GEM Measure Functional Specification Document

Performance Measure Name: Eye Exam (retinal) Performed for Beneficiaries with Diabetes

Description: The percentage of beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 18–75 years as of December 31, 2006 who had continuous enrollment during 2006.

There are two methods for identifying diabetic beneficiaries:

- Pharmacy data
- Claim/encounter data

The organization must use *both* methods to identify the eligible population; however, to be included in the measure, a beneficiary needs to be identified in only one method. Beneficiaries may be identified as having diabetes during 2006 or 2005.

(1) Pharmacy data. Beneficiaries who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during 2006 or 2005 on an ambulatory basis.

(2) Claim/encounter data. Beneficiaries who had *two* face-to-face encounters with different dates of service in an outpatient setting or nonacute inpatient setting or *one* face-to-face encounter in an acute inpatient or emergency department (ED) setting during 2006 or 2005 with a diagnosis of diabetes. The organization may count services that occur over both years.

Denominator Exclusion Statement:

(1) Exclude beneficiaries with a diagnosis of polycystic ovaries who did not have any face-to-face encounters with the diagnosis of diabetes, in any setting, during 2006 or 2005. Diagnosis of polycystic ovaries can occur at any time in the beneficiary's history, but must have occurred by December 31, 2006.

(2) Exclude beneficiaries with gestational diabetes or steroid-induced diabetes, who did not have any face-to-face encounters with the diagnosis of diabetes (in any setting), during 2006

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:

(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*

(2) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf

or 2005. Diagnosis of gestational diabetes or steroid-induced diabetes can occur during 2006 or 2005, but must have occurred by December 31, 2006.

Numerator Statement:

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

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2006.
- A *negative* retinal exam (no evidence of retinopathy) by an eye care professional in 2005.

For exams performed in 2005, an automated result must be available.

Deviation(s) from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. The following addition criteria are also used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
   3) Beneficiaries cannot have any periods of Medicare secondary payer status.
   4) Beneficiaries cannot reside outside of the United States.
   5) Beneficiaries must have a record in the Medicare enrollment files.
   6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusions to be optional. However, for the GEM project, all optional denominator exclusion criteria specified in HEDIS were made mandatory. For the exclusion based on a diagnosis of polycystic ovaries, HEDIS specifies that the diagnosis can occur at any time in the beneficiary's history, as long as it occurred by December 31, 2006. GEM can exclude patients from the denominator if we can find a diagnosis of polycystic ovaries in 2005 or 2006.

4. Part D (pharmacy) coverage began only in 2006 and was not universal and equal for all Medicare beneficiaries in this project. Therefore, identification of patients in the denominator for the GEM project through Part D data alone will cover only a portion of patients who may otherwise have been dispensed oral hypoglycemics/antihyperglycemics.

Algorithm Flowchart: See Flowchart 3.

Denominator and Numerator Codes

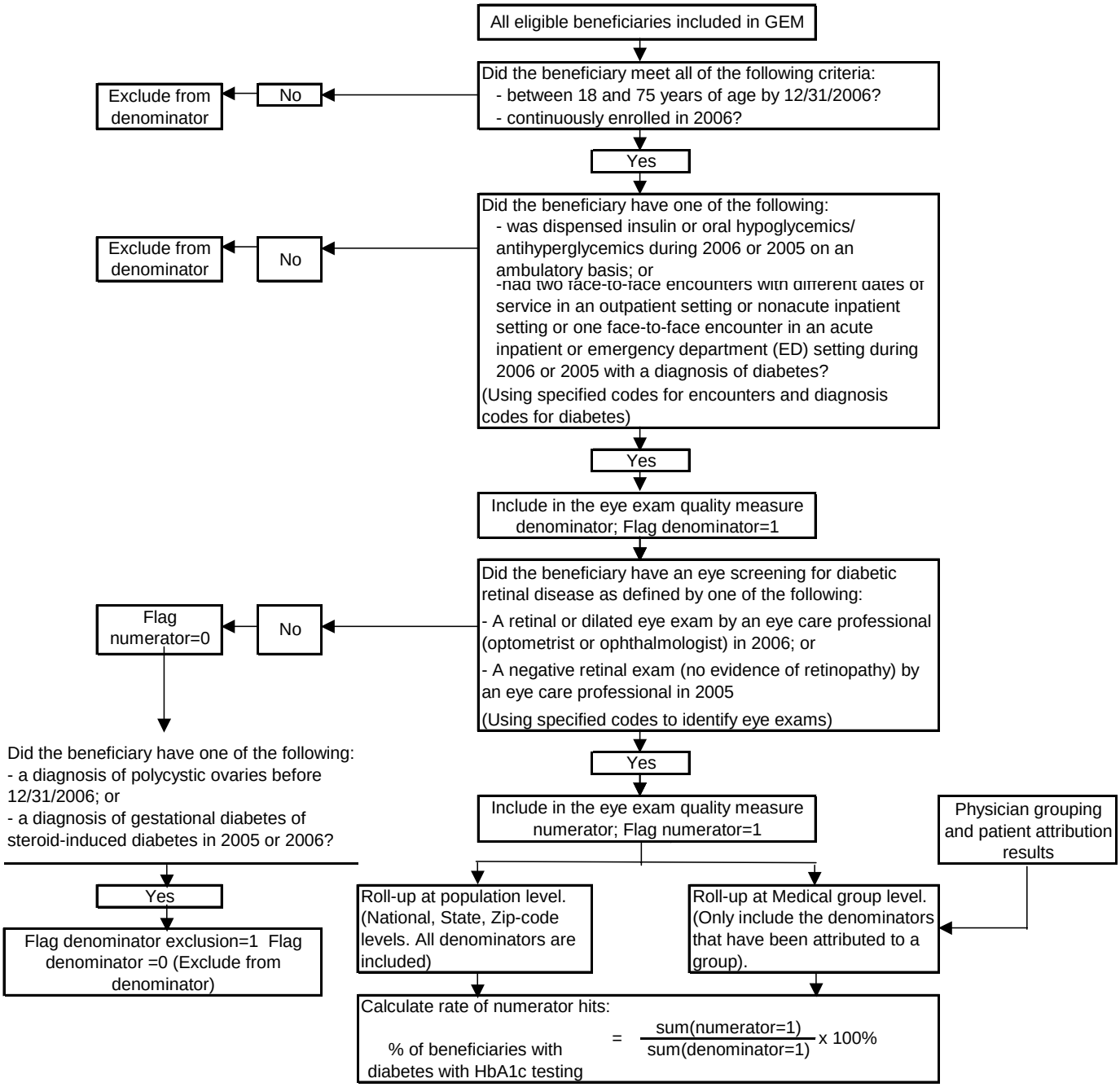
Measure Category	Description	SubCategory	Coding Scheme	Codes
Denominator Inclusion	Diagnosis for diabetes		ICD-9-CM Diagnosis	250, 357.2, 362.0, 366.41, 648.0
			DRG	294, 295
	Procedure (Two face-to-face encounters with different dates of service)	Outpatient	CPT	92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499
			UB-92 Revenue	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
		Nonacute inpatient	CPT	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337
			UB-92 Revenue	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x, 0524, 0525
	Procedure (One face-to-face encounter)	Acute inpatient	CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291
			UB-92 Revenue	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
		Emergency department	CPT	99281-99285
			UB-92 Revenue	045x, 0981
	Drug class for diabetes (Insulin; Oral hypoglycemic/antihyperglycemic)		NDC	Any NDC in "CDC_A_Denominator_07.xls"[1]
Denominator Exclusion	Diagnosis of polycystic ovaries		ICD-9-CM Diagnosis	256.4
	Diagnosis of steroid-induced diabetes		ICD-9-CM Diagnosis	251.8, 962.0
	Diagnosis of gestational diabetes		ICD-9-CM Diagnosis	648.8
Numerator Inclusion	Eye Exam[2]		CPT	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, 99203-99205, 99213-99215, 99242-99245
			CPT II[3]	2022F, 2024F, 2026F, 3072F
			HCPCS	S0625, S3000, S0620, S0621
			ICD-9-CM Diagnosis	V72.0
			ICD-9-CM Procedure	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16

[1] The source of this table can be found in the "Comprehensive Diabetes Care (CDC) Denominator" link of the following NCQA website: www.ncqa.org/tabid/210/Default.aspx

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

[3] The organization does not need to limit CPT Category II codes to an optometrist or an ophthalmologist because the codes can be used by other provider types to document services provided by an optometrist or ophthalmologist.

