ODJFS Methods for Clinical Performance Measures

For the Aged, Blind, or Disabled (ABD) Managed Care Program

For the Provider Agreement effective through June 30, 2007

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OVERVIEW

Methodology

These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in NCQA HEDIS 2007 Technical Specifications manual. Measures that are not based on HEDIS methodology are:

- Cardiac Related Hospital Readmission Rate
- SMD – Inpatient Hospital Readmission Rate
- Substance Abuse – Inpatient Hospital Readmission Rate

Note: the inpatient discharge and emergency department utilization rates will be condition-specific, for both the numerator and denominator.

Data Source

The source of the data for calculating the measures is as follows:
(1) MCP submitted encounter data and Medicaid fee-for-service (FFS) claims data.
(2) ODJFS recipient master file to obtain recipient demographic and eligibility information.
(3) ODJFS provider master file.

Report Period

The applicable reporting year for the methods included in this document is January 1, 2007 – December 31, 2007. Note: The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Prior Reporting Year

Certain measures include claims and/or enrollment data from the 'year prior to the reporting year.' The initial 'year prior to the reporting year' will be CY 2006 (i.e., the initial reporting period is CY 2007). For the initial 'year prior to the reporting year', CY 2006 FFS claims data and FFS enrollment data will be used, as applicable, to calculate the measures. **Example**: the CHF-Inpatient Hospital Discharge Rate calculates the number of CHF-related discharges in the reporting year, per 1,000 member months, for members with a diagnosis of CHF in the year prior to the reporting year. FFS claims data in the year prior to the reporting year (i.e., CY 2006) will be used to identify those members (who were enrolled in the ABD managed care program in the reporting year/CY 2007) who had a diagnosis of CHF.

ABD Performance Measurement

HEDIS methods and specifications will be applied to the prior reporting year to determine baseline reporting results, and will then be applied to the current reporting year to determine results for evaluation. Example: for HEDIS 2008 methods and specifications, the baseline reporting year will be CY 2007 and the reporting year for evaluation will be CY 2008.

Code Tables

Methods for selected measures will reference the following code tables.

Table INP-1: Codes to Identify Acute Inpatient Discharges

UB-92 Type of Bill
111, 121, 411, 421

Table CLMS-1: List of Applicable Provider Types

Claims submitted by the following provider types will be used to identify members with specific diagnoses for the following measures, as applicable.		
01 – General Hospital		22 – Physician (DO), Individual
04 - Outpatient Health Facility		23 – Physician (DO), Group
05 – Rural Health Facility		50 – Comprehensive Clinic
12- Federally Qualified Health Center		52 – Public Health Dept. Clinic
20 – Physician (MD), Individual		53 – Clinic, Rehabilitation
21 – Physician (MD), Group		84 – Ohio Department of Mental Health
		86 – Skilled Nursing Facility

Table ED-1: Codes to Identify Emergency Department Visits

UB-92 Revenue		UB-92 Type of Bill
45x, 981	AND	13x

OR

CPT		POS
10040 – 69979	AND	23

OR

CPT
99281-99285

Congestive Heart Failure (CHF)

Table CHF-1: Codes to Identify Congestive Heart Failure

ICD-9 Diagnosis Codes	
428.xx	Heart failure
398.91	Rheumatic heart failure (congestive)

CHF – Inpatient Hospital Discharge Rate*

The number of CHF-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of CHF in the year prior to the reporting year.

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was CHF (Table CHF-1), for members included in the denominator.

Denominator: Member months in the reporting year* for members with a primary or secondary diagnosis of CHF (Table CHF-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

CHF – Emergency Department (ED) Visit Rate*

The number of CHF-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of CHF in the year prior to the reporting year.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was CHF (Table CHF-1), for members included in the denominator.
Exclusions: ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of CHF (Table CHF-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Congestive Heart Failure (CHF)

Cardiac Related Hospital Readmission*

This measure calculates the cardiac related inpatient readmission rate.

Numerator: Number of readmissions with a cardiac-related principal diagnosis (Table CHF-4-2) for members in the denominator. A readmission is defined as an admission with a cardiac-related principal diagnosis that occurs within 30 days of a prior admission with a cardiac-related principal diagnosis.

