

17 QARR

17.1 QUALITY ASSURANCE REPORTING REQUIREMENTS

QARR (Quality Assurance Reporting Requirements) and HEDIS (Healthcare Effectiveness Data and Information Set) are a set of standardized health care performance measures used by over 90% of America's health plans to measure performance. It was developed by NCQA (National Committee for Quality Assurance) as well as the New York State Department of Health.(NYSDOH) and it allows you to compare your health care performance to other health plans as well as state and national benchmarks

Data is collected and reported annually. Scores are reflective of the care and services provided to our members by our physicians.

Plan rates are published yearly and used for member assignment and quality incentives.

By comparing rates from year to year, the Plan can identify its performance compared to other health plans and identify opportunities to improve the quality of care our members receive.

Most of QARR and HEDIS data is collected through claims and encounters that are submitted for medical office visits, hospitalizations, and procedures. Plans are allowed to supplement some clinical measures by medical record review but it is of paramount importance that claims and encounters are submitted to the Plan with the correct codes.

QARR/ HEDIS reportable measures:

- Childhood Immunizations
- Lead Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening In Women
- Appropriate Testing For Children With Pharyngitis
- Appropriate Treatment For Children With Upper Respiratory Conditions
- Avoidance Of Antibiotic Treatment In Adults With Acute Bronchitis
- Use Of Spirometry Testing In The Assessment And Diagnosis Of COPD

- Pharmacotherapy Management Of COPD Exacerbation
- Use Of Appropriate Medications For People With Asthma
- Cholesterol Management For Patients With Cardiovascular Conditions
- Controlling High Blood Pressure
- Diabetes Management
- Disease Modifying Anti – Rheumatic Drug Therapy For Rheumatoid Arthritis
- Use Of Imaging Studies For Low Back Pain
- Antidepressant Medication Management
- Follow Up Care For Children Prescribed ADHD Medication
- Follow-Up Of Hospitalization For Mental Illness
- Annual Monitoring For Patients On Persistent Medications
- Annual Dental Visit
- Timeliness Of Prenatal/Postpartum Care
- Well Child Care Visits
- Adolescent Screening And Counseling
- Adult BMI
- Antidepressant Medication Management
- Appropriate Asthma Medications 3+ controllers
- HIV/AIDS Comprehensive Care
- Weight Assessment And Counseling for Nutrition and Physical Activity for children/ adolescents

17.1.1 IMMUNIZATIONS

This measure evaluates the number of children who received all required immunizations by their 2nd birthday.

Immunization regimens are consistent with those guidelines set by the *American Academy of Pediatrics (AAP)*, *Center for Disease Control and Prevention (CDC)*, and the *Advisory Committee on Immunization Practices (ACIP)*. These recommendations are as follows:

| Vaccination | Required # of Vaccinations |
|------------------------|---|
| DtaP/DT | Four DtaP vaccinations with different dates of service on or before the child's second birthday. DtaP administered prior to 42 days after birth can not be counted. |
| IPV | At least three polio vaccinations (IPV) with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth can not be counted. |
| MMR | At least one measles, mumps and rubella vaccination with a date of service on or before the second birthday. |
| HIB | Three H influenza type B (HiB) vaccinations, with different dates of service on or before the child's second birthday. HIB administered prior to 42 days after birth can not be counted. |
| Hepatitis B | Three Hepatitis B vaccinations, with different dates of service on or before the child's second birthday. |
| VZV | At least (1) Varicella Zoster vaccine with a date of service falling on or before the child's second birthday. |
| Pneumococcal Conjugate | At least four pneumococcal conjugate vaccinations with different dates of service on or before the child's second birthday. Do not count any vaccination administered prior to 42 days after birth. |
| Hepatitis A | Two Hepatitis A vaccinations, with different dates of service on or before the child's second birthday. |
| Rotavirus | The child must receive the required number of rotavirus vaccinations (two doses or three doses, depending on which vaccine is administered), on different dates of service on or before the child's second birthday. Do not count any vaccination administered prior to 42 days |

| Vaccination | Required # of Vaccinations |
|-------------|--|
| | after birth. The number of rotavirus doses varied based on which vaccine is given. There is a two-dose schedule and a three-dose schedule. The vaccines are identified by different CPT codes (Table below). |
| Influenza | Two influenza vaccinations, with different dates of service on or before the child's second birthday. Do not count any vaccination administered prior to six months after birth. |

