounters with different dates of service in an outpatient or nonacute inpatient setting on or between January 1 and November 30 of the measurement year with any diagnosis of rheumatoid arthritis. A diagnosis code from Table ART-A must be in conjunction with a visit type code in Table ART-B.

Table ART-A: Codes to Identify Rheumatoid Arthritis

Description	ICD-9-CM Diagnosis
Rheumatoid arthritis	714.0, 714.1, 714.2, 714.81

Table ART-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x

Administrative Specification

Denominator The eligible population.

Numerator Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year. Table ART-C lists the DMARDs included in this measure.

Table ART-C: DMARDs

Description	Prescription			J Codes
5-Aminosalicylates	sulfasalazine			
Alkylating agents	cyclophosphamide			
Aminoquinolines	hydroxychloroquine			
Anti-rheumatics	auranofin aurothioglucose	gold sodium thiomalate leflunomide	methotrexate penicillamine	J1600, J2910, J9250, J9260
Immunomodulators	abatacept adalimumab anakinra	etanercept golimumab infliximab	rituximab	J0129, J0135, J1438, J1745, J9310
Immunosuppressive agents	azathioprine	cyclosporine		J7502, J7515, J7516
Tetracyclines	minocycline			

Note: NCQA will post a comprehensive list of medications and NDC codes to *www.ncqa.org* by November 16, 2009.

Exclusions *(optional)*

Members diagnosed with HIV. Look for evidence of HIV diagnosis as far back as possible in the member's history through December 31 of the measurement year.

Members who have a diagnosis of pregnancy during the measurement year.

Table ART-D: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
HIV	042, V08
Pregnancy	630-679, V22, V23, V28

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ART-1/2/3: Data Elements for DMARD Therapy for Rheumatoid Arthritis

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

Osteoporosis Management in Women Who Had a Fracture (OMW)

SUMMARY OF CHANGES TO HEDIS 2010

Added ICD-9-CM Diagnosis codes 733.93–733.98 to Table OMW-A.

Deleted HCPCS S2362 from Table OMW-A.

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 the fracture.

Definitions

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 the first fracture.

IESD — Index Episode Start Date. The earliest date of service for any encounter during the Intake Period with a diagnosis of fracture (Table OMW-A).

For an outpatient or ED claim/encounter, the IESD is date of service.

For an inpatient claim/encounter, the IESD is the date of discharge.

For direct transfers, the IESD is the discharge date from the second admission.

Negative Diagnosis History — A period of 60 days prior to the IESD, 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. For direct transfers, use the first admission to determine the 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 IESD through 6 months (180 days) after the IESD.

Allowable gap — No more than one gap in enrollment of up to 45 days during the continuous enrollment period.

Anchor date — IESD.

Benefits — Medical and pharmacy.

Event/ diagnosis — The earliest fracture during the Intake Period.

Follow the steps below to identify the eligible population.

Step 1 Identify all members who had a fracture (Table OMW-A) during the 12-month Intake Period. 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
21800-21825, 22305-22328, 22520, 22521, 22523, 22524, 23500-23515, 23570-23630, 23665-23680, 24500-24587, 24620, 24635, 24650-24685, 25500-25652, 25680, 25685, 26600, 26605, 26607, 26608, 26615, 27193-27248, 27254, 27267-27269, 27500-27514, 27520-27540, 27750-27828, 28400, 28405, 28406, 28415, 28420, 28430, 28435, 28436, 28445, 28450, 28455, 28456, 28465, 28470, 28475, 28476, 28485, 29850, 29851, 29855, 29856	S2360	733.1, 733.93-733.98, 805-806, 807.0-807.4, 808-815, 818-825, 827, 828	79.01-79.03, 79.05-79.07, 79.11-79.13, 79.15-79.17, 79.21-79.23, 79.25-79.27, 79.31-79.33, 79.35-79.37, 79.61- 79.63, 79.65-79.67, 81.65, 81.66

*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 IESD. For fractures requiring an inpatient stay, use the admission date to determine Negative Diagnosis History. For direct transfers, use the first admission to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled during the 12 months prior to the fracture through 6 months (180 days) post-fracture.

Step 4 Exclude members who had a BMD test (Table OMW-B) or who received any osteoporosis treatment (Table OMW-C) during the 365 days prior to the IESD.

For an inpatient claim/encounter, use the admission date to determine the 365 days prior to the IESD.

Administrative Specification

Denominator The eligible population.

Numerator Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria.

A BMD test (Table OMW-B) on the IESD or in the 180-day period after the IESD, ***or***

A BMD test (Table OMW-B) during the inpatient stay for the fracture (applies only to fractures requiring hospitalization), ***or***

A dispensed prescription (Table OMW-C) to treat osteoporosis on the IESD or in the 180-day period after the IESD

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

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
76070, 76071, 76075-76078, 76977, 77078-77083, 78350, 78351	G0130	V82.81	88.98

Table OMW-C: FDA-Approved Osteoporosis Therapies

Description	Prescription			J Codes
Biphosphonates	alendronate alendronate-cholecalciferol calcium carbonate-risedronate	ibandronate risedronate zoledronic acid		J3488
Estrogens	conjugated estrogens conjugated estrogens synthetic esterified estrogens	estradiol estradiol acetate estradiol cypionate	estradiol valerate estropipate ethinyl estradiol	
Miscellaneous hormones	calcitonin	raloxifene	teriparatide	
Sex hormone combinations	conjugated estrogens—medroxy-progesterone estradiol-levonorgestrel	estradiol-norethindrone estradiol-norgestimate ethinyl estradiol-norethindrone		

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Data Elements for Reporting

Organizations that submit 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	✓

Antidepressant Medication Management (AMM)

SUMMARY OF CHANGES TO HEDIS 2010

Clarified Negative Diagnosis History for inpatient claims/encounters and transfers.

Deleted CPT codes 90871, 99261–99263 from Table AMM-B.

Description

The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

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

IESD — Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression (Table AMM-A) that meets the following criteria.

A 120-day Negative Diagnosis History

A 90-day Negative Medication History

For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge.

For a direct transfer, the IESD is the discharge date from the facility to which the member was transferred.

Negative Diagnosis History — A period of 120 days (4 months) prior to the IESD, during which time the member had no claims/encounters with any diagnosis of major depression (Table AMM-A) or prior episodes of depression (Table AMM-C).

For an inpatient (acute or nonacute) claim/encounter, use the date of admission to determine Negative Diagnosis History.

For direct transfers, use the first admission to determine Negative Diagnosis History.

IPSD — Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).

Negative Medication History — A period of 90 days (3 months) prior to the IPSD, during which time the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication (Table AMM-D).

Treatment days The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Eligible Population

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

Ages 18 years and older as of April 30 of the measurement year.

Continuous enrollment 120 days prior to the IESD through 245 days after the IESD.

Allowable gap One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date IESD.

Benefits Medical, pharmacy and mental health (inpatient and outpatient).

Event/diagnosis The organization should follow the steps below to identify the eligible population, which should be used for both rates.

Step 1 Identify all members who met at least one of the following criteria during the Intake Period.

- At least one principal diagnosis of major depression (Table AMM-A) in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B), ***or***
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B) on different dates of service with any diagnosis of major depression (Table AMM-A), ***or***
- At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table AMM-A)

Table AMM-A: Codes to Identify Major Depression

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

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

Table AMM-B: Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 077x, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

CPT		POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

Step 2 Determine the IESD. For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/encounter for any diagnosis of major depression (Table AMM-A) or prior episodes of depression (Table AMM-C) during the 120 days prior to the IESD.

Table AMM-C: Additional Codes to Identify Depression

Description	ICD-9-CM Diagnosis
Depression	296.26, 296.36, 296.4-296.9, 309.0, 309.28

Step 4 Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Table AMM-D) during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period.

Step 5 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD.

***Step* 6** Calculate continuous enrollment. Members must be continuously enrolled for 120 days prior to the IESD to 245 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerators

Effective Acute Phase Treatment At least 84 days (12-weeks) of continuous treatment with antidepressant medication (Table AMM-D) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period.

Allowable medication changes or gaps include:

Washout period gaps to change medication

Treatment gaps to refill the same medication

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

Table AMM-D: Antidepressant Medications

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

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Effective Continuation Phase Treatment At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period.

Allowable medication changes or gaps include the following.

Washout period gaps to change medication

Treatment gaps to refill the same medication

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

Note

Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame specified (e.g., during the Intake Period).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AMM-1/2/3: Data Elements for Antidepressant Medication Management

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS 2010

Deleted CPT codes 90871, 99261–99263 from Table FUH-C.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

1. The percentage of members who received follow-up within 30 days of discharge
2. The percentage of members who received follow-up within 7 days of discharge

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/ diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Table FUH-A) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

Table FUH-A: Codes to Identify Mental Health Diagnosis

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

Mental health readmission or direct transfer

If the discharge is followed by readmission or direct transfer to an *acute facility* for any mental health principal diagnosis (Tables MPT-A, MPT-B) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

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

Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for any mental health principal diagnosis (Tables MPT-A, MPT-B) within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify nonacute care.

Non-mental health readmission or direct transfer

Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes any ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Table FUH-B: Codes to Identify Nonacute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Table FUH-C: Codes to Identify Visits

CPT	HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53

UB Revenue
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes.
0513, 0900-0905, 0907, 0911-0917, 0919
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with any diagnosis code from Table FUH-A.
0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983

Note

Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame required for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

Refer to Appendix 3 for the definition of mental health practitioner.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

Annual Monitoring for Patients on Persistent Medications (MPM)

SUMMARY OF CHANGES TO HEDIS 2010

Clarified numerator criteria for Rates 1–3.

Clarified codes that identified a lab panel in Table MPM-A.

Deleted LOINC codes 24320-4, 24321-2, 24326-1, 24322-0, 24323-8, 24362-6, 34554-6, 34555-3, 45064-3, 45065-0, 45066-8, 50261-7 from Table MPM-A.

Deleted LOINC codes 34540-5, 34545-4 from Table MPM-E.

Description

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate.

Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)

Annual monitoring for members on digoxin

Annual monitoring for members on diuretics

Annual monitoring for members on anticonvulsants

Total rate (the sum of the four numerators divided by the sum of the four denominators)

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one 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.

Benefits Medical and pharmacy.

Event/ diagnosis Members on persistent medications—defined as members who received at least 180 treatment days of ambulatory medication in the measurement year. Refer to *Additional Eligible Population Criteria* for each rate.

Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 31 treatment days).

Administrative Specification

For each product line, report each of the four rates separately and as a combined rate. The total rate is the sum of the four numerators divided by the sum of the four denominators.

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

Additional eligible population criteria Members who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year. Refer to Table CDC-L to identify ACE inhibitors and ARBs.

Note: *Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).*

Numerator At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table MPM-A). The member must meet one of the following criteria to be compliant.

- A code for a *lab panel* test during the measurement year
- A code for a serum potassium ***and*** a code for serum creatinine during the measurement year
- A code for serum potassium ***and*** a code for blood urea nitrogen during the measurement year

Note: *The tests do not need to occur on the same service date, only within the measurement year.*

Table MPM-A: Codes to Identify Physiologic Monitoring Tests

Description	CPT	LOINC
Lab panel	80047, 80048, 80050, 80053, 80069	
Serum potassium (K+)	80051, 84132	2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 29349-8, 32713-0, 34548-8, 39789-3, 39790-1, 41656-0, 51618-7
Serum creatinine (SCr)	82565, 82575	2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 26752-6, 31045-8, 33558-8, 35203-9, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4, 39955-0, 39956-8, 39957-6, 39958-4, 39959-2, 39960-0, 39961-8, 39962-6, 39963-4, 39964-2, 39965-9, 39966-7, 39967-5, 39968-3, 39969-1, 39970-9, 39971-7, 39972-5, 39973-3, 39974-1, 39975-8, 39976-6, 40112-5, 40113-3, 40114-1, 40115-8, 40116-6, 40117-4, 40118-2, 40119-0, 40120-8, 40121-6, 40122-4, 40123-2, 40124-0, 40125-7, 40126-5, 40127-3, 40128-1, 40248-7, 40249-5, 40250-3, 40251-1, 40252-9, 40253-7, 40254-5, 40255-2, 40256-0, 40257-8, 40258-6, 40264-4, 40265-1, 40266-9, 40267-7, 40268-5, 40269-3, 40270-1, 40271-9, 40272-7, 40273-5, 44784-7, 50380-5, 50381-3, 51619-5, 51620-3
Blood urea nitrogen (BUN)	84520, 84525	3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 44734-2, 49071-4

Rate 2: Annual Monitoring for Members on Digoxin

Additional eligible population criteria

Members who received at least 180 treatment days of digoxin (Table MPM-B) during the measurement year.

Table MPM-B: Drugs to Identify Members on Digoxin

Description	Prescription
Inotropic agents	• digoxin

Numerator

At least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table MPM-A). The member must meet one of the following criteria to be compliant.

A code for a *lab panel* test during the measurement year

A code for a serum potassium ***and*** a code for serum creatinine during the measurement year

A code for serum potassium ***and*** a code for blood urea nitrogen during the measurement year

Note: *The two tests do not need to occur on the same service date, only within the measurement year.*

Rate 3: Annual Monitoring for Members on Diuretics

Additional eligible population criteria

Members who received at least 180 treatment days of a diuretic (Table MPM-C), during the measurement year.

Note: *Members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days supply for those medications count toward the total 180 treatment days.*

Table MPM-C: Drugs to Identify Members on Diuretics

Description	Prescription		
Antihypertensive combinations	aliskiren-hydrochlorothiazide amiloride-hydrochlorothiazide amlodipine-hydrochlorothiazide-valsartan atenolol-chlorthalidone benazepril-hydrochlorothiazide bendroflumethiazide-nadolol bisoprolol-hydrochlorothiazide candesartan-hydrochlorothiazide captopril-hydrochlorothiazide chlorthalidone-clonidine enalapril-hydrochlorothiazide eprosartan-hydrochlorothiazide fosinopril-hydrochlorothiazide hydrochlorothiazide-irbesartan	hydrochlorothiazide-lisinopril hydrochlorothiazide-losartan hydrochlorothiazide-methyldopa hydrochlorothiazide-metoprolol hydrochlorothiazide-moexipril hydrochlorothiazide-olmesartan hydrochlorothiazide-propranolol hydrochlorothiazide-quinapril hydrochlorothiazide-spironolactone hydrochlorothiazide-telmisartan hydrochlorothiazide-timolol hydrochlorothiazide-triamterene hydrochlorothiazide-valsartan polythiazide-prazosin	
Loop diuretics	bumetanide ethacrynic acid	furosemide torsemide	
Potassium-sparing diuretics	amiloride eplerenone	spironolactone triamterene	
Thiazide diuretics	bendroflumethiazide chlorothiazide chlorthalidone hydrochlorothiazide	hydroflumethiazide indapamide methyclothiazide metolazone	polythiazide trichlormethiazide

Numerator

At least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table MPM-A). The member must meet one of the following criteria to be compliant.

