NQF-Endorsed™ National Voluntary Consensus Standards for Physician-Focused Ambulatory Care
APPENDIX A –NCQA Measure Technical Specifications
April, 2008 V.7

The following measures represent NQF-Endorsed™ voluntary consensus standards for physician-focused ambulatory care and are intended to allow for the standardization of quality measurement in this area. These measures therefore, may have different specifications and implementation methods than NCQA's HEDIS health plan measures

AMBULATORY SURGERY CENTERS

Selection of Prophylactic Antibiotic, 1st or 2nd Generation Cephalosporin (Source: NCQA/AMA PCPI)
DESCRIPTION: The percentage of surgical patients aged ≥ 18 years undergoing procedures with the indications for a 1st OR 2nd generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Timing of Prophylactic Antibiotics, Ordering Physician (Source: NCQA/AMA PCPI)
DESCRIPTION: The percentage of surgical patients aged ≥ 18 years undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required).
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Timing of Prophylactic Antibiotics, Administering Physician (Source: NCQA/AMA PCPI)
DESCRIPTION: The percentage of surgical patients aged ≥ 18 years who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Discontinuation of Prophylactic Antibiotics, Non-Cardiac Procedures (Source: NCQA/AMA PCPI)
DESCRIPTION: The percentage of non-cardiac surgical patients aged ≥ 18 years undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

ASTHMA AND RESPIRATORY ILLNESS

Use of Appropriate Medications for People with Asthma (Source: NCQA)
DESCRIPTION: The percentage of patients 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.
DEFINITIONS: • Dispensing Event: A dispensing event is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). In addition, two different prescriptions dispensed on the same day are counted as two different dispensing events.

Use of Appropriate Medications for People with Asthma (Source: NCQA)

- Inhaler Dispensing Event: Inhalers count as one dispensing event; for example, an inhaler with a 90-day supply is considered one dispensing event. In addition, multiple inhalers of the same medication filled on the same date of service should be counted as one dispensing event; for example a patient may obtain two inhalers on the same day (one for home and one for work), but intend to use both during the same 30-day period.

NUMERATOR

ELECTRONIC SPECIFICATION:
Dispensed at least one prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines during the measurement year. (Table ASM-C)

MEDICAL RECORD SPECIFICATION:
At least one written prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines during the measurement year.

DENOMINATOR

ELECTRONIC SPECIFICATION:
All patients ages 5-56 years as of December 31 of the measurement year with persistent asthma reported in three age stratifications (5-9, 10-17, 18-56) and as a combined rate. The combined rate is the sum of the three numerators divided by the sum of the three denominators.

Follow the steps below to identify the eligible population for the measure.

Step 1:
Identify patients as having persistent asthma who met at least one of the four criteria below, 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 emergency department (ED) visit (Table ASM-B) with asthma (Table ASM-A) as the principal diagnosis
- at least one acute inpatient discharge (Table ASM-B), with asthma as the principal diagnosis (Table ASM-A)
- at least four outpatient asthma

EXCLUSIONS

ELECTRONIC SPECIFICATION:
Exclude from the eligible population all patients diagnosed with emphysema and chronic obstructive pulmonary disease (COPD) any time on or prior to December 31 of the measurement year as identified by the codes documented within Table ASM-E.

MEDICAL RECORD SPECIFICATION:
Exclude from the eligible population all patients diagnosed with emphysema and chronic obstructive pulmonary disease (COPD) any time on or prior to December 31 of the measurement year.

CODES

Table ASM-A: Codes to Identify Asthma

Description	ICD-9-CM Diagnosis
Asthma	493

Table ASM-B: Codes to Identify Visit Type

Description	CPT	UB-92 Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987
Emergency department	99281-99285	045x, 0981

DATA SOURCE

Patient demographics, claims or encounter data for visits, procedures, and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Use of Appropriate Medications for People with Asthma (Source: NCQA)

visits (Table ASM-B), with asthma as one of the listed diagnoses (Table ASM-A) and at least two asthma medication dispensing events (Table ASM-C)

- at least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions) (Table ASM-C).

Step 2:
For a patient identified as having persistent asthma because of at least four asthma medication dispensing events (Table ASM-C), where leukotriene modifiers were the sole asthma medication dispensed, the patient must:

- meet any of the other three criteria in step 1 in the same year as the leukotriene modifier, or
- have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (i.e. measurement year or year prior to the measurement year).

MEDICAL RECORD SPECIFICATION:
A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which

Table ASM-C: Asthma Medications

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

Use of Appropriate Medications for People with Asthma (Source: NCQA)

the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.

Table ASM-D: Preferred Asthma Therapy Medications

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

Table ASM-E: Codes to Identify Exclusions

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

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (Source: NCQA)

DESCRIPTION: The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

DEFINITIONS:

- Episode Date: The date of service for any outpatient or ED visit (Table AAB-B) during the Intake Period with any diagnosis of acute bronchitis (Table AAB-A).
- Index Episode State Date (IESD): The *earliest* Episode Date during the Intake Period that meets all of the following criteria.
  - A 30-day Negative Medication History prior to the Episode Date (Table AAB-D).
  - A 12-month Negative Comorbid Condition History prior to the Episode Date (Table AAB-C).
  - A Negative Competing Diagnosis during the 30 days prior to through 7 days after the Episode Date.
- Intake Period: The Intake Period is from January 1–December 24 of the measurement year. The Intake Period captures eligible episodes of treatment.
- Negative Medication History: To qualify for Negative Medication History, the following criteria must be met.
  - A period of 30 days prior to the Episode Date, during which time the patient had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
  - No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date (Table AAB-D).

  A prescription is considered active if the "days supply" indicated on the date the patient filled the prescription is the number of days or more between the date the prescription was filled and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period (see definition of Intake Period).
- Negative Comorbid Condition History: A period of 12 months prior to and including the Episode Date, during which time the patient had no claims/encounters containing either a principal or

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (Source: NCQA)

secondary diagnosis for a comorbid condition (Table AAB-C).

- Negative Competing Diagnosis History: A period of 30 days prior to through 7 days after the Episode Date (inclusive), during which time the patient had no claims/encounters with any competing diagnosis (Table URI-C).

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: A dispensed outpatient prescription for antibiotic medication (Table AAB-D) on or within three days after the IESD. MEDICAL RECORD SPECIFICATION: Documentation of patient having received a prescription for antibiotic medications on or within 3 days after the IESD.	ELECTRONIC SPECIFICATION: Outpatient visit with any diagnosis of acute bronchitis during the Intake Period. Follow the steps below to identify the eligible population: Step 1: Identify all patients in the specified age range who during the Intake Period had an outpatient or ED visit (Table AAB-B) with any diagnosis of acute bronchitis (Table AAB-A). Step 2: Determine all acute bronchitis Episode Dates. For each patient identified in step 1, determine all outpatient or ED claims/encounters with a diagnosis of acute bronchitis. Step 3: Test for Negative Comorbid Condition History. Exclude Episode Dates for which the patient had a claim/encounter with a diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date (Table AAB-C). Step 4: Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active	None.	Table AAB-A: Codes to Identify Acute Bronchitis Description: Acute bronchitis — ICD-9-CM Diagnosis: 466.0 Table AAB-B: Codes to Identify Visit Type Outpatient — CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99499 — UB Revenue: 051x, 0520-0523, 0526-0529, 077x, 0982, 0983 ED* — CPT: 99281-99285 — UB Revenue: 045x, 0981 *Do not include ED visits that result in an inpatient admission. Table AAB-C: Codes to Identify Comorbid Conditions HIV disease; asymptomatic HIV — 042, V08 Cystic fibrosis — 277.0 Disorders of the immune system — 279 Malignancy neoplasms — 140-208 Chronic bronchitis — 491 Emphysema — 492 Bronchiectasis — 494 Extrinsic allergic alveolitis — 495 Chronic airway obstruction, chronic obstructive asthma — 493.2, 496 Pneumoconiosis and other lung disease due to external agents — 500-508 Other diseases of the respiratory system — 510-519 Tuberculosis — 010-018	Patient demographics, claims or encounter data for visits, procedures, and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (Source: NCQA)

on the Episode Date (refer to Table AAB-D).

Step 5: Test for Competing Diagnoses. Exclude Episode Dates where during the period 30 days prior to 7 days after the Episode Date (inclusive) the patient had a claim/encounter with any competing diagnosis (Table URI-C).

Step 6: Select the IESD. This measure examines the earliest eligible episode per member.

MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.

Table AAB-D: Antibiotic Medications

Description	Prescription		
5-aminosalicylates	• sulfasalazine		
Amebicides	• metronidazole		
Aminoglycosides	• amikacin • gentamicin	• kanamycin • neomycin	• streptomycin • tobramycin
Aminopenicillins	• amoxicillin	• ampicillin	
Antipseudomonal penicillins	• piperacillin	• ticarcillin	
Beta-lactamase inhibitors	• amoxicillin-clavulanate • ampicillin-sulbactam	• piperacillin-tazobactam	• ticarcillin-clavulanate
First generation cephalosporins	• cefadroxil • cefazolin	• cephalexin • cephradine	
Fourth generation cephalosporins	• cefepime		
Ketolides	• telithromycin		
Lincomycin derivatives	• clindamycin	• lincomycin	
Macrolides	• azithromycin • clarithromycin	• erythromycin • erythromycin ethylsuccinate	• erythromycin lactobionate • erythromycin stearate
Miscellaneous antibiotics	• aztreonam • chloramphenicol • dalfopristin-quinupristin	• daptomycin • erythromycin-sulfisoxazole • linezolid	• metronidazole
Sulfamethoxazole-trimethoprim DS	• doxycycline	• sulfamethoxazole-trimethoprim	• vancomycin
Natural penicillins	• penicillin G benzathine-procaine • penicillin G	• penicillin G procaine • penicillin G sodium	• penicillin V potassium

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (Source: NCQA)

	potassium	
Penicillinase resistant penicillins	• dicloxacillin • nafcillin • oxacillin	
Quinolones	• ciprofloxacin • levofloxacin • Norfloxacin • gatifloxacin • lomefloxacin • ofloxacin • gemifloxacin • moxifloxacin • sparfloxacin	
Rifamycin derivatives	• rifampin	
Second generation cephalosporin	• cefaclor • cefoxitin • cefuroxime • cefotetan • cefprozil • loracarbef	
Sulfonamides	• sulfadiazine • sulfisoxazole • sulfamethoxazole-trimethoprim	
Tetracyclines	• doxycycline • minocycline • tetracycline	
Third generation cephalosporins	• cefdinir • cefotaxime • ceftibuten • cefixime • ceftazidime • ceftriaxone • cefoperazone	
Urinary anti-infectives	• fosfomycin • nitrofurantoin macrocrystals-monohydrate • nitrofurantoin • trimethoprim • nitrofurantoin macrocrystals	

Appropriate Treatment for Children with Upper Respiratory Infection (Source: NCQA)

DESCRIPTION: The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

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

DEFINITIONS:

- Episode Date: The date of service for any outpatient or ED visit (Table URI-B) during the Intake Period with only a diagnosis of URI (Table URI-A). Exclude claims/encounters with more than one diagnosis.
- Index Episode Start Date(IESD): The *earliest* Episode Date during the Intake Period that meets all of the following criteria.
  - A 30-day Negative Medication History prior to the Episode Date.
  - A Negative Competing Diagnosis during the 3 days after the Episode Date.
- Intake Period: A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture

Appropriate Treatment for Children with Upper Respiratory Infection (Source: NCQA)

eligible episodes of treatment.

- Negative Medication History: To qualify for Negative Medication History, the following criteria must be met.
  - A period of 30 days prior to the Episode Date during which time the patient had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
  - No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date (Table CWP-C).

  A prescription is considered active if the "days supply" indicated on the date when the patient filled the prescription is the number of days or more between the date the prescription was filled and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period (see definition of Intake Period).
- Negative Competing Diagnosis: The Episode Date and three days following the Episode Date during which the patient had no claims/encounters with any competing diagnosis (Table URI-C).

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Dispensed prescription for antibiotic medication (Table CWP-C) on or three days after the IESD. MEDICAL RECORD SPECIFICATION: Documentation of a written prescription for antibiotic medication on the Episode Date. The measure examines one eligible episode per patient. Refer to Table CWP-C in *Appropriate Testing for Children with*	ELECTRONIC SPECIFICATION: Outpatient or ED visit with only a diagnosis of URI during the Intake Period. Follow the steps below to identify the eligible population: Step 1: Identify all members who had an outpatient or ED visit (Table URI-B) with only a diagnosis of URI(Table URI-A) during the Intake Period. Exclude claims/encounters with more than one diagnosis. Step 2: Determine all URI Episode Dates. For each patient identified in step 1, determine all outpatient or ED claims/encounters with a URI diagnosis. Step 3: Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or which was active on the Episode Date (Refer to Table CWP-C in *Appropriate Testing for Children with Pharyngitis*). Step 4: Test for Negative Competing Diagnosis. Exclude Episode Dates where the patient had a claim/encounter	N/A	Table URI-A: Codes to Identify URI Description | ICD-9-CM Diagnosis Acute nasopharyngitis (common cold) | 460 URI | 465 Table URI-B: Codes to Identify Outpatient Visits Description | CPT | UB Revenue Outpatient | 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99420, 99429, 99499 | 051x, 0520-0523, 0526-0529, 077x, 0982, 0983 ED* | 99281-99285 | 045x, 0981 *Do not include ED visits that result in an inpatient admission.	Patient demographics, claims or encounter data for visits, procedures, and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Appropriate Treatment for Children with Upper Respiratory Infection (Source: NCQA)

Pharyngitis for a list of medications.

with a competing diagnosis (Table URI-C) on or 3 days after the Episode Date.

MEDICAL RECORD SPECIFICATION: A systematic sample from the eligible population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.

Table URI-C: Codes to Identify Competing Diagnoses

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

Appropriate Testing for Children with Pharyngitis (Source: NCQA)

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

DEFINITIONS:

- Episode Date: The date of service for any outpatient or ED visit (Table CWP-B) during the Intake Period with only a diagnosis of pharyngitis (Table CWP-A). Exclude claims/encounters with more than one diagnosis.
- Index Episode Start Date (IESD): The *earliest* Episode Date during the Intake Period that meets all of the following criteria.
  - Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date.
  - A 30-day Negative Medication History prior to the Episode Date.
- Intake Period: A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture eligible episodes of treatment.
- Negative Medication History: To qualify for Negative Medication History, the following criteria must be met.
  - A period of 30 days prior to the Episode Date, during which time the patient had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
  - No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date (Table CWP-C).

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

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: A strep test (Table CWP-D) in the 7-day period from 3 days prior through 3 days after the IESD. MEDICAL RECORD SPECIFICATION: Documentation of a strep test administered in the 7-day period from 3 days prior to the IESD through 3 days	Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period. Follow the steps below to identify the eligible population: Step 1: Identify all members in the specified age range who had an outpatient or ED visit (Tables CWP-B) with only a diagnosis of pharyngitis (Table CWP-A) during the Intake Period. Exclude claims/encounters with more than one diagnosis. Step 2: Determine all pharyngitis Episode Dates. For each patient identified in step 1, determine all outpatient or ED encounters/claims with only a diagnosis of pharyngitis.	N/A	Table CWP-A: Codes to Identify Pharyngitis Acute pharyngitis: 462 Acute tonsillitis: 463 Streptococcal sore throat: 034.0 Table CWP-B: Codes to Identify Outpatient Visits Outpatient: CPT 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429, 99499; UB Revenue 051x, 0520-0523, 0526-0529, 077x, 0982, 0983 ED*: CPT 99281-99285; UB Revenue 045x, 0981 *Do not include ED visits that result in an inpatient admission.	Patient demographics, claims or encounter data for visits, procedures, and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic

Appropriate Testing for Children with Pharyngitis (Source: NCQA)

after the IESD.

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

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

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

Step 5: Select the IESD. This measure examines the earliest eligible episode per measure.

MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in

Table CWP-D: Antibiotic Medications

Description	Prescription	
Aminopenicillins	• amoxicillin	• ampicillin
Beta-lactamase inhibitors	• amoxicillin-clavulanate	
First generation cephalosporins	• cefadroxil • cefazolin	• cephalexin • cephradine
Folate antagonist	• trimethoprim	
Lincomycin derivatives	• clindamycin	
Macrolides	• azithromycin • clarithromycin • erythromycin • erythromycin ethylsuccinate	• erythromycin lactobionate • erythromycin estolate • erythromycin stearate
Miscellaneous antibiotics	• erythromycin-sulfisoxazole	
Natural penicillins	• penicillin G potassium • penicillin G sodium	• penicillin V potassium
Penicillinase resistant penicillins	• dicloxacillin	
Quinolones	• ciprofloxacin • gatifloxacin • levofloxacin • lomefloxacin	• moxifloxacin • ofloxacin • sparfloxacin
Second generation cephalosporins	• cefaclor • cefprozil	• cefuroxime • loracarbef
Sulfonamides	• sulfamethoxazole-trimethoprim	• sulfisoxazole
Tetracyclines	• doxycycline • minocycline	• tetracycline
Third generation cephalosporins	• cefdinir • cefixime • cefpodoxime	• ceftibuten • ceftriaxone

medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Appropriate Testing for Children with Pharyngitis (Source: NCQA)				
	the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.		Table CWP-D: Codes to Identify Group A Streptococcus Tests CPT: 87070, 87071, 87081, 87430, 87650-87652, 87880 LOINC: 626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 11475-1, 17656-0, 18481-2, 31971-5	

BONE and JOINT DISEASE

Use of Imaging Studies for Low Back Pain (Source: NCQA)

DESCRIPTION: The percentage of patients 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.