Flowchart 3: Eye Exam (retinal) Performed for Beneficiaries with Diabetes



GEM Measure Functional Specification Document

Performance Measure Name: Hemoglobin A1c (HbA1c) Testing for Beneficiaries with Diabetes

Description: The percentage of beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 18–75 years as of December 31, 2006 who had continuous enrollment during 2006.

There are two methods for identifying diabetic beneficiaries:

- Pharmacy data
- Claim/encounter data

The organization must use *both* methods to identify the eligible population; however, to be included in the measure, a beneficiary needs to be identified in only one method. Beneficiaries may be identified as having diabetes during 2006 or 2005.

(1) Pharmacy data. Beneficiaries who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during 2006 or 2005 on an ambulatory basis.

(2) Claim/encounter data. Beneficiaries who had *two* face-to-face encounters with different dates of service in an outpatient setting or nonacute inpatient setting or *one* face-to-face encounter in an acute inpatient or emergency department (ED) setting during 2006 or 2005 with a diagnosis of diabetes. The organization may count services that occur over both years.

Denominator Exclusion Statement:

(1) Exclude beneficiaries with a diagnosis of polycystic ovaries who did not have any face-to-face encounters with the diagnosis of diabetes, in any setting, during 2006 or 2005. Diagnosis of polycystic ovaries can occur at any time in the beneficiary's history, but must have occurred by December 31, 2006.

(2) Exclude beneficiaries with gestational diabetes or steroid-induced diabetes, who did not have any face-to-face encounters with the diagnosis of diabetes (in any setting), during 2006

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:

(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*

(2) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf

or 2005. Diagnosis of gestational diabetes or steroid-induced diabetes can occur during 2006 or 2005, but must have occurred by December 31, 2006.

Numerator Statement:

An HbA1c test performed during 2006, as identified by claim/ encounter or automated laboratory data.

Deviation(s) from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. The following addition criteria are also used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
   3) Beneficiaries cannot have any periods of Medicare secondary payer status.
   4) Beneficiaries cannot reside outside of the United States.
   5) Beneficiaries must have a record in the Medicare enrollment files.
   6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusions to be optional. However, for the GEM project, all optional denominator exclusion criteria specified in HEDIS were made mandatory. For the exclusion based on a diagnosis of polycystic ovaries, HEDIS specifies that the diagnosis can occur at any time in the beneficiary's history, as long as it occurred by December 31, 2006. GEM can exclude patients from the denominator if we can find a diagnosis of polycystic ovaries in 2005 or 2006.

4. Part D (pharmacy) coverage began only in 2006 and was not universal and equal for all Medicare beneficiaries in this project. Therefore, identification of patients in the denominator for the GEM project through Part D data alone will cover only a portion of patients who may otherwise have been dispensed oral hypoglycemics/antihyperglycemics.

5. Identifying numerator compliance through the use of LOINC codes is not expected in Medicare claims data.

Algorithm Flowchart: See Flowchart 4.