Denominator: Number of cardiac related admissions identified by principal diagnosis code (Table CHF-4-2) during the reporting year for members with a primary or secondary diagnosis of CHF (Table CHF-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Claims data, Fee-for-Service Claims data

Table CHF-4-2 : Codes to Identify Cardiac Related Admissions/Readmissions

ICD-9 Primary Diagnosis Codes		Type of Bill Codes
393.xx – 398.xx, 401.xx – 405.xx, 410.xx – 414.xx, 415.xx – 417.xx, 420.xx – 429.xx, 440.xx – 448.xx, 451.xx – 469.xx	***with***	11x, 12x, 41x, 42x

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Coronary Artery Disease (CAD)

Table CAD-1: Codes to Identify Coronary Artery Disease

ICD-9 Diagnosis Codes	
410.xx	Acute Myocardial Infarction
411.xx	Other acute/subacute forms of ischemic heart disease
412.xx	Old myocardial infarction
413.xx	Angina pectoris
414.0x	Coronary atherosclerosis
414.8	Other specified forms of ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
429.2	Cardiovascular disease, unspecified
996.03	Mechanical complication of cardiac device/coronary bypass graft
V45.81	Aortocoronary bypass status

CAD – Inpatient Hospital Discharge Rate*

The number of acute CAD-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of CAD in the year prior to the reporting year.

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was CAD (Table CAD-1), for members included in the denominator.

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of CAD (Table CAD-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

*The length of the initial baseline and reporting ‘year’ may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Coronary Artery Disease (CAD)

CAD – Emergency Department (ED) Visit Rate*

The number of CAD-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of CAD in the year prior to the reporting year.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was CAD (Table CAD-1), for members included in the denominator.
Exclusions: ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of CAD (Table CAD-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

Cardiac Related Hospital Readmission*

This measure calculates the cardiac related inpatient readmission rate.

Numerator: Number of readmissions with a cardiac-related principal diagnosis (Table CAD-2) for members in the denominator. A readmission is defined as an admission with a cardiac-related principal diagnosis that occurs within 30 days of a prior admission with a cardiac-related principal diagnosis.

Denominator: Number of cardiac related admissions identified by principal diagnosis (Table CAD-2) during the reporting year for members with a primary or secondary diagnosis of CAD (Table CAD-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Claims data, Fee-for-Service Claims data

Table CAD-2: Codes to Identify Cardiac Related Admissions

ICD-9 Primary Diagnosis Codes		Type of Bill Codes
393.xx – 398.xx, 401.xx – 405.xx, 410.xx – 414.xx, 415.xx – 417.xx, 420.xx – 429.xx, 440.xx – 448.xx, 451.xx – 469.xx	***with***	11x, 12x, 41x, 42x

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Coronary Artery Disease (CAD)

Beta-Blocker Treatment after Heart Attack*

This measure calculates the percentage of members 35 years and older during the reporting year who were hospitalized and discharged alive from January 1-December 24th of the reporting year with a diagnosis of acute myocardial infarction (AMI) and who received an ambulatory prescription for beta blockers within seven days of discharge.

Numerator: Number of members in the denominator who received a prescription for a beta-blocker within seven days after discharge. The list of drugs included in the numerator can be found at www.ncqa.org. Members who are on beta-blocker prescriptions that are active at the time of admission can also be included in the numerator if the "days supply" indicated on the pharmacy encounter claim is the number of days or more between the date the prescription was filled and the relevant admission date. Also, a member will be included in the denominator if a claim with CPT category II code 4006F has a service date on or between the discharge date and seven days after discharge.

Denominator: Number of members 35 years of age and older as of December 31 of the reporting year who were hospitalized and discharged alive from January 1 – December 24th of the reporting year with a diagnosis of myocardial infarction (Table CAD-3) and who were enrolled at least seven days after discharge.

Exclusions: If a member had a prescription for one of the drugs listed in NCQA's "beta-blocker treatment after a heart attack - exclusions" list, then the member is excluded from the measure. Members with a claim with a primary diagnosis listed in table CAD-4 in the reporting year or the year prior to the reporting year will be excluded from the denominator.

Notes: If a member has more than one episode of AMI from January 1 – December 24th of the reporting year, then only the first discharge will be included in the measure.

Data Source: Encounter Data, Fee-for-Service Claims Data

Table CAD-3: Codes to Identify AMIs

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

Table CAD-4: Exclusions

Description	ICD-9-CM Diagnosis
History of asthma	493
Hypotension	458
Heart block >1 degree	426.0, 426.12, 426.13, 426-426.4, 426.51,-426.54, 426.7
Sinus bradycardia	427.81
COPD	491.2, 496, 506.4

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

Beta-Blocker Treatment after Heart Attack* (continued)

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

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

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed*

The percentage of members who had a cardiovascular condition in the year prior to the reporting year, who were enrolled for at least 11 months in the reporting year and the year prior to the reporting year and enrolled in the last month of the reporting year, and who received a lipid profile during the reporting year.

Numerator: Members in the denominator who received a lipid profile (Table CAD-5) during the reporting period.