As with all vaccines, if a child has a severe allergy to one or some of the vaccine's components, it must be documented in the chart. If a child has been exposed to the natural infection (e.g. varicella, measles, rubella) it should be clearly documented in the chart.

Patients often receive vaccines at more than one provider's office.

For our New York City providers, we would like to stress the importance of reporting all vaccinations to the New York City Department of Health's Citywide Online Immunization Registry (CIR).

Codes to Identify Childhood Immunizations

| Immunization | CPT | HCPCS | ICD-9-CM Diagnosis* | ICD-9-CM Procedure |
|------------------------|----------------------------------|-------|---------------------|--------------------|
| DTaP | 90698, 90700, 90721, 90723 | | | 99.39 |
| Diphtheria and tetanus | 90702 | | | |
| Diphtheria | 90719 | | | 99.36 |
| Tetanus | 90703 | | | 99.38 |
| Acellular pertussis | | | | 99.37 |
| IPV | 90698, 90713, 90723 | | | 99.41 |
| MMR | 90707, 90710 | | | 99.48 |
| Measles and rubella | 90708 | | | |
| Measles | 90705 | | 055 | 99.45 |
| Mumps | 90704 | | 072 | 99.46 |
| Rubella | 90706 | | 056 | 99.47 |
| HiB | 90645-90648, 90698, 90721, 90748 | | | |

| Immunization | CPT | HCPCS | ICD-9-CM Diagnosis* | ICD-9-CM Procedure |
|----------------------------------|-----------------------------------|-------|----------------------|--------------------|
| Hepatitis B** | 90723, 90740, 90744, 90747, 90748 | G0010 | 070.2, 070.3, V02.61 | |
| VZV | 90710, 90716 | | 052, 053 | |
| Pneumococcal conjugate | 90669 | G0009 | | |
| Hepatitis A | 90633 | | 070.0, 070.1 | |
| Rotavirus (two doses schedule) | 90681 | | | |
| Rotavirus (three doses schedule) | 90680 | | | |
| Influenza | 90655, 90657, 90661, 90662 | G0008 | | 99.52 |

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

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

17.1.2 LEAD TESTING

This measure evaluates the number of children who received at least one capillary or venous lead test by their 2nd birthday.

Any medical record documentation, including laboratory slips, is considered sufficient provided that it includes all of the following:

- ❖ Child's Name and ID Number
- ❖ Child's date of birth (a notation of the child's age is not sufficient evidence of DOB)
- ❖ Date test was performed
- ❖ Result of the test

Primary care providers (PCPs) are expected to retain a copy of their patients' laboratory test results and provide relevant follow-up even if the PCP has not ordered the test (e.g. lead test, cervical cancer screening and immunizations). Federal Medicaid regulations require that all children receive a blood lead screening test at ages 12 and 24 months.

For our New York City providers, we would like to stress the importance of reporting all vaccinations to the New York City Department of Health's Citywide Online Registry.

Codes to Identify Lead Tests

| CPT | LOINC |
|-------|---|
| 83655 | 17052-2, 5671-3, 10368-9, 27129-6, 5674-7, 10912-4, 14807-2, 32325-3, 25459-9 |

17.1.3 BREAST CANCER SCREENING

This measure evaluates the percentage of women, age 40 – 69 who had a mammography to screen for breast cancer.

The mammogram had to be performed during the measurement year or the year prior to the measurement year.

If there is a strong family history of breast cancer occurring at an early age, a mammogram is recommended prior to the age of 35. In addition, patients should be advised to perform a monthly self-breast exam.