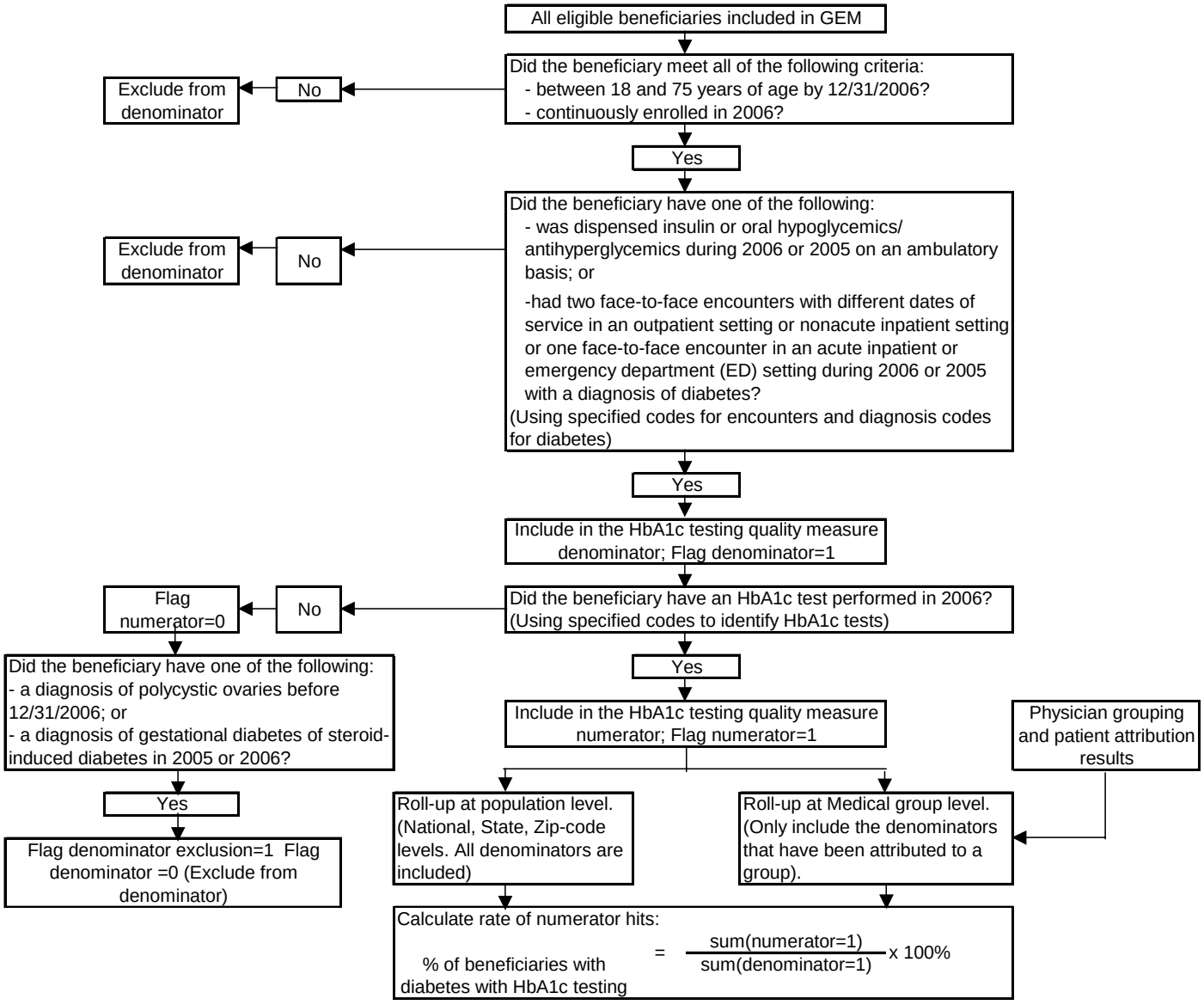
Denominator and Numerator Codes

Measure Category	Description	SubCategory	Coding Scheme	Codes
Denominator Inclusion	Diagnosis for diabetes		ICD-9-CM Diagnosis	250, 357.2, 362.0, 366.41, 648.0
			DRG	294, 295
	Procedure (Two face-to-face encounters with different dates of service)	Outpatient	CPT	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
			UB-92 Revenue	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
		Nonacute inpatient	CPT	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337
			UB-92 Revenue	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x, 0524, 0525
	Procedure (One face-to-face encounter)	Acute inpatient	CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291
			UB-92 Revenue	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
		Emergency department	CPT	99281-99285
			UB-92 Revenue	045x, 0981
	Drug class for diabetes (Insulin; Oral hypoglycemic/antihyperglycemic)		NDC	Any NDC in "CDC_A_Denominator_07.xls"[1]
Denominator Exclusion	Diagnosis of polycystic ovaries		ICD-9-CM Diagnosis	256.4
	Diagnosis of steroid-induced diabetes		ICD-9-CM Diagnosis	251.8, 962.0
	Diagnosis of gestational diabetes		ICD-9-CM Diagnosis	648.8
Numerator Inclusion	HbA1c test		CPT	83036, 83037
			CPT II	3046F, 3047F
			LOINC[2]	4548-4, 4549-2, 17856-6

[1] The source of this table can be found in the "Comprehensive Diabetes Care (CDC) Denominator" link of the following NCQA website: www.ncqa.org/tabid/210/Default.aspx

[2] LOINC codes are not available in the Medicare claims data.

Flowchart 4: HbA1c Testing for Beneficiaries with Diabetes



GEM Measure Functional Specification Document

Performance Measure Name: LDL-C Screening for Beneficiaries with Cardiovascular Conditions

Description: The percentage of members 18-75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty from January 1 to November 1 of 2005, *or* who had a diagnosis of ischemic vascular disease (IVD) during 2006 and 2005, who had LDL-C screening performed.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 18 – 75 years of age as of December 31, 2006 who had continuous enrollment during 2006 and 2005.

Beneficiaries are identified for the denominator in one of two ways: event or diagnosis. The organization must see both criteria to identify the eligible population.

1) *Event:* Discharged alive for AMI, CABG, or PTCA on or between January 1, 2005 and November 1, 2005. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, emergency room).

2) *Diagnoses:* Identify members as having IVD who met at least one of the two criteria below, during *both* 2006 and 2005 (criteria need not be the same across both years):
   • At least one outpatient visit with an IVD diagnosis;
   • At least one acute inpatient visit with an IVD diagnosis

Denominator Exclusion Statement:

There are no denominator exclusions.

Numerator Statement:

[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:
(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*
(2) National Committee for Quality Assurnace (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf*

An LDL-C test performed any time during 2006, as identified by claim/encounter or automated laboratory data.

Deviation from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. The following addition criteria are also used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
   3) Beneficiaries cannot have any periods of Medicare secondary payer status.
   4) Beneficiaries cannot reside outside of the United States.
   5) Beneficiaries must have a record in the Medicare enrollment files.
   6) Beneficiaries cannot have any months of Hospice coverage.

3. Identifying numerator compliance through the use of LOINC codes is not expected in Medicare claims data.

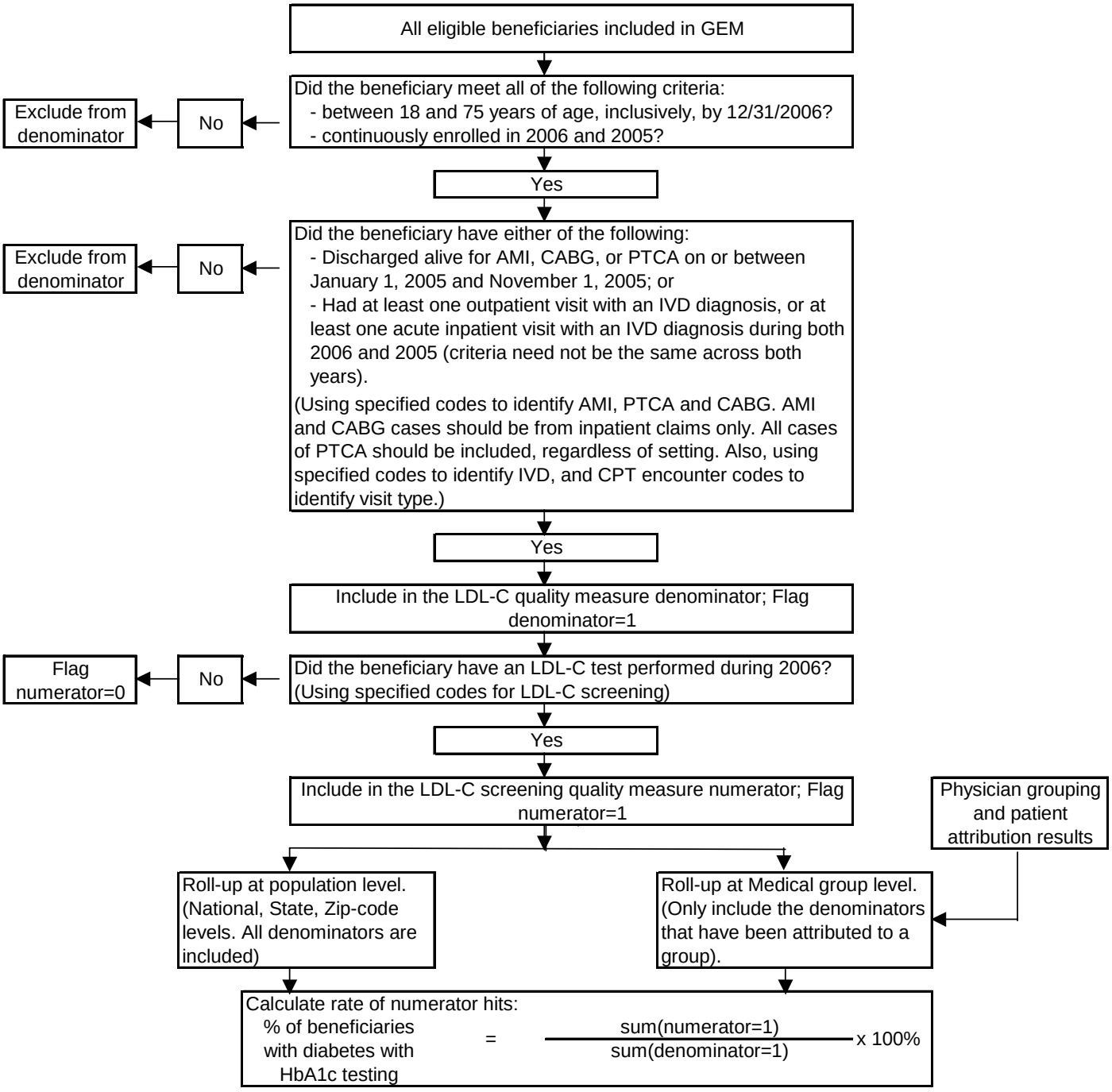
Algorithm Flowchart: See Flowchart 5.