Denominator:
Members discharged alive for AMI, CABG, or PTCA on or between January 1 and November 1 of the year prior to the reporting year (Table CAD-6) or members with at least one outpatient or acute inpatient visit -with any diagnosis of IVD (Table CAD-7) during the measurement year and the year prior to the measurement year (members must meet the outpatient or inpatient visit criteria during both the measurement year and the year prior to the measurement year – criteria need not be the same across years).

Data Source: Encounter claims data, fee-for-service data

Table CAD-5: Codes to Identify LDL-C Screening

CPT Codes
80061, 83700, 83701, 83704, 83715, 83716, 83721

Table CAD-6: Codes to Identify AMI, PTCA and CABG

Description	CPT	HCPCS	ICD-9 Diagnosis	ICD-9 Procedure
AMI (inpatient only)			410.x1	
PTCA	33140, 92980-92982, 92984, 92995, 92996			00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09
CABG (inpatient only)	33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572	S2205-S2209		36.1, 36.2

Table CAD-7: Codes to Identify IVD

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

Table CAD-8: 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	51x, 520-523, 526-529, 57x-59x, 77x, 982,983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	10x, 110-114, 119, 120-124, 129, 130-134, 139, 140-144, 149, 150-154, 159, 16x, 20x-22x, 72x, 987

Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed* (continued)

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December) and continuous enrollment will be adjusted accordingly [i.e., enrolled five out of six months]).

Hypertension (non-mild)

Table HYP-1: Codes to Identify Hypertension (Non-Mild)

ICD-9 Diagnosis Codes	
362.11	Hypertensive retinopathy
401.0	Essential hypertension, malignant
402.xx	Hypertensive heart disease
403.xx	Hypertensive kidney disease
404.xx	Hypertensive heart and kidney disease
437.2	Hypertensive encephalopathy

Hypertension (non-Mild) – Inpatient Hospital Discharge Rate*

The number of acute non-mild hypertension-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of non-mild hypertension in the year prior to the reporting year.

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was non-mild hypertension (Table HYP-1), for members included in the denominator.

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of non-mild hypertension (Table HYP-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

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Hypertension (non-Mild) – Emergency Department (ED) Visit Rate*

The number of hypertension (non-mild)-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of hypertension (non-mild) in the year prior to the reporting year.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was non-mild hypertension (Table HYP-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of non-mild hypertension (Table HYP-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

***The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Diabetes

Table DIAB-1: Codes to Identify Diabetes

ICD-9 Diagnosis Codes			
250	Diabetes mellitus	366.41	Diabetic cataract
357.2	Polyneuropathy in diabetes	648.0	Diabetes mellitus
362.0	Diabetic retinopathy		

Diabetes – Inpatient Hospital Discharge Rate*

The number of acute diabetes-related inpatient hospital discharges in the reporting year, per thousand member months, for members identified as diabetic in the year prior to the reporting year.

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was diabetes (Table DIAB-1), for members included in the denominator.

Denominator: Member months in the reporting year for members identified as diabetic (Table DIAB-2) in the year prior to the reporting year.

Data Source: Encounter Data, Fee-for-Service Claims Data

Diabetes – Emergency Department (ED) Visit Rate*

The number of diabetes-related emergency department (ED) visits in the reporting year, per thousand member months, for members identified as diabetic in the year prior to the reporting year.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was diabetes (Table DIAB-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members identified as diabetic (Table DIAB-2) in the year prior to the reporting year.

Data Source: Encounter Data, Fee-for-Service Claims Data

*****The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Diabetes

Comprehensive Diabetes Care (CDC)/Eye Exam*

The percentage of diabetic members who received an applicable exam or screening (as specified in the Numerator) during the reporting year.

Numerator: Number of members in the denominator who received a retinal exam by an optometrist or ophthalmologist (Table Diab-4). Note: the number of members in the denominator who received the following tests and screenings will also be reported as 'informational only' measures: HbA1c testing (Table Diab-5), LDL-C screening (Table Diab-6), and screening or treatment for nephropathy (Table Diab-7).

Denominator: Number of members identified as diabetic (Table Diab-2) in the reporting year or the year prior to the reporting year, who were enrolled for at least 11 months in the reporting year, and who were enrolled during the last month of the reporting year.