Codes to Identify Breast Cancer Screening

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

Exclusions of bilateral mastectomy must be documented in the medical record

17.1.4 CERVICAL CANCER SCREENING

This measure evaluates the percentage of women between the ages of 21-64 years old with one (or more) Pap tests during the measurement year or the two years prior to the measurement year.

The following must clearly be documented in the patient’s medical record/chart:

- ✧ Date the PAP test was performed
- ✧ Result or finding(s)

If a woman is referred elsewhere to have a pap test performed, it is expected that a copy of the result or finding(s) be in the patient’s chart.

Exclusionary evidence indicating a hysterectomy with no residual cervix must be documented in the medical record.

Codes to Identify Cervical Cancer Screening

| CPT | HCPCS | ICD-9-CM Diagnosis | ICD-9-CM Procedure | UB Revenue | LOINC |
|---|---|--------------------|--------------------|------------|---|
| 88141-88143, 88147, 88148, 88150, 88152- 88155, 88164- 88167, 88174- 88175 | G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 | V72.32, V76.2 | 91.46 | 0923 | 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0 |

17.1.5 CHLAMYDIA SCREENING IN WOMEN

Women aged 16-24 as of Dec 31, identified as sexually active*, with at least one Chlamydia test in the measurement year.

The two methods to identify sexually active women; pharmacy data and claim/encounter data.

Prescriptions to Identify Contraceptives

Contraceptives

- desogestrel-ethinyl estradiol
- drospirenone-ethinyl estradiol
- estradiol-medroxyprogesterone
- ethinyl estradiol-ethynodiol
- ethinyl estradiol-etonogestrel
- ethinyl estradiol-levonorgestrel
- ethinyl estradiol-norelgestromin
- ethinyl estradiol-norethindrone
- ethinyl estradiol-norgestimate
- ethinyl estradiol-norgestrel
- etonogestrel
- levonorgestrel
- medroxyprogesterone
- mestranol-norethindrone

Diaphragm

- diaphragm

Spermicide

- nonxynol 9

Codes to Identify Sexually Active Women

CPT 11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025,

82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84704, 86592-86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87660, 87800, 87801, 87808, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269

HCPCS G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0180, S0199, S4981, S8055

ICD-9-CM Diagnosis 042, 054.10, 054.11, 054.12, 054.19, 078.11, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 614-616, 622.3, 623.4, 626.7, 628, 630-679, 795.0, 795.1, 996.32, V01.6, V02.7, V02.8, V08, V15.7, V22-V28, V45.5, V61.5-V61.7, V69.2, V72.3, V72.4, V73.81, V73.88, V73.98, V74.5, V76.2

ICD-9-CM Procedure 69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 88.78, 97.24, 97.71, 97.73

UB Revenue 0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925

Codes to Identify Chlamydia Screening

| CPT | LOINC |
|---|--|
| 87110, 87270, 87320, 87490, 87491, 87492, 87810 | 557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 16602-5, 20993-2, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43406-8, 53925-4, 53926-2. |

17.1.6 APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

The number of children 2 – 18 years of age, who had only a diagnose of pharyngitis* and, dispensed an antibiotic **and** received a strep test for the episode.

Codes to Identify Pharyngitis

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

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

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

Diagnosis of streptococcal pharyngitis with the appropriate laboratory test, i.e., throat culture, “rapid strep” test, should be completed **prior to** prescribing antibiotics. Include any secondary diagnosis if appropriate.

17.1.7 APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY CONDITIONS

The percentage of children 3 months -18 years of age who had only a diagnosis of upper respiratory infection (URI) and were **not** dispensed an antibiotic. Include any secondary diagnosis if appropriate.

Codes to Identify URI

Acute nasopharyngitis (common cold) 460
URI 465

17.1.8 AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

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

There are several published evidence-based clinical practice guidelines on the appropriate use of antibiotics.

Codes to Identify Acute Bronchitis

Acute bronchitis 466.0

Please note that the key component related to this guideline is:

There is no evidence to support the use of antibiotics in the treatment of children with simple upper respiratory infections or acute bronchitis in healthy adults. Symptomatic treatment with fluids and antipyretics is the recommended course.