Denominator and Numerator Codes

Measure Category	Category	SubCategory	Description	Coding Scheme	Codes
Denominator Inclusion	Event		AMI (inpatient only)	ICD-9-CM Diagnosis	410.x1
				DRG	121, 122, 516
			PTCA (all settings)	CPT	33140, 92980-92982, 92984, 92995, 92996
				ICD-9-CM Procedure	00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09
				DRG	516, 517, 526, 527, 555-558
			CABG (inpatient only)	CPT	33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572
				HCPCS	S2205-S2209
				ICD-9 CM Procedure	36.1, 36.2
				DRG	106, 107, 109, 547-550
	Diagnosis	Diagnosis	IVD	ICD-9 CM Diagnosis	411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445
				DRG	140, 559
		Visits	Outpatient	CPT Codes	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
				UB92 Revenue	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983
			Acute inpatient	CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291
				UB92 Revenue	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987
Numerator Inclusion			LDL Screening	CPT	80061, 83700, 83701, 83704, 83715, 83716, 83721
				CPT-II	3048F, 3049F, 3050F
				LOINC[1]	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 24331-1, 39469-2

[1] LOINC codes are not available in the Medicare claims data.

Flowchart 5: LDL-C Screening for Beneficiaries with Cardiovascular Conditions



GEM Measure Functional Specification Document

Performance Measure Name: Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Description: The percentage of members 35 years of age and older during 2006 who were hospitalized and discharged alive from January 1, 2006 to June 30, 2006 with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 35 years of age and older as of December 31, 2006 who had continuous enrollment for both medical services and pharmacy from the discharge date through 180 days after discharge. Beneficiaries are identified for the denominator by event/diagnosis. Additional rules follow as to how to count transfers and readmissions.

Event/Diagnosis: Discharged alive from an acute inpatient setting with an AMI between January 1, 2006 through June 30, 2006. If a beneficiary has more than one episode of AMI from January 1, 2006through June 30, 2006 the organization should include only the first discharge.

Transfers to acute facilities: Include hospitalizations in which the beneficiary was transferred directly to another *acute care facility* for any diagnosis. Count the discharge from the subsequent, not the initial, acute inpatient facility. The discharge date from the facility to which the beneficiary was transferred must occur on or before June 30, 2006.

Readmissions: If the beneficiary was readmitted to an *acute or nonacute care facility* for any diagnosis, include the beneficiary in the denominator and use the discharge date from the original hospitalization.

Transfers to non-acute facilities. Exclude from the denominator hospitalizations in which the beneficiary was transferred directly to a non-acute care facility for any diagnosis.

Denominator Exclusions:

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:

(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*

(2) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf

The organization should exclude from the denominator beneficiaries who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-blocker therapy. The organization should look back look back as far as possible in the beneficiary's history through the end of the continuous enrollment period in administrative data for evidence of a contraindication to beta-blocker therapy.

Numerator Statement:

A 180-day course of treatment with beta-blockers. Identify all beneficiaries in the denominator population whose days supply dispensed is ≥135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days supply filled.

Treatment days (covered days) is defined as the actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (i.e., a prescription of 90 days' supply dispensed on the 100th day will have 80 days counted in the 180-day interval). To determine continuity of treatment during the 180-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days + 45 gap days = 180 days); identify all prescriptions filled within 180 days of the Discharge Date.

To account for beneficiaries who are on beta-blockers prior to admission, the organization should factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.

Deviation from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. In addition, the following criteria will be used to exclude beneficiaries:
    1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
    2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
    3) Beneficiaries cannot have any periods of Medicare secondary payer status.
    4) Beneficiaries cannot reside outside of the United States.
    5) Beneficiaries must have a record in the Medicare enrollment files.
    6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusions to be optional. However, for the GEM project, all optional denominator exclusion criteria specified in HEDIS were made mandatory. For the exclusion based on contraindications to beta-blockers, HEDIS specified that the diagnosis can occur at any time in the beneficiary's history through the end of the continuous enrollment period, defined as discharge date through 180 days after discharge. GEM can exclude patients from the denominator if we can find a diagnosis of contraindications to beta-blockers in 2005 or 2006.

4. Since the GEM project will have pharmacy data only for 2006, the time window for denominator inclusion must start in 2006.

Algorithm Flowchart: See Flowchart 6.

Denominator and Numerator Codes

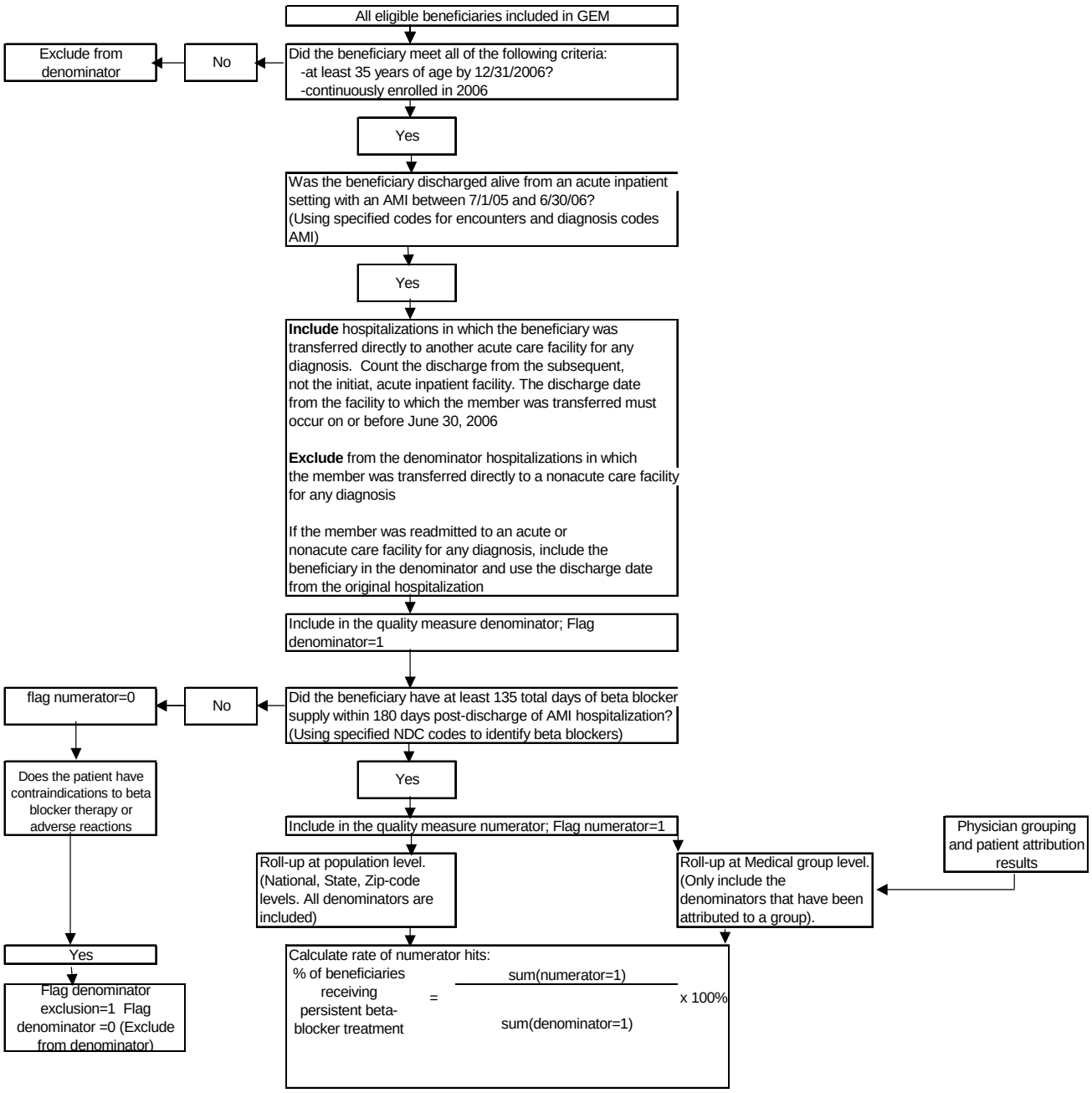
Measure Category	Description	Subcategory	Code Type	Codes
Denominator inclusions (event)	Diagnosis for AMI		ICD-9 CM Diagnosis	410.x1[1]
			DRG Code	121, 122, 516, 526
Denominator exclusion	Contraindications for beta-blocker therapy	History of asthma	NDC Codes	Any NDC in "PBH_Denominator_Exclusions_07.xls"[2]
			ICD-9 CM Diagnosis	493
		Hypotension	ICD-9 CM Diagnosis	458
		Heart block > 1 degree	ICD-9 CM Diagnosis	426.0, 426.12, 426.13, 426.2-426.4, 426.51-426.54, 426.7
		Sinus bradycardia	ICD-9 CM Diagnosis	427.81
		COPD	ICD-9 CM Diagnosis	491.2, 496, 506.4
Numerator inclusion	Beta-blocker Medications • Acebutolol HCL • Atentolol • Betaxolol HCL • Bisoprolol fumarate • Carteolol HCL • Carvedilol • Labetolol HCL • Metoprolol succinate • Metoprolol tartrate • Nadolol • Penbutolol sulfate • Pindolol • Propanolol HCL • Sotalol HCL • Timolol maleate		NDC Codes	Any NDC in "PBH_Numerator_Inclusions_07.xls"[3]