CALCULATION: The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

DEFINITIONS:

- Index Episode Start Date (IESD): The *earliest* date of service for any outpatient or ED encounter (Table LBP-B) during the Intake Period with a primary diagnosis of low back pain (Table LBP-A).
- Intake Period: January 1-December 3 of the measurement year. The Intake Period is used to identify the first outpatient or ED encounter with a diagnosis of low back pain.
- Negative Diagnosis History: A period of 180 days (6 months) prior to the IESD during which time the patient had no claims/encounters with any diagnosis of low back pain (Table LBP-A).

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: An imaging study (plain x-ray, MRI, CT scan) conducted on the IESD or in the 28 days following the IESD. Refer to Table LBP-D in order to identify imaging studies. A diagnosis code from Table LBP-A must be	ELECTRONIC SPECIFICATION: All patients aged 18-50 years as of December 31 of the measurement year with a new episode of low back pain. Follow steps below to determine the eligible population: Step 1: Identify all patients in the specified age range who had an outpatient or ED encounter (Table LBP-B) with a primary diagnosis of low back pain (Table LBP-A) during the Intake Period. Step 2: Determine the IESD. For each	Included in specs	Table LBP-A: Codes to Identify Low Back Pain ICD-9-CM Diagnosis: 721.3, 722.10, 722.32, 722.52, 722.93, 724.02, 724.2, 724.3, 724.5, 724.6, 724.70, 724.71, 724.79, 738.5, 739.3, 739.4, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2	Patient demographics, claims or encounter data for visits, procedures, mental health and pharmacy. The medical record option requires manual or electronically coded data for

Use of Imaging Studies for Low Back Pain (Source: NCQA)

in conjunction with an imaging study code in Table LBP-D.

MEDICAL RECORD SPECIFICATION: Patients with documentation of an imaging study (plain x-ray, MRI, CT scan) conducted on the IESD or in the 28 days following the IESD.

Documentation of imaging study could include: physician orders for study, imaging results/report from radiologist, or other clear indication study performed during the timeframe.

Documentation must include the date and result of the study.

patient identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Step 3: Test for Negative Diagnosis History. Exclude patients with any low back pain diagnosis during the 180 days (6 months) prior to the IESD.

Step 4: Test for clinically appropriate imaging studies. Refer to Table LBP-C to identify patients who have a diagnosis for which an imaging study in the presence of low back pain is clinically indicated.

- *Cancer:* Exclude patients who have a diagnosis of cancer. Look for evidence of cancer as far back as possible in the patient's history.
- *Recent trauma, intravenous drug abuse, neurological impairment:* Exclude patients who have any of these diagnoses in the 12 months prior to the IESD.

MEDICAL RECORD SPECIFICATION: A systematic sample of patients aged 18 – 50 years with a new episode of low back pain.

Table LBP-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
ED	99281-99285	045x, 0981

Table LBP-C: Codes to Identify Exclusions (Clinically *Appropriate* Indications for Low Back Imaging)

Description	ICD-9-CM Diagnosis
Cancer	140-208, 230-239
Trauma	800-839, 850-854, 860-869, 905-909, 926.11, 926.12, 929, 952, 958-959
IV drug abuse	304.0, 304.1x, 304.2x, 304.4x, 305.4x, 305.5x, 305.6x, 305.7x
Neurologic impairment	344.60, 729.2

Table LBP-D: Codes to Identify Imaging Studies

Description	CPT	UB Revenue
Imaging studies	72010, 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220	0320, 0329, 0350, 0352, 0359, 0610, 0612, 0614, 0619, 0972

visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Osteoporosis Management in Women Who Had a Fracture (Source: NCQA)

DESCRIPTION: The percentage of women 65 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:

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

Osteoporosis Management in Women Who Had a Fracture (Source: NCQA)

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, use the discharge date from the second admission as the IESD.

- 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.
- Negative Diagnosis History: A period of 60 days prior to the IESD, during which time the patient 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.

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Patients who were appropriately treated or tested for osteoporosis after the fracture. Appropriate treatment or testing is 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 or in the 180-day period after the IESD. MEDICAL RECORD	ELECTRONIC SPECIFICATION: Women 67 years and older as of December 31 of the measurement year who had a fracture between July 1 of the year prior to the measurement year through June 30 of the measurement year. If a patient has more than one fracture during the specified period, include only the first fracture identified through the following criteria: Step 1: Identify all patients who had a fracture (Table OMW-A) during the 12-month Intake Period. If the patient had more than one fracture, include only the first. Step 2: Test for Negative Diagnosis History. Exclude patients with a fracture (Table OMW-A) during the 60 days prior to the IESD. For fractures requiring an	Included in specs	Table OMW-A: Codes to Identify Fractures* CPT: 21800-21825, 22305-22328, 22520, 22521, 22523, 22524, 23500-23515, 23570-23630, 23665-23680, 24500-24587, 24620, 24635, 24650-24685, 25500-25652, 25680, 25685, 27193-27248, 27254, 27500-27514, 27520-27540, 27750-27828 HCPCS: S2360, S2362 ICD-9-CM Diagnosis: 733.1, 805-806, 807.0-807.4, 808-815, 818-825, 827, 828 ICD-9-CM Procedure: 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 DRG: 235, 236 *Fractures of finger, toe, face and skull are not included in this measure. Table OMW-B: Codes to Identify Bone Mineral Density Test CPT: 76070, 76071, 76075-76077, 76078, 76977, 77078-77083, 78350-78351 HCPCS: G0130 ICD-9-CM Diagnosis: V82.81 ICD-9-CM Procedure: 88.98	Patient demographics, claims or encounter data for visits, procedures, mental health and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Osteoporosis Management in Women Who Had a Fracture (Source: NCQA)

SPECIFICATION:

Documentation in the medical record of appropriate treatment or testing for osteoporosis after the fracture defined by any one of the three criteria below:

- Documentation of a BMD test on the IESD or in the 180-day period after the IESD, including the test date and result
- Documentation of a BMD test during the inpatient stay for the fracture (applies only to fractures requiring hospitalization), including the test date and result
- Documentation of a prescription to treat osteoporosis on the IESD or in the 180-day period after the IESD, including the date on which the prescription was written

The following describe BMD tests and treatments

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: Exclude patients 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 patients with an inpatient stay, use the admission date to determine the 365 days prior to the IESD.

MEDICAL RECORD SPECIFICATION: A systematic sample of women 67* years and older as of December 31 of the measurement year who had a fracture between July 1 of the year prior to the measurement year through June 30 of the measurement year. If a patient has more than one fracture during the specified period, include only the first fracture identified through the following criteria:
Step 1: Select the first

Table OMW-C: FDA-Approved Osteoporosis Therapies

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

Note:

- *If the patient had a direct transfer to another acute care facility, the discharge date from the second admission should be used to evaluate compliance with the measure.*

Osteoporosis Management in Women Who Had a Fracture (Source: NCQA)				
for the prevention of osteoporosis: • Computerized axial tomography bone density study, • Dual energy x-ray absorptiometry (DEXA), bone density study, • Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), • Ultrasound bone density measurement and interpretation, • Bone density (bone mineral content) study, and • Special screening for osteoporosis Allowable therapies: Alendronate Risedronate Calcitonin Raloxifene Estrogen Teriparatide Alendronate-cholecalciferol (Fosamax Plus D) Ibandronate (Boniva) Injectable Estrogens	eligible fracture documented during the 12-month intake period Step 2: Identify the IESD and Negative Diagnosis History. For each patient identified in step 1, determine the Index Episode Start Date by finding the earliest fracture documented in the 12-month period. Identify patients who were diagnosed with a new fracture by determining if the patient has a Negative Diagnosis History. Patients with a documented diagnosis of fracture within 60 days prior to the IESD should be excluded from the measure. For patients with an inpatient stay, use the admission date to determine a negative diagnosis. Step 3: Exclude patients who have received documented osteoporosis screening or documented treatment in the prior year. Exclude patients who had documentation for a BMD test during the 365 days prior to the Index Episode Start Date. For patients with an inpatient stay, use the			

Osteoporosis Management in Women Who Had a Fracture (Source: NCQA)				
	admission date to determine a negative diagnosis. Exclude patients who were prescribed any medication listed above during the 365 days prior to the Index Episode Start Date. For patients with an inpatient stay, use the admission date to determine a negative medication history. Fractures of the finger, toe, face and skull are not included in this measure. *Note:* Given the measurement look back period, women 65 years and older will be captured in this measure.			

Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (Source: NCQA)

DESCRIPTION: The percentage of patients 18 years and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Patients who had at least one ambulatory prescription dispensed for a	ELECTRONIC SPECIFICATION: All patients, aged 18 years and older as of December 31 of the measurement year, with a	• Exclude from the denomina tor patients who have a	Table ART-A: Codes to Identify Rheumatoid Arthritis Description: Rheumatoid arthritis ICD-9-CM Diagnosis: 714.0, 714.1, 714.2, 714.81	Patient demographics, claims or encounter data for visits, procedures, mental health

Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (Source: NCQA)

disease modifying anti-rheumatic drug (DMARD) during the measurement year. Table ART-C lists the DMARDs included in this measure.

MEDICAL RECORD SPECIFICATION: Patients who had documentation of at least one ambulatory prescription for a disease modifying antirheumatic drug (DMARD) (medication list above) during the measurement year.

diagnosis of rheumatoid arthritis (RA). 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 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.

MEDICAL RECORD SPECIFICATION: A systematic sample of patients, ages 18 years and older as of December 31 of the measurement year, with a diagnosis of rheumatoid arthritis (RA). Two face-to-face physician encounters with a rheumatoid arthritis diagnosis with different dates of

diagnosis code for pregnancy during the measurement year.

- Exclude from the denominator patients who have been diagnosed with HIV. Use administrative data to look for evidence of HIV diagnosis as far back as possible in the patient's history through December 31 of the measurement year.

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, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x

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, J9250, J9260
Immunomodulators	• abatacept • adalimumab	• anakinra • etanercept	• infliximab • rituximab	J0129, J0135, J1438, J1745
Immunosuppressive agents	• azathioprine	• cyclosporine		J7502, J7515, J7516
Tetracyclines	• minocycline			

*Use the listed J codes as these infused medications that may not be captured via NDC codes.

Table ART-D: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Human immunodeficiency virus	042, V08
Pregnancy	630-677, V22, V23, V28

and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (Source: NCQA)				
	service in an outpatient or nonacute inpatient setting between January 1 and November 30 of the measurement year are required to confirm a rheumatoid arthritis diagnosis.			

Osteoporosis: Communication with the Physician Managing Ongoing Care Post-Fracture (Source: AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older (Source: AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)
DESCRIPTION: The percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Osteoporosis: Management Following Fracture (Source: AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Osteoporosis: Pharmacologic Therapy (Source: AAFP/AAOS/AACE/AC Rheum/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Low Back Pain measures (NCQA)
An addendum containing the Low Back Pain measure specifications will be posted online at a later date.

DIABETES

HbA1c Management: Testing (Source: NCQA/Alliance)

DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had:

- Hemoglobin A1c (HbA1c) testing

NOTE:

- *There may be a high rate of false positives when using laboratory data to identify diabetics because diabetes Diagnosis codes are frequently reported on laboratory tests used to rule out diabetes; therefore, laboratory data may not be used to identify diabetics. Using the codes provided in the scope of this measure ensures that laboratory data is not used to identify diabetics.*

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: 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. MEDICAL RECORD SPECIFICATION: One or more HbA1c tests performed during the measurement year. 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. Notation of the following in the medical record may be counted: ▪ A1c ▪ HbA1c ▪ Hemoglobin A1c	ELECTRONIC SPECIFICATION: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or the year prior to the measurement year: pharmacy and claim/encounter data. *Pharmacy data:* Patients 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).	ELECTRONIC SPECIFICATION: Exclude patients with a diagnosis of polycystic ovaries (Table CDC-O) who did not have any face-to-face encounters with a diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year. Diagnosis of polycystic ovaries can occur at any time in the patient's history, but must have occurred by December 31 of the measurement year. Exclude patients	Table CDC-A: Prescriptions to Identify Diabetics **Description** / **Prescription** Alpha-glucosidase inhibitors: • acarbose • miglitol Antidiabetic combinations: • glimepiride-pioglitazone • glimepiride-rosiglitazone • glipizide-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 pork • insulin zinc beef-pork • insulin zinc extended human • insulin zinc human • insulin zinc pork Meglitinides: • nateglinide • repaglinide Miscellaneous antidiabetic agents: • exenatide • pramlintide • sitagliptin Sulfonylureas: • acetohexamide • chlorpropamide • glimepiride • glipizide • glyburide • tolazamide • tolbutamide Thiazolidinediones: • pioglitazone • rosiglitazone • troglitazone	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling

HbA1c Management: Testing (Source: NCQA/Alliance)

- Glycohemoglobin A1c
- HgbA1c

Claim/Encounter Data: Patients 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 emergency department (ED) setting during the measurement year or the year prior to the measurement year. Services that occur over both years may be counted. Refer to Table CDC-C to identify the visit type.

MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer

with gestational diabetes or steroid-induced diabetes (Table CDC-O), who did not have any face-to-face encounters with the diagnosis of diabetes (Table CDC-B), in any setting, during the measurement year or year prior to the measurement year. Diagnosis of gestational diabetes or steroid-induced diabetes 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.

MEDICAL RECORD SPECIFICATION: Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also

Note: Glucophage /metformin is not included in Table CDC-A because it is used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis coding only.

Table CDC-B: Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis	DRG
Diabetes	250, 357.2, 362.0, 366.41, 648.0	294, 295

Table CDC-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Table CDC-D: Codes to Identify HbA1c Tests

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F, 3047F	4548-4, 4549-2, 17856-6

framework for the denominator and for determination of the numerator.

HbA1c Management: Testing (Source: NCQA/Alliance)				
	recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.	have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.	Table CDC-O: Codes to Identify Exclusions Description / ICD-9-CM Diagnosis Polycystic ovaries: 256.4 Steroid induced: 251.8, 962.0 Gestational diabetes: 648.8	

Eye Examination (Source: NCQA/Alliance)				
DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had: o Eye exam (retinal) performed				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
NOTE: • *There may be a high rate of false positives when using laboratory data to identify diabetics because diabetes Diagnosis codes are frequently reported on laboratory tests used to rule out diabetes; therefore, laboratory data may not be used to identify diabetics. Using the codes provided in the scope of this measure ensures that laboratory data is not used to identify diabetics.* • *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind, but who require a retinal exam, and those who are completely blind and therefore do not require an exam.*				
ELECTRONIC SPECIFICATION: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had	See denominator under *HbA1c Testing*	See exclusions under *HbA1c Testing*	See Tables A – D and M under *HbA1c Testing.*	Patient demographics, claims or encounter data for visits, procedures and

Eye Examination (Source: NCQA/AIliance)

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.

Use codes listed in Table CDC-G to identify eye exams. For exams performed in the year prior to the measurement year, an automated result must be available.

MEDICAL RECORD SPECIFICATION:
Documentation in the medical record of a retinal eye exam during the measurement year or a *negative* retinal eye exam during the year prior to the measurement year.
At a minimum, documentation in the medical record must include:

- A note or letter from an ophthalmologist, optometrist or other

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, 67038-67040, 67101, 67105, 67107, 67108, 67110, 67112, 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.

** Do not need to limit CPT Category II codes to an optometrist or an ophthalmologist because the codes can be used by other provider types to document services provided by an optometrist or ophthalmologist.

pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Eye Examination (Source: NCQA/Alliance)				
health-care professional summarizing the date on which the procedure was performed and the results of a retinal evaluation performed by an eye-care professional, *or* • A chart or photograph of retinal abnormalities. If fundus photography was used in the exam, there must be documentation in the medical record indicating the date on which the procedure 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, *or* • A note, which may be prepared by a primary care provider, indicating the date on which the				

Eye Examination (Source: NCQA/Alliance)				
procedure was performed, and that an ophthalmoscopic exam was completed by an eye-care professional, with results of the exam.				

Foot Examination (Source: NCQA/Alliance)

DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had:

- A foot exam

NOTE:

- *There may be a high rate of false positives when using laboratory data to identify diabetics because diabetes Diagnosis codes are frequently reported on laboratory tests used to rule out diabetes; therefore, laboratory data may not be used to identify diabetics. Using the codes provided in the scope of this measure ensures that laboratory data is not used to identify diabetics.*

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year. CPT Category II Code 2028F may be used to identify foot examination performed. MEDICAL RECORD SPECIFICATION: Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.	See denominator under *HbA1c Testing*.	See exclusions under *HbA1c Testing.*	See Tables A – D and O under *HbA1c Testing.* Codes to Identify Foot Exams Description: Foot examination — CPT Category II: 2028F	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Foot Examination (Source: NCQA/Alliance)				
Indication of a test result and date of test must be documented.				

