

## **Proposed Changes to Existing Measure for HEDIS<sup>®1</sup> 2009: Antidepressant Medication Management (AMM)**

NCQA seeks comments on proposed modifications to the *Antidepressant Medication Management* measure. We propose to retire the Optimal Practitioner Contacts Rate. The *Antidepressant Medication Management* measure would continue to assess persistence of pharmacologic management of major depression with two rates reported.

1. *Effective Acute Phase Treatment*. The percentage of members 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.
2. *Effective Continuation Phase Treatment*. The percentage of members 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 remained on an antidepressant drug for at least 180 days.

In the summer of 2007, NCQA conducted a field-test for reevaluation of the *Antidepressant Medication Management* measure. Concerns had been raised during reevaluation regarding the current specification construction, as well as the lack of evidence to support the Optimal Practitioner Contact rate. The most common requests were to assess lengthening the negative diagnosis and medication histories in order to more accurately identify new episodes of major depression. However, field-test data indicated that lengthening the negative diagnosis period or the negative medication period did not improve the measure, but instead had a negative impact on the eligible population size.

An additional component of the field-test was to assess health plans' ability to capture care management services to count toward the Optimal Practitioner Contacts rate numerator, since many organizations supplement face-to-face visits with care management services as part of depression care. We collected data on care management visits from two of three field-test sites. The third site did not use care management for depression. Including two care management visits as satisfying the numerator of the optimal contacts rate increased the rate by 2–5 percentage points.

Although permitting care management visits to count toward the optimal practitioner contacts rate offers some potential for improvement, NCQA feels the lack of evidence supporting the rate weighs more heavily. Retiring this part of the measure will enable health plans to pursue strategies to improve medication management of people treated with antidepressants without being limited to in-person, billable visits.

We invite comments on the retirement of the Optimal Practitioner Contacts rate. If you do not support retirement, we would like any specific feedback you can share with NCQA about how we might evolve measures to improve the quality of depression care.

Supporting documents for the proposed measure include the draft measure specifications and associated measure rationale work-up, which contains data obtained through field-testing measure specifications.

**NCQA thanks and acknowledges the contributions of the Behavioral Health Measurement Advisory Panel.**

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## Antidepressant Medication Management (AMM)

### SUMMARY OF CHANGES TO HEDIS 2009

- [Retired Optimal Practitioner Contacts for Medication Management Rate.](#)

#### Description

[This measure assesses persistence of pharmacologic management of major depression.](#)

~~Definitions The following components of this measure assess different facets of the successful pharmacological management of major depression.~~

- ~~*Optimal Practitioner Contacts for Medication Management.* The percentage of members 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.~~
- *Effective Acute Phase Treatment.* The percentage of members 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.
- *Effective Continuation Phase Treatment.* The percentage of members 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.

#### Eligible Population

<b>Intake Period</b>	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.
<b>IESD</b>	Index Episode Start Date. The earliest encounter during the Intake Period with a qualifying diagnosis of major depression.
<b>Index Prescription Date</b>	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.
<b>Negative Diagnosis History</b>	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 major depression (Table AMM-A).
<b>Negative Medication History</b>	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).
<b>New Episode</b>	To qualify as a New Episode, the following criteria must be met. <ul style="list-style-type: none"> <li>• A 120-day (4 months) Negative Diagnosis History prior to the IESD, and</li> <li>• A 90-day (3 months) Negative Medication History prior to the Index Prescription Date</li> </ul>

**Treatment days** The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days supply dispensed on the 100th day will have 80 days counted in the 180-day interval.

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## Eligible Population

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	18 years and older as of April 30 of the measurement year.
<b>Continuous enrollment</b>	120 days prior to the IESD through 245 days after the IESD.
<b>Allowable gap</b>	One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled).
<b>Anchor date</b>	IESD.
<b>Benefits</b>	Medical, pharmacy and mental health (inpatient and outpatient).
<b>Event/diagnosis</b>	Diagnosed with a New Episode of major depressive disorder during the Intake Period and treated with antidepressant medication.