17.1.9 USE OF SPIROMETRY TESTING IN ASSESSMENT AND DIAGNOSIS OF COPD

This measure evaluates members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD)* who received appropriate spirometry testing to confirm the diagnosis.

Codes to Identify COPD

Chronic bronchitis 491
Emphysema 492
COPD 496

Codes to Identify Spirometry Testing

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

17.1.10 PHARMOCOTHERAPY MANAGEMENT OF COPD EXACERBATION

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 – December 1 of the measurement year and who were dispensed appropriate medications.

- ✧ Dispensed a systemic corticosteroid within 14 days of the event
- ✧ Dispensed a bronchodilator within 30 days of the event

Note: NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org)

17.1.11 APPROPRIATE Asthma MEDICATIONS 3+ controllers

This measure evaluates the percentage of members 5 – 56 years of age identified as having persistent asthma* and who had 3 or more dispensing events of qualifying controller medications during the measurement year.

Codes to Identify Asthma

Asthma 493

Appropriate medications for asthma management can be found at www.ncqa.org by November 16, 2009.

Preferred Therapy

| |
|---|
| Anti-asthmatic combinations (including a methylxanthine) |
| Antibody inhibitor (omalizumab) |
| Inhaled steroid combinations |

| |
|-------------------------|
| Inhaled corticosteroids |
| Leukotriene modifiers |
| Mast cell stabilizers |
| Methylxanthines |

17.1.12 CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

This measure evaluates the number of members age 18-75 who were discharged alive after an acute myocardial infarction (AMI) or coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) in the previous year or had a diagnosis of ischemic vascular disease (IVD) during the previous year or in the measurement year and had the components of cholesterol management during the measurement year.

Codes to Identify AMI, PTCA and CABG

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

Table CMC-B: Codes to Identify IVD

IVD 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445

There are two components to this measure:

- ✧ LDL-C screening
- ✧ LDL-C result, < 100 mg/dl

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 |

17.1.13 CONTROLLING HIGH BLOOD PRESSURE

This measure evaluates how well members 18-85 years old, who have a diagnosis of hypertension (HTN)*, are adequately controlled during the measurement year.

Codes to Identify Hypertension

Hypertension 401

Adequate control is representative of both a systolic BP <140 mm Hg and a diastolic BP <90 mm Hg. All readings should be dated, noted and inclusive of the clinicians' corresponding comments in the patient's medical record.

17.1.14 COMPREHENSIVE DIABETES CARE

This measure evaluates how well members 18- 75 yrs of age are monitored for control of their Type I or Type II Diabetes*.

Ages: 18–75 years as of December 31 of the measurement year.

Codes to Identify Diabetes

Diabetes 250, 357.2, 362.0, 366.41, 648.0

The medical record is reviewed for:

- ❖ HbA1c annual screening and results (lower rate, better performance)
- ❖ LDL-C annual screening and results (LDLC <100 better performance)
- ❖ Annual Retinal or Dilated Eye Exam by an eye care professional
- ❖ Annual monitoring or treatment for kidney disease
 - Nephrologists visit
 - Nephropathy Screening or monitoring
 - Evidence or ACE inhibitors / ARB therapy
- ❖ Blood Pressure control <140/90, <130/80

*Documentation in the medical record must include date of tests and results.

Codes to Identify HbA1c Tests

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

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 |

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 |

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 |

Codes to Identify Evidence of Nephropathy

| Description | CPT | HCPSCS | ICD-9-CM Diagnosis | ICD-9-CM Procedure | DRG | LOINC |
|---------------------------------------|---|---|--|--|-------------|-----------------------------|
| Urine macro-albumin test* | 81000-81003, 81005 | | | | | 5804-0, 20454-5, 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 | 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 | 316, 317 | |
| ACE inhibitor/ARB therapy | | 4009F | | | | |

17.1.15 DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY FOR RHEUMATOID ARTHRITIS

This measure evaluates whether members 18 years and older diagnosed with Rheumatoid Arthritis had at least one ambulatory prescription dispensed for a disease-modifying anti-Rheumatic Drug in the measurement year.