HbA1c Management: Poor Control (Source: NCQA/Alliance)

DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had:

- HbA1c in poor control (>9.0%)

NOTE:

- *There may be a high rate of false positives when using laboratory data to identify diabetics because diabetes Diagnosis codes are frequently reported on laboratory tests used to rule out diabetes; therefore, laboratory data may not be used to identify diabetics. Using the codes provided in the scope of this measure ensures that laboratory data is not used to identify diabetics.*

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Use electronic laboratory data to identify the *most recent* HbA1c test during the measurement year. The patient is numerator compliant if the result for the HbA1c test is >9.0%, or the most recent test result is missing or if an HbA1c test was not done during the measurement year. The patient is not numerator compliant if the electronic result for the most recent HbA1c test during the measurement year is ≤9.0%. If the *most recent* test during the measurement year is identified by a CPT Category II code, use Table CDC-E to evaluate whether the patient is numerator compliant (3046F indicates the patient is numerator compliant; 3044F, 3045F, 3047F indicate the patient is not numerator compliant). Note: For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care). MEDICAL RECORD SPECIFIATION: The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing or was not done during the measurement year. The patient is not numerator compliant is the result for the most recent HbA1c test during the measurement year is ≤9.0%. 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.	See denominator for *HbA1c Testing.*	See exclusions for *HbA1c Testing*.	See code Tables A – D and O under *HbA1c Testing.* Table CDC-E: Codes to Identify HbA1c Levels >9.0% Description / CPT Category II Numerator compliant (HbA1c >9.0%) / 3046F *Not* numerator compliant (HbA1c ≤9.0%) / 3044F, 3045F, 3047F	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

HbA1c Test for Pediatric Patients (Source: NCQA/Alliance)

DESCRIPTION: Percentage of pediatric patients with diabetes who had a HbA1c test in a 12-month measurement period.

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: 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. MEDICAL RECORD SPECIFICATION: One or more HbA1c tests performed during the measurement year. 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. Notation of the following in the medical record may be counted: ▪ A1c ▪ HbA1c ▪ Hemoglobin A1c ▪ Glycohemoglobin A1c ▪ HgbA1c The following are not acceptable documentation of HbA1c results: fructosamine, Hgb, hemoglobin, Hb and Hg without reference to either "glycated," "glycosylated" and "A1" or "A1c" and findings reported on progress notes or other non-laboratory documentation	ELECTRONIC SPECIFICATION: Patients 5 – 17 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or year prior to measurement year, pharmacy and claim / encounter data: • Pharmacy data: Patients 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). • Claim/Encounter Data: Patients who had *two* face-to-face encounters with different dates of service in an outpatient setting or nonacute inpatient setting or *one* face-to-face encounter in an acute inpatient or emergency department (ED) setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. Services that occur over both years may be counted. Use the codes in Table CDC-B to identify a diabetes diagnosis	See exclusions under *HbA1c Testing*	See code Tables A – D and M under *HbA1c Testing.*	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

HbA1c Test for Pediatric Patients (Source: NCQA/Alliance)				
	and Table CDC-C to identify the visit type. MEDICAL RECORD SPECIFICATION: A systematic sample of patients, age 5-17 years old with a diagnosis of diabetes and/or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics for at least 12 months who has been under the care of the physician or physician group for at least 12 months. This is defined by documentation of a face-to-face visit for diabetes care between the physician and the patient that *predates* the most recent visit by at least 12 months.			

Blood Pressure Management (Source: NCQA/Alliance)				
DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had: • Blood pressure <140/90 mmHg				
NOTES: • *There may be a high rate of false positives when using laboratory data to identify diabetics because diabetes Diagnosis codes are frequently reported on laboratory tests used to rule out diabetes; therefore, laboratory data may not be used to identify diabetics. Using the codes provided in the scope of this measure ensures that laboratory data is not used to identify diabetics.* • *Do not include home BP monitoring results or member self-reported BP readings (e.g., home and health-fair BPs).*				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Using automated data, 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. When using a combination of data from internal administrative databases and CPT Category II	See denominator under *HbA1c Testing*.	See exclusions under *HbA1c Testing.*	See Tables A – C and O under *HbA1c Testing.*	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option

Blood Pressure Management (Source: NCQA/Alliance)

codes, search all sources and use the most recent result. When using CPT Category II codes to identify numerator compliance for this indicator, search for all codes in Table CDC-N and use the most recent code to evaluate whether the patient is numerator compliant.

If the most recent result is from an administrative database, the patient is numerator compliant if the BP is <140/90 mm Hg. The patient 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.

If the most recent result is from a CPT Category II code, use Table CDC-N to evaluate whether the patient is numerator compliant.

MEDICAL RECORD SPECIFICATION: Patients with most recent systolic blood pressure measurement <140 mm Hg and a diastolic blood pressure <90 mm Hg during the measurement year, as documented through medical record review. The following steps should be followed below to determine representative BP:

- *Identify the most recent visit to the doctor's office or clinic* that occurred during the measurement year in which a BP reading was noted. The medical record used should be the record from which other CDC indicators are abstracted. If the record being used for other CDC indicators does not contain a BP or if no other abstractions are being conducted for other indicators, the medical record of the

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, 3076F	3078F, 3079F
Not numerator compliant (BP ≥140/90 mm Hg)	3077F	3080F

requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Blood Pressure Management (Source: NCQA/Alliance)				
provider that manages the patient's diabetes should be used. If that medical record does not contain a BP, the record of another primary care physician or specialist providing care may be used. o To be eligible, the representative BP must have been obtained during a visit to the practitioner's office or other non-emergency outpatient facility, such as a clinic or urgent care center. Do not include BP readings from an acute inpatient stay. Outpatient visits for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) are not eligible. o BP measurements obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) or at an emergency room visit are not eligible. • *Identify the BP reading from that visit.* If there is one BP reading from that visit, it becomes the representative BP. If there are multiple BPs from a single visit, physicians should use the lowest BP of the visit as the representative BP; however, sitting BP is preferred.				

Urine Protein Screening (Source: NCQA/Alliance)

DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had:

- Medical attention for nephropathy.

NOTE:

- *There may be a high rate of false positives when using laboratory data to identify diabetics because diabetes Diagnosis codes are frequently reported on laboratory tests used to rule out diabetes; therefore, laboratory data may not be used to identify diabetics. Using the codes provided in the scope of this measure ensures that laboratory data is not used to identify diabetics.*

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: A nephropathy screening test (Table CDC-J), evidence of nephropathy (Table CDC-K), a nephrologist visit, a *positive* urine macroalbumin or evidence of ACE inhibitor/ARB therapy (Table CDC- L) during the measurement year. MEDICAL RECORD SPECIFICATION: Urine microalbumin test. At a minimum, documentation in the medical record must include a note indicating the date on which the urine microalbumin test was performed, and the result. Notation of the following may count in the medical record for urine microalbumin test: • 24-hour urine for microalbumin • timed urine for microalbumin • spot urine for microalbumin • microalbumin/creatinine ratio.	See denominator under *HbA1c Testing.*	See exclusions under *HbA1c Testing.*	See Tables A – C and O under *HbA1c Testing.* Table CDC-J: Codes to Identify Nephropathy Screening Tests Description: Nephropathy screening test CPT: 82042, 82043, 82044, 84156 CPT Category II: 3060F, 3061F LOINC: 1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13705-9, 13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32294-1, 32209-9, 32551-4, 34366-5, 34535-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1 Table CDC-K: Codes to Identify Evidence of Nephropathy Urine macro-albumin test*: CPT 81000-81003, 81005; CPT Category II 3062F; LOINC 5804-0, 20454-5, 24356-8, 24357-6 Evidence of treatment for nephropathy: CPT 36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-; CPT Category II 3066F; HCPCS G0257, G0314-G0319, G0322, G0323, G0326, G0327, G0392,; ICD-9-CM Diagnosis 250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1,; ICD-9-CM Procedure 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98,; UB Revenue 0367, 080x, 082x-085x, 088x; DRG 316, 317	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for

<table>
<tr><th colspan="8">Urine Protein Screening (Source: NCQA/Alliance)</th></tr>
<tr>
<td>Medical attention for nephropathy. Visit to a nephrologists or medical attention for nephropathy. Documentation in the medical record must include, at a minimum, a note indicating medical attention during the measurement year for:
• diabetic nephropathy
• a positive test result for urine microalbumin (i.e., urine protein or proteinuria)
• end-stage renal disease (ESRD)
• chronic renal failure (CRF)
• renal insufficiency
• acute renal failure (ARF)
• dialysis, hemodialysis or peritoneal dialysis
A positive urine macroalbumin test during the measurement year. 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 for protein in the urine. The following may be counted in the medical record:
• positive urinalysis (timed, spot, microalbumin/creatinine ratio)</td>
<td></td>
<td></td>
<td>
<table>
<tr><td></td><td>36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512</td><td></td><td>G0393, S9339</td><td>791.0, V42.0, V45.1, V56</td><td>55.4-55.6</td><td></td><td></td><td></td></tr>
<tr><td>ACE inhibitor/ARB therapy</td><td></td><td>4009F</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
*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.
</td>
<td>determination of the numerator.</td>
</tr>
</table>

Urine Protein Screening (Source: NCQA/Alliance)

- positive urine dipstick
- positive tablet reagent.

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

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

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription
Angiotensin converting enzyme inhibitors	• benazepril • enalapril • lisinopril • perindopril • ramipril • captopril • fosinopril • moexipril • quinapril • trandolaprilt
Angiotensin II inhibitors	• candesartan • irbesartan • olmesartan • valsartan • eprosartan • losartan • telmisartan
Antihypertensive combinations	• 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

Lipid Management: Screening (Source: NCQA/Alliance)

DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had:

- LDL-C screening

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: 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. A calculated LDL may be used for LDL-C screening and control indicators. MEDICAL RECORD SPECIFICATION: One or more LDL-C tests performed during the measurement year. 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.	See denominator under *HbA1c Testing.*	See exclusions under *HbA1c Testing.*	See Tables A – C and O under *HbA1c Testing.* Table CDC-H: Codes to Identify LDL-C Screening CPT: 80061, 83700, 83701, 83704, 83715, 83716, 83721 CPT Category II: 3048F, 3049F, 3050F LOINC: 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 24331-1, 39469-2, 49132-4	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or

Lipid Management: Screening (Source: NCQA/Alliance)				
A calculated LDL may be used for LDL-C screening and control indicators.				encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Lipid Management: Control (<100 mg/dL) (Source: NCQA/Alliance)

DESCRIPTION: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had the following.

- LDL-C testing <100 mg/dL

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Using automated laboratory data, identify the *most recent* LDL-C test during the measurement year. The patient 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 patient is not numerator compliant. CPT Category II code 3048F may be used to identify LDL-C results <100 mg/dL within the measurement year. If the *most recent* test during the measurement year is identified by a CPT Category II code, use Table	See denominator under *HbA1c Testing*	See exclusions under *HbA1c Testing*	See Tables A – C and M under *HbA1c Testing* 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	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the

Lipid Management: Control (<100 mg/dL) (Source: NCQA/Alliance)				
CDC-I to evaluate whether the patient is numerator compliant (3048F indicates the patient is numerator compliant; 3049F, 3050F indicate the patient is not numerator compliant). A calculated LDL may be used for LDL-C screening and control indicators. MEDICAL RECORD SPECIFICATION: The *most recent* LDL-C level performed during the measurement year is <100mg/dL. If the 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 patient is not numerator compliant. 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. A calculated LDL may be used for LDL-C screening and control indicators. LDL-C levels may be calculated 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.				sampling framework for the denominator and for determination of the numerator.

HEART DISEASE

Use of Aspirin or Another Antithrombotic (Source: NCQA)

DESCRIPTION: Patients who have documentation of use of aspirin or another antithrombotic during the 12-month measurement period.

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Documentation of use of aspirin or another antithrombotic during the 12-month measurement period. Use CPT Category II code 4011F which defines oral antiplatelet therapy prescribed (e.g. aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox). MEDICAL RECORD SPECIFICATION: Documentation of use of aspirin or another antithrombotic (e.g. aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox) during the 12 month measurement period. Documentation in the medical record must include, at a minimum, a note indicating the date on which aspirin or anther	ELECTRONIC SPECIFICATION: 1) All patients aged 18 years and older who were discharged alive for AMI, CABG or PTCA on or between 1/1-11/1 of the year prior to the measurement year. Use codes listed in Table IVD-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting. *OR* 2) All patients aged 18 years and older who have IVD, who met at least one of the two criteria below, during both the measurement year and the year prior to the measurement year (criteria need not be the same across two years). Use the codes in table IVD-B to identify an IVD diagnosis and Table IVD-		Table IVD-A: Codes to Identify AMI, PTCA and CABG **Description / CPT / HCPCS / ICD-9-CM Diagnosis / ICD-9-CM Procedure / DRG** AMI (inpatient only) / / / 410.x1 / / 121, 122, 516 PTCA / 33140, 92980-92982, 92984, 92995, 92996 / / / 00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09 / 516, 517, 526, 527, 555-558 CABG (inpatient only) / 33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572 / S2205-S2209 / / 36.1, 36.2 / 106, 107, 109, 547-550 Table IVD-B: Codes to Identify IVD **Description / ICD-9-CM Diagnosis / DRG** IVD / 411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445 / 140, 559	Patient demographics, claims or encounter data for visits, procedures and lab data. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

<table>
<tr><th colspan="5">Use of Aspirin or Another Antithrombotic (Source: NCQA)</th></tr>
<tr>
<td>antithrombotic was prescribed or documentation of prescription from another treating physician.</td>
<td>C to identify visit type.

MEDICAL RECORD SPECIFICATION:
A systematic sample of patients, age 18 years and older who either had an AMI, PTC or CABG on or between 1/1-1/11 of the year prior to the measurement year or who had a diagnosis of ischemic vascular disease (IVD), defined as either CAD, Stable Angina, Lower Extremity Arterial Disease/Peripheral Artery Disease, Ischemia, Stroke, Artheroembolism, Renal Artery Atherosclerosis, for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months.)</td>
<td></td>
<td>Table IVD-C: Codes to Identify Visit Type
<table>
<tr><th>Description</th><th>CPT</th><th>UB-92 Revenue</th></tr>
<tr><td>Outpatient</td><td>99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499</td><td>051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983</td></tr>
<tr><td>Acute inpatient</td><td>99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291</td><td>010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987</td></tr>
</table>
Table: Code to Identify Oral Anti-platelet therapy prescribed
<table>
<tr><th>Description</th><th>CPT Category II</th></tr>
<tr><td>Oral Anti-platelet therapy prescribed</td><td>4011F</td></tr>
</table></td>
<td></td>
</tr>
</table>

Persistence of Beta-Blocker Treatment after a Heart Attack (Source: NCQA)

DESCRIPTION: The percentage of patients 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 acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

DEFINITIONS:

- 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).

NUMERATOR

ELECTRONIC SPECIFICATION:
Identify all patients 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 patients who are on beta-blockers prior to admission, factor those prescriptions into

DENOMINATOR

ELECTRONIC SPECIFICATION:
All patients aged 18 years and older as of December 31 of the measurement year, discharged alive from an acute inpatient setting with an AMI between July 1 of the year prior to the measurement year through June 30 of the measurement year.

If a patient 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, include only the first discharge and use the codes listed in Table PBH-A to identify AMIs.

Transfers to acute facilities. Include hospitalizations in which the patient was transferred directly to another *acute care facility* for any diagnosis. Count the discharge from the

EXCLUSION

Exclude patients who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy. Look as far back as possible in the patient's history through either administrative data or medical record review for evidence of contraindication or a previous adverse reaction to beta-blocker therapy. Refer to Table PBH-C for codes for contraindications to beta-blocker therapy.

CODES

Table PBH-A: Codes to Identify AMI

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

*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.

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
Antihypertensive combinations	• atenolol-chlorthalidone • bendroflumethiazide-nadolol • bisoprolol-hydrochlorothiazide		• hydrochlorothiazide-metoprolol • hydrochlorothiazide-propranolol • hydrochlorothiazide-timolol

Table PBH-C: Codes to Identify Exclusions

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

DATA SOURCE

Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Persistence of Beta-Blocker Treatment after a Heart Attack (Source: NCQA)				
adherence rates if the actual treatment days fall within the 180 days following discharge. MEDICAL RECORD SPECIFICATION: The number of patients in the denominator population whose days' supply of beta blockers prescribed 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 account for patients who are on beta-blockers prior to admission, factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge. Documentation in medical record must include, at a minimum, a note indicating that the patient received a prescription for beta-blockers within the time frame specified.	subsequent acute inpatient facility, not the initial discharge. The discharge date from the facility to which the patient 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 patient was transferred directly to a *nonacute care facility* for any diagnosis. *Readmissions.* If the patient was readmitted to an *acute* or *nonacute care facility* for any diagnosis, include the patient in the denominator and use the discharge date from the original hospitalization. MEDICAL RECORD SPECIFICATION: All patients aged 18 and older as of December 31 of the measurement year, discharged alive from an acute inpatient setting with an AMI between July 1 of the year prior to the measurement year through June 30 of the			

Persistence of Beta-Blocker Treatment after a Heart Attack (Source: NCQA)				
	measurement year. If a patient 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, include only the first discharge. *Transfers to acute facilities*. Include hospitalizations in which the patient was transferred directly to another *acute care facility* for any diagnosis. Count the discharge from the subsequent, not the initial, acute inpatient facility. The discharge date from the facility to which the patient was transferred must occur on or before June 30 of the measurement year.			