Data Source: Encounter Data, Fee-for-Service Claims Data

Table DIAB-2: Methods to Identify Diabetic Members

? Two methods identify diabetic members. ? To be included in the measure, a member needs to be identified in only one method.
Method 1: Pharmacy Members who were dispensed insulin or oral hypoglecmics/antiphyperglecimcs (drug list is available on the NCQA's website at www.ncqa.org).
Method 2: Inpatient, Outpatient & Emergency Department visits
Members who had:
i. Two (2) visits with different dates of service in an outpatient or nonacute inpatient setting with a primary or secondary diagnosis of diabetes (Table DIAB-1), **OR**
ii. One (1) visit in an acute inpatient or emergency department setting with a primary or secondary diagnosis of diabetes (Table DIAB-1)

Table DIAB-3: Codes to Identify Visit Type

Description	CPT	UB-92 Revenue Codes
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	51x,-520-523, 526-529, 57x-59x, 77x, 82x-85x, 88x, 982, 983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	118, 128, 138, 148, 158, 19x, 524, 525, 55x, 66x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	10x, 110-114, 119, 120-124, 129, 130-134, 139, 140-144, 149, 150-154, 159, 16x, 20x-22x, 72x, 80x, 987
Emergency dept.	99281-99285	45x, 981

Table DIAB-4:Codes to Identify Eye Exams

CPT Codes	CPT Category II	HCPCS	ICD-9-CM Codes
67028, 67038-67040, 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 92203-92205, 92213-92215, 92242-92245	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S3000	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16, V72.0

Comprehensive Diabetes Care (CDC)/Eye Exam* (continued)

Table Diab-5: Codes to Identify HbA1C Tests

CPT	CPT Category II
83036, 83037	3046F, 3047F

Table Diab-6: Codes to Identify LDL-C Screening

CPT	CPT Category II
80061, 83700, 83701, 83704, 83715, 83716, 83721	3048F, 3049F, 3050F

Table Diab-7: Codes to Identify Nephropathy Screening Tests

CPT	CPT Category II
82042, 82043, 82044, 84156	3060F, 3061F

*****The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December) and continuous enrollment will be adjusted accordingly [i.e., enrolled five out of six months]).

Chronic Obstructive Pulmonary Disease (COPD)

Table COPD-1: Codes to Identify COPD

ICD-9 Diagnoses Codes	
491.XX	Chronic bronchitis
492.XX	Emphysema
496.XX	Chronic airway obstruction, not elsewhere classified

COPD – Inpatient Hospital Discharge Rate*

The number of acute COPD-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of COPD in the year prior to the reporting year.

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was COPD (Table COPD-1), for members included in the denominator.

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of COPD (Table COPD-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

COPD – Emergency Department (ED) Visit Rate*

The number of COPD-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of COPD in the year prior to the reporting year.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was COPD, for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of COPD (Table COPD-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

*****The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Chronic Obstructive Pulmonary Disease (COPD)

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

The percentage of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis. **Note:** Initial report period will be CY 2010.

Numerator: The number of members in the denominator with at least one/claim encounter with any of the codes listed in Table COPD-2 for spirometry 720 days before to 180 days after the episode start date.

Denominator: Members 42 years of age or older as of December 31 of the reporting year, continuously enrolled 730 days (2 years) prior to the index episode start date through 180 days after the index episode start date (IESD). One gap in enrollment is allowed in each of the 12-month periods prior to the index episode start date or in the 6-month period after the IESD.

Step 1: Identify all members who, during the intake period, had any diagnosis of COPD (Table COPD-1).

Step 2: Determine the COPD episode start date. For each member identified in step 1, identify the date of the earliest encounter during the intake period with a COPD diagnosis (table COPD-1).

Step 3: Determine if the episode start date is a new episode. Members with a new episode of COPD must have a negative diagnosis history. Members with any encounter or claim during the 730 days (2 years) prior to the IESD should be excluded from the denominator. For an inpatient index episode, use the date of admission to determine the negative diagnosis history.

Step 4: Calculate continuous enrollment. Members must be continuously enrolled in the MCO 730 days (2 years) prior to the episode start date through 180 days after the episode start date.

Table COPD-2: Codes to Identify Spirometry

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

Index episode start date: The earliest encounter during the intake period with a qualifying diagnosis of COPD (Table COPD-1). For an outpatient episode, the index episode start date is the date of service. For an inpatient episode, the index episode start date is the date of discharge.

Negative diagnosis history: A period of 730 days (2 years) prior to the IESD, during which the member had no claims/encounters containing any principal or secondary diagnosis of COPD (table COPD-1). For an inpatient index episode, use the date of admission to determine the negative diagnosis history.

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 issued to capture eligible episodes of treatment.

New Episode: To qualify as a new episode, two criteria must be met: a 730 day negative diagnosis history on or before the IESD and continuous enrollment.

Asthma

Table ASM-1: Codes to Identify Asthma

ICD-9 Diagnosis Code	
493.xx	Asthma

Asthma - Inpatient Hospital Discharge Rate*

The number of acute asthma-related inpatient hospital discharges in the reporting year, per thousand member months, for members with persistent asthma.