A code for a *lab panel* test during the measurement year

A code for a serum potassium ***and*** a code for serum creatinine during the measurement year

A code for serum potassium ***and*** a code for blood urea nitrogen during the measurement year

Note: *The two tests do not need to occur on the same service date, only within the measurement year.*

Rate 4: Annual Monitoring for Members on Anticonvulsants

Additional eligible population criteria

Members who received at least 180 treatment days for an anticonvulsant (Table MPM-D) during the measurement year.

Note: *Members who are on multiple anticonvulsant drugs count toward the denominator multiple times if they meet the persistent medications criteria for each drug taken during the measurement year (i.e., a member who received at least 180 days of phenytoin and 180 days of valproic acid is counted twice in the denominator for Rate 4, once for each drug).*

Table MPM-D: Drugs to Identify Members on Anticonvulsants

Description	Drugs
Barbiturate anticonvulsants	phenobarbital
Dibenzazepine anticonvulsants	carbamazepine
Hydantoin anticonvulsants	phenytoin
Miscellaneous anticonvulsants	divalproex sodium valproic acid

Numerator

At least one drug serum concentration level monitoring test for the prescribed drug in the measurement year (Table MPM-E).

If a member received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication (i.e., a member on phenytoin received a drug serum test for phenytoin).

If a member persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a member on both phenytoin and valproic acid with at least 180 treatment days for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug [Table MPM-E] to be considered numerator-compliant for each drug).

Table MPM-E: Codes to Identify Drug Serum Concentration Monitoring Tests

Description	CPT	LOINC
Drug serum concentration for phenobarbital	80184	3948-7, 3951-1, 10547-8, 14874-2, 34365-7
Drug serum concentration for phenytoin	80185, 80186	3968-5, 3969-3, 14877-5, 32109-1, 40460-8
Drug serum concentration for valproic acid or divalproex sodium	80164	4086-5, 4087-3, 4088-1, 14946-8, 18489-5, 21590-5, 32119-0, 32283-4
Drug serum concentration for carbamazepine	80156, 80157	3432-2, 3433-0, 9415-1, 14056-6, 14639-9, 18270-9, 29147-6, 29148-4, 32058-0, 32852-6, 47097-1

Exclusion *(optional)*

Members from each eligible population rate who had an inpatient (acute or nonacute) claim/encounter during the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table MPM-1/2/3: Data Elements for Annual Monitoring for Patients on Persistent Medications

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each of the 4 rates and total*
Numerator events by administrative data	*For each of the 4 rates and total*
Reported rate	*For each of the 4 rates and total*
Lower 95% confidence interval	*For each of the 4 rates and total*
Upper 95% confidence interval	*For each of the 4 rates and total*

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

SUMMARY OF CHANGES TO HEDIS 2010

Added CPT codes 90960–90962, 90966, 90970 to Table DDE-H "Chronic renal failure" description.

Deleted CPT code 90939 from Table DDE-H.

Description

The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication, concurrent with or after the diagnosis.

Report each of the three rates separately and as a total rate.

A history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents

Dementia and a prescription for tricyclic antidepressants or anticholinergic agents

CRF and prescription for nonaspirin NSAIDs or Cox-2 Selective NSAIDs

Total rate (the sum of the three numerators divided by the sum of the three denominators)

Members with more than one disease or condition can appear in the measure multiple times (i.e., in each indicator for which they qualify). For all three rates, a lower rate represents better performance.

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Definitions

IESD Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For an outpatient claim/encounter, the IESD is the date of service.

For an inpatient claim/encounter, the IESD is the discharge date.

For dispensed prescriptions, the IESD is the dispense date.

Eligible Population

Product line	Medicare.
Age	67 years and older 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 one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	Enrolled as of December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	Members with at least one disease or condition or procedure in the measurement year or the year prior to the measurement year. Refer to *Additional Eligible Population Criteria* for each rate.

Administrative Specification

Report each rate separately and as a combined rate. The total rate is the sum of the three numerators divided by the sum of the three denominators.

Rate 1: Drug-Disease Interactions—History of Falls and Tricyclic Antidepressants, Antipsychotics or Sleep Agents

Additional eligible population criteria

An accidental fall or hip fracture on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Follow the steps below to identify the eligible population.

Step 1 Identify members who had an accidental fall or hip fracture (Table DDE-A) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the IESD for each member.

Table DDE-A: Codes to Identify Falls or Hip Fractures

Description	CPT	ICD-9-CM Diagnosis
Falls		E880, E884, E885.9, E887, E888
Hip fracture*	27230, 27232, 27235, 27236, 27238, 27240, 27244-27246, 27248, 27254, 27267-27269, 27767-27769	820, V54.13

*Hip fracture may be used as a proxy for identifying falls.

Step 2 Exclude members with a diagnosis of psychosis (Table DDE-B) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Table DDE-B: Codes to Identify Psychosis

Description	ICD-9-CM Diagnosis
Dementias (with delirium or delusions)	290.11, 290.12, 290.20, 290.3, 290.41, 290.42, 290.8, 290.9
Transient mental disorders due to conditions classified elsewhere	293
Dementia in conditions classified elsewhere with behavioral disturbance	294.11
Schizophrenic disorders	295
Episodic mood disorders with psychotic behavior	296.x4
Delusional disorders	297
Other nonorganic psychoses	298

Numerator Dispensed an ambulatory prescription for a tricyclic antidepressant (Table DDE-C) or an antipsychotic or sleep agent (Table DDE-D) on or between the IESD and December 31 of the measurement year.

Table DDE-C: Tricyclic Antidepressants

Description	Prescription		
Psychotherapeutic combinations	amitriptyline-chlordiazepoxide	amitriptyline-perphenazine	
Tricyclic antidepressants	amitriptyline amoxapine clomipramine	desipramine doxepin imipramine	nortriptyline protriptyline trimipramine

Table DDE-D: Antipsychotics and Sleep Agents

Description	Prescription			
Miscellaneous antipsychotic agents	aripiprazole clozapine haloperidol	loxapine molindone olanzapine	paliperidone pimozide quetiapine	risperidone ziprasidone
Miscellaneous anxiolytics, sedatives and hypnotics	eszopiclone ramelteon	zaleplon zolpidem		
Phenothiazine antipsychotics	prochlorperazine chlorpromazine	fluphenazine mesoridazine	perphenazine thioridazine	trifluoperazine
Psychotherapeutic combinations	fluoxetine-olanzapine			
Thioxanthenes	thiothixene			

Rate 2: Drug-Disease Interactions—Dementia and Tricyclic Antidepressants or Anticholinergic Agents

Additional eligible population criteria

A diagnosis of dementia (Table DDE-E) or a dispensed dementia medication (Table DDE-F) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the IESD for each member.

Table DDE-E: Codes to Identify Dementia

ICD-9-CM Diagnosis
290, 291.2, 292.82, 294.0, 294.1, 294.8, 331.0, 331.1, 331.82

Table DDE-F: Medications for Dementia

Description	Prescription	
Cholinesterase inhibitors	donepezil galantamine	rivastigmine tacrine
Miscellaneous central nervous system agents	memantine	

Numerator

Dispensed an ambulatory prescription for a tricyclic antidepressant (Table DDE-C), or anticholinergic agent (Table DDE-G) on or between the IESD and December 31 of the measurement year.

Table DDE-G: Anticholinergic Agents

Description	Prescription			
Anticholinergic antiemetics	cyclizine dimenhydrinate	meclizine scopolamine	trimethobenzamide	
Anticholinergic anti-Parkinson agents	benztropine	trihexyphenidyl		
Anticholinergics/ antispasmodics	belladonna	dicyclomine	hyoscyamine	propantheline
Antihistamines	azatadine brompheniramine chlorpheniramine	clemastine cyproheptadine dexchlorpheniramine	diphenhydramine hydroxyzine hydrochloride hydroxyzine pamoate	triprolidine
Phenothiazine antiemetics	prochlorperazine	promethazine		
Skeletal muscle relaxants	carisoprodol chlorzoxazone	cyclobenzaprine metaxalone	methocarbamo orphenadrine	
Upper respiratory combinations	APAP/diphenhydramine/pseudoephedrine atropine/CPM/hyoscyamine/PSE/scopolamine brompheniramine/carbetapentane/ phenylephrine brompheniramine/dextromethorphphenylephrine brompheniramine/dextromethorphan/PSE brompheniramine/DM/guaifenesin/ phenylephrine brompheniramine/DM/guaifenesin/PSE brompheniramine/DM/phenylephrine brompheniramine/hydrocodone/phenylephrine brompheniramine/hydrocodone/pseudo-ephedrine brompheniramine-phenylephrine brompheniramine-pseudoephedrine carbetapentane/chlorpheniramine/ phenylephrine carbetapentane/CPM/ephedrine/phenylephrine carbetapentane/diphenhydramine/ phenylephrine carbetapentane-chlorpheniramine	carbetapentane-diphenhydramine chlorpheniramine/codeine/PE/K iodide chlorpheniramine/codeine/pseudoephedrine chlorpheniramine/dextromethorp/phenylephrine chlorpheniramine/dextromethorphan/PSE chlorpheniramine/dihydrocodeine/phenylephrine chlorpheniramine/dihydrocodeine/PSE chlorpheniramine/DM/guaifenesin/ phenylephrine chlorpheniramine/DM/methscopolamine chlorpheniramine/DM/phenylephrine chlorpheniramine/guaifenesin/phenylephrine chlorpheniramine/hydrocodone/phenylephrine chlorpheniramine/hydrocodone/PSE chlorpheniramine/methscopolamine/PE chlorpheniramine/methscopolamine/PSE chlorpheniramine/PE/phenyltoloxamine chlorpheniramine/phenylephrine/pyrilamine chlorpheniramine-hydrocodone chlorpheniramine-methscopolamine	chlorpheniramine-phenylephrine chlorpheniramine-pseudoephedrine codeine/phenylephrine/promethazine codeine/pseudoephedrine/triprolidine codeine-promethazine dexchlorpheniramine/dextrometho/PE/pyrilamine dexchlorpheniramine/dextromethorphan/PE dexchlorpheniramine/dextromethorphan/PSE dexchlorpheniramine/hydrocodone/phenylephrine dexchlorpheniramine/methscopolamine/PE dexchlorpheniramine/methscopolamine/PSE dexchlorpheniramine-pseudoephedrine dextromethorphan/diphenhydramine/PE dextromethorphan-promethazine diphenhydramine/hydrocodone/phenylephrine diphenhydramine-phenylephrine hydrocodone/pseudoephedrine/triprolidine phenylephrine-promethazine pseudoephedrine-triprolidine
Urinary antispasmodics	butabarbital/hyoscyamine/phenazopyridine flavoxate	hyoscyamine/methenam/m-blue/phenyl salicyl oxybutynin	tolterodine	

Rate 3: Drug-Disease Interactions—CRF and Nonaspirin NSAIDs or Cox-2 Selective NSAIDs

Additional eligible population criteria

A diagnosis of CRF (Table DDE-H) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the IESD for each member.

Table DDE-H: Codes to Identify CRF

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS
Chronic renal failure	36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90921, 90925, 90935, 90937, 90940, 90945, 90947, 90960-90962, 90966, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0317-G0319, G0323, G0327, G0392, G0393, 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	72x	65

Numerator

Dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID (Table DDE-I) on or between the IESD and December 31 of the measurement year.

Table DDE-I: NSAIDs and Cox-2 Selective NSAIDs

Description	Prescription			
Cox-2 inhibitors	celecoxib			
Nonsteroidal anti-inflammatory agents	diclofenac potassium diclofenac sodium etodolac fenoprofen flurbiprofen	ibuprofen indomethacin ketoprofen ketorolac meclofenamate	mefenamic acid meloxicam nabumetone naproxen naproxen sodium	oxaprozin piroxicam sulindac tolmetin

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table DDE-3: Data Elements for Potentially Harmful Drug-Disease Interactions in the Elderly

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each of the 3 rates and total*
Numerator events by administrative data	*For each of the 3 rates and total*
Reported rate	*For each of the 3 rates and total*
Lower 95% confidence interval	*For each of the 3 rates and total*
Upper 95% confidence interval	*For each of the 3 rates and total*

Use of High-Risk Medications in the Elderly (DAE)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The percentage of Medicare members 65 years of age and older who received at least one high risk medication

The percentage of Medicare members 65 years of age and older who received at least two different high risk medications

For both rates, a lower rate represents better performance.