Beta-Blocker Treatment after a Heart Attack (Source: NCQA)				
DESCRIPTION: The percentage of patients 35 years of age and older during the measurement year who were hospitalized and discharged alive from January 1 – December 24 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received an ambulatory prescription for beta-blockers upon discharge.				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Patients who received an ambulatory prescription for beta-blockers within seven days (inclusive) after discharge as indicated by pharmacy or claims data. Table BBH-B lists the beta-blockers included in this measure.	ELECTRONIC SPECIFICATION: Patients 35 of age and older as of December 31 of the measurement year who are *discharged alive* from an inpatient setting with an AMI from January 1 – December 24 of the measurement year. If a patient has more than one	ELECTRONIC SPECIFICATION: Exclude from the denominator patients who are identified as having a contraindication to beta-blocker therapy	Table BBH-A: Codes to Identify AMI Description | ICD-9-CM Diagnosis | DRG AMI | 410.x1* | 121, 122, 516, 526	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record

Beta-Blocker Treatment after a Heart Attack (Source: NCQA)

Prescriptions rendered on an *ambulatory basis* while a patient is hospitalized for AMI through the seventh day after discharge count toward this measure. If it cannot be determined whether or not the prescription was rendered on an inpatient or ambulatory basis, it may only count prescriptions rendered after discharge. To account for patients who are on beta-blockers prior to admission, the beta-blocker prescriptions that are active at the time of admission may also be counted.

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

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

For claims data, a code from Table BBH-C on or between the discharge

episode of AMI from January 1 – December 24 of the measurement year, only include the first eligible discharge. Use the codes listed in Table BBH-A to identify AMIs.

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

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

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

MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using

or previous adverse reaction (i.e., intolerance) to beta-blocker therapy. Use the codes in Table BBH-D to identify exclusions.

MEDICAL RECORD SPECIFICATION: Exclude from the denominator patients who are documented as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy.

Table BBH-B: Beta-Blocker Medications

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

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

Description	CPT Category II
Beta-blocker therapy prescribed	4006F

Table BBH-D: Codes to Identify Exclusions

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

option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Beta-Blocker Treatment after a Heart Attack (Source: NCQA)				
date and seven days after the discharge indicates the patient is numerator compliant. MEDICAL RECORD SPECIFICATION: Patients who received an ambulatory prescription for beta-blockers rendered within seven days after discharge. Prescriptions filled on an *ambulatory basis* anytime while the patient is hospitalized for AMI through the seventh day after discharge count toward this measure. If unable to determine if the prescription was rendered on an inpatient or ambulatory basis, count those prescriptions rendered after discharge. To account for patients who are on beta-blockers prior to admission, count prescriptions for beta-blockers that are active at the time of admission. Documentation in medical record must include, at a minimum, a note indicating that the patient received a prescription for beta-blockers within the time frame specified.	the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator			

IVD: Blood Pressure Management (Source: NCQA)

DESCRIPTION: The percentage of patients 18 years of age and older who had the following:

- Blood pressure <140/90 mmHg

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Using automated data, identify the most recent BP reading during the measurement year. When using a combination of data from internal administrative databases and CPT Category II codes, search all sources and use the most recent result. When using CPT Category II codes to identify numerator compliance for this indicator, search for all codes in the Blood Pressure Level code table and use the most recent code to evaluate whether the patient is numerator compliant. If the most recent result is from an administrative database, the patient is numerator compliant if the BP is <140/90 mm Hg. The patient 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. If the most recent result is from a CPT Category II code, use the Table of CPT II blood pressure codes to evaluate whether the patient is numerator compliant. MEDICAL RECORD SPECIFICATION: Patients with most recent systolic blood pressure measurement <140 mm Hg and a	ELECTRONIC SPECIFICATION: 1) All patients aged 18 years and older who were discharged alive for AMI, CABG or PTCA on or between 1/1-11/1 of the year prior to the measurement year. Use codes listed in Table IVD-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting. *OR* 2) All patients aged 18 years and older who have IVD, who met at least one of the two criteria below, during both the measurement year and the year prior to the measurement year		Table IVD-A: Codes to Identify AMI, PTCA and CABG **Description / CPT / HCPCS / ICD-9-CM Diagnosis / ICD-9-CM Procedure / DRG** AMI (inpatient only) / / / 410.x1 / / 121, 122, 516 PTCA / 33140, 92980-92982, 92984, 92995, 92996 / / / 00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09 / 516, 517, 526, 527, 555-558 CABG (inpatient only) / 33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572 / S2205-S2209 / / 36.1, 36.2 / 106, 107, 109, 547-550 Table IVD-B: Codes to Identify IVD **Description / ICD-9-CM Diagnosis / DRG** IVD / 411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445 / 140, 559	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

IVD: Blood Pressure Management (Source: NCQA)

diastolic blood pressure <90 mm Hg during the measurement year, as documented through medical record review. The following steps should be followed below to determine representative BP:

- *Identify the most recent visit to the doctor's office or clinic* that occurred during the measurement year in which a BP reading was noted.
  - To be eligible, the representative BP must have been obtained during a visit to the practitioner's office or other non-emergency outpatient facility, such as a clinic or urgent care center. Outpatient visits for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) are not eligible.
  - BP measurements obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) or at an emergency room visit are not

(criteria need not be the same across two years). Use the codes in table IVD-B to identify an IVD diagnosis and Table IVD-C to identify visit type.

MEDICAL RECORD SPECIFICATION: A systematic sample of patients, age 18 years and older who either had an AMI, PTC or CABG on or between 1/1-1/11 of the year prior to the measurement year or who had a diagnosis of ischemic vascular disease (IVD), defined as either CAD, Stable Angina, Lower Extremity Arterial Disease/Peripheral Artery Disease, Ischemia, Stroke, Artheroembolism, Renal Artery Atherosclerosis, for at least 12 months,

Table IVD-C: Codes to Identify Visit Type

Description	CPT	UB-92 Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987

Table: Codes to Identify Blood Pressure Levels

Description	CPT Category II
Numerator compliant (BP<140/90)	3076F with (3078F or 3079F) 3074F with (3078F or 3079F)
Not numerator compliant (BP ≥140/90)	3077F, 3080F

IVD: Blood Pressure Management (Source: NCQA)				
eligible. • *Identify the BP reading from that visit.* If there is one BP reading from that visit, it becomes the representative BP. If there are multiple BPs from a single visit, physicians should use the lowest BP of the visit as the representative BP; however, sitting BP is preferred.	who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months.)			

IVD: Complete Lipid Profile (Source: NCQA)				
DESCRIPTION: Percentage of patients 18 years and older with IVD who had a complete lipid profile				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: A complete lipid profile performed during the measurement year, as identified by claim/encounter or automated laboratory data. See associated code table. MEDICAL RECORD SPECIFICATION: A full lipid profile completed during the measurement year	ELECTRONIC SPECIFICATION: 1) All patients aged 18 years and older who were discharged alive for AMI, CABG or PTCA on or between 1/1-11/1 of the year prior to the measurement year. Use codes listed in Table IVD-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient	Exclude patient self-report or self-monitoring, LDL to HDL ratio and findings reported on progress notes or other non-laboratory documentation.		Physicians may use administrative data systems to identify eligible patients. Administrative data sources include medical encounters, medical claims and ambulatory pharmacy records. Determination of patient eligibility may be based on an administrative

IVD: Complete Lipid Profile (Source: NCQA)

with the date and result of each component of the profile documented.

- Identify the most recent visit to the doctor's office or clinic that occurred during the measurement year (but after the diagnosis of IVD was made) in which a full lipid profile was documented.
- The full profile test or each component of the profile (total cholesterol, HDL-C, triglycerides, and LDL-C) must be noted with the date of the laboratory

claims only. All cases of PTCA should be included, regardless of setting.

OR

2) All patients aged 18 years and older who have IVD, who met at least one of the two criteria below, during both the measurement year and the year prior to the measurement year (criteria need not be the same across two years). Use the codes in table IVD-B to identify an IVD diagnosis and Table IVD-C to identify visit type.

MEDICAL RECORD SPECIFICATION:
A systematic sample of patients, age 18 years and older who either had an AMI, PTC or CABG on or between 1/1-1/11 of the year prior to the measurement year or who had a diagnosis of ischemic vascular disease (IVD), defined as either CAD, Stable Angina, Lower

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

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

Table IVD-B: Codes to Identify IVD

Description	ICD-9-CM Diagnosis	DRG
IVD	411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445	140, 559

Table IVD-C: Codes to Identify Visit Type

Description	CPT	UB-92 Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987

data system, but must be supported by documentation found in the medical record. Numerator results are obtained from the medical record.

IVD: Complete Lipid Profile (Source: NCQA)				
test and results.	Extremity Arterial Disease/Peripheral Artery Disease, Ischemia, Stroke, Artheroembolism, , Renal Artery Atherosclerosis, for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months.)		Table: Codes to Identify Lipid Profile Description / CPT* / CPT* Category II / LOINC** Lipid panel / 80061 / 3011F / 24331-1 Total Cholesterol / / / 2093-3, 14647-2 High density lipoprotein (HDL) / / / 2085-9, 14646-4, 18263-4 Triglycerides / / / 2571-8, 12951-0, 14927-8, 47210-0 **A complete lipid profile consists of total cholesterol, high density lipoprotein (HDL), and triglycerides. It also generally includes a calculated low density lipoprotein (LDL). When using LOINC codes, a complete lipid profile can be identified one of two ways: LOINC code 24431-1, *or* one Total Cholesterol LOINC code, *and* one High density lipoprotein (HDL) code *and* one Triglycerides code. One code from each of the three categories must be present in order to count as a complete lipid profile unless LOINC code 24331-1 is used.	

IVD: LDL-C <100 (Source: NCQA)				
DESCRIPTION: Percentage of patients 18 years and older with IVD whose most recent LDL-C screening <100.				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Using automated laboratory data, identify the *most recent* LDL-C test during the measurement year. The patient is numerator compliant if the most recent automated LDL-C level is	ELECTRONIC SPECIFICATION: 1) All patients aged 18 years and older who were discharged alive for AMI, CABG or PTCA on or between 1/1-11/1 of the year prior to the measurement year. Use	Exclude patient self-report or self-monitoring, LDL to HDL ratio and findings reported on progress notes or other non-laboratory documentation.		Physicians may use administrative data systems to identify eligible patients. Administrative data sources include medical encounters, medical claims and ambulatory pharmacy

IVD: LDL-C <100 (Source: NCQA)

<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 patient is not numerator compliant.
If the *most recent* test during the measurement year is identified by a CPT Category II code, use the LDL Level code Table to evaluate whether the patient is numerator compliant (3048F indicates the patient is numerator compliant; 3049F, 3050F indicate the patient is not numerator compliant).

MEDICAL RECORD SPECIFICATION: The *most recent* LDL-C level performed during the measurement year is <100mg/dL. If the 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 patient is not numerator compliant. Documentation

codes listed in Table IVD-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting.
OR
2) All patients aged 18 years and older who have IVD, who met at least one of the two criteria below, during both the measurement year and the year prior to the measurement year (criteria need not be the same across two years). Use the codes in table IVD-B to identify an IVD diagnosis and Table IVD-C to identify visit type.

MEDICAL RECORD SPECIFICATION:
A systematic sample of patients, age 18 years and older who either had an AMI, PTC or CABG on or between 1/1-1/11 of the year prior to the measurement year or who had a diagnosis of ischemic vascular disease (IVD), defined as either CAD, Stable Angina,

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

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

Table IVD-B: Codes to Identify IVD

Description	ICD-9-CM Diagnosis	DRG
IVD	411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445	140, 559

Table IVD-C: Codes to Identify Visit Type

Description	CPT	UB-92 Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987

records. Determination of patient eligibility may be based on an administrative data system, but must be supported by documentation found in the medical record. Numerator results are obtained from the medical record.

<table>
<tr><th colspan="5">IVD: LDL-C <100 (Source: NCQA)</th></tr>
<tr>
<td>in the medical record must include a note indicating the date on which the LDL-C test was performed, and the result.</td>
<td>Lower Extremity Arterial Disease/Peripheral Artery Disease, Ischemia, Stroke, Artheroembolism, Renal Artery Atherosclerosis, for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months.)</td>
<td></td>
<td>Table: Codes to Identify LDL-C Levels
<table>
<tr><th>Description</th><th>CPT Category II</th></tr>
<tr><td>Numerator compliant (LDL-C <100 mg/dL)</td><td>3048F</td></tr>
<tr><td>Not numerator compliant (LDL-C ≥100 mg/dL)</td><td>3049F, 3050F</td></tr>
</table></td>
<td></td>
</tr>
</table>

HYPERTENSION

<table>
<tr><th colspan="5">Controlling High Blood Pressure (Source: CMS / NCQA)</th></tr>
<tr><td colspan="5">DESCRIPTION: The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.</td></tr>
<tr><td colspan="5">DEFINITIONS:
• Adequate control: Adequate control is both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high normal range).
• Representative BP: Representative BP is the most recent BP reading during the measurement year (as long as the BP occurred after the diagnosis of HTN was made). If multiple BP measurements occur on the same date or are notated in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume the patient is “not controlled.”</td></tr>
<tr><th>NUMERATOR</th><th>DENOMINATOR</th><th>EXCLUSION</th><th>CODES</th><th>DATA SOURCE</th></tr>
<tr>
<td>The number of patients in the denominator whose most recent blood pressure</td>
<td>A systematic sample drawn from the eligible population, patients 18-85 years of age,</td>
<td>Exclude from the eligible population all patients</td>
<td>Table CBP-A: Codes to Identify Hypertension
<table>
<tr><th>Description</th><th>ICD-9-CM Diagnosis</th></tr>
<tr><td>Hypertension</td><td>401</td></tr>
</table></td>
<td>Patient demographics, claims or</td>
</tr>
</table>

Controlling High Blood Pressure (Source: CMS / NCQA)

is adequately controlled during the measurement year.

For a patient's BP to be controlled, *both* the systolic and the diastolic BP must be <140/90 mm Hg (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Follow the steps below to determine representative BP.

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

- The reading must occur after the date the diagnosis of hypertension was made.
- Do not include BP readings from outpatient visits which were for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).

whose diagnosis of hypertension (Tables CBP- A and CBP-B) is confirmed by chart review. To confirm the diagnosis of hypertension, notation of one of the following must be found in the medical record on or before June 30 of the measurement year:

- HTN
- high blood pressure (HBP)
- elevated blood pressure (↑BP)
- borderline HTN
- intermittent HTN
- history of HTN
- hypertensive vascular disease (HVD)
- hyperpiesia
- hyperpiesis.

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:

- a problem list (this may include a diagnosis

diagnosed 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 pregnant patients (Table CBP-C) during the measurement year.

Exclude from the eligible population all patients who had an admission to a nonacute inpatient setting any time during the measurement year. Refer to Table FUH-B for codes to

Table CBP-B: Codes to Identify Outpatient Visits

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

encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Controlling High Blood Pressure (Source: CMS / NCQA)

- Do not include BP readings obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) from an acute inpatient stay or at an emergency room visit.
- Do not include BP home-monitoring results or self-reported BP readings (e.g., home and health fair BPs).

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.

prior to June 30 of the measurement year or an undated diagnosis; see *Note* at the end of this section)

- office note
- subjective, objective, assessment, plan (SOAP) note
- encounter form
- telephone call record
- diagnostic report
- hospital discharge summary.

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

Note:

- *Use an undated notation of hypertension on problem lists. Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator.*
- *If the medical record cannot be found, the patient*

identify nonacute care.

Table CBP-C: Codes to Identify Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	DRG
Evidence of ESRD	36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512	G0257, G0308-G0313, G0314-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	317
Pregnancy			630-677, V22, V23, V28			

Controlling High Blood Pressure (Source: CMS / NCQA)				
	remains in the measure denominator and is considered noncompliant for the numerator. • *An oversample of 10–15 percent is generally required t to meet the minimum required sample size (MRSS) for confirmed cases of hypertension.*			

MEDICATION MANAGEMENT

Documentation of Medication List in the Outpatient Record (Source: CMS-SCRIPT/NCQA)				
DESCRIPTION: Percentage of patients with a medication list in their medical record.				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
Patients with a medication list in their medical record. A separate, additional document can satisfy the numerator as can a list of medications simply notes in a patient's progress note.	All patients who were continuously enrolled during the measurement year.	NA	NA	Chart abstraction via paper-based abstraction tool designed for SCRIPT project.