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was asthma (Table ASM-1), for members included in the denominator.

Denominator: Member months in the reporting year for members with persistent asthma (Table ASM-2).

Data Source: Encounter Data, Fee-for-Service Claims Data

Asthma – Emergency Department (ED) Visit Rate*

The number of asthma-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of asthma in the year prior to the reporting year.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was asthma , for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members with persistent asthma (Table ASM-2).

Data Source: Encounter Data, Fee-for-Service Claims Data

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Asthma

Use of Appropriate Medications for People with Asthma

The percentage of members aged 21 to 56 with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Numerator: The number of members in the denominator who received one or more prescriptions of the recommended medications during the reporting year. A list of the medications can be found at www.ncqa.org.

Denominator: The number of members 21 to 56 years of age, as of December 31st of the reporting year, identified as having persistent asthma who had 11 or more months of enrollment in the reporting year and the year prior to the reporting year, and were enrolled as of December 31st of the reporting year.

Table ASM-2: Methods to Identify Members with Persistent Asthma

Members must meet one of the four criteria below, during both the reporting year and the year prior to the reporting year (criteria need not be the same across both years).
Group 1. Member has at least one emergency department visits (Table ASM-3) with asthma as the principal diagnosis (Table ASM-1).
Group 2. Member has at least one acute inpatient discharge (Table ASM-3) with asthma as the principal diagnosis (Table ASM-1). Group 3. Member has at least four outpatient asthma visits (Table ASM-3) with asthma as one of the listed diagnoses (Table ASM-1) and at least two asthma medication dispensing events. Group 4. Member has at least four asthma medication dispensing events (i.e., an asthma medication dispensed on four occasions). · *A members with at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed will be excluded from the denominator unless the member also has at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier.* *A list of NDC codes for the appropriate denominator (i.e., members with persistent asthma) asthma medications may be found at www.ncqa.org.*

Table ASM-3: Codes to Identify Asthma Visit Type

Description	CPT	UB-92 Revenue Codes
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99499	51x, 520-523, 526-529, 57x-59x, 77x, 82x-85x, 88x, 982, 983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	10x, 110-114, 119, 120-124, 129, 130-134, 139, 140-144, 149, 150-154, 159, 16x, 20x-22x, 72x, 80x, 987
Emergency department	99281-99285	45x, 981

Use of Appropriate Medications for People with Asthma* (continued)

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December) and continuous enrollment will be adjusted accordingly [i.e., enrolled five out of six months]).

Mental Health, Severely Mentally Disabled (SMD)

Table SMD-1: Codes to Identify SMD

ICD-9 Principal Diagnosis Codes	
293.xx	Transient mental disorders due to conditions classified elsewhere
294.xx	Persistent mental disorders due to conditions classified elsewhere
295.xx	Schizophrenic disorders
296.xx	Episodic mood disorders
297.xx	Delusional disorders
298.xx	Other nonorganic disorders
299.xx	Pervasive developmental disorders

(SMD) – Inpatient Hospital Discharge Rate*

The number of acute SMD-related inpatient hospital discharges in the reporting year, per thousand member months, for members who had a diagnosis of SMD in the year prior to the reporting year.

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was SMD (Table SMD-1), for members included in the denominator.

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of SMD (Table SMD-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

SMD – Emergency Department (ED) Visit Rate*

The number of SMD-related emergency department (ED) visits in the reporting year, per thousand member months, for members who had a diagnosis of SMD in the year prior to the reporting year.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was SMD, for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members with a primary or secondary diagnosis of SMD (Table SMD-1) in the year prior to the reporting year, as reported on claims submitted by the provider types listed in Table CLMS-1.

Data Source: Encounter Data, Fee-for-Service Claims Data

*****The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Mental Health, Severely Mentally Disabled (SMD)

SMD - Inpatient Hospital Readmission Rate*

The number of readmissions with a principal diagnosis of SMD for members who had a diagnosis of SMD in the year prior to the reporting year. A readmission is defined as an admission with a principal diagnosis of SMD that occurs within 30 days of a prior SMD related admission.

Numerator: Number of readmissions with a principal diagnosis of SMD (Table SMD-1)) and Type of Bill specified in Table INP-1 for members in the reporting year with a diagnosis of SMD (Table SMD-1) in the year prior to the reporting year. A readmission is defined as an admission with a principal diagnosis of SMD that occurs with 30 days of a prior admission with a principal diagnosis of SMD.