Follow the steps below to identify the eligible population, which is the denominator for ~~all three~~ both rates for this measure.

**Step 1** Identify all members 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 (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 (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 depression (Table AMM-A) associated with any inpatient discharge.

**Note:** Do not include lab claims when identifying members with major depression.

**Table AMM-A: Codes to Identify Major Depression**

Description	ICD-9-CM Diagnosis	DRG
Major depression*	296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311	426**
Prior depressive episodes	296.2-296.9, 298.0, 300.4, 309.0, 309.1, 309.28, 311	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 a depression diagnosis (296.4–296.9, 309.0, 309.28) are not included in this list because these codes are less specific in identifying eligible members.

\*\* The organization must *exclude* members with this code if the principal diagnosis is ICD-9-CM code 301.12.

**Step 2** Determine the IESD and test for Negative Diagnosis History. For each member identified in step 1, determine the IESD by finding the date of the member'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 (Table AMM-A).

Identify members who were diagnosed with a New Episode of major depression. The range of ICD-9-CM Diagnosis codes for prior depressive episodes in Table AMM-A is more comprehensive to exclude members diagnosed with any type of depression.

Members with any diagnosis of major depression within the previous 120 days (4 months) of the IESD should be dropped from this denominator.

**Step 3** Identify members receiving antidepressant medication therapy. Among members identified in step 2, find those who filled a prescription for an antidepressant medication within 30 days before the IESD to 14 days on or after the IESD.

**Step 4** Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days prior to the IESD to 245 days (180 medication days + 51 potential gap days + 14 days for filling the prescription) after the IESD.

**Step 5** 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 members having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit.

Similarly, prescriptions may be 14 days on or after the IESD to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication or for member delay in filling the initial prescription.

**Step 6** From the resulting members from step 5, confirm the New Episode by testing for a Negative Medication History. Members who have antidepressant prescriptions filled during the Negative Medication History period do not represent new treatment episodes and must be excluded.

**Step 7** Exclude members who had an acute inpatient stay with a principal diagnosis of mental health (Table MPT-A) or substance abuse (Table AMM-B) during the 245 days after the IESD treatment period.

**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

**Administrative Specification**

**Denominator** The eligible population.

**Numerators**

**Effective Acute Phase treatment** An 84-day (12-week) acute treatment with antidepressant medication.

Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment (Table AMM-CD) to provide continuous treatment for at least 84 days in the 114-day period. 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 the following.

- “Washout” period gaps to change medication
- “Treatment” gaps to refill the same medication

Regardless of the number of gaps, there may be no more than 30 gap days. The organization may count any combination of gaps (e.g., two washout gaps, each 15 days, or two washout gaps of 10 days each and one treatment gap of 10 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, the organization should count treatment days on the Index Prescription Date and continue to count until a total of 84 treatment days has been established. Members 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.

**Table AMM-CD: 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

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

**Effective Continuation Phase treatment**

A 180-day treatment with antidepressant medication.

Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment (Table AMM-CD) 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 the following.

- Washout period gap to change medication
- Treatment gaps to refill the same medication

Regardless of the number of gaps, there may be no more than 51 gap days. The organization may count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

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.

The organization should count treatment days on the Index Prescription Date and continue to count until a total of 180 treatment days has been established. Members whose gap days exceed 51 or who do not have 180 treatment days within 231 days after the Index Prescription Date are not counted in the numerator.

**Note**

- If the member 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 member failed to get proper authorization), the member should be included in the denominator of this measure.
- ~~A member with a mental health benefit whose claim for follow-up visits is denied is included in the denominator of this measure but must also meet all other eligibility requirements for inclusion.~~
- Refer to Appendix 3 for the definition of mental health practitioner and prescribing practitioner.