Documentation of Allergies and Adverse Reactions in the Outpatient Record (Source: CMS-SCRIPT/NCQA)

DESCRIPTION: Percentage of patients with documentation of allergies and adverse reactions in the medical record.

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
Patients with allergy and adverse reaction status present in their medical record. A separate, additional document can satisfy the numerator as can a note in a patient's progress note.	All patients who were continuously enrolled during the measurement year.	NA	NA	Chart abstraction via paper-based abstraction tool designed for SCRIPT project.

Annual Monitoring for Patients on Persistent Medications (Source: NCQA)

DESCRIPTION: The percentage of patients 18 years of age and older who received at least a 180-days supply 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.
Report each of the four rates separately and as a total rate.

- Annual monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for patients on digoxin
- Annual monitoring for patients on diuretics
- Annual monitoring for patients on anticonvulsants
- Total rate (the sum of the four numerators divided by the sum of the four denominators)

Note: NCQA will provide a comprehensive list of NDC codes for drugs to identify patients on persistent medications on its Web site at www.ncqa.org by November 15, 2007.

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Annual monitoring for patients on ACE inhibitors or ARBs: The number of patients with at least	ELECTRONIC SPECIFICATION: Annual monitoring for patients on ACE inhibitors or ARBs: The number of patients age 18 years and older who received at least a	Exclude patients from each eligible population rate who had an inpatient stay (acute or		Patient demographics, claims or encounter data for visits, labs, procedures

Annual Monitoring for Patients on Persistent Medications (Source: NCQA)

one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table MPM-A).
Note: The two tests *do not* need to occur on the same service date, only within the measurement year.

MEDICAL RECORD SPECIFICATION: Documentation of at least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.
Note: The two tests *do not* need to occur on the same service date, only within the measurement year.

180-days supply of any drug in Table CDC-L for ACE inhibitors or ARBs, including any combination products during the measurement year.
Note: Patients 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-days supply (i.e., a patient who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).

MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented.

ELECTRONIC SPECIFICATION: Annual monitoring for patients on digoxin:
The number of patients

nonacute) in the measurement year. Count any visit with an inpatient facility code or use DRGs or UB Type of Bill codes from Tables IPU-A, FUH-B, MPT-A, MPT- B, IAD-A, IAD-B to identify acute and nonacute inpatient care.

Table MPM-A: Codes to Identify Physiologic Monitoring Tests

Description	CPT	LOINC
Serum potassium (K+)	80048, 80050, 80051, 80053, 80069, 84132	2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 24320-4, 24321-2, 24322-0, 24323-8, 24326-1, 24362-6, 29349-8, 32713-0, 34548-8, 34554-6
WITH		
Serum creatinine (SCr)	80048, 80050, 80053, 80069, 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, 24321-2, 24322-0, 24323-8, 24320-4, 24362-6, 26752-6, 33558-8, 34555-3, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4
OR		
Blood urea nitrogen (BUN)	80048, 80050, 80053, 80069, 84520, 84525	3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 24320-4, 24321-2, 24322-0, 24323-8, 24362-6

‘

Table MPM-B: Drugs to Identify Members on Digoxin

Description	Prescription
Inotropic agents	• digoxin

and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Annual Monitoring for Patients on Persistent Medications (Source: NCQA)

patients with 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). MEDICAL RECORD SPECIFICATION: The number of patients with documentation of at least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.	age 18 years and older who received at least a 180-days supply of any drug in Table MPM-B for digoxin, including any combination products, during the measurement year. MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented.		Table MPM-C: Drugs to Identify Members on Diuretics (see table below)
ELECTRONIC SPECIFICATION: Annual monitoring for patients on diuretics: The number of patients with 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). Note: The two tests *do not* need to occur on	ELECTRONIC SPECIFICATION: Annual monitoring for patients on diuretics: The number of patients age 18 years and older who received at least a 180-days supply of any drug in Table MPM-C, including any combination products, during the measurement year. *Note:* Patients may switch therapy within any medication listed in Table		Table MPM-D: Drugs to Identify Members on Anticonvulsants (see table below)

Table MPM-C: Drugs to Identify Members on Diuretics

Description	Prescription		
Antihypertensive combinations	• amiloride-hydrochlorothiazide • 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

Table MPM-D: Drugs to Identify Members on Anticonvulsants

Description	Drugs	
Barbiturate anticonvulsants	• phenobarbital	
Dibenzazepine anticonvulsants	• carbamazepine	
Hydantoin anticonvulsants	• phenytoin	
Miscellaneous	• divalproex	• valproic

Annual Monitoring for Patients on Persistent Medications (Source: NCQA)

the same service date, only within the measurement year. MEDICAL RECORD SPECIFICATION: The number of patients with documentation of at least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.	MPM-C during the measurement year and have the days supply for those medications count toward the total 180-days supply. MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented.		
ELECTRONIC SPECIFICATION: Annual monitoring for patients on anticonvulsants: The number of patients with at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year (Table MPM-E). If a patient received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as	ELECTRONIC SPECIFICATION: Annual monitoring for patients on anticonvulsants: The number of patients age 18 years and older who received at least a 180-days supply for any anticonvulsant in Table MPM-D during the measurement year. Note: Patients 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		anticonvulsants | sodium | acid 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, 34540-5
Drug serum concentration for valproic acid	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, 34545-4

Annual Monitoring for Patients on Persistent Medications (Source: NCQA)				
a persistent medication (i.e., a patient on phenytoin received a drug serum test for phenytoin). If a patient persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a patient on both phenytoin and valproic acid with at least a 180-days supply 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). MEDICAL RECORD SPECIFICATION: The number of patients with documentation of at least one drug serum concentration level monitoring test for the prescribed drug	measurement year (i.e., a patient who received at least 180 days of phenytoin and 180 days of valproic acid) will be counted twice in the denominator for Rate 4, once for each drug. MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented.			

Annual Monitoring for Patients on Persistent Medications (Source: NCQA)				
in the measurement year. If a patient received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication. If a patient persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a patient on both phenytoin and valproic acid with at least a 180-days supply for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug to be considered numerator-compliant for each drug).				

Use of High-Risk Medications in the Elderly (Source: NCQA)

DESCRIPTION: This measure summarizes:

- The percentage of Medicare patients 65 years of age and older who received at least one high risk medication
- The percentage of Medicare patients 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 provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 15, 2007.

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: 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. MEDICAL RECORD SPECIFICATION: Numerator 1: Patients 65 years of age and older with documentation of a prescription for at least one high risk medication (drug list above) in the elderly in the measurement	ELECTRONIC SPECIFICATION: All patients ages 65 years and older as of December 31 of the measurement year. MEDICAL RECORD SPECIFCIATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data	N/A	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-tripelennamine • diphenhydramine-magnesium salicylate • diphenhydramine-phenylephrine • diphenhydramine-pseudoephedrine • hydroxyzine hydrochloride • hydroxyzine pamoate • phenylephrine-promethazine • promethazine • tripelennamine **Antipsychotic, typical** • mesoridazine • thioridazine **Amphetamines** • amphetamine-dextroamphetamine • dextroamphetamine • diethylpropion • pemoline • phendimetrazine	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Use of High-Risk Medications in the Elderly (Source: NCQA)

year. Numerator 2: Patients 65 years of age and older with documentation of prescriptions for at least two different high risk medications (drug list above) in the elderly in the measurement year.	should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.			

	• benzphetamine • dexmethylphenidate	• methamphetamine • methylphenidate	• phentermine
Barbiturates	• amobarbital • amobarbital-secobarbital • 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 antispasmodics	• dicyclomine	• propantheline	
Belladonna alkaloids (includes combination drugs)	• atropine • 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

Oral hypoglycemics	• chlorpropamide	
Narcotics (includes combination	• ASA/caffeine/propoxyphene • acetaminophen-pentazocine • acetaminophen-propoxyphene	• meperidine-promethazine • naloxone-pentazocine • pentazocine

Use of High-Risk Medications in the Elderly (Source: NCQA)				
			drugs)	• belladonna-opium • meperidine • 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
			Note: NCQA will provide a list of NDC codes for drugs on its Web site at www.ncqa.org	

MENTAL HEALTH and SUBSTANCE USE DISORDERS

Antidepressant Medication Management: Optimal Practitioner Contacts for Medication Management (Source: NCQA)

DESCRIPTION:

- *Optimal Practitioner Contacts for Medication Management.* The percentage of patients 18 years of age and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase. At least one of the three follow-up contacts must be with a prescribing practitioner.

DEFINITIONS:

- Intake Period: The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
- Index Episode Start Date: The earliest encounter during the Intake Period with a qualifying diagnosis of major depression.
- Index Prescription Date: The earliest prescription for antidepressants filled within a 44-day period, defined as 30 days prior to through 14 days on or after the IESD.
- Negative Diagnosis History: A period of 120 days (4 months) prior to the IESD, during which time the member had no claims/encounters containing either a principal or secondary diagnosis of depression (Table AMM-A).
- Negative Medication History: A period of 90 days (3 months) prior to the Index Prescription Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antidepressant drug (refer to the medication listing at the end of this measure specification).
- New Episode: To qualify as a New Episode, two criteria must be met.
  - A 120-day (4-month) Negative Diagnosis History prior to the IESD, and
  - A 90-day (3-month) Negative Medication History prior to the Index Prescription Date.
- Treatment Days: The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval.
- Mental Health Practitioner: A practitioner who provides mental health services and meets any of the following criteria.
  - An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic

Antidepressant Medication Management: Optimal Practitioner Contacts for Medication Management (Source: NCQA)

education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice
- An individual who is licensed as a psychologist in his/her state of practice
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board of Certified Counselors (NBCC)

- Prescribing Practitioner: A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

NOTES:

- *The intent of the telephone visit is that the exchange occurred between the patient and one of the practitioner types (mental health and non-mental health practitioners) that count for face-to-face visits. Do no count contacts from other types of services (e.g., disease management, case management) toward the Optimal Practitioner Contacts measure.*
- *If the patient has a mental health or pharmacy benefit with the organization (or if the organization contracts with the mental health or pharmacy benefit with a separate vendor) and the claim for major depression treatment or antidepressant medication is denied (e.g., the patient failed to get proper authorization), the patient should be included in the denominator.*
- *A patient with a mental health benefit whose claim for follow-up visits is denied is included in the denominator but must also meet all other eligibility requirements for inclusion.*
- *There may be 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 admit date, a discharge date and units of service. Those 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 84 days [12 weeks] after the IESD).*

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Three or more outpatient, intensive outpatient or partial hospitalization follow-up visits with a practitioner (at least one of which is a prescribing practitioner) within the	ELECTRONIC SPECIFICATION: Patients 18 years and older as of April 30th of the measurement year diagnosed with a New Episode of Major Depressive Disorder during the Intake Period and treated with antidepressant medication. Follow the steps below to	N/A	Table AMM-A: Codes to Identify Major Depression Major depression*: ICD-9-CM Codes 296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311; DRG 426** Prior depressive episodes: ICD-9-CM Codes 296.2-296.9, 298.0, 300.4, 309.0, 309.1, 309.28, 311; DRG 426** * 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 depression diagnosis (296.4-296.9, 309.0, 309.28) are not included in this list because these codes are less	Patient demographics, claims or encounter data for visits, procedures, mental health and pharmacy. The medical record option requires

Antidepressant Medication Management: Optimal Practitioner Contacts for Medication Management (Source: NCQA)

84 day Acute Treatment Phase after a new diagnosis of major depression. All three follow-up visits should be for mental health. Two of the three follow-up visits must be face-to-face. Case management services should not be counted toward this measure.
Identify all patients in the denominator population who had:

- three face-to-face follow-up office visits (Table AMM-C) with a practitioner within 84 days (12 weeks) after the Index Episode Start Date, or
- two face-to-face visits and one telephone visit (Table AMM-C) with a practitioner

identify the population:

Step 1:
Identify all patients with a diagnosis of major depression who had at least one of the following during the 12-month intake period.

- At least one principal diagnosis of major depression (refer to Table AMM-A) in any setting (e.g., outpatient or ED visits, inpatient discharges or partial hospitalizations), or
- At least two secondary diagnoses of major depression (refer to Table AMM-A) on different dates of service in any outpatient setting (e.g., outpatient or ED visits), or
- At least one secondary diagnosis of major

specific in identifying eligible patients.
** *Exclude* patients with this code if the principal diagnosis is ICD-9-CM code 301.12.

Table AMM-B: Codes to Identify Substance Abuse

ICD-9-CM Diagnosis	DRG
291-292, 303-305, 960-979 with a secondary diagnosis of chemical dependency	433, 521-523

Table AMM-C: Codes to Identify Visits

Description	CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS and UB Revenue codes may be with a mental health or non-mental health practitioner (i.e., the organization does not need to determine practitioner type).			
Face-to-face visits	90804-90815	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0513, 0900-0905, 0907, 0911-0917, 0919

Description	CPT	UB Revenue
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner *or* in conjunction with any mental health diagnosis code (Table MPT-A).		
Face-to-face visits	98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983
Telephone visits	99371-99373	

Description	CPT		POS
Visits identified by the following 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).			
Face-to-face visits	90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876	*WITH*	05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72
Face-to-face visits	90816-90819, 90821-90824, 90826-90829	*WITH*	52, 53

manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Antidepressant Medication Management: Optimal Practitioner Contacts for Medication Management (Source: NCQA)

within 84 days (12 weeks) after the Index Episode Start Date.

Do not count the Index Episode Start Date visit in cases where the patient had two visits with a secondary diagnosis of depression. Include the second visit with a secondary diagnosis of depression toward the optimal contacts rate.

MEDICAL RECORD SPECIFICATION:
Three or more outpatient follow-up visits, intensive outpatient or partial hospitalization follow-up visits with a practitioner (at least one of which is a prescribing practitioner) within 84 days (i.e., within the 12-week acute treatment phase) after depression (refer to Table AMM-A) associated with any inpatient discharge.

Note: Do not include lab claims when identifying patients with depression.

Step 2:
Determine the IESD and test for Negative Diagnosis History. For each patient identified in step 1, determine the IESD by finding the date of the patient's earliest encounter during the Intake Period (i.e., outpatient or ED visit date, inpatient discharge date, partial hospitalization visit date) with a qualifying major depression diagnosis (refer to Table AMM-A).

Identify patients who were diagnosed with a New Episode of major depression. Patients with a New Episode of major depression are those who have a Negative Diagnosis History. The range of ICD-9-CM diagnosis codes for prior depressive episodes listed in Table AMM-A is more comprehensive to exclude patients diagnosed with any

Visits identified by the following CPT/POS codes must be with a mental health practitioner *or* in conjunction with any mental health diagnosis code (Table MPT-A).			
Face-to-face visits	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263	*WITH*	52, 53

Table AMM-D: Antidepressant Medications

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

Antidepressant Medication Management: Optimal Practitioner Contacts for Medication Management (Source: NCQA)				
major depression. All three follow-up visits are expected to be for mental health. Two of the three follow-up visits must be face-to-face. Case management services should not be counted toward this measure. Identify all patients in the denominator population who had: • three face-to-face follow-up office visits or intermediate treatment with a practitioner within 84 days (12 weeks) after the Index Episode Start Date, or • two face-to-face visits and one telephone visit with either a practitioner within 84 days (12 weeks) after the Index Episode Start Date. Do not count the Index Episode Start Date	type of depression. Patients with any diagnosis of major depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from this denominator. Step 3: Identify patients receiving antidepressant medication therapy. Among patients identified in step 2, find those who filled a prescription for an antidepressant medication within 30 days before the Index Episode Start Date to 14 days on or after the Index Episode Start Date. Step 4: Identify the Index Prescription Date. Identify the earliest prescription up to 30 days before the IESD to 14 days on or after the IESD. Prescriptions may be up to 30 days before the IESD to account for patients having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, prescriptions may be 14 days on or after the			

Antidepressant Medication Management: Optimal Practitioner Contacts for Medication Management (Source: NCQA)				
visit in cases where the patient had two visits with a secondary diagnosis of depression. Include the second visit with a secondary diagnosis of depression toward the optimal contacts rate.	IESD to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication or for patient delay in filling the initial prescription. Step 5: From the resulting patients from step 4, confirm the New Episode by testing for a Negative Medication History. Patients who have antidepressant prescriptions filled during the Negative Medication History period do not represent new treatment episodes and must be excluded. Step 6: Exclude patients who had an acute inpatient stay with a principal diagnosis of mental health (Tables MPT-A, MPT-B) or substance use (Table AMM-B) during the 245 days after the IESD treatment period. MEDICAL RECORD SPECIFICATION: MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in			

Antidepressant Medication Management: Optimal Practitioner Contacts for Medication Management (Source: NCQA)				
	which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.			