17.1.16 USE OF IMAGING STUDIES FOR LOW BACK PAIN

The percentage of members 18 – 50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

17.1.17 ANTIDEPRESSANT MEDICATION MANAGEMENT

This measure evaluates the successful pharmacological managements for members 18 years of age and older who were diagnosed with a new episode of depression and treated with antidepressant medication and remained on an antidepressant medication*.

Codes to Identify Major Depression

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, and 309.28) are not included in this list because these codes are less specific in identifying members with major depression.

There are 2 components to this measure

- ✧ The percentage of newly diagnoses and treated members who remained on an antidepressant medication for at least 84 day (12 week) Acute Treatment Phase **and**
- ✧ The percentage of newly diagnoses and treated members who remained on an antidepressant drug for at least 180 days (6 months) (Continuation Phase)

17.1.18 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) MEDICATION

This measure evaluates the number of children 6-12 years old who were newly prescribed ADHD medications and who had a follow-up visit within 30 days after initial prescription.

This measure also evaluates children who remained on the medication for 10 months' and had two follow up visits during that time frame.

ADHD Medications

CNS stimulants:

- amphetamine-dextroamphetamine
- atomoxetine
- dexamethylphenidate
- dextroamphetamine
- lisdexamfetamine
- methamphetamine
- methylphenidate

This measure has 2 components

- ✧ One outpatient visit with a practitioner with prescribing authority within 30 days of the initiation phase. This encounter must be face to face.
- ✧ For members who remained on medication for at least 210 days, they had at least 2 follow up visits from day 31-300. One of the two visits may be by telephone. ER visits do not count.

17.1.19 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

This measure evaluates members 6 years of age and older who were hospitalized for treatment of mental health disorders and were seen on an outpatient basis, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

There are two components to this review:

- ✧ Members who had an outpatient or intermediate mental health visit on date of discharge, up to 30 days after discharge.
- ✧ Members who had an outpatient or intermediate mental health visit on date of discharge up to 7 days after discharge.

17.1.20 ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

This measure evaluates the number of members 18 years of age and older on persistent medication* who had at least one therapeutic monitoring event in the same measurement year.

*Persistent medication is defined as members who received at least a 180 days supply of an ambulatory medication listed in the table below.

Members may switch particular medications within the same category as long as the total days supply is 180 days.

| Class of medications | Required Monitoring |
|-----------------------------|--|
| ACE or ARB | Serum Potassium, and either serum creatinine or BUN |
| Digoxin | Serum Potassium, and either serum creatinine or BUN |
| Diuretics | Serum Potassium, and either serum creatinine or BUN |
| Anticonvulsants | Drug serum concentration level* *If member received one type of anticonvulsant, the drug serum concentration level test must be for that drug. If member is on more than one medication, each medication must have its own drug serum concentration level. |

17.1.21 ANNUAL DENTAL VISIT

This measure evaluates the number of members' age 2 – 21 who had at least one dental visit during the measurement year.

Though Primary Care Providers (PCP) are not directly responsible for the administration of dental care to our members, we are certain that our providers recognize the importance and implications of good dental hygiene in the overall benefit and well being of the patient. Therefore, we have added the requirements for this HEDIS measure for your information and review. We encourage our PCPs to remind their patients to get an annual dental check-up.

17.1.22 TIMELINESS OF PRENATAL/POSTPARTUM CARE

Prenatal Care includes:

The number of women who received a prenatal care visit in the first trimester or within 42 days of enrollment in the Plan. This care should be administered by an OB practitioner, midwife or family practitioner or other primary care practitioner with documentation when prenatal care was initiated.