Denominator: Number of admissions with a principal diagnosis of SMD (Table SMD-1) and Type of Bill specified in Table INP-1 during the reporting year for members with a primary or secondary diagnosis of SMD in the year prior to the reporting year.

Data Source: Encounter Claims data, Fee-for-Service Claims data

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Mental Health

Follow-up After Hospitalization for Mental Illness*

The percentage of discharges for members who were hospitalized for treatment of selected mental health disorders and were enrolled from the date of discharge through 30 days after discharge, who were seen on an outpatient basis or were in intermediate treatment with a mental health provider after discharge.

Numerator: Note: Two separate measures will be calculated. Members in the denominator who had an ambulatory mental health encounter or intermediate treatment with a mental health practitioner (Table SMD-3) up to:

1) 30 days after discharge, and
2) 7 days after discharge.

An outpatient visit on the date of discharge should be included in the measures.

Denominator: Members discharged from an inpatient setting of an acute care facility (including acute care psychiatric facilities) with a discharge date occurring on or before December 1 of the measurement year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified in Table SMD-2. Exclusions: 1) Discharges followed by a readmisson or a direct transfer to an acute or nonacute facility for any mental health principal diagnosis within the 30-day follow-up period. 2) discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis.

Table SMD-2: Codes to Identify Mental Health Disorders

ICD-9-CM Codes
295-299, 300.3, 300.4, 301, 308, 309, 311-314

Table SMD-3: Codes to Identify Ambulatory Mental Health Encounter or Intermediate Treatment

<table>
<tr><th colspan="3">CPT/HCPCS codes</th><th>UB-92 Revenue Codes</th></tr>
<tr><td colspan="3">90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 09853, 90857, 90862, 90870, 90871, 90875-90876, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99510
G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S9480, S9848, S9485
Z1831 – Pharmacological Mgt., Z1832 – MH Assessment, non-MD, Z1833 – Counseling & Therapy, Indiv., Z1834 – Counseling & Therapy, Group, Z1837 – Crisis Intervention, Z1839 – Psychiatric Dx Interview, Z1840 – Community Psyc. Support Tx, Individual, Z1841 – Community Psych. Support, Group</td><td>513, 900, 901, 905-907, 909-916, 961

Practitioner/provider type does not need to be determined for follow-up visits identified by UB-92 revenue code.</td></tr>
<tr><td colspan="3">With</td><td></td></tr>
<tr><td>Provider Type
02 – Mental Hospital 42 – Psychologist, Individual
51 – Clinic, Mental, Drug, Alcohol
67 – Psychologist, Group 84 - Mental Health Dept.</td><td>or</td><td>Physician Specialty
23 - Psychiatry</td><td></td></tr>
<tr><td colspan="3"></td><td></td></tr>
<tr><td colspan="3">CPT codes listed above reported with one of the following modifiers to identify the type of mental health provider (other than Types 02, 42, 51, 67, 84 specified above), providing services under the supervision of a physician.</td><td></td></tr>
</table>

Modifier AJ – clinical social worker HP - doctoral level trained professional HO – master's degree level trained professional HN – bachelor's level clinical staff person	**with**	**Individual physician or group Provider Type: 20, 21, 22, 23**

Follow-up After Hospitalization for Mental Illness* (continued)

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Mental Health

Antidepressant Medication Management

The percentage of members who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.

Note: Initial report period will be CY 2009.

Numerator: Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 180 days.

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 or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 51 days. The MCO may count any combination of gaps. 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 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.

Denominator:

Step 1: Identify all members with a diagnosis of depression who, during the 12-month intake period, had:

At least one principal diagnosis of major depression (Table ADM-1) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges or partial hospitalizations), or

At least two secondary diagnoses of major depression (Table ADM-1) on different dates of service in any outpatient setting (e.g., outpatient or emergency room visits), or

At least one secondary diagnosis of major depression (Table ADM-1) associated with any discharge.

Step 2: Determine the index episode start date and test for negative diagnosis history. For each member identified in step 1, determine the index episode start date by finding the date of the member's earliest encounter during the intake period (i.e., outpatient or emergency room visit date, inpatient discharge date, partial hospitalization visit date) with a qualifying major depression diagnosis (Table ADM-1).

Identify members who were diagnosed with a new episode of depression. The range of ICD-9-CM diagnosis codes for prior depressive episodes in Table ADM-1 is more comprehensive to exclude members diagnosed with any type of depression.

Members with any diagnosis of depression within the previous 120 days (4 months) of the index episode start date 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 index episode start date to 14 days on or after the index episode start date.

Antidepressant Medication Management (continued)

Step 4: Calculate continuous enrollment. Members must be continuously enrolled in the MCO for 120 days prior to the index episode start date to 245 days (180 medication days plus 51 potential gap days plus 14 days for filling the prescription) after the index episode start date.