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 16, 2009.*

Eligible Population

Product line	Medicare.
Age	65 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	Enrolled as of December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator 1	At least one prescription dispensed for any high-risk medication (Table DAE-A) during the measurement year.
Numerator 2	At least two prescriptions dispensed for different high risk medications (Table DAE-A) during the measurement year. ***Note:*** *Identify different drugs using the Drug ID field located in the NDC list on NCQA's Web site (www.ncqa.org).*

Table DAE-A: High-Risk Medications

Description	Prescription
Antianxiety (includes combination drugs)	aspirin-meprobamate meprobamate
Antiemetics	scopolamine trimethobenzamide
Analgesics (includes combination drugs)	• acetaminophen-diphenhydramine • diphenhydramine-magnesium salicylate ketorolac
Antihistamines (includes combination drugs)	• APAP/dextromethorphan/diphenhydramine • APAP/diphenhydramine/phenylephrine • APAP/diphenhydramine/pseudoephedrine • acetaminophen-diphenhydramine atropine/CPM/hyoscyamine/PE/PPA/scopolamine carbetapentane/diphenhydramine/phenylephrine codeine/phenylephrine/promethazine codeine-promethazine cyproheptadine dexchlorpheniramine dexchlorpheniramine/dextromethorphan/PSE • dexchlorpheniramine/guaifenesin/PSE dexchlorpheniramine/hydrocodone/phenylephrine dexchlorpheniramine/methscopolamine/PSE • dexchlorpheniramine-pseudoephedrine dextromethorphan-promethazine diphenhydramine diphenhydramine/hydrocodone/phenylephrine • diphenhydramine-magnesium salicylate diphenhydramine-phenylephrine diphenhydramine-pseudoephedrine hydroxyzine hydrochloride hydroxyzine pamoate phenylephrine-promethazine promethazine tripelennamine
Antipsychotic, typical	mesoridazine thioridazine
Amphetamines	amphetamine-dextroamphetamine benzphetamine dextroamphetamine diethylpropion methamphetamine methylphenidate pemoline phendimetrazine phentermine dexmethylphenidate
Barbiturates	amobarbital butabarbital mephobarbital pentobarbital phenobarbital secobarbital
Long-acting benzodiazepines (includes combination drugs)	amitriptyline-chlordiazepoxide chlordiazepoxide chlordiazepoxide-clidinium diazepam flurazepam
Calcium channel blockers	nifedipine—short-acting only
Gastrointestinal anti-spasmodics	dicyclomine propantheline
Belladonna alkaloids (includes combination drugs)	atropine atropine/CPM/hyoscyamine/PE/scopolamine atropine/hyoscyamine/PB/scopolamine atropine-difenoxin atropine-diphenoxylate atropine-edrophonium belladonna belladonna/caffeine/ergotamine/pentobarbital belladonna/ergotamine/phenobarbital butabarbital/hyoscyamine/phenazopyridine digestive enzymes/hyoscyamine/ phenyltoloxamine hyoscyamine hyoscyamine/methenam/m-blue/phenyl salicyl hyoscyamine-phenobarbital
Skeletal muscle relaxants (includes combination drugs)	ASA/caffeine/orphenadrine ASA/carisoprodol/codeine aspirin-carisoprodol aspirin-meprobamate aspirin-methocarbamol carisoprodol chlorzoxazone cyclobenzaprine metaxalone methocarbamol orphenadrine
Oral estrogens (includes combination drugs)	conjugated estrogen conjugated estrogen-medroxyprogesterone esterified estrogen esterified estrogen-methyltestosterone estropipate

Table DAE-A: High-Risk Medications *(continued)*

Description	Prescription	
Oral hypoglycemics	chlorpropamide	
Narcotics (includes combination drugs)	ASA/caffeine/propoxyphene acetaminophen-pentazocine acetaminophen-propoxyphene belladonna-opium meperidine	meperidine-promethazine naloxone-pentazocine pentazocine propoxyphene hydrochloride propoxyphene napsylate
Vasodilators	cyclandelate dipyridamole—short-acting only	ergot mesyloid isoxsuprine
Others (including androgens and anabolic steroids, thyroid drugs, urinary anti-infectives)	methyltestosterone nitrofurantoin nitrofurantoin macrocrystals	nitrofurantoin macrocrystals-monohydrate thyroid desiccated

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table DAE-3: Data Elements for Use of High-Risk Medications in the Elderly

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*For each of the 2 rates*
Reported rate	*For each of the 2 rates*
Lower 95% confidence interval	*For each of the 2 rates*
Upper 95% confidence interval	*For each of the 2 rates*

Medication Reconciliation Post-Discharge (MRP)

SUMMARY OF CHANGES TO HEDIS 2010

Added definition of "medication reconciliation."

Clarified medical record documentation for evidence of medication reconciliation.

Description

The percentage of discharges from January 1–December 1 of the measurement year for members 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.

Definition

Medication reconciliation	A type of review in which the discharge medications are reconciled with the current medication list in the outpatient medical record.

Eligible Population

Product line	Medicare SNP.
Ages	66 years and older as of December 31 of the measurement year.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	Date of discharge.
Benefit	Medical.
Event/diagnosis	An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have one or more discharges on or between January 1 and December 1 of the measurement year.
Readmission or direct transfer	If the discharge is followed by a readmission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator Medication reconciliation (Table MRP-A) conducted by a prescribing practitioner or clinical pharmacists on or within 30 days of discharge. A member had a medication reconciliation if a claim/encounter contains a code in Table MRP-A.

Table MRP-A: Codes to Identify Medication Reconciliation

Description	CPT Category II
Medication reconciliation	1111F

Hybrid Specification

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

The denominator is based on episodes, not members. Members may appear more than once in the sample.

Numerator Medication reconciliation conducted by a prescribing practitioner or clinical pharmacist, as documented through either administrative data or medical record review on or within 30 days of discharge.

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

Medical record Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria.

Notation that the medications prescribed or ordered upon discharge were reviewed, ***or***

Notation that no medications were prescribed or ordered upon discharge

Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required. A medication list in a discharge summary obtained from the hospital or inpatient chart should not be used as evidence of medication reconciliation, but the intent of the measure is met if the discharge summary is in the outpatient chart.

Note

The denominator is based on the discharge date found in administrative/claims data. This date must be used, regardless of subsequent data errors or corrections found during medical record review.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table MRP-3: Data Elements for Medication Reconciliation Post-Discharge

	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 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	✓	✓

Medicare Health Outcomes Survey (HOS)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 6: Specifications for the Medicare Health Outcomes Survey*.

Description

This measure provides a general indication of how well a Medicare organization manages the physical and mental health of its members. The survey measures each member's physical and mental health status at the beginning and the end of a two-year period.

A two-year change score is calculated and each member's physical and mental health status is categorized as better, the same or worse than expected, taking into account risk adjustment factors. Organization-specific results are assigned as percentages of members whose health status was better, the same or worse than expected.

Fall Risk Management (FRM)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 6: Specifications for the Medicare Health Outcomes Survey.*

Description

The following components of this measure assess different facets of fall risk management.

Discussing Fall Risk The percentage of Medicare members 75 years of age and older or 65–74 years of age with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.

Managing Fall Risk The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.

Management of Urinary Incontinence in Older Adults (MUI)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 6: Specifications for the Medicare Health Outcomes Survey.*

Description

The following components of this measure assess the management of urinary incontinence in older adults.

Discussing Urinary Incontinence	The percentage of Medicare members 65 years of age and older who reported having a problem with urine leakage in the past six months and who discussed their urine leakage problem with their current practitioner.
Receiving Urinary Incontinence Treatment	The percentage of Medicare members 65 years of age and older who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem.

Osteoporosis Testing in Older Women (OTO)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 6: Specifications for the Medicare Health Outcomes Survey.*

Description

The percentage of Medicare women 65 years of age and older who report ever having received a bone density test to check for osteoporosis.

Physical Activity in Older Adults (PAO)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 6: Specifications for the Medicare Health Outcomes Survey.*

Description

The following components of this measure assess different facets of promoting physical activity in older adults.

Discussing Physical Activity — The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity.

Advising Physical Activity — The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level exercise or physical activity.

Flu Shots for Older Adults (FSO)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 3: Specifications for Survey Measures.*

Description

The percentage of Medicare members 65 years of age and older as of January 1 of the measurement year who received an influenza vaccination between September 1 of the measurement year and the date on which the Medicare CAHPS survey was completed.

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 3: Specifications for Survey Measures.*

Description

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation.

Advising Smokers and Tobacco Users to Quit	A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year.
Discussing Cessation Medications	A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended medications to quit during the measurement year.
Discussing Cessation Strategies	A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.

Pneumonia Vaccination Status for Older Adults (PNU)

SUMMARY OF CHANGES TO HEDIS 2010

This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2010, Volume 3: Specifications for Survey Measures.*

Description

The percentage of Medicare members 65 years of age and older as of January 1 of the measurement year who have ever received a pneumococcal vaccine

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

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	20–65 years and older as of December 31 of the measurement year. Report three age stratifications and a total rate. 20–44 years 45–64 years 65 years and older Total Total. The total rate is the sum of the three numerators divided by the sum of the three denominators.
Continuous enrollment	*Medicaid and Medicare:* The measurement year. *Commercial:* The measurement year and the two years prior to the measurement year.
Allowable gap	No more than one 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 (report each age stratification separately).

Numerator *Medicaid and Medicare:* One or more ambulatory or preventive care visits (Table AAP-A) during the measurement year.

Commercial: One or more ambulatory or preventive care visits (Table AAP-A) during the measurement year or the two years prior to the measurement year.

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

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 052x, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344		077x
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AAP-1/2/3: Data Elements for Adults' Access to Preventive/Ambulatory Health Services

	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*

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

SUMMARY OF CHANGES TO HEDIS 2010

Deleted CPT codes 99261–99263 from Table IET-B.

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Definitions

Intake Period — January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.

Index Episode — The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.

For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.

IESD — Index Episode Start Date. The earliest date of service for any inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with any diagnosis of AOD.

For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED (not resulting in an inpatient stay) claim/encounter, the IESD is the date of service.

For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge.

For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge.

For direct transfers, the IESD is the discharge date from the second admission.

Negative Diagnosis History

A period of 60 days prior to the IESD, during which the member had no claims/ encounters with any diagnosis of AOD dependence.

For an inpatient claim/encounter, use the admission date to determine the Negative Diagnosis History.

For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

Eligible Population

Product lines

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

Age

13 years and older as of the December 31 of the measurement year. Report two age stratifications and a total rate.

13-17 years

18+ years

Total

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

Continuous enrollment

60 days prior to the IESD through 44 days after the IESD (inclusive).

Allowable gap

None.

Anchor date

None.

Benefits

Medical and chemical dependency (inpatient and outpatient).

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/ diagnosis

New episode of AOD during the Intake Period.

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

Step 1 Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following.

An outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with a diagnosis of AOD (Table IET-A)

A detoxification visit (Table IET-C)

An ED visit (Table IET-D) with a diagnosis of AOD (Table IET-A)

An inpatient discharge with a diagnosis of AOD as identified by either of the following.

An inpatient facility code in conjunction with a diagnosis of AOD (IET-A)

An inpatient facility code in conjunction with an AOD procedure code (IET-E)

For members with more than one episode of AOD, use the first episode.

For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.

Select the IESD.

Table IET-A: Codes to Identify AOD Dependence

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

Table IET-B: Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization Visits

CPT	HCPCS	UB Revenue
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 077x, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983

CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53

Table IET-C: Codes to Identify Detoxification Visits

HCPCS	ICD-9-CM Procedure	UB Revenue
H0008-H0014	94.62, 94.65, 94.68	0116, 0126, 0136, 0146, 0156

Table IET-D: Codes to Identify Emergency Department Visits

CPT	UB Revenue
99281-99285	045x, 0981

Table IET-E: Codes to Identify AOD Procedures

ICD-9-CM Procedure
94.61, 94.63, 94.64, 94.66, 94.67, 94.69

Step 2 Test for Negative Diagnosis History. Exclude members who had a claim/encounter with any diagnosis of AOD (Table IET-A) during the 60 days prior to the IESD.

For an inpatient IESD, use the admission date to determine the Negative Diagnosis History.

For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled without any gaps 60 days prior to the IESD through 44 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of AOD Treatment Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant
- If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with any AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive)
  - If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive)
- Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment

Exclude from the denominator members whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Engagement of AOD Treatment Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement time period.

- If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).
- Do not count engagement encounters that include detoxification codes (including inpatient detoxification)

Note

Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations that bill comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame required for the rate (e.g., within 14 days of the IESD or within 30 days after the date of the initiation encounter).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table IET-1/2/3: Data Elements for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

	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*

Call Abandonment (CAB)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The percentage of calls received by the organization's Member Services call centers (during operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice. Lower rates represent better performance.

Definitions

Abandonment — The caller dials directly into the organization's Member Services call center or selects the Member Services option, is placed in the call queue and hangs up the phone, disconnecting from the call center before being answered by a Member Services representative.

Call — Telephone contact initiated by an external caller that connects to the organization Member Services call center. For calls transferred from other parts of the organization telephone system, measure time from after the call is transferred into the call center and the member chooses the option to speak to a Member Services representative and is placed in the call queue.

Member Services operating hours — Hours of live call-center operation indicated by membership materials (e.g., ID card, summary organization descriptions, enrollment materials).

Member Services representative — An employee at the organization's Member Services call center responsible for answering calls regarding enrollment, benefits and claims processing.

Member Services call center — An entity within the organization or under contract with the organization that is responsible for handling the organization's network Member Services inquiries regarding enrollment, benefits and claims processing.

Queue — A sequence of calls waiting to be handled by a Member Services representative. The wait time on a queued call is calculated by Automatic Call Distribution (ACD), which tracks incoming calls.

Calculation

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

Note: *An organization that uses the same systems, policies and procedures and staff to answer calls for all product lines may report the same rate for all product lines if it is not possible for it to report data by individual product line.*

Denominator — The number of calls received by the organization's Member Services call center (during hours of operation) during the measurement year where the member called directly into Member Services or selected a Member Services option and was put in the call queue.

Exclude calls to the organization's benefit contractor (e.g., mental health, dental, vision, pharmacy) when the contractor has its own call center.

Numerator The number of calls abandoned by the caller or the system before being answered by a live voice.

Note: *Calls abandoned within 30 seconds remain in the measure and are compliant for the numerator. Calls sent directly to voicemail should also remain in the measure and are considered compliant.*

Formulas *For an organization with one call center that answers all the organization's calls and has the organization as its only client,* report the measure as specified.

For an organization with one call center that answers all the organization's calls and also has multiple clients, if the call center is unable to report abandonment data for the organization, report abandonment for the entire volume of calls the center handles.

For an organization with multiple call centers, each of which answers a portion of the total amount of calls for the organization and has the organization as its only client, report the measure as a weighted average (see the formula below).

Definitions

Let N_1 = The total number of Member Services calls received by call center 1.

Let N_2 = The total number of Member Services calls received by call center 2.

Let P_{CAB1} = The rate for the *Call Abandonment* HEDIS measure for call center 1.

Let P_{CAB2} = The rate for the *Call Abandonment* HEDIS measure for call center 2.

Set-up calculations

Let W_1 = The weight assigned to call center 1. This result is calculated by the formula $W_1 = N_1/(N_1+N_2)$.

Let W_2 = The weight assigned to call center 2. This result is calculated by the formula $W_2 = N_2/(N_1+N_2)$.

Pooled analysis The pooled result from the two rates is calculated as:

$$P_{CA\ pooled} = W_1*P_{CAB1} + W_2*P_{CAB2}$$

Note

If during peak call periods (or any regular business hours), the organization blocks calls by immediately giving members a busy signal and keeping the calls from reaching the call queue, the auditor assesses the percentage of blocked calls and its impact on the measure.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CAB-1/2/3: Data Elements for Call Abandonment

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

Call Answer Timeliness (CAT)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The percentage of calls received by the organization's Member Services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Definitions

Call	Telephone contact initiated by an external caller connects with the organization's Member Services call center. For calls transferred from other parts of the organization's telephone system, measure time from after the call is transferred into the Member Services call center, the member chooses the option to speak to a Member Services representative and is placed in the call queue.
Member Services operating hours	Hours of live call-center operation indicated by membership materials (e.g., ID card, summary organization descriptions, enrollment materials).
Member Services representative	An employee at the organization's Member Services call center responsible for answering calls regarding enrollment, benefits and claims processing.
Member Services call center	An entity within the organization or under contract with the organization that is responsible for handling the organization's network Member Services inquiries regarding enrollment, benefits and claims processing.
Queue	A sequence of calls waiting to be handled by the Member Services representative. The wait time on a queued call is calculated by ACD, which tracks incoming calls.