[1]An organization that does not have a 5th digit specificity must develop a methodology to ensure that only the first eligible episode of an AMI is included in the measure[1]

[2].The source of this table can be found in the "Persistence of Beta-blocker treatment after a heart attack (PBH) – Exclusions" link of the following NCQA website: http://www.ncqa.org/tabid/210/default.aspx

[3].The source of this table can be found in the "Persistence of Beta-blocker treatment after a heart attack (PBH) – Numerator" link of the following NCQA website: http://www.ncqa.org/tabid/210/default.aspx

Flowchart 6: Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)



GEM Measure Functional Specification Document

Performance Measure Name: Annual Monitoring for Patients on Persistent Medications (MPM)

Description: The percentage of beneficiaries 18 years of age and older during 2006 who received at least 180-days supply of ambulatory medication therapy for a selected therapeutic agent (ACE/ARBs, digoxin, diuretics, anticonvulsants) during 2006 and at least one therapeutic monitoring event for that therapeutic agent within 2006.

For each product line, report each of the four rates separately and as a total rate.

- Annual monitoring for beneficiaries on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for beneficiaries on digoxin
- Annual monitoring for beneficiaries on diuretics
- Annual monitoring for beneficiaries on anticonvulsants.
- Total rate (the sum of the 4 numerators divided by the sum of the four denominators)

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 18 years of age and older as of December 31, 2006 who had continuous enrollment in 2006.

Event/Diagnosis: Beneficiaries on persistent medications—defined as beneficiaries receiving at least a 180-days supply of ambulatory medication in 2006 for any medication listed in the medications table for each of the four rates in the measure. To determine continuity of treatment during the 365-day period, sum the number of treatment days (days supply from all the scripts filled during the year) for a total of 180 days.

Denominator Exclusion:

The organization should exclude beneficiaries from each eligible population rate who had an inpatient stay (acute or nonacute) during 2006. Exclude any visit with an inpatient facility code or use UB-92 Type of Bill codes and DRG codes to identify inpatient care.

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:

(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*

(2) National Committee for Quality Assurnace (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf

Rate 1: Annual Monitoring for Beneficiaries on ACE/ARBs

Additional Denominator Statement:

The number of beneficiaries in the eligible population who received at least a 180-days supply of any ACE inhibitors or ARBs, including any combination products during 2006.

Note: Beneficiaries may switch therapy within the ACE/ARB class during 2006 and have the days supply for those medications count toward the total 180-days supply (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).

Numerator Statement:

The number of beneficiaries with at least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in 2006.

Note: The two tests do not need to occur on the same service date, only within 2006.

Rate 2: Annual Monitoring for Beneficiaries on Digoxin

Additional Denominator Statement:

The number of beneficiaries in the eligible population who received at least a 180-days supply of any drug for digoxin, including any combination products, during 2006.

Note: Beneficiaries may switch therapy within digoxin medication class during 2006 and have the days supply for those medications count toward the total 180-days supply.

Numerator Statement:

The number of beneficiaries with at least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in 2006.

Note: The two tests do not need to occur on the same service date, only within 2006.

Rate 3: Annual Monitoring for Beneficiaries on Diuretics

Additional Denominator Statement:

The number of beneficiaries in the eligible population who received at least a 180-days supply of any diuretic, including any combination products, during 2006.

Note: Members may switch therapy within any diuretics during 2006 and have the days supply for those medications count toward the total 180-days supply.

Numerator Statement:

The number of beneficiaries with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during 2006.

Note: The two tests do not need to occur on the same service date, only within 2006.

Rate 4: Annual Monitoring for Beneficiaries on Anticonvulsants

Additional Denominator Statement:

The number of beneficiaries in the eligible population who received at least a 180-days supply for any anticonvulsant during 2006.

Note: Beneficiaries who are on multiple anticonvulsant drugs count toward the denominator multiple times if they meet the persistent medications criteria for each drug taken during 2006 (i.e., a beneficiary who received at least 180 days of phenytoin and 180 days of valproic acid will be counted twice in the denominator for Rate 4, once for each drug)

Numerator Statement:

The number of beneficiaries with at least one drug serum concentration level monitoring test for the prescribed drug in 2006. If a member received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication (i.e., a member on phenytoin received a drug serum test for phenytoin).

If a beneficiary persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a beneficiary on both phenytoin and valproic acid with at least a 180-days supply for each drug in 2006 must separately show evidence of receiving drug serum concentration tests for each drug to be considered numerator-compliant for each drug.

Deviation from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. In addition, the following criteria will be used to exclude beneficiaries:

    1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
    2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
    3) Beneficiaries cannot have any periods of Medicare secondary payer status.
    4) Beneficiaries cannot reside outside of the United States.

5) Beneficiaries must have a record in the Medicare enrollment files.
6) Beneficiaries cannot have any months of Hospice coverage

3. HEDIS allows the denominator exclusions to be optional. However, for the GEM project, all optional denominator exclusion criteria specified in HEDIS were made mandatory, hence requiring excluding beneficiaries from each eligible population rate who had an inpatient stay (acute or nonacute) during 2006.

4. HEDIS specifies reporting a total rate as the sum of the 4 numerators divided by the sum of the 4 denominators. In the GEM project, the report for Cardiology groups will include only ACE/ARBs, digoxin and diuretics, hence the total rate will be based on these 3 medications. The report for Neurology groups will include only anticonvulsants, hence the total rate will be based on this single medication.

5. Identifying numerator compliance through the use of LOINC codes is not expected in Medicare claims data.

Algorithm Flowcharts: See Flowcharts 7.a through 7.e.