**Data Elements for Reporting**

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

**Table AMM-1/2/3: Data Elements for Antidepressant Medication Management**

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	Each of the <del>22</del> rates
Reported rate	Each of the <del>32</del> rates
Lower 95% confidence interval	Each of the <del>32</del> rates
Upper 95% confidence interval	Each of the <del>32</del> rates

## **Proposed Changes to Existing Measure for HEDIS<sup>®1</sup> 2009: Breast Cancer Screening (BCS)**

NCQA seeks comments on the proposed modification to add Diagnostic Mammography codes to the *Breast Cancer Screening* measure.

The measure is currently designed as a primary prevention measure that assesses the percentage of women 40–69 years of age who had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year. In order to be considered numerator compliant, the measure requires women to have had a screening mammogram and does not currently allow biopsies, breast ultrasounds or other diagnostic mammograms for compliance.

In the past, NCQA's Advisory Panels have contended that diagnostic mammography is not a first-line screening method to detect for breast cancer in this age group, according to guidelines, and should not be included in the measure. Part of the rationale for nonallowance has been that if a woman was to detect a change in her breast through self-examination, which led her straight to a diagnostic test, counting the test would lead to overreporting of appropriate first-line screening.

Over time, NCQA has increasingly received comments related to nonallowance of diagnostic mammography in the *Breast Cancer Screening* measure. Criticism is that there are women for whom diagnostic mammography is considered first-line screening; that is, women at higher risk for breast cancer (e.g., those with a family history of the disease, previous breast cancer diagnoses, implants). Feedback from plans and clinicians indicates that the measure, as specified, underreports women who have truly been appropriately screened with diagnostic mammography in these specific cases.

Given this feedback, our staff recently performed a thorough review of the current clinical guidelines and found that overall guidelines support (albeit in a limited fashion) diagnostic mammography as appropriate first-line screening for certain women.

Given this, NCQA proposes the addition of Diagnostic Mammography codes to the measure for numerator compliance. An alternative proposal for consideration that would not penalize plans and also would not count diagnostic mammography as numerator compliant would be to exclude those women who have had diagnostic mammography from the denominator. NCQA appreciates your comments and feedback relative to these proposed options.

Included is a copy of the draft specifications with the proposed addition of diagnostic mammography codes for numerator compliance.

**NCQA thanks and acknowledges the contributions of the Breast and Cervical Cancer Subgroup.**

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## Breast Cancer Screening (BCS)

### SUMMARY OF CHANGES TO HEDIS 2009

- Added [HCPCS](#) codes [G0204](#) and [G0206](#) to Table BCS-A.
- Added [UB-04](#) code [0401](#) to Table BCS-A.

### Description

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

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	<p>Women 42–69 years as of December 31 of the measurement year. Report two age stratifications and a total rate.</p> <ul style="list-style-type: none"> <li>• 42–51 years</li> <li>• 52–69 years</li> <li>• Total</li> </ul> <p>The total rate is the sum of the two numerators divided by the sum of the two denominators.</p>
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

### Administrative Specification

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

**Table BCS-A: Codes to Identify Breast Cancer Screening**

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
76083, 76090-76092, 77055-77057	G0202, <u>G0204</u> , <u>G0206</u>	V76.11, V76.12	87.36, 87.37	<u>0401</u> , 0403

**Exclusion (optional)**

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

**Table BCS-B: Codes to Identify Exclusions**

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

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

**Note**

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

**Data Elements for Reporting**

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

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

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

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## Proposed Changes to Existing Measure for HEDIS<sup>®1</sup> 2009: Childhood Immunization Status (CIS)

NCQA seeks comments on proposed modifications to the *Childhood Immunization Status (CIS)* measure with the addition of the hepatitis A, rotavirus (rota) and influenza (flu) vaccines. With the inclusion of these new vaccines, the *Childhood Immunization Status* measure will evaluate the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (Tdap); three polio (IPV); one measles, mumps and rubella (MMR), three H influenza type B (HiB), three hepatitis B, one chicken pox (VZV), four pneumococcal conjugate; *two hepatitis A; three Rota; and two flu vaccines* by their second birthday. The measure calculates a rate for each vaccine and three separate combination rates.