Calculation

Product lines

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

Note: *An organization that uses the same systems, policies and procedures and staff to answer calls for all product lines may report the same rate for all product lines if it is not possible for it to report data by individual product line.*

Denominator

The number of calls received by the Member Services call centers (during hours of operation) during the measurement year, where the member called directly into Member Services or selected a Member Services option and was put in the call queue. Exclude calls to a benefits contractor (e.g., mental health, dental, vision, pharmacy) that uses its own call center.

Numerator

The number of calls answered by a live voice within 30 seconds.

Time measured begins when the member is placed in the call queue and is waiting to speak to a Member Services representative.

Note: *Calls abandoned within 30 seconds remain in the measure and are noncompliant for the numerator. Calls sent directly to voicemail should also remain in the measure and are considered noncompliant.*

Formulas

For an organization with one call center that answers all the organization's calls and has the organization as its only client, report the measure as specified.

For an organization with one call center that answers all the organization's calls and also has multiple clients, if the call center is unable to report timeliness data for the specific organization, report timeliness for the entire volume of calls the center handles.

For an organization with multiple call centers, each of which answers a portion of the total calls for the organization and has the organization as its only client, report the measure as a weighted average (see the formula below).

Definitions

Let N_1 = The total number of Member Services calls received by call center 1.

Let N_2 = The total number of Member Services calls received by call center 2.

Let P_{CAT1} = The rate for the *Call Answer Timeliness* HEDIS measure for call center 1.

Let P_{CAT2} = The rate for the *Call Answer Timeliness* HEDIS measure for call center 2.

Set-up calculations

Let W_1 = The weight assigned to call center 1. This result is calculated by the formula $W_1 = N_1/(N_1+N_2)$.

Let W_2 = The weight assigned to call center 2. This result is calculated by the formula $W_2 = N_2/(N_1+N_2)$.

Pooled analysis

The pooled result from the two rates is calculated as:

$$P_{CAT\ pooled} = W_1*P_{CAT1} + W_2*P_{CAT2}$$

Note

If during peak call periods (or any regular business hours), the organization blocks calls by immediately giving members a busy signal and keeping the calls from reaching the call queue, the auditor assesses the percentage of blocked calls and its impact on the measure.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CAT-1/2/3: Data Elements for Call Answer Timeliness

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

Total Membership (TLM)

SUMMARY OF CHANGES TO HEDIS 2010

Retired the *Years in Business* portion of the measure.

Renamed the measure.

Clarified Total Membership count.

Description

The number of members enrolled as of December 31 of the measurement year.

Calculation

For each product line the licensed organization offers (i.e., HMO, POS, PPO or FFS), report the number of members enrolled as of December 31 of the measurement year by product line (i.e., commercial, Medicaid, Medicare or other**). The total category should equal the licensed organization's total membership as of December 31 of the measurement year. The organization should complete this measure once and report the information for each HEDIS submission.

Include all products and product lines (i.e., across all books of business), even if they were not included in a HEDIS submission. Include:

Special Needs Plans (SNP) in the Medicare count

ASO members in either the commercial HMO, POS or PPO count, as appropriate

EPO members in either the HMO, POS or PPO count, as appropriate

CHIP members in the Medicaid product line.

Table TLM-1/2/3: Total Membership*

Organization Name: _____

Product/Product Line	Total Number of Members	Product/Product Line	Total Number of Members
HMO		**POS**	
Medicaid	_____	Medicaid	_____
Commercial	_____	Commercial	_____
Medicare	_____	Medicare	_____
Other	_____	Other	_____
Total HMO:	_____	***Total POS:***	_____
PPO		**FFS**	
Medicaid	_____	Medicaid	_____
Commercial	_____	Commercial	_____
Medicare	_____	Medicare	_____
Other	_____	Other	_____
Total PPO:	_____	***Total FFS:***	_____
Total:	_____		

*Total number of members in each category as of December 31 of the measurement year.

Frequency of Selected Procedures (FSP)

SUMMARY OF CHANGES TO HEDIS 2010

Added CPT codes 22856, 22861, 22864, 27267–27269 to Table FSP-A.

Added ICD-9-CM Procedure codes 80.53, 80.54 to table FSP-A ("back surgery" description).

Deleted CPT codes 63035, 63043, 63044, 63048, 63057, 63066, 63076, 63078, 63082, 63086, 63088, 63091, 63103 from Table FSP-A.

Removed CMS-DRGs from Table FSP-A.

Description

This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Calculations

Product lines

Report the following tables for each applicable product line.

Table FSP-1a	Total Medicaid*
Table FSP-2	Commercial—by Product or Combined HMO/POS
Table FSP-3	Medicare

* *Report this measure for* Total Medicaid only; *reporting by eligibility category will result in small numbers.*

Member months

For each product line and table, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Procedures

Use Table FSP-A to identify procedures for reporting. Report counts for the procedures as specified regardless of the site of care (e.g., inpatient or ambulatory setting). Report the number of procedures rather than the number of members who received the procedures. Do not double-count the same procedure. The two examples below illustrate scenarios counted as one procedure.

Count as one procedure…

If the date of service for two procedures is the same and both codes indicate CABG

If the date of service for a procedure falls between the admission and discharge dates for an inpatient stay where the procedure was performed

For example, if a CABG was billed by a surgeon on March 4 of the measurement year and the facility bill shows a CABG for an admission that started on March 2 and lasted until March 7 of the measurement year, combine these to count one CABG

Myringotomy	Report myringotomy or myringotomy and adenoidectomy. Report toward both measures, myringotomy and tonsillectomy occurring on the same date of service. Report as two separate procedures, two myringotomies performed on the same date of service by the same provider. Do not report adenoidectomy performed alone.
Tonsillectomy	Report tonsillectomy or tonsillectomy and adenoidectomy. Report toward both measures myringotomy and tonsillectomy occurring on the same date of service. Do not report adenoidectomy performed alone.
Nonobstetric D&C	Report nonobstetric D&C. Do not report obstetric D&C or termination of pregnancy D&C. Do not report a nonobstetric D&C performed in conjunction with (i.e., on the same date of service as) a hysterectomy. These services are reported under hysterectomy.
Hysterectomy	Report abdominal and vaginal hysterectomy separately.
Cholecystectomy	Report open and closed (laparoscopic) cholecystectomy separately.
Back surgery	Report all spinal fusion and disc surgery, including codes relating to laminectomy with and without disc removal.
Coronary angioplasty (PTCA)	Report all PTCAs performed separately. Do not report angioplasty or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the angioplasty or the cardiac catheterization rate; report only the CABG.
Cardiac catheterization	Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with (i.e., on the same date of service as) an angioplasty in the cardiac catheterization rate; report only the angioplasty. Do not report angioplasty or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the angioplasty or the cardiac catheterization rate; report only the CABG.
CABG	Coronary artery bypass graft. Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved. Do not report angioplasty or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the angioplasty or the cardiac catheterization rate; report only the CABG.
Prostatectomy	Report the number of prostatectomies.
Reduction of fracture of femur	Report the number of reductions of fracture of the femur.

Total hip replacement	Report the number of total hip replacements.
Total knee replacement	Report the number of total knee replacements.
Partial excision of large intestine	Report the number of partial excisions of the large intestine.
Carotid endarterectomy	Report the number of carotid endarterectomies.
Mastectomy	Report the number of mastectomies. Report bilateral mastectomy procedures as two procedures, even if performed on the same date.
Lumpectomy	Report the number of lumpectomies. Report multiple lumpectomies on the same date of service as one lumpectomy procedure per patient.

Table FSP-A: Codes to Identify Selected Procedures

Description	CPT	HCPCS	ICD-9-CM Procedure	MS—DRG
Myringotomy or myringotomy with adenoidectomy	69433, 69436		20.01	
Tonsillectomy or tonsillectomy with adenoidectomy	42820, 42821, 42825, 42826, 42860		28.2-28.4	
Nonobstetric dilation and curettage	58120		69.09	
Hysterectomy (abdominal)	51925, 58150, 58152, 58180, 58200, 58210, 58240, 58541-58544, 58548, 58570-58573, 58951, 58953, 58954, 58956, 59135, 59525		68.3, 68.4, 68.6, 68.8, 68.9	
Hysterectomy (vaginal)	58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58552-58554		68.5, 68.7	
Cholecystectomy (open)	47600, 47605, 47610, 47612, 47620		51.21, 51.22	
Cholecystectomy (closed/ laparoscopic)	47562-47564		51.23, 51.24	
Back surgery	22220, 22222, 22224, 22532, 22533, 22548, 22554, 22556, 22558, 22590, 22595, 22600, 22610, 22612, 22630, 22830, 22856, 22857, 22861, 22862, 22864, 22865, 63001, 63003, 63005, 63011, 63012, 63015-63017, 63020, 63030, 63040, 63042, 63045-63047, 63050, 63051, 63055, 63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101-63102	S2348, S2350	03.02, 03.09, 80.5, 81.0, 81.3, 81.6, 84.6, 84.8	453-460
Coronary angioplasty (PTCA)	92980, 92982, 92995		00.66, 36.06, 36.07, 36.09	246-251
Cardiac catheterization	93501, 93510, 93511, 93514, 93524, 93526-93529, 93539-93545		37.21-37.23, 88.55-88.57	216-218, 222-225, 286, 287
CABG	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209	36.1, 36.2	231-236

Table FSP-A: Codes to Identify Selected Procedures *(continued)*

Description	CPT	HCPCS	ICD-9-CM Procedure	MS—DRG
Prostatectomy	52601, 52612, 52614, 52620, 52630, 52647, 52648, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866		60.2-60.6	665-667
Reduction of fracture of femur	27230, 27232, 27235, 27236, 27238, 27240, 27244-27246, 27248, 27267-27269		79.05, 79.15, 79.25, 79.35	
Total hip replacement	27130, 27132, 27134		00.70, 81.51, 81.53	
Total knee replacement	27446, 27447, 27486, 27487		00.80, 81.54, 81.55	
Partial excision of large intestine	44140, 44141, 44143-44147, 44160, 44204-44208		45.7	
Carotid endarterectomy	34001, 35001, 35301, 35501, 35601		38.12	
Mastectomy	***Bilateral:*** 19303-19307 with a modifier .50 code ***Unilateral:*** 19303-19307		***Bilateral:*** 85.42, 85.44, 85.46, 85.48 ***Unilateral:*** 85.41, 85.43, 85.45, 85.47	**NA** (no MS-DRGs are specific to total mastectomy)
Lumpectomy	19120, 19125, 19301, 19302		85.2	584, 585

Table FSP-1: Frequency of Selected Procedures

Member Months			
Age	**Male**	**Female**	**Total**
0-4			
0-9			
5-19			
10-19			
15-44			
20-44			
30-64			
45-64			

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Months
Myringotomy	0-4 5-19	Male and Female		
Tonsillectomy	0-9 10-19	Male and Female		
D&C	15-44 45-64	Female		
Hysterectomy, abdominal	15-44 45-64	Female		
Hysterectomy, vaginal	15-44 45-64	Female		
Cholecystectomy, open	30-64	Male		
	15-44 45-64	Female		
Cholecystectomy, closed (laparoscopic)	30-64	Male		
	15-44 45-64	Female		
Back surgery	20-44	Male		
		Female		
	45-64	Male		
		Female		
Mastectomy	15-44 45-64	Female		
Lumpectomy	15-44 45-64	Female		

Table FSP-2: Frequency of Selected Procedures

Member Months			
Age	**Male**	**Female**	**Total**
0-4			
0-9			
5-19			
10-19			
15-44			
20-44			
30-64			
45-64			
65+			

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Myringotomy	0-4 5-19	Male and Female		
Tonsillectomy	0-9 10-19	Male and Female		
D&C	15-44 45-64	Female		
Hysterectomy, abdominal	15-44 45-64 65+	Female		
Hysterectomy, vaginal	15-44 45-64 65+	Female		
Cholecystectomy, open	30-64	Male		
	15-44 45-64	Female		
	65+	Male		
		Female		
Cholecystectomy, closed (laparoscopic)	30-64	Male		
	15-44 45-64	Female		
	65+	Male		
		Female		

Table FSP-2: Frequency of Selected Procedures *(continued)*

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Back surgery	20-44	Male		
		Female		
	45-64	Male		
		Female		
	65+	Male		
		Female		
PTCA	45-64	Male		
		Female		
	65+	Male		
		Female		
Cardiac catheterization	45-64	Male		
		Female		
	65+	Male		
		Female		
CABG	45-64	Male		
		Female		
	65+	Male		
		Female		
Prostatectomy	45-64	Male		
	65+			
Mastectomy	15-44	Female		
	45-64			
	65+			
Lumpectomy	15-44	Female		
	45-64			
	65+			

Table FSP-3: Frequency of Selected Procedures

Member Months		
Age	**Male**	**Female**
<65	_____	_____
65-74	_____	_____
75-84	_____	_____
85+	_____	_____

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
CABG	<65	Male	_____	_____
		Female	_____	_____
	65-74	Male	_____	_____
		Female	_____	_____
	75-84	Male	_____	_____
		Female	_____	_____
	85+	Male	_____	_____
		Female	_____	_____
PTCA	<65	Male	_____	_____
		Female	_____	_____
	65-74	Male	_____	_____
		Female	_____	_____
	75-84	Male	_____	_____
		Female	_____	_____
	85+	Male	_____	_____
		Female	_____	_____
Cardiac catheterization	<65	Male	_____	_____
		Female	_____	_____
	65-74	Male	_____	_____
		Female	_____	_____
	75-84	Male	_____	_____
		Female	_____	_____
	85+	Male	_____	_____
		Female	_____	_____

Table FSP-3: Frequency of Selected Procedures *(continued)*

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Carotid endarterectomy	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Cholecystectomy, open	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Cholecystectomy, closed (laparoscopic)	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Back surgery	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		

Table FSP-3: Frequency of Selected Procedures *(continued)*

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Hysterectomy (abdominal)	<65	Female		
	65-74			
	75-84			
	85+			
Hysterectomy (vaginal)	<65	Female		
	65-74			
	75-84			
	85+			
Prostatectomy	<65	Male		
	65-74			
	75-84			
	85+			
Reduction of fracture of femur	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Total hip replacement	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Total knee replacement	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		

Table FSP-3: Frequency of Selected Procedures *(continued)*

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Partial excision of large intestine	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Mastectomy	<65	Female		
	65-74			
	75-84			
	85+			
Lumpectomy	<65	Female		
	65-74			
	75-84			
	85+			

Inpatient Utilization—General Hospital/Acute Care (IPU)

SUMMARY OF CHANGES TO HEDIS 2010

Removed CMS-DRGs from Tables IPU-A and IPU-B.

Added ICD-9-CM Diagnosis codes 678–679 to Table IPU-B "Maternity" description.