Antidepressant Medication Management: Effective Acute Phase Treatment (Source: NCQA)				
DESCRIPTION: • *Effective Acute Phase Treatment.* The percentage of patients 18 years of age and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.				
DEFINITIONS: See definitions listed under *Optimal Contacts for Medication Management*				
NOTES: See notes listed under *Optimal Contacts for Medication Management*				
NUMERATOR^	DENOMINATOR^	EXCLUSIONS^	CODES^	DATA SOURCE
ELECTRONIC SPECIFICATION: An 84-day (12-week) acute treatment of antidepressant medication. Identify all patients in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication (Table AMM-D) treatment to provide continuous treatment for at least 84 days in the 114-day period.	See denominator under *Optimal Contacts for Medication Management. (electronic specification)*	N/A	See codes under *Optimal Contacts for Medication Management. (electronic specification)*	Patient demographics, claims or encounter data for visits, procedures, mental health and

Antidepressant Medication Management: Effective Acute Phase Treatment (Source: NCQA)				
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, the total gap days may be no more than 30 days. Any combination of gaps may be counted (e.g., two washout gaps, each 15 days, or two washout gaps of 10 days each and one treatment gap of 10 days). The total gap days may not exceed 30 days. To determine continuity of treatment during the 114-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e., 84 treatment days + 30 gap days = 114 days). For all prescriptions filled within 114 days of the Index Prescription Date, count treatment days from the Index Prescription Date and continue to count until a total of 84 treatment days has been established. Patients whose gap days exceed 30 or who do not have 84 treatment days within 114 days after the Index Prescription Date are not counted in the numerator. MEDICAL RECORD SPECIFICATION: An 84-day (12-week) acute treatment of antidepressant medication. Identify all patients in the denominator population who have sufficient documentation in their medical record of a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 84 days in the 114-day period. The continuous treatment definition 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.				pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Antidepressant Medication Management: Effective Acute Phase Treatment (Source: NCQA)				
Regardless of the number of gaps, the total gap days may be no more than 30 days. Any combination of gaps may be counted (e.g., two washout gaps, each 15 days, or two washout gaps of 10 days each and one treatment gap of 10 days). The total gap days may not exceed 30 days. To determine continuity of treatment during the 114-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e., 84 treatment days + 30 gap days = 114 days). For all prescriptions prescribed within 114 days of the Index Prescription Date, count treatment days from the Index Prescription Date and continue to count until a total of 84 treatment days has been established. Patients whose gap days exceed 30 or who do not have 84 treatment days within 114 days after the Index Prescription Date are not counted in the numerator.				

Antidepressant Medication Management: Effective Continuation Phase Treatment (Source: NCQA)
• DESCRIPTION: • *Effective Continuation Phase Treatment.* The percentage of patients 18 years of age and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression and treated with anti-depressant medication and who remained on an antidepressant drug for at least 180 days.
DEFINITIONS: See definitions listed under *Optimal Contacts for Medication Management*
NOTES: See notes listed under *Optimal Contacts for Medication Management*

Antidepressant Medication Management: Effective Continuation Phase Treatment (Source: NCQA)				
NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: A 180-day treatment of antidepressant medication. Identify all patients in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment (Table AMM-D) to provide continuous treatment for at least 180 days in the 231-day period. The continuous treatment definition allows gaps in medication treatment up to a total of 51 days during the 231-day period. Allowable medication changes or gaps include: • "washout" period gap to change medication • "treatment" gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 51 days. Any combination of gaps may be counted (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days). Total gap days may not exceed 51 days. To determine continuity of treatment during the 231-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 231 days (i.e., 180 treatment days + 51 gap days = 231 days); identify all prescriptions filled within the 231 days of the Index Prescription Date. Count treatment days from the Index Prescription Date and continue to count until a total of 180 treatment days has been established. Patients whose gap days exceed 51 or who do not have 180 treatment days within 231 days after the Index Prescription Date are not counted in the numerator. MEDICAL RECORD SPECIFICATION: A 180-day treatment of antidepressant medication. Identify all patients in the denominator population who have sufficient documentation in their medical record of separate	See denominator under *Optimal Contacts for Medication Management.(electronic specification)*	N/A	See codes under *Optimal Contacts for Medication Management.(electronic specification)*	Patient demographics, claims or encounter data for visits, procedures, mental health and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Antidepressant Medication Management: Effective Continuation Phase Treatment (Source: NCQA)				
NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 180 days in the 231-day period. The continuous treatment definition allows gaps in medication treatment up to a total of 51 days during the 180-day period. Allowable medication changes or gaps include: • "washout" period gap to change medication • "treatment" gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 51 days. Any combination of gaps may be counted (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days). Total gap days may not exceed 51 days. To determine continuity of treatment during the 231-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 231 days (i.e., 180 treatment days + 51 gap days = 231 days); identify all prescriptions filled within the 231 days of the Index Prescription Date. Count treatment days from the Index Prescription Date and continue to count until a total of 180 treatment days has been established. Patients whose gap days exceed 51 or who do not have 180 treatment days within 231 days after the Index Prescription Date are not counted in the numerator.				

Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)

DESCRIPTION: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have at least 3 follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. The following 2 rates in the measure assess follow-up care for children prescribed an ADHD medication.

- Initiation Phase: The percentage of patients 6–12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- Continuation and Maintenance (C&M) Phase: The percentage of patients 6–12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

DEFINITIONS:

- Intake Period: The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.
- Negative Medication History: A period of 120 days (4 months) prior to the Index Prescription Episode Start Date, during which time the patient had no ADHD medications dispensed for either new or refill prescriptions (Table ADD-A).
- Index Prescription Start Date: The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
- Initiation Phase: The 30 days following the Index Prescription Episode Start Date.
- C&M Phase: The 31–300 days following the Index Prescription Episode Start Date (9 months).
- New Episode: The patient must have a 120-day (4-month) Negative Medication History on or before the Index Prescription Episode Start Date.
- Continuous Medication Treatment: The number of medication treatment days during the 10-month follow-up period must be equal to or greater than 210 days (i.e., 300 treatment days – 90 gap days).
- Treatment Days (covered days): The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (i.e., a prescription of 90 days' supply dispensed on the 220th day will have 80 days counted in the 300-day interval).
- Mental Health Practitioner: A practitioner who provides mental health services and meets any of the following criteria.
    - An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice
    - An individual who is licensed as a psychologist in his/her state of practice
    - An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice
    - A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice
    - An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy
    - An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board of Certified Counselors (NBCC)
- Prescribing Practitioner: A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)

NOTES:

- *Patients who switch product lines between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1.*
- *Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supplied.*
- *There may be 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 admit date, a discharge date and units of service. Those 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 the IPSD or from 31-300 days after the IPSD).*

<table>
<tr><th>NUMERATOR</th><th>DENOMINATOR</th><th>EXCLUSIONS</th><th>CODES</th><th>DATA SOURCE</th></tr>
<tr>
<td>ELECTRONIC SPECIFICATION:
Initiation Phase: Patients with at least one outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority within 30 days after the Index Prescription Start Date. Use Table ADD-B to identify the follow-up visit. This visit must be face-to-face with a practitioner. Note: Do not count the Index Prescription Start Date visit as the Initiation Phase visit.

Continuation and Maintenance (C&M) Phase: Patients who had an Initiation Phase Visit in the first 30 days AND had at least two follow-up visits with a practitioner from 31-300 days after the Index Prescription Start Date.</td>
<td>ELECTRONIC SPECIFICATION:
Initiation Phase: Children 6 – 12 years of age with an ambulatory ADHD prescription dispensed. The following steps should be followed to identify the eligible population.

Step 1:
Identify all children 6 years of age as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an ADHD medication during the 12-month Intake Period (Table ADD-A).

Step 2:
For each child identified in Step 1; test each ADHD prescription for a Negative Medication History. The Index Prescription Episode</td>
<td>Exclude from the eligible population all patients diagnosed with narcolepsy, at any point in the patient's history, as identified by the code in Table ADD-D.</td>
<td>Table ADD-A: ADHD Medications
<table>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>CNS stimulants</td><td>• amphetamine-dextroamphetamine
• atomoxetine
• dexmethylphenidate
• dextroamphetamine
• methamphetamine
• methylphenidate</td></tr>
</table>
Table ADD-B: Codes to Identify Follow-Up Visits
<table>
<tr><th>CPT</th><th>HCPCS</th><th>UB Revenue</th></tr>
<tr><td>90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99404, 99411, 99412, 99510</td><td>G0155, G0176, G0177, H0002, H0004, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485</td><td>0510, 0513, 0515-0517, 0519-0523, 0526-0529, 077x, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983</td></tr>
</table>
<table>
<tr><th colspan="2">CPT</th><th colspan="2">POS</th></tr>
<tr><td colspan="2">90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876</td><td>WITH</td><td>05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72</td></tr>
<tr><td colspan="2">99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263</td><td>WITH</td><td>52, 53</td></tr>
</table></td>
<td>Patient demographics, claims or encounter data for visits, procedures, mental health and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for</td>
</tr>
</table>

<table>
<tr><th colspan="5">Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)</th></tr>
<tr>
<td>One of the two visits (during days 31-300) may be a telephone visit with practitioner. Refer to Table ADD-B for codes to identify follow-up visits; refer to Table ADD-C for codes to identify telephone visits. Do not count the Initiation Phase follow-up visit toward C&M follow-up visits.

MEDICAL RECORD SPECIFICATION:
Initiation Phase: Patients with at least one outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority within 30 days after the Index Prescription Start Date. Use Table ADD-B to identify the follow-up visit. This visit must be face-to-face with a practitioner. Note: Do not count the Index Prescription Start Date visit as the Initiation Phase visit.

Continuation and Maintenance (C&M) Phase: Patients who had an Initiation Phase Visit in the first 30 days AND had at least two follow-up visits</td>
<td>Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3:
Exclude patients who had an acute inpatient stay with a principal diagnosis of mental health (Tables MPT-A, MPT-B) or substance abuse (Table AMM-B) during the 30 days after the Index Prescription Start Date.

Continuation and Maintenance (C&M) Phase: Children 6 – 12 years of age who during the 12-month Intake Period had at least one dispensing event for an ADHD medication.

Follow the steps below to identify the eligible population for the C&M Phase.

Step 1:
Identify all patients who meet the eligible patient population criteria for the Initiation Phase rate.</td>
<td></td>
<td>Table ADD-C: Codes to Identify Telephone Visits

<table><tr><th>CPT</th></tr><tr><td>99371-99373</td></tr></table>
Table ADD-D: Code to Identify Exclusions
<table><tr><th>Description</th><th>ICD-9-CM Diagnosis</th></tr><tr><td>Narcolepsy</td><td>347</td></tr></table></td>
<td>determination of the numerator.</td>
</tr>
</table>

Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)				
with a practitioner from 31-300 days after the Index Prescription Start Date. One of the two visits (during days 31-300) may be a telephone visit with practitioner. Refer to Table ADD-B for codes to identify follow-up visits; refer to Table ADD-C for codes to identify telephone visits. Do not count the Initiation Phase follow-up visit toward C&M follow-up visits.	Step 2: For each patient identified in step 1, the continuous medication treatment definition allows gaps in medication treatment up to a total of 90 days during the 300-day (10 month) period. This period spans the Initiation Phase (1 month) and the C&M Phase (9months). Allowable medication changes or gaps include: • "washout" period gaps to change medication • "treatment" gaps to refill the same medication • "drug holidays" from stimulant medication Regardless of the number of gaps, the total gap may be no more than 90 days. Any combination of gaps may be counted (e.g. one washout gap of 14 days and numerous weekend drug holidays). Step 3:			

Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)				
	an acute inpatient stay with a principal diagnosis of mental health (Tables MPT-A, MPT-B) or substance abuse (Table AMM-B) during the 300 days after the Index Prescription Start Date. MEDICAL RECORD SPECIFICATION: Initiation Phase: Children 6 – 12 years of age with an ambulatory ADHD prescription dispensed. The following steps should be followed to identify the eligible population. Step 1: Identify all children 6 years of age as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an ADHD medication during the 12-month Intake Period (Table ADD-A). Step 2: For each child identified in Step 1; test each ADHD prescription for a Negative Medication History. The			

Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)				
	Index Prescription Episode Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History. Step 3: Exclude patients who had an acute inpatient stay with a principal diagnosis of mental health (Tables MPT-A, MPT-B) or substance abuse (Table AMM-B) during the 30 days after the Index Prescription Start Date. Continuation and Maintenance (C&M) Phase: Children 6 – 12 years of age who during the 12-month Intake Period had at least one dispensing event for an ADHD medication. Follow the steps below to identify the eligible population for the C&M Phase. Step 1: Identify all patients who meet the eligible patient population criteria for the Initiation Phase rate.			

Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)				
	Step 2: For each patient identified in step 1, the continuous medication treatment definition allows gaps in medication treatment up to a total of 90 days during the 300-day (10 month) period. This period spans the Initiation Phase (1 month) and the C&M Phase (9months). Allowable medication changes or gaps include: • "washout" period gaps to change medication • "treatment" gaps to refill the same medication • "drug holidays" from stimulant medication Regardless of the number of gaps, the total gap may be no more than 90 days. Any combination of gaps may be counted (e.g. one washout gap of 14 days and numerous weekend drug holidays). Step 3: Exclude patients who had an acute inpatient stay			

Follow-Up Care for Children Prescribed ADHD Medication (Source: NCQA)				
	with a principal diagnosis of mental health (Tables MPT-A, MPT-B) or substance abuse (Table AMM-B) during the 300 days after the Index Prescription Start Date.			

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)

DESCRIPTION: This measure calculates two rates for adult patients and two rates for adolescent patients with Alcohol and Other Drug (AOD) dependence.

- *Initiation of AOD Dependence Treatment.* The percentage of adolescent and adult patients diagnosed with AOD dependence who initiate treatment through either:
  - An inpatient AOD admission, ***or***
  - An outpatient service, for AOD dependence *and* an additional AOD service within 14 days.
- *Engagement of AOD Treatment*. An intermediate step between initially accessing care (initiation treatment) and completing a full course of treatment. This measure is designed to assess the degree to which patients engage in treatment with two additional AOD services within 30 days after initiation.

DEFINITIONS:

- Index Episode Start Date - Either the discharge date of the earliest inpatient encounter or the service date of the earliest intermediate, ED or outpatient encounter between January 1 and November 15 of the measurement year with a qualifying diagnosis of AOD dependence.
- Intake Period - January 1 through November 15 of the measurement year. To ensure adequate opportunities for care are initiated within 14 days of a new episode of care, and two subsequent visits occur within an additional 30 days after initiation (inclusive), the last 45 days of the measurement year are not included in the Intake Period.
- Negative Diagnosis History - A period of 60 days prior to the Index Episode Start Date, during which the patient had no claims/encounters with any diagnosis of AOD dependence (Tables IET-A through IET-C). If the Index Episode Start Date was an inpatient visit, use the admission date to determine the 60-day Negative Diagnosis History.
- New Episode - To qualify as a New Episode, the following criterion must be met: a 60-day Negative Diagnosis History prior to the Index Episode Start Date. If the Index Episode Start Date was an inpatient visit, use the admission date to determine the 60-day negative diagnosis history.
- Inpatient Facility Code - The place of service or facility code, indicating that care was provided at an inpatient facility.

NUMERATOR	DENOMINATOR	EXCLUSIONS	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: Initiation of AOD Dependence Treatment: Initiation of AOD treatment can occur: If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of	ELECTRONIC SPECIFICATION: Initiation of AOD Dependence Treatment: All patients who meet the following criteria, and stratified by age group according to the age classifications below: • 13 years and older as of	N/A		Patient demographics, claims or encounter data for visits, procedures, mental health and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)

treatment, or if the Index Episode was a detoxification, ED visit or outpatient visit, the patient must have a subsequent service within 14 days of the Index Episode Start Date to be considered initiated. ED and detoxification visits count only toward the denominator and should not be included as the initiation visit.

Step 1: Identify all patients in the denominator population whose Index Episode Start Date was an inpatient discharge with a primary or secondary AOD diagnosis. This visit counts as the initiation event.

Step 2: Identify all patients in the denominator whose Index Episode Start Date was an outpatient visit, detoxification visit or emergency department visit

Step 3: Use the codes below to determine if the patients in step 2 had an additional outpatient visit

December 31 of the measurement year

- Adolescent Age Band: 13 – 17 year-olds
- Adult Age Bands: 18 – 25 years old, 26-24 years old, 35-64 years old, 65+ years old
- Total

The following steps should be followed to identify the eligible population which is the denominator for this measure:

Step 1: Identify all patients 13 years and older who:

- Had an AOD outpatient claim/encounter or intermediate claim/encounter between January 1 and November 15 of the measurement year, or
- Had a detoxification or ED visit between January 1 and November 15 of the measurement year, or
- Had an inpatient discharge between January 1 and November 15 of the measurement year.

Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year

Table IET-A: Codes to Identify Intermediate Care and Outpatient Visits

CPT		HCPCS
90801-90802, 90804-90815, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99420	*OR*	G0155, G0176, G0177, H0001, H0002, H0004-H0007, H0015, H0016, H0020, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S9480, S9484, S9485, T1006, T1012

WITH

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 Detoxification and Emergency Department Services

CPT		HCPCS		ICD-9-CM Procedure		UB-92 Revenue
99281-99285 *WITH* An ICD-9 diagnosis code from IET-A	*OR*	H0008-H0014, S9475 *WITH* An ICD-9 diagnosis code from IET-A	*OR*	94.62, 94.63, 94.65, 94.66, 94.68, 94.69 (ICD-9 procedure codes do not require a diagnosis of chemical dependency)	*OR*	045x *WITH* An ICD-9 diagnosis code from IET-A

determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

<table>
<tr><th colspan="5">Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)</th></tr>
<tr>
<td>or inpatient admission with any AOD diagnosis within 14 days of the Index Episode Start Date (inclusive).
Step 4: Exclude from the denominator patients whose initiation service was an inpatient stay with a discharge date after December 1.

Engagement of AOD Treatment: Identify patients who had an initiation of AOD treatment visit and two or more services with AOD dependence diagnosis within 30 days after the date of the initiation visit (inclusive). Use the codes below to identify engagement treatment:

For patients who initiated treatment via inpatient stay, 30 days starts at the patient's inpatient discharge date. To determine if the 30-day criterion is met for engagement inpatient stays, count days to the next outpatient service or the admission date of the subsequent inpatient stay,</td>
<td>(e.g. outpatient, detoxification or ED visit date, and inpatient discharge date) with any qualifying AOD dependence diagnosis.
Step 3: Determine if the Index Episode Start Date is a New Episode. Patients with a New Episode of AOD dependence have a Negative Diagnosis History of 60 days without an AOD diagnosis. For patients with an inpatient visit, use the admission date to determine Negative Diagnosis History.
Engagement of AOD Treatment: All patients who meet the following criteria, and stratified by age group according to the age classifications below:
13 years and older as of December 31 of the measurement year
Adolescent Age Band: 13 – 17 year-olds
Adult Age Bands: 18 – 25 years old, 26-24 years old, 35-64 years old, 65+ years old
Total
The following steps should be followed to identify the</td>
<td></td>
<td>Table IET-C: Codes to Identify Inpatient Services<table><tr><th>ICD-9-CM Diagnosis</th><th></th><th>DRG</th></tr><tr><td>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
WITH
An inpatient facility code</td><td>OR</td><td>433, 521-523</td></tr></table></td>
<td></td>
</tr>
</table>

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)				
not the discharge date. ED and detoxification visits count only toward the denominators and should not be included as an engagement visit. MEDICAL RECORD SPECIFICATION: Initiation of AOD Dependence Treatment: The number of patients with documentation that Initiation of AOD treatment occurred through any of the following mechanisms. If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment, or if the Index Episode was a detoxification, ED visit or outpatient visit, the patient must have a subsequent service within 14 days of the Index Episode Start Date to be considered initiated. ED and detoxification visits count only toward the denominator and should not be included as	eligible population which is the denominator for this measure: Step 1: Identify all patients 13 years and older who: • Had an AOD outpatient claim/encounter or intermediate claim/encounter between January 1 and November 15 of the measurement year, or • Had a detoxification or ED visit between January 1 and November 15 of the measurement year, or • Had an inpatient discharge between January 1 and November 15 of the measurement year. Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year (e.g. outpatient, detoxification or ED visit date, inpatient discharge date) with any qualifying AOD dependence diagnosis (see ICD-9-CM Principal Diagnosis list above) Step 3: Determine if the Index Episode Start Date is a			

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)				
the initiation visit. Step 1: Identify all patients in the denominator population whose Index Episode Start Date was an inpatient discharge with a primary or secondary AOD diagnosis. This visit counts as the initiation event. Step 2: Identify all patients in the denominator whose Index Episode Start Date was an outpatient visit, detoxification visit or emergency department visit. Step 3: Determine if the patients in step 2 had an additional outpatient visit or inpatient admission with any AOD diagnosis within 14 days of the Index Episode Start Date (inclusive). To determine if the 14-day criterion is met for inpatient stays, use the admission date, not the discharge date. Step 4: Exclude from the denominator patients whose initiation service was an inpatient stay with	New Episode. Patients with a New Episode of AOD dependence have a Negative Diagnosis History of 60 days without an AOD diagnosis. For patients with an inpatient visit, use the admission date to determine Negative Diagnosis History. MEDICAL RECORD SPECIFICATION: Initiation of AOD Dependence Treatment: All patients with documentation of meeting the following criteria, and stratified by age group according to the age classifications below: • 13 years and older as of December 31 of the measurement year • Adolescent Age Band: 13 – 17 year-olds • Adult Age Bands: 18 – 25 years old, 26-24 years old, 35-64 years old, 65+ years old • Total The following steps should be followed to identify the eligible population which is the denominator for this			

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)				
a discharge date after December 1. Engagement of AOD Treatment: Identify patients who had documentation of an initiation of AOD treatment visit and two or more services with AOD dependence diagnosis within 30 days after the date of the initiation visit (inclusive): For patients who initiated treatment via inpatient stay, 30 days starts at the patient's inpatient discharge date. To determine if the 30-day criterion is met for engagement inpatient stays, count days to the next outpatient service or the admission date of the subsequent inpatient stay, not the discharge date. ED and detoxification visits count only toward the denominator and should not be included as an engagement visit.	measure: Step 1: Identify all patients 13 years and older who: • Had an outpatient claim/encounter or intermediate AOD claim/encounter between January 1 and November 15 of the measurement year, or • Had a detoxification or ED visit between January 1 and November 15 of the measurement year, or • Had an inpatient discharge between January 1 and November 15 of the measurement year. Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year (e.g. outpatient, detoxification or ED visit date, inpatient discharge date) with any qualifying AOD dependence diagnosis Step 3: Determine if the Index Episode Start Date is a New Episode. Patients with a New Episode of AOD dependence have a Negative Diagnosis History of 60 days			

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)				
	without an AOD diagnosis. For patients with an inpatient visit, use the admission date to determine Negative Diagnosis History. Engagement of AOD Treatment: All patients with documentation of meeting the following criteria, and stratified by age group according to the age classifications below: • 13 years and older as of December 31 of the measurement year • Adolescent Age Band: 13 – 17 year-olds • Adult Age Bands: 18 – 25 years old, 26-24 years old, 35-64 years old, 65+ years old • Total The following steps should be followed to identify the eligible population which is the denominator for this measure: Step 1: Identify all patients 13 years and older who: • Had an outpatient claim/encounter or intermediate AOD claim/encounter between January 1 and			

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Source: NCQA/WC)				
	November 15 of the measurement year, or • Had a detoxification or ED visit between January 1 and November 15 of the measurement year, or • Had an inpatient discharge between January 1 and November 15 of the measurement year. Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year (e.g. outpatient, detoxification or ED visit date, inpatient discharge date) with any qualifying AOD dependence diagnosis Step 3: Determine if the Index Episode Start Date is a New Episode. Patients with a New Episode of AOD dependence have a Negative Diagnosis History of 60 days without an AOD diagnosis. For patients with an inpatient visit, use the admission date to determine Negative Diagnosis History.			

PREVENTION, IMMUNIZATION AND SCREENING - TOBACCO CESSATION

Advising Smokers To Quit (Source: NCQA)			
DESCRIPTION: The number of patients in the denominator who responded to the survey and indicated that they had received advice to quit smoking from a doctor or other health provider during the measurement year.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in the denominator who responded to the survey and indicated that they had received advice to quit smoking from a doctor or other health provider during the measurement year. Patient choices must be as follows to be included in the numerator: Q: In the last 12 months, on how many visits were you advised to quit smoking by a doctor or other health care provider? A: "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" must be chosen from the options of "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" or "I had no visits in the last 12 months"	The number of patients 18 and older who responded to the survey and indicated that they were current smokers and had one or more visits during the measurement year. Patient choices must be as follows to be included in the denominator: Q: Do you now smoke cigarettes every day, some days, or not at all? A: "Every day" or "Some days" must be chosen from the options of "Every day", "Some days", "Not at all" or "Don't know". Q: In the last 12 months, on how many visits were you advised to quit smoking by a doctor or other health provider in your plan? A: "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits"	Patients who responded "I had no visits in the last 12 months" and who smoke cigarettes "not at all" are excluded.	Patient survey

Discussing Smoking Cessation Medication (Source: NCQA)			
DESCRIPTION: The number of patients in the denominator who responded to the survey and indicated that medication to assist with quitting smoking was recommended or discussed.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in the denominator who responded to the survey and indicated that medication to assist with quitting smoking was recommended or discussed. Patient choices must be as follows to be included in the numerator: Q: On how many visits was medication recommended or discussed to assist you with quitting smoking (for example: nicotine gum, patch, nasal spray, inhaler, prescription medicine)? A: "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" must be chosen from the options of "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits", or "I had no visits in the last 12 months"	The number of patients 18 and older who responded to the survey and indicated that they were current smokers and had one or more visits during the measurement year. Patient choices must be as follows to be included in the denominator: Q: Do you now smoke cigarettes every day, some days, or not at all? A: "Every day" or "Some days" must be chosen from the options of "Every day", "Some days", "Not at all" or "Don't know". Q: On how many visits was medication recommended or discussed to assist you with quitting smoking (for example: nicotine gum, patch, nasal spray, inhaler, prescription medicine)? A: "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits"	Patients who responded "I had no visits in the last 12 months" and who smoke cigarettes "not at all" are excluded.	Patient survey

Discussing Smoking Cessation Strategies (Source: NCQA)			
DESCRIPTION: The number of patients in the denominator who responded to the survey and indicated that their doctor or health care provider recommended or discussed methods and strategies other than medication to assist with quitting smoking.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in the denominator who responded to the survey and indicated that their doctor or health care provider recommended or discussed methods and strategies other than medication to assist with quitting smoking. Patient choices must be as follows to be included in the	The number of patients 18 and older who responded to the survey and indicated that they were current smokers and had one or more visits during the measurement year. Patient choices must be as follows to be included in the denominator:	Patients who responded "I had no visits in the last 12 months" and who smoke cigarettes "not at all" are excluded.	Patient survey

Discussing Smoking Cessation Strategies (Source: NCQA)			
numerator: Q: On how many visits did your doctor or health provider recommend or discuss methods and strategies (other than medication) to assist you with quitting smoking? A:"1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" must be chosen from the options of "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" or "I had no visits in the last 12 months"	Q: Do you now smoke cigarettes every day, some days, or not at all? A: "Every day" or "Some days" must be chosen from the options of "Every day", "Some days", "Not at all" or "Don't know". Q: On how many visits did your doctor or health provider recommend or discuss methods and strategies (other than medication) to assist you with quitting smoking? A: "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits"		

PREVENTION, IMMUNIZATION AND SCREENING – GENERAL PREVENTION

Physical Activity in Older Adults (Source: NCQA)

DESCRIPTION:
Discussing Physical Activity: The percentage of Medicare patients 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 patients 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.

NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
Discussing Physical Activity: • The number of patients in the denominator who responded "yes" to the question, "In the last 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise." Advising Physical Activity: • The number of patients in the denominator who responded "yes" to the question, "In the last 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program."	Discussing Physical Activity: • The number of patients 65 years and older as of December 31st of the measurement year who responded "yes" or "no" to the question, "In the last 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity?" Advising Physical Activity: • The number of patients 65 years and older as of December 31st of the measurement year who responded "yes" or "no" to the question, "In the last 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?"	N/A	Patient survey

Discussing Urinary Incontinence (Source: NCQA)			
DESCRIPTION: The percentage of patients 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.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in denominator 1 who indicated they discussed their urine leakage problem with their current provider. Patient choices must be as follows to be included in the numerator: Q: "In the last six months, have you talked with your current doctor or other health care provider about your urine leakage problem?" A: "Yes" must be chosen from the options of: "Yes" or "No" or "I did not see a doctor or health provider in the last six months".	The number of patients 65 years and older who responded to the survey indicating they had a urine leakage problem in the last 6 months. Patient choices must be as follows to be included in the numerator: Q: "Many people experience problems with urinary incontinence, the leakage of urine. In the last six months, have you accidentally leaked urine?" A: "Yes" must be chosen from the options of: "Yes" or "No" Q: "How much of a problem, if any, was the urine leakage for you?" A: "A big problem" or "A small problem" must be chosen from the options of: "A big problem" or "A small problem" or Not a problem".	Patients who did not have a doctor's visit in the last year or who reported they did not have a problem with UI, are excluded.	Patient survey

Receiving Urinary Incontinence Treatment (Source: NCQA)			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
DESCRIPTION: The percentage of patients 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.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in denominator 2 who indicated they received treatment for their current urine leakage problem. Patient choices must be as follows to be included in the numerator: Q: "There are many ways to treat urinary incontinence including bladder training, exercises, medication and	The number of patients 65 years and older who responded to the survey indicating they had a urine leakage problem in the last 6 months and discussed their urine leakage problem with their current provider. Patient choices must be as follows to be included in the numerator: Q: "Many people experience problems with	Patients who did not have a doctor's visit in the last year or who reported they did not have a problem with UI, are excluded.	Patient survey

Receiving Urinary Incontinence Treatment (Source: NCQA)			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
surgery. Have you received these or any other treatments for your current urine leakage problem?" A: "Yes" must be chosen from the options of: "Yes" or "No"	urinary incontinence, the leakage of urine. In the last six months, have you accidentally leaked urine?" A: "Yes" must be chosen from the options of: "Yes" or "No" Q: "How much of a problem, if any, was the urine leakage for you?" A: "A big problem" or "A small problem" must be chosen from the options of: "A big problem" or "A small problem" or Not a problem". Q: "In the last six months, have you talked with your doctor or other health provider about your current urine leakage problem?" A: "Yes" must be chosen from the options of: "Yes" or "No" or "I did not see a doctor or health provider in the last six months".		

PREVENTION, IMMUNIZATION AND SCREENING - SCREENING

Breast Cancer Screening (Source: CMS/NCQA)

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

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

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: 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	ELECTRONIC SPECIFICATION: Women 42-69 years as of December 31 of the measurement year. Note: Given the measurement look back period, women 40-69 will be	ELECTRONIC SPECIFICATION: Exclude women who had a bilateral mastectomy. Look for evidence of bilateral mastectomy as far back as possible in the patient's history, through administrative data. If there is evidence of two separate mastectomies, this patient	Table BCS-A: Codes to Identify Breast Cancer Screening CPT: 76083, 76090-76092, 77055-77057 HCPCS: G0202 ICD-9-CM Diagnosis: V76.11, V76.12 ICD-9-CM Procedure: 87.36, 87.37 UB Revenue: 0403	Patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for

Breast Cancer Screening (Source: CMS/NCQA)

one of the codes in Table BCS-A.

MEDICAL RECORD SPECIFICATION: One or more mammograms during the measurement year or the year prior to the measurement year.

Documentation in the medical record must include both of the following:

- a note indicating the date the mammogram was performed, and
- the result or finding.

captured in this measure.

MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled

may be excluded from the measure. The bilateral mastectomy must have occurred by December 31st of the measurement year. For Bilateral and Unilateral codes see Table BCS-B.

MEDICAL RECORD SPECIFICATION: Exclude women who had a bilateral mastectomy. Look for evidence of bilateral mastectomy as far back as possible in the patient's history, through medical record review. If there is evidence of two separate mastectomies, this patient may be excluded from the measure. The bilateral mastectomy must have occurred by December 31st of the measurement year.

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.

visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Breast Cancer Screening (Source: CMS/NCQA)

	or single insurer) data can be used to identify the denominator			

Cervical Cancer Screening (Source: NCQA)

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

NOTES:

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

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: One or more Pap tests during the measurement year or the two years prior to the measurement year. A woman had a Pap test if claim/encounter data contains any one of the codes in Table CCS-A. MEDICAL RECORD SPECIFICATION: One or more Pap tests during the measurement year or the two years prior to the measurement year. Documentation in the	ELECTRONIC SPECIFICATION: Women 24–64 years of age as of December 31 of the measurement year. Note: Given the measurement look back period, women 21-64 will be captured in this measure. MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the	ELECTRONIC SPECIFICATION: Women who had a hysterectomy and with no residual cervix. Look for evidence of a hysterectomy as far back as possible in the patient's history, through administrative data. The hysterectomy must have occurred by December 31 of the measurement year. Use the codes in Table CCS-B to identify a hysterectomy. MEDICAL RECORD SPECIFICATION: Women who had a hysterectomy and with no residual cervix. Look for evidence of a hysterectomy as far back as possible in the patient's history, through medical record review. The	Table CCS-A: Codes to Identify Cervical Cancer Screening **CPT:** 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175 **HCPCS:** G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 **ICD-9-CM Diagnosis:** V72.32, V76.2 **ICD-9-CM Procedure:** 91.46 **UB Revenue:** 0923 **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7 Table CCS-B: Codes to Identify Exclusions **Description:** Hysterectomy **CPT:** 51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550-58554, 58951, 58953, 58954, 58956, 59135 **ICD-9-CM Procedure:** 68.4-68.8 **ICD-9-CM Diagnosis:** 618.5, V76.01, V76.47	Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Cervical Cancer Screening (Source: NCQA)				
medical record must include both of the following:· • a note indicating the date the test was performed, and • the result or finding.	measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator	hysterectomy must have occurred by December 31 of the measurement year. Exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix. Documentation of "complete hysterectomy," "total hysterectomy," "total abdominal or vaginal hysterectomy" or "radical hysterectomy" meets the criteria for hysterectomy with no residual cervix. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of "hysterectomy" alone does not meet the criteria because it does not indicate the cervix has been removed. Use the codes in Table CCS-B has synonyms for a hysterectomy with no residual cervix.		