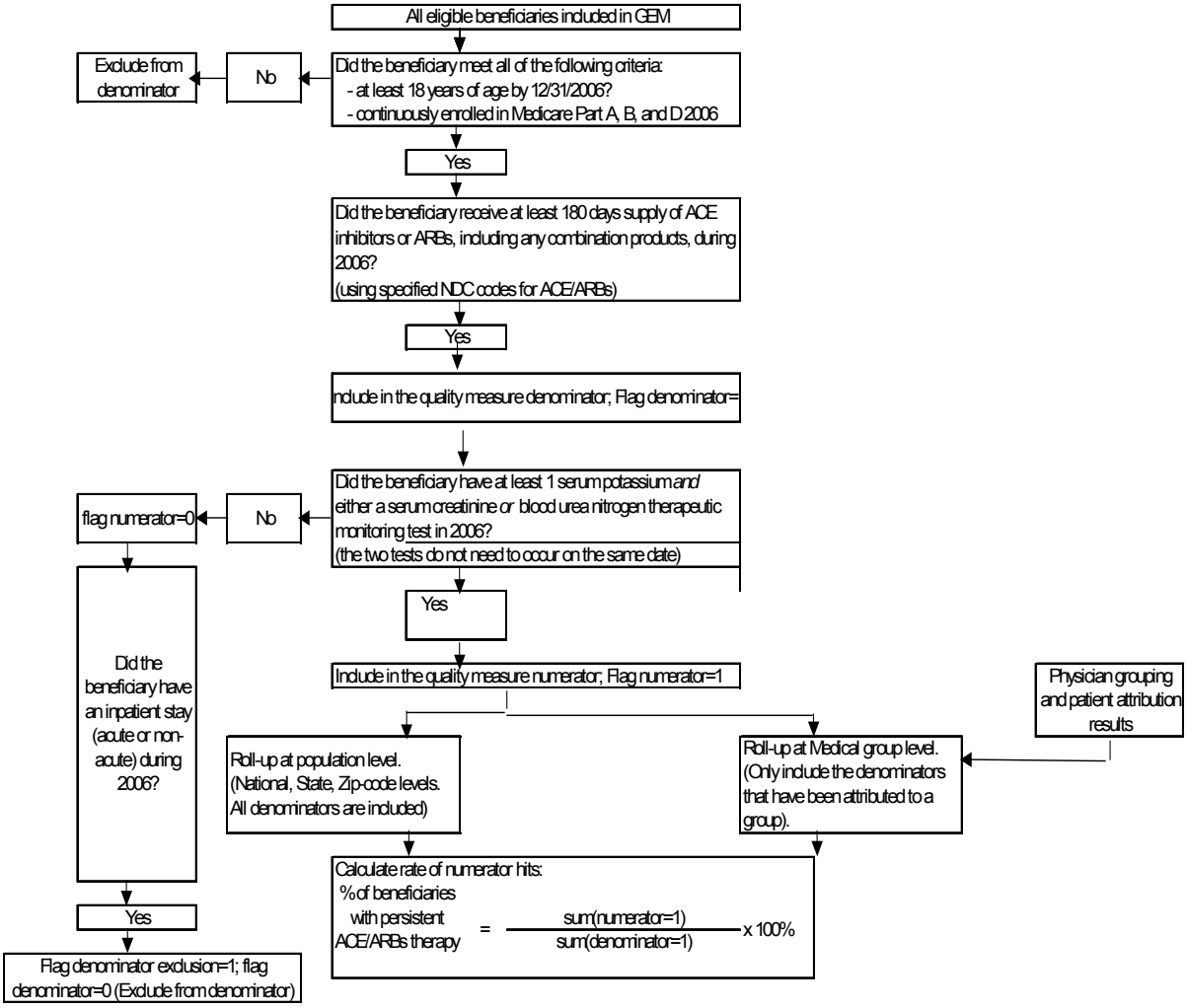
Numerator and Denominator Codes

Measure Category	Description	Code Type	Codes
Denominator inclusions	ACE Inhibitors or ARBs	NDC	Any NDC in "MPM_A_ACEs_and_ARBs_07.xls" [1]
	Anticonvulsants	NDC	Any NDC in "MPM_E_Anticonvulsants_07.xls" [1]
	Digoxin	NDC	Any NDC in "MPM_C_Digoxins_07.xls" [1]
	Diuretics	NDC	Any NDC in "MPM_D_Diuretics_07.xls"[1]
Denominator exclusions	Inpatient stay	UB-92 Revenue Codes	*Inpatient non-acute*: 0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659, 019x; 0118, 0128, 0138, 0148, 0158; 0655
		UB-92 Bill Type	*Inpatient acute:* 11x, 12x, 41x, 42x, 84x *Inpatient non-acute:* 81x, 82x, 21x, 22x, 18x
		DRG	*Inpatient acute:*1-423, 439-455, 461, 463-471, 473, 475-520, 524-559 *Inpatient non-acute*: 462
Numerator inclusions (Physiologic Monitoring Tests for ACE/ARB; Digoxin; diuretics)	Serum potassium (K+)	CPT	84132, 80050, 80051, 80053, 80048, 80069
		LOINC[2]	2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 24320-4, 24321-2, 24322-0, 24323-8, 24326-1, 24362-6, 29349-8, 32713-0, 34548-8, 34554-6
	WITH		
	Serum creatinine (SCr)	CPT	82565, 80050, 80053, 80048, 80069, 82575
		LOINC	2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 24321-2, 24322-0, 24323-8, 24320-4, 24362-6, 26752-6, 33558-8, 34555-3, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4
	OR		
	Blood urea nitrogen (BUN)	CPT	84520, 84525, 80050, 80053, 80048, 80069
		LOINC[3]	3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 24320-4, 24321-2, 24322-0, 24323-8, 24362-6
Numerator inclusions (drug serum concentration monitoring tests for Anticonvulsants)	Drug serum concentration for phenobarbital	CPT	80184
		LOINC[3]	3948-7, 3951-1, 10547-8, 14874-2, 34365-7
	Drug serum concentration for phenytoin	CPT	80185, 80186
		LOINC[3]	3968-5, 3969-3, 14877-5, 32109-1, 34540-5
	Drug serum concentration for valproic acid (dipropylacetic acid)	CPT	80164
		LOINC[3]	4086-5, 4087-3, 4088-1, 14946-8, 18489-5, 21590-5, 32119-0, 32283-4
	Drug serum concentration for carbamazepine	CPT	80156, 80157
		LOINC[3]	3432-2, 3433-0, 9415-1, 14056-6, 14639-9, 18270-9, 29147-6, 29148-4, 32058-0, 32852-6, 34545-4