Description

This measure summarizes utilization of acute inpatient care and services in the following categories.

Total inpatient

Medicine

Surgery

Maternity

Calculations

Product lines

Report the following tables for each applicable product line.

Table IPU-1a	Total Medicaid
Table IPU-1b	Medicaid/Medicare Dual-Eligibles
Table IPU-1c	Medicaid—Disabled
Table IPU-1d	Medicaid—Other Low Income
Table IPU-2	Commercial—by Product or Combined HMO/POS
Table IPU-3	Medicare

Member months

For each product line and table, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Maternity rates are reported per 1,000 male and per 1,000 female total member months in order to capture deliveries as a percentage of the total inpatient discharges.

Discharges

Refer to the codes in Table IPU-A to identify total inpatient discharges, then use Table IPU-B to separate discharges into *Maternity, Surgery* and *Medicine*.

Table IPU-A: Codes to Identify Total Inpatient Discharges

Principal ICD-9-CM Diagnosis		MS—DRG
001-289, 317-999, V01-V29, V40-V86	*OR*	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	*OR*	Any acute inpatient facility code

Days Count all days associated with the identified discharges. Report days for total inpatient, maternity, surgery and medicine.

ALOS Refer to the *Specific Instructions for Use of Services Tables* for the formula. Calculate average length of stay for total inpatient, medicine, surgery and maternity.

Total inpatient Use Table IPU-A to identify acute inpatient discharges.

The Total Inpatient should be the sum of the three categories *(Medicine, Surgery, Maternity)* and any MS-DRGs defined as "principal diagnosis invalid as discharge diagnosis or ungroupable."

Use Table IPU-B to identify maternity, surgery and medicine inpatient discharges.

Medicine DRGs are the preferred method to identify medical discharges. An organization that uses ICD-9-CM Diagnosis codes must identify total acute inpatient discharges, remove maternity related discharges and remove all discharges accompanied by UB revenue code 036X.

Report MS-DRGs 789–795 under *Medicine* if newborn care is rendered after the baby has been discharged home from delivery and is subsequently rehospitalized.

Surgery DRGs are the preferred method to identify surgical discharges. An organization that uses ICD-9-CM Diagnosis codes must identify total inpatient, remove maternity-related discharges and include the remaining discharges accompanied by UB revenue code 036X.

Maternity Include birthing center deliveries in this measure and count them as one day of stay. Refer to Table IPU-B for ICD-9-CM Principal Diagnosis codes, UB Revenue, UB Type of Bill and DRG codes.

Table IPU-B: Codes to Identify Medicine, Surgery and Maternity Inpatient Discharges

Description	Principal ICD-9-CM Diagnosis	UB Revenue	UB Type of Bill	MS—DRG
Medicine	Total—Maternity—Surgery			052-103, 121-125, 146-159, 175-208, 280-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-700, 722-730, 754-761, 789-795, 808-816, 834-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977
Surgery	Total—Maternity*	036x		001-013, 020-042, 113-117, 129-139, 163-168, 215-264, 326-358, 405-425, 453-517, 573-585, 614-630, 652-675, 707-718, 734-750, 799-804, 820-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-989
Maternity	630-676, 678-679, V24.0	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	765-770, 774-782

* If the organization uses ICD-9-CM Diagnosis codes to report this measure, all discharges reported in the *Surgery* group must be in conjunction with UB revenue code 036x.

Exclusions *(required)*

The measure does not include mental health or chemical dependency services. Exclude claims and encounters that contain any of the following codes.

Table IPU-C: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis	*WITH*	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Table IPU-1: Inpatient Utilization—General Hospital/Acute Care

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Table IPU-1: Inpatient Utilization—General Hospital/Acute Care *(continued)*

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Total Inpatient					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total:					
Medicine					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total:					
Surgery					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total:					

Table IPU-1: Inpatient Utilization—General Hospital/Acute Care *(continued)*

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Maternity*					
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

*The maternity category is calculated using member months for members 10–64 years.

Table IPU-2/3: Inpatient Utilization—General Hospital/Acute Care

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Age	Discharges	Discharges/1,000 Member Years	Days	Days/1,000 Member Years	Average Length of Stay
Total Inpatient					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

Table IPU-2/3: Inpatient Utilization—General Hospital/Acute Care *(continued)*

Age	Discharges	Discharges/1,000 Member Years	Days	Days/1,000 Member Years	Average Length of Stay
Medicine					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____
Surgery					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____
Maternity					
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

Ambulatory Care (AMB)

SUMMARY OF CHANGES TO HEDIS 2010

Added CPT code 99461 to Table AMB-A.

Description

This measure summarizes utilization of ambulatory care in the following categories.

Outpatient Visits

ED Visits

Ambulatory Surgery/Procedures

Observation Room Stays

Calculations

Product lines

Report the following tables for each applicable product line.

Table AMB-1a	Total Medicaid
Table AMB-1b	Medicaid/Medicare Dual-Eligibles
Table AMB-1c	Medicaid—Disabled
Table AMB-1d	Medicaid—Other Low Income
Table AMB-2	Commercial—by Product or Combined HMO/POS
Table AMB-3	Medicare

Member months

For each product line and table, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Counting multiple services

For ambulatory surgery/procedures that occur on the same date of service as an ED visit, report as a single ED visit.

For Observation Room visits that occur on the same date of service as an ambulatory surgery/procedure, report as a single ambulatory surgery/procedure.

For Observation Room visits that occur on the same date of service as an ED visit, report as a single ED visit.

For all other combinations of multiple ambulatory services falling in different categories on the same day, report each service that meets the criteria in the appropriate category.

Outpatient visits Use Table AMB-A to identify outpatient visits. Count each occurrence of the CPT codes listed in Table AMB-A if rendered by different practitioners (a CPT code may count more than once on the same date of service if rendered by different practitioners).

Report services without regard to practitioner type, training or licensing. Include office-based surgical procedures (use the Ambulatory Surgery/Procedures codes in Table AMB-C and include surgeries conducted at the practitioner's office).

Table AMB-A: Codes to Identify Outpatient Visits

Description	CPT	UB Revenue
Office or other outpatient visits	99201-99205, 99211-99215, 99241-99245	051x, 052x, 0982, 0983
Home visits	99341-99345, 99347-99350	
Nursing facility care	99304-99310, 99315, 99316, 99318	
Domiciliary or rest home care	99324-99328, 99334-99337	
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	
Newborn care	99432, 99461	
Ophthalmology and optometry	92002, 92004, 92012, 92014	

ED visits Use Table AMB-B to identify ED visits. Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

Table AMB-B: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

OR

CPT	*WITH*	POS
10040-69979		23

Ambulatory surgery/ procedures Use Table AMB-C to identify ambulatory surgeries/procedures. Identify encounters using Option A *or* Option B. Option A is the preferred method for this measure, though when necessary, the organization should use Option A *and* Option B.

Report only ambulatory surgeries/procedures performed at a hospital outpatient facility or at a free-standing surgery center. Do not report office-based surgeries/ procedures in this category; report them under *Outpatient Visits.* Count multiple ambulatory surgeries/procedures on the same date of service as one ambulatory surgery/procedure.

Table AMB-C: Codes to Identify Ambulatory Surgery/Procedures

Option A

CPT		POS
All codes included in the CMS 2009 ASC Approved HCPCS Codes and Payment Rates file* and 92953, 92970, 92971, 92975, 92980, 92982, 92986, 92990, 92992, 92993, 92995, 92996, 93501-93533, 93600-93652	*WITH*	22, 24

Option B

ICD-9-CM Procedure		UB Revenue		UB Type of Bill
01-86, 88.4, 88.5, 98.5	*WITH*	0320, 0321, 0323, 036x, 0480, 0481, 049x, 075x, 079x	*WITH*	13x, 83x

*The CMS 2009 ASC Approved HCPCS Codes and Payment Rates files are available on the CMS Web site (http://www.cms.hhs.gov/ASCPayment/) under the *Addenda Updates* section. Use the file that was valid at the end of the measurement year.

Observation Room stays

Use Table AMB-D to identify Observation Room stays.

Count once, each observation visit that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple observation visits on the same date of service as one visit.

Table AMB-D: Codes to Identify Observation Room Stays

CPT	UB Revenue
99217-99220	0762

Exclusions *(required)*

The measure does not include mental health or chemical dependency services. Exclude from all categories claims and encounters that contain any code in Table AMB-E.

Table AMB-E: Codes to Identify Exclusions

CPT	Principal ICD-9-CM Diagnosis	ICD-9-CM Procedure
90801-90899	290-316	94.26, 94.27, 94.6
Principal ICD-9-CM Diagnosis	***WITH***	**Secondary ICD-9-CM Diagnosis**
960-979		291-292, 303-305

Note

This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.

Table AMB-1: Ambulatory Care

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

	Outpatient Visits		ED Visits		Ambulatory Surgery/ Procedures		Observation Room Stays	
Age	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months	Procedures	Procedures/ 1,000 Member Months	Stays	Stays/ 1,000 Member Months
<1	_____	_____	_____	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	_____		_____		_____		_____	
Total:	_____	_____	_____	_____	_____	_____	_____	_____

Table AMB-2/3: Ambulatory Care

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

	Outpatient Visits		ED Visits		Ambulatory Surgery/ Procedures		Observation Room Stays	
Age	Visits	Visits/ 1,000 Member Years	Visits	Visits/ 1,000 Member Years	Procedures	Procedures/ 1,000 Member Years	Stays	Stays/ 1,000 Member Years
<1	_____	_____	_____	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	_____		_____		_____		_____	
Total:	_____	_____	_____	_____	_____	_____	_____	_____

Inpatient Utilization—Nonacute Care (NON)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

This measure summarizes utilization of nonacute inpatient care in hospice, nursing home, rehabilitation, SNF, transitional care and respite.

Calculations

Product lines Report the following tables for each applicable product line.

Table NON-1a	Total Medicaid
Table NON-1b	Medicaid/Medicare Dual-Eligibles
Table NON-1c	Medicaid—Disabled
Table NON-1d	Medicaid—Other Low Income
Table NON-2	Commercial—by Product or Combined HMO/POS
Table NON-3	Medicare

Member months For each product line and table, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Discharges Refer to the codes listed in Table NON-A to report discharges for nonacute inpatient care.

Table NON-A: Codes to Identify Nonacute Care

Description	UB Revenue	UB Type of Bill
Hospice	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x
SNF	019x	21x, 22x, 28x
Hospital transitional care, swing bed or rehabilitation		18x
Rehabilitation	0118, 0128, 0138, 0148, 0158	
Respite	0655	
Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)		

Days Count all days associated with the identified discharges.

ALOS Refer to *Specific Instructions for Use of Services Tables* for the formula.

Total nonacute inpatient care Use the codes in Table NON-A to identify nonacute care. Include care from any institution that provides long-term/specialty nonacute care.

Exclusions *(required)*

The measure does not include mental health or chemical dependency services. Exclude claims and encounters that contain any of the following codes.

Table NON-B: Codes to Identify Exclusions

CPT	Principal ICD-9-CM Diagnosis	ICD-9-CM Procedure
90801-90899	290-316	94.26, 94.27, 94.6

Principal ICD-9-CM Diagnosis	*WITH*	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Table NON-1: Inpatient Utilization—Nonacute Care

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

Table NON-2/3: Inpatient Utilization—Nonacute Care

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Age	Discharges	Discharges/1,000 Member Years	Days	Days/1,000 Member Years	Average Length of Stay
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

Mental Health Utilization (MPT)

SUMMARY OF CHANGES TO HEDIS 2010

Removed CMS-DRGs from Table MPT-B.

Deleted CPT codes 90871, 99261-99263 from Table MPT-C.

Added CPT codes 96102, 96103, 96105, 96119, 96120, 96125 to Table MPT-D.

Deleted CPT code 90871 from Table MPT-D.

Description

The number and percentage of members receiving the following mental health services during the measurement year.

Any services

Inpatient

Intensive outpatient or partial hospitalization

Outpatient or ED

Calculations

Product lines

Report the following tables for each applicable product line.

Table MPT-1a	Total Medicaid
Table MPT-1b	Medicaid/Medicare Dual-Eligibles
Table MPT-1c	Medicaid—Disabled
Table MPT-1d	Medicaid—Other Low Income
Table MPT-2	Commercial—by Product or Combined HMO/POS
Table MPT-3	Medicare

Count members who received inpatient, intensive outpatient, partial hospitalization, outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits.

Count members in the *Any Services* column only if they had at least one inpatient, intensive outpatient, partial hospitalization, outpatient or ED claim/encounter during the measurement year.

For members who have had more than one encounter, count only the first visit in the measurement year and report the member in the respective age category as of the date of service or discharge.

Benefit

Mental health.

Member months

For each product line and table, report all member months during the measurement year for members with the benefit. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the *Any* column should include all members with any mental health benefit.

Inpatient

Include inpatient care at either a hospital or treatment facility with mental health as the principal diagnosis.

Use one of the following criteria to identify inpatient services.

An inpatient facility code in conjunction with a principal mental health diagnosis (Table MPT-A), ***or***

DRGs (Table MPT-B)

Include discharges associated with residential care and rehabilitation.

Table MPT-A: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
290, 293-302, 306-316

Note: *DSM-IV codes mirror ICD-9-CM codes. A health plan that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for ICD-9-CM codes.*

Table MPT-B: Codes to Identify Inpatient Services

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Intensive outpatient and partial hospitalization

Report intensive outpatient and partial hospitalization claims/encounters (Table MPT-C) in conjunction with a principal mental health diagnosis (Table MPT-A).

Count services provided by physicians and nonphysician practitioners.

Exclude any services the health plan knows to be inpatient based on type of bill, place of service or location of service codes.

Table MPT-C: Codes to Identify Intensive Outpatient and Partial Hospitalization Services

HCPCS	UB Revenue		
Visits identified by the following HCPCS, UB revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).			
H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913,		
			POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876		***WITH***	52, 53*
Visits identified by the following CPT/POS codes must be with a mental health practitioner.			
99221-99223, 99231-99233, 99238, 99239, 99251-99255		***WITH***	52, 53*

***** POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization uses POS 53 for reporting, it must have a system to confirm the visit was in an intensive outpatient or partial hospitalization setting.

Outpatient and ED

Report outpatient and ED claims/encounters (Table MPT-D) in conjunction with a principal mental health diagnosis (Table MPT-A). Count services provided by physicians and nonphysicians.

Only include observation stays and ED visits that do not result in an inpatient stay.