Step 5: Identify the index prescription date. Identify the earliest prescription up to 30 days before the index episode start date to 14 days on or after the index episode start date. Prescriptions may be up to 30 days before the index episode start date 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 index episode start date 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 or substance abuse during the 245 days after the index episode start date treatment period. Use principal diagnosis codes 290-316 and 960-979 with a secondary diagnosis of chemical dependency (291-292, 303-304, 305.0, 305.2-305.9, 535.3, 571.1) to identify acute mental health inpatient services and

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 depressions.

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 index episode start date.

Negative diagnosis history: A period of 120 days (4 months) prior to the index episode start date, during which time the member had no claims/encounters containing either a principal or secondary diagnosis of depression (Table ADM-1).

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 index episode start date 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. 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.

Table ADM-1

Description	ICD-9-CM Diagnosis
Major depression	296.2, 296.3, 298.0, 300.4, 309.1, 311
Prior depressive episodes	296.2-296.9, 298.0, 300.4, 309.1, 309.28, 311

Substance Abuse

Table AOD-1: Codes to Identify AOD

ICD-9 Diagnosis Codes	
291.xx	Alcohol induced mental disorders
292.xx	Drug induced mental disorders
303.xx	Alcohol dependence syndrome
304.xx	Drug dependence
305.0x	Alcohol abuse
305.2x-305.9x	Other drug abuse
535.3	Alcohol gastritis
571.1	Acute alcohol hepatitis

Substance Abuse – Inpatient Hospital Discharge Rate*

The number of acute substance abuse-related inpatient hospital discharges in the reporting year, per thousand member months, for members who in the year prior to the reporting year, had one of the following: an alcohol and other drug abuse or dependence (AOD) -related acute inpatient admission or two AOD-related emergency department visits

Numerator: The number of acute inpatient hospital discharges (Table INP-1) in the reporting year unduplicated by recipient ID and discharge date where the principal diagnosis was AOD (Table AOD-1), for members included in the denominator.

Denominator: Member months in the reporting year for members who in the year prior to the reporting year had one of the following: at least one AOD-related acute inpatient admission or at least two AOD-related Emergency Department (ED) visits. "AOD-related" includes acute inpatient admissions or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (see Table AOD-1).

Data Source: Encounter Data, Fee-for-Service Claims Data

Note: Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addictions Services will not be used in this measure.

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

AOD – Emergency Department (ED) Visit Rate*

The number of AOD-related emergency department (ED) visits in the reporting year, per thousand member months, for members with AOD.

Numerator: The number of ED visits (Table ED-1) in the reporting year unduplicated by recipient ID and date of service where the primary diagnosis was AOD (Table AOD-1), for members included in the denominator. **Exclusions:** ED visits resulting in an inpatient stay (i.e., ED visits on the day prior to, or the same day, as the first day of an inpatient admission).

Denominator: Member months in the reporting year for members who in the year prior to the reporting year had one of the following: at least one AOD-related acute inpatient admission or at least two AOD-related Emergency Department (ED) visits. "AOD-related" includes acute inpatient admissions or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim (see Table AOD-1).

Data Source: Encounter Data, Fee-for-Service Claims Data

Note: Claims for Medicaid services provided by the Ohio Department of Alc ohol and Drug Addictions Services will not be used in this measure.

Substance Abuse – Inpatient Hospital Readmission Rate*

The number of alcohol and other drug abuse or dependence (AOD) - related readmissions for members who had a diagnosis of AOD in the year prior to the reporting year. A readmission is defined as an AOD-related admission that occurs within 30 days of a prior AOD- related admission.

Numerator: Number of readmissions with a principal diagnosis of AOD (Table AOD-1) for members in the denominator. A readmission is defined as an admission with a principal diagnosis of AOD (Table AOD-1) that occurs within 30 days of a prior admission with a principal diagnosis of AOD. Exclusions: readmissions that occur within 30 days of a prior admission for detoxification therapy. Admissions for detoxification therapy are identified using an AOD diagnosis (AOD-1) in conjunction with one of following ICD-9 procedure codes for detoxification therapy: 94.25, 94.62, 94.63, 04.65, 94.66, 94.68, 94.69.

Denominator: Number of substance abuse-related admissions identified by principal diagnosis (Tables AOD-1 and INP-1) during the reporting year for members with a primary or secondary diagnosis of substance abuse in the year prior to the reporting year.

Data Source: Encounter Claims data, Fee-for-Service Claims data

Note: Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addictions Services will not be used in this measure.