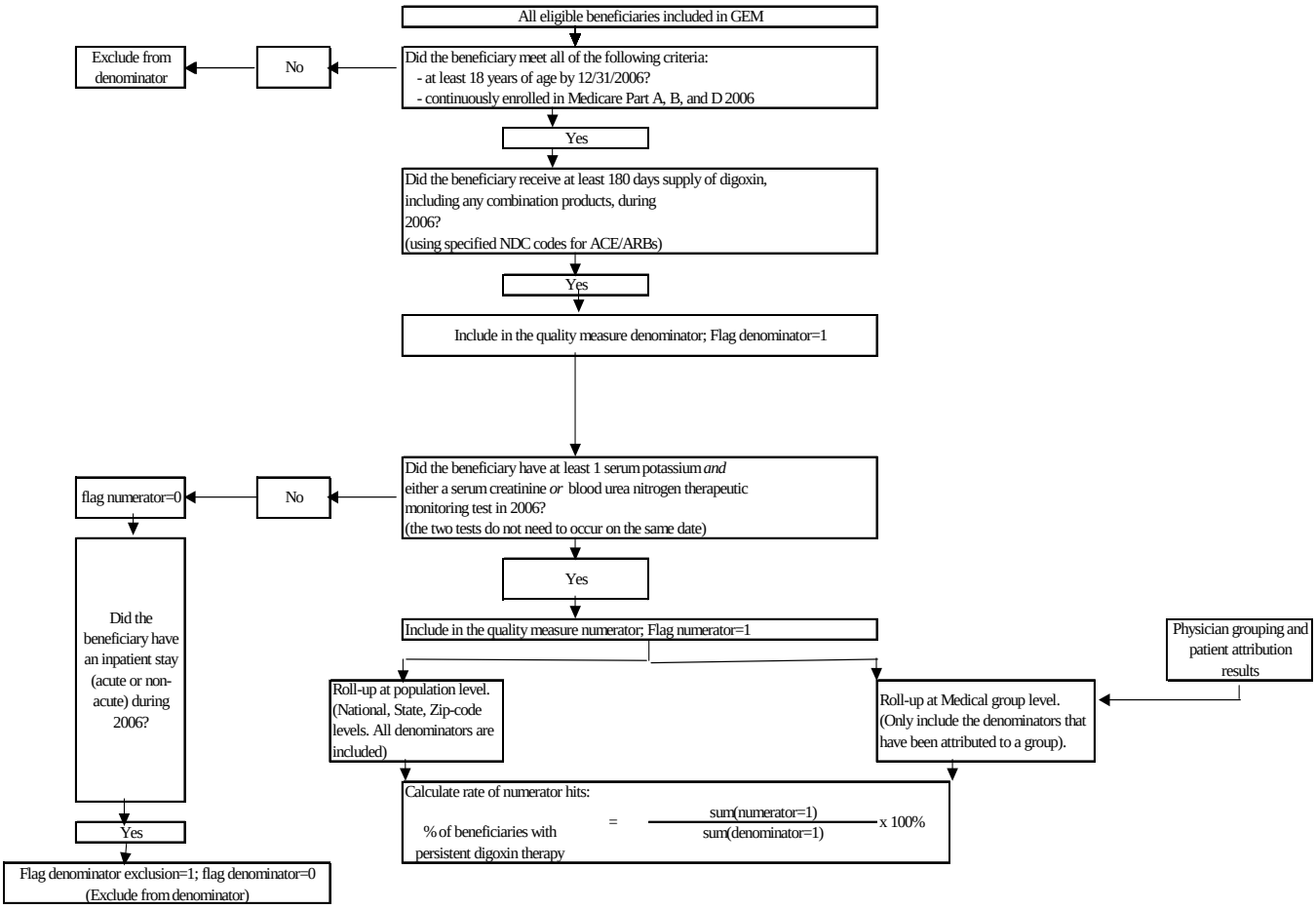
[1] The source of this table can be found in the "Annual Monitoring for Patients on Persistent Medications (MPM)" link of the following NCQA website: http://www.ncqa.org/tabid/210/default.aspx