Table MPT-D: Codes to Identify Outpatient and ED Services

CPT	HCPCS	UB Revenue	
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).			
90804-90815, 96101-96103, 96105, 96110, 96111, 96116, 96118-96120, 96125CPT	G0155, G0176, G0177, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485	0513, 0900-0904, 0911, 0914-0919	
			POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876		***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 23, 33, 49, 50, 53*, 71, 72
CPT		**UB Revenue**	
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.			
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510		045x, 0510, 0515-0517, 0519-0523, 0526-0529, 0762, 077x, 0981-0983	

***** POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization uses POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

Table MPT-1/2/3: Mental Health Utilization

Member Months (Any Services)				Member Months (Inpatient)		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
0-12	_____	_____	_____	_____	_____	_____
13-17	_____	_____	_____	_____	_____	_____
18-64	_____	_____	_____	_____	_____	_____
65+	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____
Member Months (Intensive Outpatient/Partial Hospitalization)				**Member Months (Outpatient/ED)**		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
0-12	_____	_____	_____	_____	_____	_____
13-17	_____	_____	_____	_____	_____	_____
18-64	_____	_____	_____	_____	_____	_____
65+	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

		Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Age	**Sex**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-12	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
13-17	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
18-64	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
65+	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____

Identification of Alcohol and Other Drug Services (IAD)

SUMMARY OF CHANGES TO HEDIS 2010

Removed CMS-DRGs from Table IAD-B.

Deleted CPT codes 90871, 99261-99263 from Table IAD-C.

Added CPT codes 96102, 96103, 96105, 96119, 96120, 96125 to Table IAD-D.

Deleted CPT code 90871 from Table IAD-D.

Description

This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year.

Any services

Inpatient

Intensive outpatient or partial hospitalization

Outpatient or ED

Calculations

Product lines

Report the following tables for each applicable product line.

Table IAD-1a	Total Medicaid
Table IAD-1b	Medicaid/Medicare Dual-Eligibles
Table IAD-1c	Medicaid—Disabled
Table IAD-1d	Medicaid—Other Low Income
Table IAD-2	Commercial—by Product or Combined HMO/POS
Table IAD-3	Medicare

Count members who received inpatient, intensive outpatient, partial hospitalization, outpatient and ED chemical dependency services in each column. Count members in each column only once, regardless of number of visits.

Count members in the *Any Services* column only if they had at least one inpatient, intensive outpatient, partial hospitalization, outpatient or ED claim/encounter during the measurement year.

For members who had more than one encounter, count only the first visit in the measurement year and report the member in the respective age category as of the date of service or discharge.

Benefit

Chemical dependency.

Member months

For each product line, report all member months during the measurement year for members with the benefit. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* for more information.

Because some organizations may offer different benefits for inpatient and outpatient chemical dependency services, denominators in the columns of the member months table may vary. The denominator in the *Any* column should include all members with any chemical dependency benefit.

Inpatient

Include inpatient care, including inpatient detoxification, at either a hospital or treatment facility with any diagnosis of chemical dependency.

Use one of the following criteria to identify inpatient services.

An inpatient facility code in conjunction with any diagnosis of chemical dependency (Table IAD-A), ***or***

A code in Table IAD-B

Include discharges associated with residential care and rehabilitation.

Table IAD-A: Codes to Identify Chemical Dependency Diagnosis

ICD-9-CM Diagnosis
291-292, 303-304, 305.0, 305.2-305.9, 535.3, 571.1

Table IAD-B: Codes to Identify Inpatient Services

ICD-9-CM Procedure	MS—DRG
94.6x ***WITH*** an inpatient facility code	894-897

Intensive outpatient and partial hospitalization

Report intensive outpatient and partial hospitalization claims/encounters (Table IAD-C) in conjunction with any chemical dependency diagnosis (Table IAD-A).

Count services provided by physician and nonphysician practitioners.

Intensive outpatient and partial hospitalization are reported separate from outpatient and ED services because these programs represent a significant number of services rendered.

Exclude any services the health plan knows to be *inpatient* based on type of bill, place of service or location of service codes.

Table IAD-C: Codes to Identify Intensive Outpatient and Partial Hospitalization Services

HCPCS		UB Revenue
Visits identified by the following HCPCS, UB revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (i.e., the organization does not need to determine practitioner type).		
H0015, H0035, H2001, H2012, S0201, S9480		0905-0907, 0912, 0913
CPT		**POS**
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53*

*****POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization uses POS 53 for reporting, it must have a system to confirm the visit was in an intensive outpatient or partial hospitalization setting.

Outpatient and ED

Report outpatient and ED claims/encounters (Table IAD-D) in conjunction with any chemical dependency diagnosis (Table IAD-A).

Count services provided by physicians and nonphysician practitioners.

Only include observation stays and ED visits that do not result in an inpatient stay.

Table IAD-D: Codes to Identify Outpatient and ED Services

CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS, UB revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (i.e., the organization does not need to determine practitioner type).		
90804-90815, 96101-96103, 96105, 96110, 96111, 96116, 96118-96120, 96125, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99408, 99409, 99411, 99412, 99420, 99510	G0155, G0176, G0177, G0396, G0397, H0001, H0002, H0004, H0005, H0007, H0012-H0014, H0016, H0020, H0022, H0031, H0034, H0036, H0037, H0039, H0040, H0049, H0050, H2000, H2010, H2011, H2013-H2020, H2035, H2036, M0064, S9475, S9484, S9485, T1006, T1012	045x, 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0762, 077x, 0900-0904, 0911, 0914-0919, 0944, 0945, 0981-0983

CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 23, 33, 49, 50, 53*, 57, 71, 72

***** POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization uses POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

Table IAD-1/2/3: Identification of Alcohol and Other Drug Services

Member Months (Any Services)				Member Months (Inpatient)		
Age	Male	Female	Total	Male	Female	Total
0-12	_____	_____	_____	_____	_____	_____
13-17	_____	_____	_____	_____	_____	_____
18-24	_____	_____	_____	_____	_____	_____
25-34	_____	_____	_____	_____	_____	_____
35-64	_____	_____	_____	_____	_____	_____
65+	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____
Member Months (Intensive Outpatient/Partial Hospitalization)				**Member Months (Outpatient/ED)**		
Age	Male	Female	Total	Male	Female	Total
0-12	_____	_____	_____	_____	_____	_____
13-17	_____	_____	_____	_____	_____	_____
18-24	_____	_____	_____	_____	_____	_____
25-34	_____	_____	_____	_____	_____	_____
35-64	_____	_____	_____	_____	_____	_____
65+	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-12	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
13-17	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
18-24	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
25-34	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____

Table IAD-1/2/3: Identification of Alcohol and Other Drug Services *(continued)*

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
35-64	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
65+	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____	_____	_____	_____	_____
	Female	_____	_____	_____	_____	_____	_____	_____	_____
	Total:	_____	_____	_____	_____	_____	_____	_____	_____

Outpatient Drug Utilization (ORX)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

This measure summarizes data on outpatient utilization of drug prescriptions, stratified by age, during measurement year. The following data are reported.

Total cost of prescriptions

Average cost of prescriptions PMPM

Total number of prescriptions

Average number of prescriptions PMPY

Calculations

Product lines Report the following tables for each applicable product line.

Table ORX-1a	Total Medicaid
Table ORX-1b	Medicaid/Medicare Dual-Eligibles
Table ORX-1c	Medicaid—Disabled
Table ORX-1d	Medicaid—Other Low Income
Table ORX-2	Commercial—by Product or Combined HMO/POS
Table ORX-3	Medicare

Age Age as of the date the prescription is dispensed.

Benefit Pharmacy.

Member months Report all member months for the measurement year for members with the benefit. Refer to *Specific Instructions for Use of Services Tables.*

Prescription One 30-day (or less) supply of pharmaceuticals.* Supplies (e.g., syringes) do not count toward this measure.

**To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round up to convert. For example, a 100-day prescription is equal to 4 dispensing events (100/30 = 3.33, rounded up to 4).*

Formulas **Total cost of prescriptions** = Discounted ingredient cost + dispensing or professional fees + administrative fees – formulary or other rebates.

The plan may be responsible for part of the total prescription cost and the member may be responsible for the remainder of the total cost. The total cost of prescriptions may be alternatively calculated as:

Total cost of prescriptions = plan cost + member cost.

Average total cost of prescriptions per member per month = [Discounted ingredient costs (before member copayments or deductibles) + dispensing or professional fees + administrative fees – formulary or other rebates]/member months for members with a pharmacy benefit.

Alternatively, average total cost of prescriptions = [plan costs + member costs]/ member months for members with a pharmacy benefit. For example, the average wholesale price for prescription "X" is $50. The plan negotiates a 20 percent discount with the pharmacy. There is a $5 dispensing fee and member copay is $4. Assuming no administrative fees or other rebates or formularies, the discounted ingredient cost is $40 ($50 average wholesale price less the 20 percent discount). The *total cost of prescriptions* is $45 ($40 discounted ingredient cost + $5 dispensing fee). While the cost to the member is $4 and the plan cost is $41 (for a total of $45), the breakdown of total prescription cost between the plan and the member is not reported.

Average total number of prescriptions per member per year = [Total number of prescriptions/member months for members with a pharmacy benefit] × 12 months.

Note

Results of this measure might be affected by differences in pharmacy benefits across health plans.

A health plan that dispenses rebates on a lump-sum basis should average the rebates over the total number of prescriptions.

Table ORX-1/2/3: Outpatient Drug Utilization

Age	Member Months
0-9	
10-17	
18-34	
35-49	
50-64	
65-74	
75-84	
85+	
Unknown	
Total:	

Table ORX-1/2/3: Outpatient Drug Utilization *(continued)*

Age	Total Cost of Prescriptions	Average Cost of Prescriptions PMPM	Total Number of Prescriptions	Average Number of Prescriptions PMPY
0-9	_____	_____	_____	_____
10-17	_____	_____	_____	_____
18-34	_____	_____	_____	_____
35-49	_____	_____	_____	_____
50-64				
65-74	_____	_____	_____	_____
75-84	_____	_____	_____	_____
85+	_____	_____	_____	_____
Unknown	_____		_____	
Total:	_____	_____	_____	_____

Antibiotic Utilization (ABX)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender.

- Total number of antibiotic prescriptions
- Average number of antibiotic prescriptions per member per year (PMPY)
- Total days supplied for all antibiotic prescriptions
- Average days supplied per antibiotic prescription
- Total number of prescriptions for antibiotics of concern
- Average number of prescriptions PMPY for antibiotics of concern
- Percentage of antibiotics of concern for all antibiotic prescriptions
- Average number of antibiotics PMPY reported by drug class:
  - For selected "antibiotics of concern"
  - For all other antibiotics

Note: *NCQA will provide a list of NDC codes for antibiotic medications on its Web site (www.ncqa.org) by November 16, 2009.*

Measure Attributes

Product lines Report the following tables for each applicable product line.

Table ABX-1a	Total Medicaid
Table ABX-1b	Medicaid/Medicare Dual-Eligibles
Table ABX-1c	Medicaid—Disabled
Table ABX-1d	Medicaid—Other Low Income
Table ABX-2	Commercial—by Product or Combined HMO/POS
Table ABX-3	Medicare

Report the information in Tables ABX-1/2/3 (a–c) by age and sex.

Age Age as of the date the prescription is dispensed.

Benefit Pharmacy.

Member months Report all member months for the measurement year for members with the benefit. IDSS automatically produces member years data for all product lines: Medicaid, commercial and Medicare. Refer to *Specific Instructions for Use of Services Tables.*

Antibiotic prescription A dispensed antibiotic for any duration.

Calculations

Total number of antibiotic prescriptions

Total number of all antibiotic prescriptions for the measurement year of any duration of the medication.

Average number of antibiotic prescriptions PMPY

Annual total number of antibiotic prescriptions PMPY = [Total number of antibiotic prescriptions in the year/member months for members with a pharmacy benefit] × 12 months.

Total days supplied for all antibiotic prescriptions

Count the number of days supplied for all antibiotic prescriptions during the measurement year. Organizations should identify the number of days supplied for each antibiotic prescription and sum the days for all antibiotic prescriptions during the measurement year.

Average number of days supplied per antibiotic prescription

Average number of days supplied per prescription = [Total days supplied for all antibiotics prescription in the year/Total number of antibiotic prescriptions in the year].

Table ABX-A: Antibiotic Medications

Description	Prescription		
Antibiotics of concern	amoxicillin-clavulanate	cefpodoxime	gemifloxacin
	azithromycin	cefprozil	levofloxacin
	aztreonam	ceftazidime	lomefloxacin
	clarithromycin	ceftibuten	moxifloxacin
	cefaclor	ceftizoxime	loracarbef
	cefdinir	ceftriaxone	linezolid
	cefditoren	cefuroxime	norfloxacin
	cefepime	clindamycin	ofloxacin
	cefixime	chloramphenicol	sparfloxacin
	cefotaxime	ciprofloxacin	telithromycin
	cefotetan	dalfopristin-quinupristin	vancomycin
	cefoxitin	gatifloxacin	
All other antibiotics	amikacin	erythromycin-sulfisoxazole	penicillin V potassium
	amoxicillin	fosfomycin	piperacillin
	ampicillin	gentamicin	piperacillin-tazobactam
	ampicillin-sulbactam	kanamycin	rifampin
	carbenicillin	lincomycin	sulfadiazine
	cefadroxil	metronidazole	sulfamethoxazole-trimethoprim
	cefazolin	minocycline	sulfasalazine
	cephalexin	nafcillin	sulfisoxazole
	cephradine	nitrofurantoin	tetracycline
	daptomycin	nitrofurantoin macrocrystals	ticarcillin
	doxycycline	dicloxacillin	ticarcillin-clavulanate
	erythromycin	oxacillin	streptomycin
	erythromycin estolate	penicillin G benzathine	tobramycin
	erythromycin ethylsuccinate	penicillin G potassium	trimethoprim
	erythromycin lactobionate	penicillin G procaine	
	erythromycin stearate	penicillin G sodium	

Calculations for Antibiotics of Concern

Total number of prescriptions for antibiotics of concern

Total number of all prescriptions for antibiotics of concern during the measurement year. Table ABX-B contains all antibiotics of concern.

Average number of prescriptions PMPY for antibiotics of concern

Annual total number of prescriptions for antibiotics of concern per member per year = [Annual number of prescriptions for antibiotics of concern/member months for members with a pharmacy benefit] × 12 months.

Percentage of antibiotics of concern of all antibiotic prescriptions

Percentage of prescriptions for antibiotics of concern of all antibiotic prescriptions = [Total number of prescriptions for antibiotics of concern in the year/Total number of antibiotic prescriptions in the year].