The addition of these vaccines and the optional exclusions align with the Centers for Disease Control and Prevention (CDC) and the Advisory Council on Immunization Practices (ACIP) guidelines for immunizations and contraindications. The ACIP recommends routine vaccination of infants with 3 doses of rotavirus vaccine administered orally at ages 2, 4 and 6 months. This vaccine should not be administered after age 32 weeks because of insufficient data on the safety and efficacy of rotavirus vaccine in infants after this age (CDC MMWR Rotavirus 2006). The hepatitis A vaccine is recommended for all children 1 year of age (more specifically, 12–23 months), with the two doses being administered 6 months apart (American Academy of Pediatrics Committee on Infectious Diseases 2007). The ACIP recommends that all children aged 6–59 months receive the influenza vaccine each year, with the first dose accompanied by a primer dose (American Academy of Pediatrics Committee on Infectious Diseases 2007).

NCQA's policy has been to implement changes to the ACIP 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. In general, vaccinations have been added to the measures without field-testing unless a particular situation required it. The addition of the hepatitis A and rota vaccinations are proposed based solely on ACIP recommendations, while the addition of the flu vaccination is proposed based both on recommendations and on field-test results. Field-testing was pursued for the flu vaccine because uncertainty existed regarding the place of administration, dosage timing and impact of possible shortages.

### Influenza Vaccine Field-Test

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NCQA conducted a field-test in the summer of 2007 to assess the feasibility of adding the flu vaccination to the CIS measure. Results are based on data from three health plans, representing members from commercial and Medicaid product lines.

With respect to the place of administration, in talking with experts and reviewing field-test results, we determined that flu vaccines for children are generally given in providers' offices or health departments and not in pharmacies, as with adults. Consequently, data should be able to be captured through administrative billing, medical record documentation or immunization registries.

With respect to dosage timing and number of flu vaccines administered by 2 years of age, rates of performance were analyzed for a two-flu-shot and a three-flu-shot requirement. Performance rates were significantly lower for the three-shot requirement and it was very difficult for plans to accurately assess which vaccine was the primer dose. With respect to the two-shot requirement, field-test data confirmed that there is variation and significant room for improvement. Based on hybrid data collection and rate calculation, rates for the two commercial plans ranged from 26 percent–66.7 percent, whereas hybrid performance for the Medicaid plan was lower, at 13.3 percent.

In addition to the new antigens, two new combination rates will be added to the measure; one to include the flu vaccine and one without it. In years where a shortage has been determined to have an impact on rates, the combination rate without the flu vaccine can be used for reporting.

Attached is a copy of the draft specifications with the proposed changes.

**NCQA thanks and acknowledges the contributions of the Centers for Disease Control and Prevention (CDC).**

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## Childhood Immunization Status (CIS)

### SUMMARY OF CHANGES TO HEDIS 2009

- [Added the following vaccines: hepatitis A, rotavirus and influenza](#)
- [Retired Combination 2](#)
- [Added Combination 4 and 5](#)

### Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B, one chicken pox (VZV); four pneumococcal conjugate; [two hepatitis A](#); [three rotavirus \(rota\)](#); and [two influenza \(flu\)](#) vaccines by their second birthday. The measure calculates a rate for each vaccine and [three](#) separate combination rates.

### Eligible Population

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

### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerators</b>	For MMR, hepatitis B, VZV <a href="#">and hepatitis A</a> , count any of the following. <ul style="list-style-type: none"> <li>• Evidence of the antigen or combination vaccine, <b>or</b></li> <li>• Documented history of the illness, <b>or</b></li> <li>• A seropositive test result</li> </ul>

For DTaP, IPV, HiB, pneumococcal conjugate, [rotavirus and influenza](#), count only the following.