*The length of the initial baseline and reporting 'year' may be adjusted depending on the ABD managed care program implementation completion date (e.g., if the last region(s) to enroll members has an initial membership effective date of July 1, 2007, the initial baseline and reporting year will be a six month period, July through December).

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure: Initiation: The percentage of members diagnosed with AOD dependence who initiate treatment through an inpatient AOD admission, or an outpatient service with an additional AOD service within 14 days. Engagement: the percentage of members who initiate treatment who have two or more AOD services within 30 days after the date of the initiation visit (inclusive). ***Note:*** *Initial report period will be CY 2008.*

Numerator:
Initiation of AOD treatment

Step 1: Identify all members in the denominator whose index episode start date was an inpatient discharge with any AOD diagnosis. This visits counts as the initiation event.

Step 2: Identify all members in the denominator whose index episode start date was an outpatient visit, detoxification visit or emergency department visit.

Step 3: Use Table IAD-2 or Table IAD-4 to determine if the members 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 members whose initiation service was an inpatient stay with a discharge date after December 1.

Engagement of AOD Treatment
Identify members who had an initiation of AOD treatment visit and two or more services with an AOD dependence diagnosis within 30 days after the date of the initiation visit (inclusive). Use Table IAD-2 or Table IAD-4 to identify engagement treatment. For members who initiated treatment via an inpatient stay, 30 days starts at the member's inpatient discharge. To determine if the 30 day criterion is met for engagement inpatient stays, use the admission date of the subsequent inpatient stay, not the discharge date.

Denominator:
Step 1: Identify members who had:

- an outpatient claim (Table IAD-2) for AOD services between January 1 and November 15 of the measurement year, or
- a detoxification or emergency department (Table IAD-3) claim between January 1 and November 15 of the measurement year, or
- an inpatient claim (Table IAD-4), with a discharge date between January 1 and November 15 of the measurement year.

Step 2: Determine the index episode start date. For each member identified in step 1, determine the index episode start date by identifying the date of the member's earliest encounter during the measurement year (e.g., outpatient, detoxification or emergency department visit date; inpatient discharge date) with any qualifying AOD dependence diagnosis (Tables IAD-2).

Step 3: Determine if the index episode start date is a new episode. Members with a new episode of AOD dependence have a negative diagnosis history. Negative Diagnosis History: A period of 60 days prior to the Index Episode Start date, during which the member had no claims/encounters with any diagnosis of AOD dependence (Tables IAD-2, IAD-3, IAD-4). For members with an inpatient visit, use the admission date to determine negative diagnosis history.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
(continued)

Step 4: Calculate continuous enrollment. The member must be continuously enrolled without any gaps for 60 days prior through 44 days after the index episode start date.

Data Source: Encounter Claims data, Fee-for-Service Claims data

Note: Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addiction Services will not be used in this measure.

Table IAD-2: Outpatient Visit Codes

CPT		HCPCS
90801, 90802, 90804-90815, 90826-90829, 90845, 90847, 09849, 90853, 90857, 90862, 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, H2010-H2020, H2035, H2036, M0064, S9480, S9484, S9485, T1006, T1012
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, 305.20-350.22, 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 IAD-3: Detoxification and Emergency Department Services Codes

CPT		HCPCS		ICD-9-CM Procedure		UB-92 Revenue
99281-99285 with a diagnosis code from Table IAD-2	**or**	H0001 – H00014, S9475 with a diagnosis code from Table IAD-2	**or**	94.62, 94.63, 94.65, 94.66, 94.68, 94.69	**or**	045X with a diagnosis code from Table IAD-2

Table IAD-4: Codes to Identify Inpatient Services

ICD-9-CM diagnosis code from Table IAD-2	with	UB-92 bill Type: 11x, 12x, 18x, 21x, 22x, 41x, 42x, 84x,

Inpatient Discharge & Emergency Department Visit Rates With Age Group Breakouts

Inpatient Hospital Discharge Rate with Age Group Breakouts

The condition-specific inpatient hospital discharge rates will be calculated by age group (Table AGE-1). For hospitalizations, the age of the member is the age as of the date of discharge. For member months, age is the age of the member as of the last day of the month.

Emergency Department Visit Rate with Age Group Breakouts

The condition-specific emergency department visit rates will be calculated by age group (Table AGE-1). For visits, the age of the member is the age as of the date of service. For member months, age is the age of the member as of the last day of the month.

Table AGE-1

Age	Discharges/Visits	Member Months	Discharges/Visits per 1,000 Member Months
20-44	xx	Xx	xx
45-64	xx	xx	xx
65-74	xx	xx	xx
75-84	xx	xx	xx
85+	xx	xx	xx
Total	xx	xx	xx