Table ABX-B: Antibiotics of Concern by NCQA Drug Class

Description	Prescription		
Quinolone	ciprofloxacin gatifloxacin gemifloxacin	levofloxacin lomefloxacin moxifloxacin	norfloxacin ofloxacin sparfloxacin
Azithromycin and clarithromycin	azithromycin	clarithromycin	
Cephalosporin (second, third, fourth generation)	cefaclor cefdinir cefditoren cefepime cefixime cefotaxime	cefotetan cefoxitin cefpodoxime cefprozil ceftazidime ceftibuten	ceftizoxime ceftriaxone cefuroxime loracarbef
Amoxicillin/clavulanate	amoxicillin-clavulanate		
Ketolide	telithromycin		
Clindamycin	clindamycin		
Miscellaneous antibiotics of concern	aztreonam chloramphenicol	dalfopristin-quinupristin linezolid	vancomycin

Calculations for Reporting by Drug Class

Antibiotic utilization by drug class

For each product line, report the utilization of antibiotic prescriptions by drug class in Tables ABX-1/2/3(b) and (c) for the following.

Antibiotics of concern

All other antibiotics

Antibiotics of concern

Report the utilization of antibiotics of concern by the following antibiotic drug classes in Table ABX-1/2/3(b).

Amoxicillin/clavulanate

Azithromycin and clarithromycin

Cephalosporin (includes second-, third- and fourth-generation cephalosporins)

Clindamycin

Ketolide

Quinolone

Miscellaneous antibiotics of concern

Refer to Table ABX-B for a list of antibiotics of concern and therapeutic classes.

All other antibiotics

Report the utilization of all other antibiotics by the following antibiotic drug classes in Table ABX-1/2/3(c).

Absorbable sulfonamide

Aminoglycoside

Cephalosporin (includes first generation only)

Lincosamide (other than clindamycin)

Macrolide (other than azithromycin and clarithromycin)

Penicillin (other than amoxicillin/clavulanate)

Tetracycline

Miscellaneous antibiotics

Refer to Table ABX-C for a list of all other antibiotics of concern and therapeutic classes.

Table ABX-C: All Other Antibiotics by NCQA Drug Class

Description	Prescription		
Absorbable sulfonamide	sulfadiazine sulfamethoxazole-trimethoprim	sulfasalazine sulfisoxazole	
Aminoglycoside	amikacin gentamicin	kanamycin streptomycin	tobramycin
Cephalosporin (first generation)	cefadroxil cefazolin	cephalexin cephradine	
Lincosamide (other than clindamycin)	lincomycin		
Macrolide (other than azithromycin and clarithromycin)	erythromycin erythromycin estolate erythromycin ethylsuccinate	erythromycin lactobionate erythromycin stearate erythromycin-sulfisoxazole	
Penicillin (other than amoxicillin/ clavulanate)	ampicillin ampicillin-sulbactam amoxicillin carbenicillin dicloxacillin nafcillin oxacillin penicillin G benzathine	penicillin G potassium penicillin G procaine penicillin G sodium penicillin V potassium piperacillin piperacillin-tazobactam ticarcillin ticarcillin-clavulanate	
Tetracyclines	doxycycline	minocycline	tetracycline
Miscellaneous antibiotics	daptomycin fosfomycin metronidazole nitrofurantoin	nitrofurantoin macrocrystals rifampin trimethoprim	

Table ABX-1/2/3: Plan Member Months

Member Months			
Age	**Male**	**Female**	**Total**
0-9	_____	_____	_____
10-17	_____	_____	_____
18-34	_____	_____	_____
35-49	_____	_____	_____
50-64	_____	_____	_____
65-74	_____	_____	_____
75-84			
85+	_____	_____	_____
Unknown	_____	_____	_____
Total:	_____	_____	_____

Table ABX-1/2/3(a): Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips for Antibiotics PMPY	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Anti-biotic Scrip	Total Scrips for Antibiotics of Concern	Average Scrips for Antibiotics of Concern PMPY	% of Antibiotics of Concern of All Antibiotic Scrips
0-9	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
10-17	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
18-34	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%

Table ABX-1/2/3(a): Antibiotic Utilization *(continued)*

Age	Sex	Total Antibiotic Scrips	Average Scrips for Antibiotics PMPY	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Scrips for Antibiotics of Concern	Average Scrips for Antibiotics of Concern PMPY	% of Antibiotics of Concern of All Antibiotic Scrips
35-49	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
50-64	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
65-74	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
75-84	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
85+	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
Unknown	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%
Total	Male	_____	_____	_____	_____	_____	_____	_____%
	Female	_____	_____	_____	_____	_____	_____	_____%
	Total:	_____	_____	_____	_____	_____	_____	_____%

Table ABX-1/2/3(b): Antibiotics of Concern Utilization by Drug Class

Age	Sex	Total Quino-lone Scrips	Avg Scrips for Quino-lone PMPY	Total Ceph-alo-sporin Scrips	Avg Scrips for Ceph-alo-sporin PMPY	Total Azithro-mycin & Clar-ithro-mycin Scrips	Avg Scrips for Azithro-mycin & Clar-ithro-mycin PMPY	Total Amox-icillin/ Clavu-lanate Scrips	Avg Scrips PMPY for Amox-icillin/ Clavu-lanate PMPY	Total Keto-lide Scrips	Avg Scrips for Keto-lide PMPY	Total Clinda-mycin Scrips	Avg Scrips for Clinda-mycin PMPY	Total Misc Anti-biotics of Concern Scrips	Avg Scrips for Misc Anti-biotics of Concern PMPY
0-9	Male														
	Female														
	Total:														
10-17	Male														
	Female														
	Total:														
18-34	Male														
	Female														
	Total:														
35-49	Male														
	Female														
	Total:														
50-64	Male														
	Female														
	Total:														
65-74	Male														
	Female														
	Total:														
75-84	Male														
	Female														
	Total:														

Table ABX-1/2/3(b): Antibiotics of Concern Utilization by Drug Class *(continued)*

Age	Sex	Total Quino-lone Scrips	Avg Scrips for Quino-lone PMPY	Total Ceph-alo-sporin Scrips	Avg Scrips for Ceph-alo-sporin PMPY	Total Azithro-mycin & Clar-ithro-mycin Scrips	Avg Scrips for Azithro-mycin & Clar-ithro-mycin PMPY	Total Amox-icillin/ Clavu-lanate Scrips	Avg Scrips PMPY for Amox-icillin/ Clavu-lanate PMPY	Total Keto-lide Scrips	Avg Scrips for Keto-lide PMPY	Total Clinda-mycin Scrips	Avg Scrips for Clinda-mycin PMPY	Total Misc Anti-biotics of Concern Scrips	Avg Scrips for Misc Anti-biotics of Concern PMPY
85+	Male														
	Female														
	Total:														
Unknown	Male														
	Female														
	Total:														
Total:	Male														
	Female														
	Total:														

Table ABX-1/2/3(c): All Other Antibiotic Utilization by Drug Class

Age	Sex	Total Absorb-able sulfona-mide Scrips	Avg Scrips for Absorb-able sulfona-mide PMPY	Total Amino-glyco-side Scrips	Avg Scrips for Amino-glyco-side PMPY	Total 1st Gen Ceph-alo-spor-ins Scrips	Avg Scrips for 1st Gen Ceph-alo-spor-ins PMPY	Total Linco-samide Scrips	Avg Scrips for Linco-samide PMPY	Total Macro-lides (not azith., clar.) Scrips	Avg Scrips for Macro-lides (not azith. , clar.) PMPY	Total Peni-cillin Scrips	Avg Scrips for Peni-cillin PMPY	Total Tetra-cycline Scrips	Avg Scrips for Tetra-cyc-line PMPY	Total Misc. Anti-biotics Scrips	Avg Scrips for Misc. Anti-biotics PMPY
0-9	M																
	F																
	Tot.																
10-17	M																
	F																
	Tot.																
18-34	M																
	F																
	Tot.																
35-49	M																
	F																
	Tot.																
50-64	M																
	F																
	Tot.																
65-74	M																
	F																
	Tot.																
75-84	M																
	F																
	Tot.																

Table ABX-1/2/3(c): All Other Antibiotic Utilization by Drug Class *(continued)*

Age	Sex	Total Absorb-able sulfona-mide Scrips	Avg Scrips for Absorb-able sulfona-mide PMPY	Total Amino-glyco-side Scrips	Avg Scrips for Amino-glyco-side PMPY	Total 1st Gen Ceph-alo-spor-ins Scrips	Avg Scrips for 1st Gen Ceph-alo-spor-ins PMPY	Total Linco-samide Scrips	Avg Scrips for Linco-samide PMPY	Total Macro-lides (not azith., clar.) Scrips	Avg Scrips for Macro-lides (not azith. , clar.) PMPY	Total Peni-cillin Scrips	Avg Scrips for Peni-cillin PMPY	Total Tetra-cycline Scrips	Avg Scrips for Tetra-cyc-line PMPY	Total Misc. Anti-biotics Scrips	Avg Scrips for Misc. Anti-biotics PMPY
85+	M	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	F	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	Tot.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Un.	M	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	F	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	Tot:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Total	M	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	F	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	Tot.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Board Certification (BCR)

SUMMARY OF CHANGES TO HEDIS 2010

Clarified that physicians listed in an organization's directory should be included.

Description

The percentage of the following physicians whose board certification is *active* as of December 31 of the measurement year.

Family medicine physicians	Pediatricians	Geriatricians
Internal medicine physicians	OB/GYN physicians	Other physician specialists

Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association. The organization should report separately for each product as of December 31 of the measurement year.

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

Physicians This measure applies to independent physicians or group of physicians who provide care for members.

***Organizations must* include:**

Physicians who have an independent relationship with the organization. An **independent relationship** exists when the organization selects and directs its members to see a specific physician or group of physicians. An independent relationship is not synonymous with an "independent contract." Physicians may contract directly with the organization or indirectly (e.g., physicians contract with an IPA).

Physicians who are listed in the organization's directory.

Physicians who see members outside of the inpatient hospital setting or outside of free-standing facilities.

Physicians who are hospital based and who see members as a result of their independent relationship with the organization; for example:

- Anesthesiologists with pain management practices
- Hospital-based cardiologists
- Hospital-based faculty (provided that they meet the criteria listed above)

***Organizations must* exclude:**

Physicians who practice exclusively within the inpatient hospital setting and who provide care for members only as a result of members being directed to the hospital; for example:

Pathologists	ED physicians
Radiologists	Chiropractors
Anesthesiologists	Podiatrists
Neonatologists	

Physicians who practice exclusively within free-standing facilities and who provide care for members only as a result of members being directed to the facility; for example:

Mammography centers

Urgent care centers

Surgicenters

Dentists who do not provide care under the organization's medical benefits; for example:

Endodontists

Oral surgeons

Periodontists

Dentists who provide primary dental care under a dental plan or rider.

Categories Table BCR-A indicates how to identify physicians.

Table BCR-A: Identifying Physicians

Product Line	Family Medicine	Internal Medicine	Pediatricians	OB/GYN	Geriatricians	Other Physician Specialists
Commercial	✓	✓	✓	✓	✓	✓
Medicaid	✓	✓	✓	✓	✓	✓
Medicare	✓	✓			✓	✓

Definitions

Family medicine physician A physician who provides preventive and diagnostic health care services for individuals and families. Report general practitioners in the *Family Medicine* category.

Internal medicine physician A physician who provides long-term and comprehensive care and manages common and complex illness of adolescents, adults and the elderly.

Pediatrician A physician who provides preventive and diagnostic health care services for infants, children and adolescents.

OB/GYN physician A physician who provides medical and surgical care relating to the female reproductive system and associated disorders.

Geriatrician A family medicine or internal medicine physician who has special knowledge of the aging process and special skills in the diagnostic, therapeutic, preventive and rehabilitative aspects of illness in the elderly.

Other physician specialist Any other physician specialist or physician subspecialist not specified above.

Calculation of Board Certification

Number of physicians in each practice area

Refer to Table BCR-1/2/3. For each product line, identify the number of physicians (with active or inactive board certification) in each practice area, by type and number, with whom the organization contracted as of December 31 of the measurement year.

Physicians are assumed to practice in the clinical area or areas in which they are listed in the organization's *internal* directory or classification system. Physicians listed under more than one category should be counted as many times as they are listed and should be included in each area of practice. For example, a family medicine physician who also practices as a geriatrician should be reported in both the Family Medicine category and the Geriatrician category.

Physicians do not have to be listed in the organization's external provider directory to be included in the measure. Physicians associated with an entity (e.g., vendor) should only be counted if located in areas where the organization is licensed to operate.

Board certification number

Report the number of physicians in each practice area with active board certification. For example, to be counted as a board-certified geriatrician, a physician must have a specialty certification in geriatric medicine.

A physician with recent board certification who has not completed a residency/fellowship may be counted as board certified.

Confirmation by the appropriate certifying body that a physician is eligible for, and has applied to, a board-certification program, may not be counted as board certification.

Board certification percentage

For each type of physician, calculate the percentage whose board certification is active by dividing the board certification number by the number of physicians in each practice area.

First, determine the number of areas of specialization and board certification status for each physician; then determine how to count them in the denominator (i.e., number of physicians in each practice area) and numerator (i.e., number of active board-certified physicians) of the calculation.

A physician with only one specialty who is not board certified in that specialty counts as 1 in the denominator and 0 in the numerator.

A physician with only one specialty whose board certification is active in that specialty counts as 1 in the denominator and 1 in the numerator.

A physician with more than one specialty counts as 1 in the denominator for each specialty. Count in the numerator the number of specialty areas in which the physician has active board certification.

Example

A physician listed under both hematology and medical oncology counts as 2 in the denominator for *Other Physician Specialists*.

A physician whose board certification is active in both hematology and medical oncology counts as 2 in the numerator.

A physician whose board certification is active in only one of these two areas counts as 1 in the numerator.

A physician whose board certification is not active in either area counts as 0 in the numerator.

Note

The physician definitions for this measure are based on the American Board of Medical Specialties (ABMS) definitions for physician specialties.

The numbers in the column Number of Physicians in Each Practice Area *may not be the same as the* organization*'s actual number of physicians because some physicians may practice in more than one area and will be counted in the denominators of several percentages.*

Table BCR-1/2/3: Board Certification

Type of Physician	Number of Physicians in Each Practice Area	Active Board Certification	
		Number	Percentage
Family medicine			
Internal medicine			
Pediatricians			
OB/GYN			
Geriatricians			
Other physician specialists			

Enrollment by Product Line (ENP)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The total number of members enrolled in the product line, stratified by age and sex.

Calculations

Product lines Report the following tables for each applicable product line, stratified by age and sex.

Table ENP-1a	Total Medicaid
Table ENP-1b	Medicaid/Medicare Dual-Eligibles
Table ENP-1c	Medicaid—Disabled
Table ENP-1d	Medicaid—Other Low Income
Table ENP-2	Commercial—by Product or Combined HMO/POS
Table ENP-3	Medicare

Member months For each product line, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Use of Services Tables* in *Guidelines for Use of Services Measures* for more information.