Chlamydia Screening in Women (Source: NCQA)

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

NUMERATOR

ELECTRONIC SPECIFICATION: At least one chlamydia test during the measurement year as documented through administrative data. A woman had a test if claim/encounter data during the measurement year contains one or more of the codes in Table CHL-C.

MEDICAL RECORD SPECIFICATION: Documentation in the medical record of at least one chlamydia test during the measurement year. A woman is considered as having a test if there is documentation of

DENOMINATOR

ELECTRONIC SPECIFICATION: Women 16-25 years of age (reported in stratifications of 16-20, 21-25 and overall) as of December 31 of the measurement year. Two methods are provided to identify sexually active women: pharmacy data and claims/encounter data. Use **both** methods to identify the eligible population, although a patient must appear in only one method to be eligible for the measure.

Pharmacy data: Patients who were dispensed prescription contraceptives (oral contraceptives, IUD, diaphragm or other prescribed contraceptive) during the measurement year. Refer to Table CHL-A.

Claims/encounter data: Patients who had at least one encounter during the measurement year with any code listed in Table CHL-B.

MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined

EXCLUSION

ELECTRONIC SPECIFICATION: Patients may be excluded who had a pregnancy test during the measurement year followed within seven days (inclusive) by **either** a prescription for isotretinoin (Accutane) **or** an x-ray. This exclusion does not apply to patients who qualify for the denominator based on services other than the pregnancy test alone. The codes in Table CHL-D are provided to identify exclusions.

MEDICAL RECORD SPECIFICATION: Patients may be excluded who had a pregnancy test during the measurement year followed within seven days (inclusive) by either a prescription

CODES

Table CHL-A: Prescriptions to Identify Contraceptives

Description	Prescription	
Contraceptives	• desogestrel-ethinyl estradiol • drospirenone-ethinyl estradiol • 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	• octoxynol

Note: NCQA will provide a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org) by November 15, 2007.

Table CHL-B: Codes to Identify Sexually Active Women

Description	Codes
CPT	11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84703, 86592-86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 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

DATA SOURCE

Patient demographics, claims or encounter data for visits, procedures and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Chlamydia Screening in Women (Source: NCQA)

a *Chlamydia trachomatis* or *species test* with a service date during the measurement year.	using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator	for isotretinoin (Accutane) or an x-ray. This exclusion does not apply to patients who qualify for the denominator based on services other than the pregnancy test alone.	

ICD-9-CM Diagnosis	042, 054.10, 054.11, 054.12, 054.19, 078.1, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 614-616, 622.3, 623.4, 626.7, 628, 630-677, 795.0, 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, V73.88, V73.98, V74.5, V76.2
ICD-9-CM Procedure	69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 97.24, 97.71, 97.73
UB Revenue	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925
LOINC	557-9, 560-3, 660-1, 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 1832-5, 1834-1, 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9,2114-7, 2115-4, 2118-8, 2119-6, 4993-2, 5028-6, 5291-0, 5292-8, 5392-6, 5393-4, 5394-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 6487-3, 6488-1, 6489-9, 6510-2, 6511-0, 6514-4, 6516-9, 6561-5, 6562-3, 7975-6, 8041-6, 10524-7, 10705-2, 11083-3, 11084-1, 11481-9, 11597-2, 12222-6, 12223-4, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 14509-4, 14510-2, 14513-6, 15019-3, 16280-0, 16600-9, 16601-7, 16602-5, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 18500-9, 19080-1, 19171-8, 19176-7, 19177-5, 19180-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 20403-2, 20404-0, 20415-6, 20507-0, 20508-8, 20993-2, 20994-0, 21189-6, 21190-4, 21191-2, 21192-0, 21198-7, 21414-8, 21415-5, 21416-3, 21440-3, 21441-1, 21613-5, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 23838-6, 23908-7, 24110-9, 24111-7, 24312-1, 24364-2, 25372-4, 25373-2, 26009-1, 29311-8, 30167-1, 31147-2, 31771-9, 31772-7, 31775-0, 31777-6, 31905-3, 31906-1, 31993-9, 32198-4, 32199-2, 32705-6, 33717-0, 33773-3, 34382-2, 34493-7, 34656-9, 34670-0, 34718-7, 35457-1, 36902-5, 36903-3, 38372-9, 42316-0, 42481-2, 42931-6, 43304-5, 43404-3, 43406-8

Table CHL-C: Codes to Identify Chlamydia Screening

CPT	LOINC
87110, 87270, 87320, 87490, 87491, 87492, 87810	557-9, 560-3, 4993-2, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 16602-5, 20993-2, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 6349-5, 43304-5, 43404-3, 43406-8

Chlamydia Screening in Women (Source: NCQA)

Table CHL-D: Codes to Identify Exclusions

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

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

Colorectal Cancer Screening (Source: NCQA)

DESCRIPTION: The percentage of adults 50–80 years of age who had appropriate screening for colorectal cancer.

NOTES:

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

NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFCIATION: One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below: • fecal occult blood test (FOBT) during the measurement year	ELECTRONIC SPECIFCIATION: Patients 51–80 years of age during the measurement year	ELECTRONIC SPECIFCIATION: Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or		Patient demographics, claims or encounter data for visits and procedures. The medical record option requires

Colorectal Cancer Screening (Source: NCQA)

- flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year.
- colonoscopy during the measurement year or the nine years prior to the measurement year.

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

MEDICAL RECORD SPECIFCATION: One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:

- fecal occult blood test (FOBT) during the measurement year
- flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- double contrast barium enema (DCBE) or air contrast enema during the

Note: Given the measurement look back period, adults 50-80 will be captured in this measure.

MEDICAL RECORD SPECIFCATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful

total colectomy as far back as possible in the patient's history, through administrative data. Use the codes or descriptions of the codes in Table COL-B to identify allowable exclusions.

MEDICAL RECORD SPECIFCATION: Patients 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 patient's history, through medical record review. Use the codes in Table COL-B as synonyms for a diagnosis of colorectal cancer or total colectomy.

Table COL-A: Codes to Identify Colorectal Cancer Screening

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

Table COL-B: Codes to Identify Exclusions for Colorectal Cancer Screening

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

manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Colorectal Cancer Screening (Source: NCQA)				
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.. Documentation in the medical record must include the following: • A note indicating the date the colorectal cancer screening was performed • For a notation in the progress notes, the result or finding must also be present (this ensures the screening was preformed and not merely ordered). For a notation in the medical history, a result is not required. Documentation in the medical history pertains to screenings that occurred in the past and it is assumed that the result was negative (a positive result would have been noted as such). A notation in the medical history must include a date reference that meets the timeline outlined in the specifications.	sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator			

Fall Risk Management in Older Adults (Source: NCQA)

DESCRIPTION:

Discussing Fall Risk: The percentage of Medicare patients,

- 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 patients 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.

NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
Discussing Fall Risk: • The number of patients in the denominator 1 who responded "yes" to the question, "A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?" Managing Fall Risk: • The number of patients in the denominator 2 who responded "yes" to the question, "Has your doctor or other health provider done these or anything else to help prevent falls or treat problems with balance or walking?" Some examples of things they might do include: • Suggest that you use a cane or walker • Check your blood pressure lying or standing • Suggest that you do an exercise or physical therapy program • Suggest a vision or hearing testing	Discussing Fall Risk: • All patients 75 years and older as of December 31 of the measurement year, AND patients 65 years to 74 years as of December 31 of the measurement year who responded "yes" to either of the questions, "Did you fall in the past 12 months?" OR "yes" to the question, "In the past 12 months, have you had problems with balance or walking?" and who indicated they were seen by a provider during the measurement year. Managing Fall Risk: • Patients 65 years and older as of December 31 of the measurement year who responded "yes" to either of the questions, "Did you fall in the past 12 months?" OR "yes" to the question, "In the past 12 months, have you had problems with balance or walking?" and who indicated they were seen by a provider during the measurement year.	N/A	Patient survey

Osteoporosis Testing (Source: NCQA)			
DESCRIPTION: The percentage of women 65 years of age and older who have ever been tested for osteoporosis via a bone density test.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in the denominator who responded "yes" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel, or finger."	Women 65 and older as of December 31 of the measurement year who answered "yes" or "no" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel, or finger."	N/A	Patient survey

PREVENTION, IMMUNIZATION AND SCREENING - IMMUNIZATION

Childhood Immunization (Source: NCQA)				
DESCRIPTION: The percentage of children two years of age who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.				
NOTE: NCQA follows the Centers for Disease Control and Prevention (CDC) and the Advisory Council on Immunization Practices (ACIP) guidelines for immunizations. HEDIS implements any changes to the guidelines (e.g., new vaccine recommendations) after three years to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
ELECTRONIC SPECIFICATION: For DTaP, IPV, HiB and pneumococcal conjugate, evidence of the antigen or vaccine must be found. For MMR, hepatitis B and VZV, any of the following may be counted. • Evidence of the antigen or combination vaccine, *or* • Documented history of the illness, *or* • A seropositive test result. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), evidence of all the antigens must be found. DTaP / DT: Four DTaP vaccinations with	ELECTRONIC SPECIFICATION: Children who turn two years of age during the measurement year. MEDICAL RECORD SPECIFICATION: A systematic sample from the population listed above should be determined using the most accurate data available in the settings in	ELECTRONIC SPECIFICATION: Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Exclusion of contraindicated children may only be done for those children where the administrative data does not indicate that the contraindicated		Patient demographics, claims or encounter data for visits and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records

Childhood Immunization (Source: NCQA)

different dates of service on or before the child's second birthday. Do not count any vaccination administered prior to 42 days after birth.

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

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

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

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

Hepatitis B:
Three hepatitis B vaccinations, with

which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator

immunization was rendered. The exclusion must have occurred by the child's 2nd birthday. Exclusions should be looked for as far back as possible in the child's history. The codes listed in table CIS-B may be used to identify allowable exclusions.

MEDICAL RECORD SPECIFICATION:
Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Exclusion of contraindicated children may only be done for those children where the medical record data does not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the child's

Table CIS-A: Codes to Identify Childhood Immunizations

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
DTaP	90698, 90700, 90721, 90723			99.39
Diphtheria and tetanus	90702			
Diphtheria	90719			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			
Hepatitis B**	90723, 90740, 90744, 90747, 90748	G0010	070.2, 070.3, V02.61	
VZV	90710, 90716		052, 053	
Pneumococcal conjugate	90669	G0009		

* ICD-9-CM Diagnosis codes indicate evidence of disease.
** The two-dose hepatitis B antigen Recombivax is recommended for children between 11 and 14 years of age only and is not included in this table.

to both confirm information in the sampling framework for the denominator and for determination of the numerator.

Childhood Immunization (Source: NCQA)

different dates of service on or before the child's second birthday.

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

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

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

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

MEDICAL RECORD SPECIFICATION: For DTaP, IPV,

2nd birthday. Exclusions should be looked for as far back as possible in the child's history.

Table CIS-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.4
DTaP	Encephalopathy	323.51* *with* (E948.4 or E948.5 or E948.6)
IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin	
MMR and VZV	Immunodeficiency, including genetic (congenital) immunodeficiency syndromes	279
MMR and VZV	HIV disease; asymptomatic HIV	042, V08
MMR and VZV	Cancer of lymphoreticular or histiocytic tissue	200-202
MMR and VZV	Multiple myeloma	203
MMR and VZV	Leukemia	204-208
MMR and VZV	Anaphylactic reaction to neomycin	
HiB	None	
Hepatitis B	Anaphylactic reaction to common baker's yeast	
Pneumococcal conjugate	None	

*Use ICD-9-CM Diagnosis code 323.5 (with no fifth digit) to identify DTaP prior to October 1, 2006; the date of service *must be* before October 1, 2006.

Childhood Immunization (Source: NCQA)				
HiB and pneumococcal conjugate, evidence of the antigen or vaccine must be found. For MMR, hepatitis B and VZV, any of the following may be counted. • Evidence of the antigen or combination vaccine, *or* • Documented history of the illness, *or* • A seropositive test result. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), evidence of all the antigens must be found. For immunization information obtained from the medical record, count patients where there is evidence that the antigen was rendered from: • A note indicating the name of the specific antigen and the date of the immunization, or· • A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. For documented history of illness or a seropositive test result, find a note indicating the date of the event. The event must have occurred by the patient's second birthday.				

Childhood Immunization (Source: NCQA)				
Notes in the medical record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "patient is up-to-date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for this measure. Note: DTP vaccinations are no longer manufactured, but notations of DTP in medical records count toward the numerator.				

Flu Shots for Adults Ages 50-64 (Source: NCQA)			
DESCRIPTION: The percentage of patients 50–64 years of age as of September 1 of the measurement year who received an influenza vaccination.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in the denominator who responded, "Yes" to the question "Have you had a flu shot since September 1,YYYY?	The number of patients 50-64 years who responded "Yes" or "No" to the question "Have you had a flu shot since September 1, YYYY?"	N/A	Patient Survey

Flu Shots for Older Adults (Source: CMS / NCQA)			
DESCRIPTION: The percentage of patients 65 years of age and older as of January 1 of the measurement year who received an influenza vaccination.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in the denominator who responded "Yes" to the question, "Have you had a flu shot since September 1, YYYY?"	The number of patients 65 years or older who responded "Yes" or "No" to the question, "Have you had a flu shot since September 1, YYYY?"	N/A	Patient survey

Pneumonia Vaccination for Older Adults (Source: NCQA)			
DESCRIPTION: The percentage of patients 65 years of age and older as of January 1 of the measurement year who have ever received a pneumococcal vaccine.			
NUMERATOR	DENOMINATOR	EXCLUSION	DATA SOURCE
The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."	The number of patients 65 years and older as of January 1 of the measurement year who responded, "Yes" or "No" to the questions "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."	N/A	Patient Survey

Pneumonia Vaccination (Source: CMS / NCQA)				
DESCRIPTION: The percentage of patients 65 years and older who ever received a pneumococcal vaccination.				
NUMERATOR	DENOMINATOR	EXCLUSION	CODES	DATA SOURCE
Patients who have ever received a pneumococcal vaccination.(Refer to Table PV-A)	All patients ≥ 65 years of age in the measurement year.	• Previous anaphylactic reaction to the vaccine or any of its components. • Other medical reason(s) documented by the practitioner for not receiving a pneumococcal vaccination • Patient reason(s) (e.g., economic, social, religious)	Table PV-A: Codes to Identify Pneumococcal Vaccinations CPT: 90732 HCDCS: G0009	Patient demographics, claims or encounter data for visits and procedures.

EYE CARE

Primary Open Angle Glaucoma: Optic Nerve Evaluation (Source: AAO/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of primary open angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (Source: AAO/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level lf severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Source: AAO/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

EMERGENCY CARE

Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain (Source: ACEP/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Aspirin at Arrival for Acute Myocardial Infarction (AMI) (Source: ACEP/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients, regardless of age, with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Electrocardiogram (ECG) Performed for Syncope (Source: ACEP/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had a 12-lead ECG performed.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia (Source: ACEP/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Assessment of Mental Status for Community-Acquired Bacterial Pneumonia (Source: ACEP/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Empiric Antibiotic for Community-Acquired Bacterial Pneumonia (Source: ACEP/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

GERIATRICS

Medication Reconciliation (Source: AGS/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Advance Care Plan (Source: AGS/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan in the medical record.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (Source: AGS/AMA PCPI/NCQA)
DESCRIPTION: The percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Characterization of Urinary Incontinence in Women Aged 65 Years and Older (Source: AGS/AMA PCPI/NCQA)
DESCRIPTION: The percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older (Source: AGS/AMA PCPI/NCQA)
DESCRIPTION: The percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Screening for Future Fall Risk (Source: AGS/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

STROKE AND STROKE REHABILITATION

Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage (Source: AAN/ACR/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who received DVT prophylaxis by end of hospital day two.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Discharged on Antiplatelet Therapy (Source: AAN/ACR/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antiplatelet therapy at discharge.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge (Source: AAN/ACR/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Tissue Plasminogen Activator (t-PA) Considered (Source: AAN/ACR/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Screening for Dysphagia (Source: AAN/ACR/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Consideration of Rehabilitation Services (Source: AAN/ACR/AMA PCPI/NCQA)
DESCRIPTION: The percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

Carotid Imaging Reports (Source: AAN/ACR/AMA PCPI/NCQA)
DESCRIPTION: The percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older with the diagnosis of ischemic stroke or transient ischemic attack (TIA) that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement.
Measure specifications can be found on the AMA's website http://www.ama-assn.org/ama/pub/category/17493.html#s.

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