The following must be clearly documented in the patient's medical record/chart:

- ✧ Diagnosis of pregnancy
- ✧ Date of initial prenatal visit

and evidence of one of the following:

- ✧ A basic physical obstetrical examination that includes auscultation for fetal heart tone or pelvic exam with obstetric observations or measurement of fundus height (a standardized prenatal OB form may be used) or
- ✧ Evidence that a prenatal care procedure was performed, such as:
 - a screening test in the form of an obstetric panel (e.g., hematocrit, differential WBC count, platelet count, Hep B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing)
 - TORCH antibody panel alone or a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing.
 - Ultrasound of a pregnant uterus.
- ✧ Documentation of LMP or EDD in conjunction with either:
 - Prenatal risk assessment and counseling/education.
 - A complete obstetrical history.

Postpartum Care includes:

Postpartum care is the care provided to a woman on or between 21-56 days after delivery (live birth). Postpartum care must be evidenced by clear dated documentation of:

- ✧ A pelvic exam
- ✧ An evaluation of weight, blood pressure, breasts and abdomen
- ✧ A notation of "postpartum care"

17.1.23 WELL CHILD CARE

The American Academy of Pediatrics (AAP) recommends a total of 28 well care visits, beginning with birth and continuing to age 21:

| AGE | Scheduled # of Well Child Visits |
|--------------------|----------------------------------|
| By 15 months | ≥6 visits per year |
| 3 – 6 years of age | 1 or more/year |
| 12-21 years of age | 1 or more/year |

Codes to Identify Well-Child Visits

| CPT | ICD-9-CM Diagnosis |
|-----------------------------------|---|
| 99381, 99382, 99391, 99392, 99432 | V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 |

Codes to Identify Well-Child Visits 3-6 years

| CPT | ICD-9-CM Diagnosis |
|----------------------------|---|
| 99382, 99383, 99392, 99393 | V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 |

Table AWC-A: Codes to Identify Adolescent Well-Care Visits

| CPT | ICD-9-CM Diagnosis |
|--------------------------|---|
| 99383-99385, 99393-99395 | V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 |

17.1.24 ADOLESCENT PREVENTIVE CARE MEASURES

This measure evaluates the percentage of adolescents' ages 12 – 17 years of age who had an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year and received the following four components of care.

There are 4 components to this measure:

1. Assessment, counseling or education on risk behaviors and preventative actions associated with sexual activity.
2. Assessment, counseling or education for depression
3. Assessment, counseling or education about the risks of tobacco usage
4. Assessment, counseling or education about the risks of substance use (including alcohol and excluding tobacco)

Exclusions: Members who are pregnant during the measurement year.

17.1.25 ADULT BMI

This measure evaluates members ages 18-74 who had their body mass index (BMI) documented during the measurement year.

Documentation in the medical record must indicate the date of the BMI and the BMI value. For members younger than 19 years on date of service, documentation of the

BMI must also include:

- Notation of BMI documented as a value (e.g., 85th percentile).
- BMI percentile plotted on an age-growth chart.

Height and weight alone is not compliant.

| Codes to Identify BMI | |
|-----------------------|--------------------|
| HCPCS | ICD-9-CM Diagnosis |
| G8417-G8420 | V85.0-V85.5 |

Exclusions: Members who are pregnant during the measurement year or the year prior to the measurement year.

17.1.26 WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN /ADOLESCENTS

This measure evaluates members' ages 2-17 years who have evidence of their BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Documentation for BMI must include:

- ✧ A note indicating the date on which the BMI percentile was documented and evidence of either of the following.
 - BMI percentile, or
 - BMI percentile plotted on age-growth chart.

Documentation or counseling for Nutrition must include:

- ✧ Discussion or current nutrition behaviors (e.g., eating habits, dieting behaviors).
- ✧ Checklist indicating nutrition was addressed.
- ✧ Counseling or referral for nutrition education.
- ✧ Member received educational materials on nutrition.
- ✧ Anticipatory guidance for nutrition.

Documentation of counseling for Physical Activity must include:

- ✧ A note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indication physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity.
- Anticipatory guidance for physical activity

Exclusions: Members who are pregnant during the measurement year.