Medicaid Beneficiary Category Assignment

The organization assigns Medicaid members to beneficiary categories based on a state-provided list of all payment-rate categories used by that state and the organization in their contract. The state should use the algorithm provided below (described in Categories A–D) to assign each payment-rate category it uses to one of the three beneficiary categories and provide this categorization of rate categories to the organization. The organization should then report Medicaid members using the state's categories. The state should classify beneficiaries according to the hierarchy below, beginning with Category A.

This algorithm addresses variables most likely to influence utilization patterns.

The presence of a Medicare benefit

The presence of a disability

Whether or not there is a restricted benefits package

This last group is not reported separately because of its anticipated small numbers, but it is included in the total count of Medicaid members

Category A

Total Medicaid—Table ENP-1a Include all Medicaid members enrolled in the organization who receive Medicaid benefits, including those who receive a restricted benefits package smaller in scope than the other Medicaid members enrolled in the same organization. A **restricted benefits package** meets one of the following criteria.

- Pregnant women whose Medicaid eligibility is based on poverty-related coverage and whose Medicaid benefits are restricted to services related to pregnancy and other conditions that may complicate pregnancy, ***or***
- Other individuals whose benefits are limited (e.g., emergency services)

The organization should include individuals in either of these two groups in this category. Total Medicaid also includes the sum of Categories B–D.

Go to Category B if a member does not meet the criteria for Category A.

Category B

Medicaid/Medicare Eligible—Table ENP-1b Include all Medicaid members (including children) entitled both to the state's full Medicaid benefit for which the organization has contracted and to Medicare Part A or B benefits.

Qualified Medicare Beneficiaries (QMB), other specified low-income Medicare beneficiaries, Qualified Disabled and Working Individuals (QDWI) and Qualified COBRA Continuation Beneficiaries whose Medicaid benefit is limited to the payment of a premium for Medicare or commercial coverage are not included in this category because these individuals do not receive the Medicaid benefit package.

Go to Category C if a member does not meet the criteria for Category B.

Category C

Disabled—Table ENP-1c Include all Medicaid members who do not meet the criteria for Category B *and* who receive Medicaid benefits wholly or in part because of physical or mental disability. This category includes supplemental security income (SSI) beneficiaries, SSI-related beneficiaries and other disabled, medically needy beneficiaries.

Go to Category D if a Medicaid beneficiary does not meet the criteria for Category B and does not receive Medicaid based on a disability (Category C).

Category D

Other Low Income—Table ENP-1d Include all non-disabled, non-Medicare, low-income Medicaid beneficiaries who do not meet the criteria for Category B or Category C.

Note

NCQA recognizes that most organizations do not serve Medicaid beneficiaries in all categories. Not many serve the few individuals with a restricted benefits package (see Category A).

Table Instructions

Use Table ENP-1/2/3 to report the organization's enrollment by product line for the most recent calendar year, based on member months.

Medicaid (Tables 1a-1d)

Assign Medicaid beneficiaries to Categories A–D based on the definitions provided above.

Report by eligibility category the number of member months by age and sex, including subtotals.

Calculate the subtotal percentages within each eligibility category by dividing the total subtotal member months into total member months by sex (e.g., [X member months of enrolled Medicaid disabled males, 0–19/Y member months for all Medicaid disabled males, 0–90+ and age unknown] x 100 = Z percent of member months for Medicaid disabled males, 0–19 years of all male Medicaid disabled member months).

Commercial (Table 2)

Report by commercial product line the number of member months by age and sex, including subtotals.

Calculate the subtotal percentages within the commercial product line by dividing the total subtotal member months into total member months by sex (e.g., [X member months of enrolled commercial product males, 0–19/Y member months for all commercial product males, 0–90+ and age unknown] x 100 = Z percent of member months for commercial product males, 0–19 years of age of all male commercial product member months).

Medicare (Table 3)

Report by Medicare product line the number of member months by age and sex, including subtotals.

Calculate the subtotal percentages within the Medicare product line by dividing the total subtotal member months into total member months by sex (e.g., [X member months of enrolled Medicare males 0-19/Y member months for all Medicare males, 0–90+ and age unknown] x 100 = Z percent of member months for Medicare males, 0–19 years of age of all male Medicare member months).

Table ENP-1/2/3: Member Months of Enrollment by Product Line

Age	Male	Female	Total
<1			
1-4			
5-9			
10-14			
15-17			
18-19			
0-19 Subtotal:			
0-19 Subtotal (%):	%	%	%
20-24			
25-29			
30-34			
35-39			
40-44			
20-44 Subtotal:			
20-44 Subtotal (%):	%	%	%
45-49			
50-54			
55-59			
60-64			
45-64 Subtotal:			
45-64 Subtotal (%):	%	%	%
65-69			
70-74			
75-79			
80-84			
85-89			
≥90			
≥65 Subtotal:			
≥65 Subtotal (%):	%	%	%
Age unknown			
Total:			

Enrollment by State (EBS)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

The number of members enrolled as of December 31 of the measurement year, by state.

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

Anchor Date December 31 of the measurement year.

Calculation

Calculate enrollment by state using the address on record for members on December 31 of the measurement year, to be determined according to the organization's administrative processes. Report by categories (states and territories) listed in Table EBS-1/2/3. If the member's address is unknown or does not match, report as "Other." If a child's address is not captured, the organization may use the address of the policyholder, parent or caretaker.

Report on total unduplicated membership as of December 31 of the measurement year. If the organization assigns a new member number to members who disenroll and reenroll during the measurement year, it must develop a system to avoid double-counting members.

Table EBS-1/2/3: Member Enrollment by State

State	Number	State	Number	State	Number
Alabama		Michigan		Utah	
Alaska		Minnesota		Vermont	
Arizona		Mississippi		Virginia	
Arkansas		Missouri		Washington	
California		Montana		West Virginia	
Colorado		Nebraska		Wisconsin	
Connecticut		Nevada		Wyoming	
Delaware		New Hampshire		American Samoa	
District of Columbia		New Jersey		Fed. Sts. of Micronesia	
Florida		New Mexico		Guam	
Georgia		New York		Cmnwlth. of N. Marianas	
Hawaii		North Carolina		Puerto Rico	
Idaho		North Dakota		Virgin Islands	
Illinois		Ohio		Other	
Indiana		Oklahoma		***Total:***	
Iowa		Oregon			
Kansas		Pennsylvania			
Kentucky		Rhode Island			
Louisiana		South Carolina			
Maine		South Dakota			
Maryland		Tennessee			
Massachusetts		Texas			

Race/Ethnicity Diversity of Membership (RDM)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.

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

Calculations

Table instructions Report the number and percentage of members by race/ethnicity stratified by gender for the product population. If a member's race or ethnicity is unknown or unavailable from the state agency or CMS, report as "Unknown."

Report on total unduplicated membership during the measurement year. If the organization assigns a new member number to members who disenroll and reenroll during the measurement year, it must develop a system to prevent double counting members.

Data source Obtain race and ethnicity data from enrollment information furnished by state Medicaid agencies or by CMS, or supplemented through the organization's own direct data collection from members (e.g., surveys, health risk assessments, disease management registries) or through other available indirect methods (e.g., surname analysis, geocoding). When using CMS as the data source, refer to Table RDM-A for a crosswalk of reporting categories for the RDM measure.

Race Reporting Category Definitions

White People whose origins are in any of the original peoples of Europe, the Middle East or North Africa; including people who indicated their race or races as "White" or wrote in entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab or Polish.

Black or African American People whose origins are in any of the Black racial groups of Africa; including people who indicated their race or races as "Black, African Am., or Negro," or wrote in entries such as African American, Afro-American, Nigerian or Haitian.

American Indian and Alaska Native People whose origins are in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment; including people who indicated their race or races by marking this category or writing in their principal or enrolled tribe, such as Rosebud, Sioux, Chippewa or Navajo.

Asian People who are Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese and "Other Asian," which may include people who are Burmese, Hmong, Pakistani, Thai or from two or more Asian subgroups.

Native Hawaiian and Other Pacific Islander	People whose origins are in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands; including Carolinian, Fijian, Kosraean, Melanesian, Micronesian, Northern Mariana Islander, Palauan, Papua New Guinean, Ponapean (Pohnpelan), Polynesian, Solomon Islander, Tahitian, Tarawa Islander, Tokelauan, Tongan, Trukese (Chuukese) and Yapese.
Some Other Race	People whose race information has been collected but does not fit into any of the other seven race categories. This category includes people who may be Mulatto, Creole and Mestizo or another race not specified in the Census race categories.
Two or More Races	People with any combination of races, including "Some Other Race."
Ethnicity reporting category: **Hispanic or Latino**	People of Spanish, Mexican, Puerto Rican or Cuban origins. ***Note:*** *NCQA encourages collecting and reporting race and Hispanic ethnicity based on categories adapted from the official U.S. census forms established by the U.S. Department of Commerce, Bureau of the Census and defined by the Office of Management and Budget (OMB). Because CMS and state agencies may have varying classification schemes for race and ethnicity, refer to Table RDM-A for HEDIS reporting.*

Table RDM-A: CMS/HEDIS Crosswalk for Reporting Categories

CMS Category	HEDIS Race	HEDIS Ethnicity
0 = Unknown	Unknown	Unknown
1 = White not Hispanic	White	Not Hispanic
2 = Black not Hispanic	Black	Not Hispanic
3 = Other	Some Other Race	Unknown
4 = Asian	Asian	Unknown
5 = Hispanic	Unknown	Hispanic
6 = North American Native	American Indian/AN	Unknown

Table RDM-1/3: Race/Ethnicity Diversity of Membership

Data Source: _____
Values include NR, CMS, Health plan direct, Surname analysis/geo-coding, Multiple sources, Other
Total unduplicated membership during the measurement year:
Number of members: _____

The total unduplicated count of members in the organization is the denominator for calculating the percentages. Each cell represents the proportion of members of a specific race/ethnicity combination of the total unduplicated count of members in the organization.

Percentage of members with known race information (sum all the race categories, except Unknown Race, and divide by the number of total unduplicated members during the measurement year): _____

Percentage of members with known ethnicity information (sum all the ethnicity categories, except Unknown Ethnicity, and divide by the number of total unduplicated members during the measurement year): _____

Table RDM-1/3: Race/Ethnicity Diversity of Membership *(continued)*

Race	Sex	Hispanic or Latino		Not Hispanic or Latino		Unknown Ethnicity		Total	
		Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
White	Male								
	Female								
	Total:								
Black or African-American	Male								
	Female								
	Total:								
American-Indian and Alaska Native	Male								
	Female								
	Total:								
Asian	Male								
	Female								
	Total:								
Native Hawaiian and Other Pacific Islander	Male								
	Female								
	Total:								
Some other race	Male								
	Female								
	Total:								
Two or more races	Male								
	Female								
	Total:								
Unknown	Male								
	Female								
	Total:								
Total	Male								
	Female								
	Total:								100%

Language Diversity of Membership (LDM)

SUMMARY OF CHANGES TO HEDIS 2010

No changes to this measure.

Description

An unduplicated count and percentage of Medicaid and Medicare members enrolled at any time during the measurement year by demand for language interpreter services and spoken language.

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

Calculations

Table instructions

Report the number and percentage of members by demand for language interpreter services and spoken language stratified by gender for each product population. If a member's interpreter service needs or spoken language is unknown or unavailable from the state agency or CMS, report as "Unknown."

Report total unduplicated membership during the measurement year. If the organization assigns a new member number to members who disenroll and reenroll during the measurement year, it must develop a system to prevent double-counting members.

Data source

Obtain interpretation service needs and language spoken from enrollment information furnished by state Medicaid agencies or supplemented through data that the organization collected from its members (e.g., surveys, health risk assessments, disease management registries) or through indirect methods (e.g., surname analysis, geo-coding).

Need/Want Interpreter

Identify individuals who need or want interpreter services; enter this information in Table LDM-1/3. This information should be reported by gender for the organization population.

Data collection guidance for organizations and agencies. This information can be gathered through a two-part question to beneficiaries/members:

(Does the Medicaid or Medicare beneficiary) Do you need or want an interpreter to communicate with a doctor or health care practitioner?

No

Yes

Unknown (if data are unavailable)

Spoken Language

Indicate the language spoken by the member at home most of the time; enter this information in Table LDM-1/3. This information should be reported by gender for the organization population.

Data collection guidance for organizations and agencies. This information may be gathered through the second part of a two-part question:

What language (does the beneficiary) do you speak most of the time at home?

Note

The U.S. Census asks Does this person speak a language other than English at home?

Table LDM-1/3: Language Diversity of Membership

Data source: _____

Values include NR, CMS, Health plan direct, Surname analysis/geo-coding, Multiple sources, Other

Total unduplicated membership during the measurement year:

Number of members _____

The total unduplicated count of members in the organization is the denominator for calculating the percentages. Each cell represents the proportion of members with identified demand for interpreter services and indicated spoken language of the total unduplicated count of members in the organization.

Demand for Language Interpretation Services	Sex	Number	Percentage
Need/Want an Interpreter Yes	Male		
	Female		
	Total:		
Need/Want an Interpreter No	Male		
	Female		
	Total:		
Need/Want an Interpreter Unknown	Male		
	Female		
	Total:		
Total: *(This should sum to 100%)*	Male		
	Female		
	Total:		
Percentage of members with known interpretation needs: *(Sum the Yes/No categories and divide by the number of total unduplicated members during the measurement year)*			
English	Male		
	Female		
	Total:		
Spanish (or Spanish Creole)	Male		
	Female		
	Total:		
Other Indo-European Languages (e.g., French or French Creole, Italian, Portuguese or Portuguese Creole, German, Yiddish, Scandinavian languages, Greek, Russian, Polish, Serbo-Croatian, Armenian, Persian, Gujarathi, Hindi, Urdu)	Male		
	Female		
	Total:		
Asian and Pacific Island Languages (e.g., Chinese, Japanese, Korean, Mon-Khmer, Cambodian, Miao, Hmong, Thai, Laotian, Vietnamese, Tagalog and Other Pacific Island languages)	Male		
	Female		
	Total:		

Table LDM-1/3: Language Diversity of Membership *(continued)*

Spoken Language at Home	Sex	Number	Percentage
Other Languages (e.g., Navajo, Other Native North American languages, Hungarian, Arabic, Hebrew, African languages)	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Unknown	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Total: *(this should sum to 100%)*	Male	_____	_____
	Female	_____	_____
	Total:	_____	_____
Percentage of members with known spoken language: *(Sum all the language categories, except unknown and divide by the number of total unduplicated members during the measurement year)*		_____	_____

Note

CMS does not provide language information on its Medicare beneficiaries. Medicare organizations should obtain language data through alternate sources, including surveys and case management and enrollment registries.