- Evidence of the antigen or combination vaccine

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

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

**IPV** At least three IPV vaccinations, 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 MMR vaccination, with a date of service falling on or before the child's second birthday.

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

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

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

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

**Pneumococcal conjugate** At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. [Do not count any vaccination administered prior to 42 days after birth.](#)

[Hepatitis A](#) [Two hepatitis A vaccinations, with different dates of service on or before the child's second birthday.](#)

[Rotavirus](#) [Three rotavirus vaccinations, with different dates of service on or between 42 days after birth and the child's second birthday.](#)

[Influenza](#) [At least two influenza vaccinations, with different dates of service on or before the child's second birthday. Do not count any vaccination administered prior to 6 months after birth.](#)

~~**Combination 2 (DTaP, IPV, MMR, HiB, hepatitis B, VZV)** Children who receive four DTaP; three IPV; one MMR; three HiB; 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 receive four DTaP; three IPV; one MMR; three HiB; three hepatitis B; one VZV vaccination and four pneumococcal conjugate vaccinations on or before the child's second birthday.

**Combination 4 (DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal conjugate, hepatitis A, rotavirus)** Children who receive all antigens listed in Combination 3; two hepatitis A vaccinations and three rotavirus vaccinations.

**Combination 5 (DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal conjugate, hepatitis A, rotavirus, influenza)** Children who receive all antigens listed in Combination 4 and at least two influenza vaccinations.

**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		
<u>Hepatitis A</u>	<u>90633</u>		<u>070.0, 070.1</u>	
<u>Rotavirus</u>	<u>90680</u>			
<u>Influenza</u>	<u>90655, 90657</u>	<u>G0008</u>		<u>99.52</u>

\* 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.

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**Exclusion (optional)**

Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. An organization that excludes contraindicated children may do so only if the administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the second birthday. Organizations should look for exclusions as far back as possible in the member's history and use the codes in Table CIS-B to identify allowable exclusions.

**Table CIS-B: Codes to Identify Exclusions**

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.4
DTaP	Encephalopathy	323.51* <i>with</i> (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	
<del>HiB</del>	<del>None</del>	
Hepatitis B	Anaphylactic reaction to common baker's yeast	
<del>Pneumococcal conjugate</del>	<del>None</del>	

\*Use ICD-9-CM Diagnosis code 323.5 (with not fifth digit) to identify DTaP prior to October 1, 2006; the date of service *must* be before October 1, 2006.

**Hybrid Specification**

**Denominator** A systematic sample drawn from the eligible population for each product line. The organization may reduce the sample size using the current year's administrative rate for Combination ~~3-4~~, *or the prior year's audited, product-line specific results for Combination 3*. For information on reducing sample size, refer to the *Guidelines for Calculations and Sampling*.

**Numerators** For MMR, hepatitis B, VZV *and hepatitis A*, count any of the following.

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

For DTaP, HiB, IPV, pneumococcal conjugate, *rotavirus and influenza*, count *only* the following.

- Evidence of the antigen or combination vaccine

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

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

**Medical record** For immunization evidence obtained from the medical record, the organization may count members where there is evidence that the antigen was rendered from one of the following.

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

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

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

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

### Exclusion (optional)

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

### Note

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

## Data Elements for Reporting

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

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

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		Each of the <u>913</u> rates
Current year's administrative rate (before exclusions)		Each of the <u>913</u> rates
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		Each of the <u>139</u> rates
Administrative rate on FSS		Each of the <u>913</u> rates
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	Each of the <u>139</u> rates	Each of the <u>913</u> rates
Numerator events by medical records		Each of the <u>913</u> rates
Reported rate	Each of the <u>139</u> rates	Each of the <u>139</u> rates
Lower 95% confidence interval	Each of the <u>139</u> rates	Each of the <u>139</u> rates
Upper 95% confidence interval	Each of the <u>913</u> rates	Each of the <u>139</u> rates