[2] LOINC codes are not available in the Medicare claims data

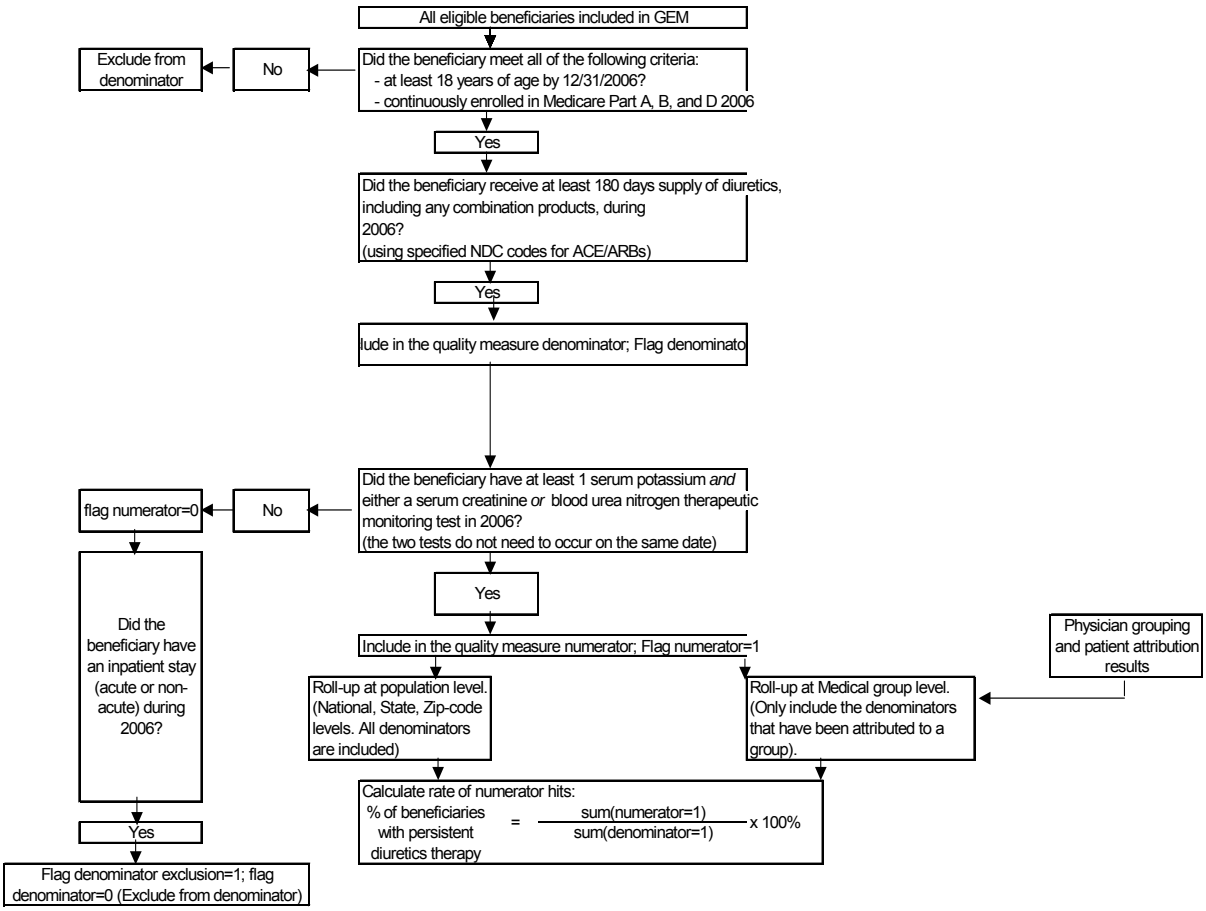
Flowchart 7.a: ACE/ARBs



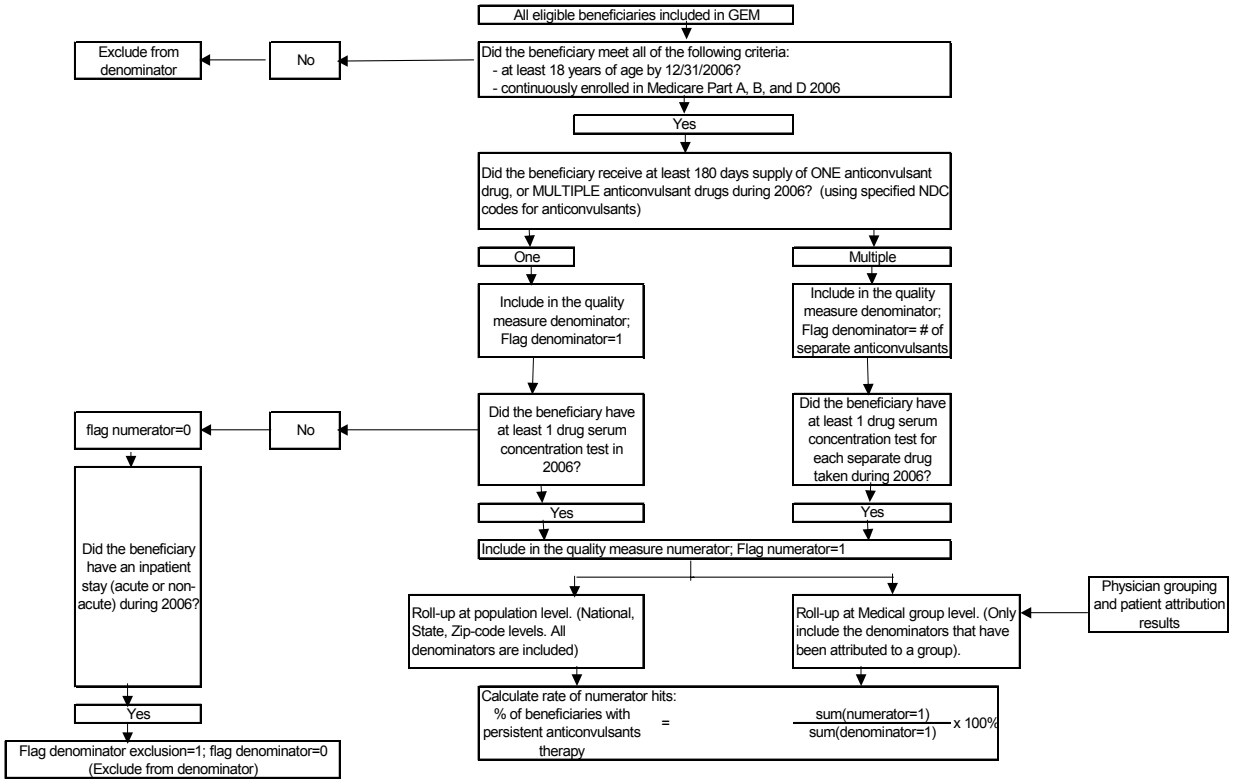
Flowchart 7.b: Digoxin



Flowchart 7.c: Diuretics



Flowchart 7.d: Anticonvulsants



Flowchart 7e: Composite Score:

$$\text{\% of beneficiaries with persistent medication therapy} = \frac{\sum(\text{individual ACE/ARBS numerator}) + \sum(\text{individual digoxin numerator}) + \sum(\text{individual diuretics numerator}) + \sum(\text{individual anticonvulsants numerator})}{\sum(\text{individual ACE/ARBS denominator}) + \sum(\text{individual digoxin denominator}) + \sum(\text{individual diuretics denominator}) + \sum(\text{individual anticonvulsants denominator})} \times 100\%$$

GEM Measure Functional Specification Document

Performance Measure Name: Antidepressant Medication Management - Effective Acute Phase Treatment

Description: The percentage of members 18 years of age and older as of April 30, 2006 who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries who were 18 years and older as of April 30, 2006 who were diagnosed with a New Episode of major depressive disorder during the window starting on March 18, 2006 and ending on September 8, 2006 ("Intake Period") and treated with antidepressant medication.

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, which is the earliest encounter during the Intake Period with a qualifying diagnosis of major depression. During the negative diagnosis history period, the beneficiary must have no claims/encounters containing either a principal or secondary diagnosis of depression.
- A 90-day (3-month) Negative Medication History prior to the Index Prescription Date, which is 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. During the negative medication history period, the beneficiary must have no pharmacy claims for either new or refill prescriptions for a listed antidepressant drug. The period of medication history accounts for both the fill date as well as the days supplied of the prescription. That is, a prescription filled prior to the interval of 90 days prior to the Index Prescription Date, but with a number of days supplied that would overlap the 90 day interval, would violate the negative medication history requirement.

The following are the steps for identifying the denominator:

(1) Identify all beneficiaries with a diagnosis of depression who, during the Intake Period, had:

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

[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:
(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*
(2) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf*

- At least two secondary diagnoses of major depression 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 associated with any inpatient discharge.

(2) Determine the Index Episode Start Date and test for Negative Diagnosis History. For each beneficiary identified in step 1, determine the Index Episode Start Date by finding the date of the beneficiary'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.

Identify beneficiaries who were diagnosed with a New Episode of depression. A new episode of depression is the earliest episode, during the intake period that meets the definition of a "New Episode".
According to NCQA "Only the earliest event during the intake period is used and tested against the criteria for each step. If the earliest event does not meet the criteria the member is dropped. Events that occur subsequent to the earliest event should not be considered."

(3) Identify beneficiaries receiving antidepressant medication therapy. Among beneficiaries 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. The Episode Start Date is considered day #1 of the 14 days.

(4) Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 120 days prior to the Index Episode Start Date to 114 days (84 medication days plus 30 potential gap days) after the Index Prescription Start Date. For GEM beneficiaries, this specification requires that the actual start date be identified for the beneficiary.

(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. The Episode Start Date is considered day #1 of the 14 days. Prescriptions may be up to 30 days before the Index Episode Start Date to account for beneficiaries 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 beneficiary delay in filling the initial prescription.

(6) From the resulting beneficiaries from step 5, confirm the New Episode by testing for a Negative Medication History.

(7) Given the potential for beneficiaries to have less than a full year of 2006 Part D enrollment, denominator inclusion criteria requires that the beneficiary have Part D enrollment for 3 months (i.e. 90 days) before the New Episode start date and 114 days after the Index Prescription Date.

Denominator Exclusion Statement:

(1) Beneficiaries with any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from the denominator.

(2) Beneficiaries who have antidepressant prescriptions filled during the Negative Medication History period do not represent new treatment episodes and must be excluded.

(3) Beneficiaries who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 114 days after the Index Prescription Start Date treatment period must be excluded.

These criteria do *not* set an exclusion flag. They merely define further denominator inclusion criteria and those beneficiaries who do not meet the denominator inclusion criteria.

Numerator Statement:

An 84-day (12-week) acute treatment with antidepressant medication.

Identify all beneficiaries in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 84 days.

Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 84-day period. Allowable medication changes or gaps include:

- "washout" period gaps to change medication
- "treatment" gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 30 days. 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). The total gap days may not exceed 30 days.

To determine continuity of treatment during the 114-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e., 84 treatment days + 30 gap days = 114 days).

For all prescriptions filled within 114 days of the Index Prescription Date, 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. Beneficiaries 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.

Deviation(s) from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. The following criteria will be used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
   3) Beneficiaries cannot have any periods of Medicare secondary payer status.
   4) Beneficiaries cannot reside outside of the United States.
   5) Beneficiaries must have a record in the Medicare enrollment files.
   6) Beneficiaries cannot have any months of Hospice coverage.

3. The Intake Period for seeking New Episodes of depression was defined as March 18, 2006 through September 8, 2006, in order to properly handle constraints of Part D enrollment starting in 2006 only.

4. Via NCQA advice, DRG codes are removed for the diagnosis of depression.

5. Codes for identifying visit type are not included in HEDIS 2007. Via NCQA's advice, we used codes from HEDIS 2009 for identifying visit type.

Algorithm Flowchart: See Flowchart 8.

Denominator and Numerator Codes

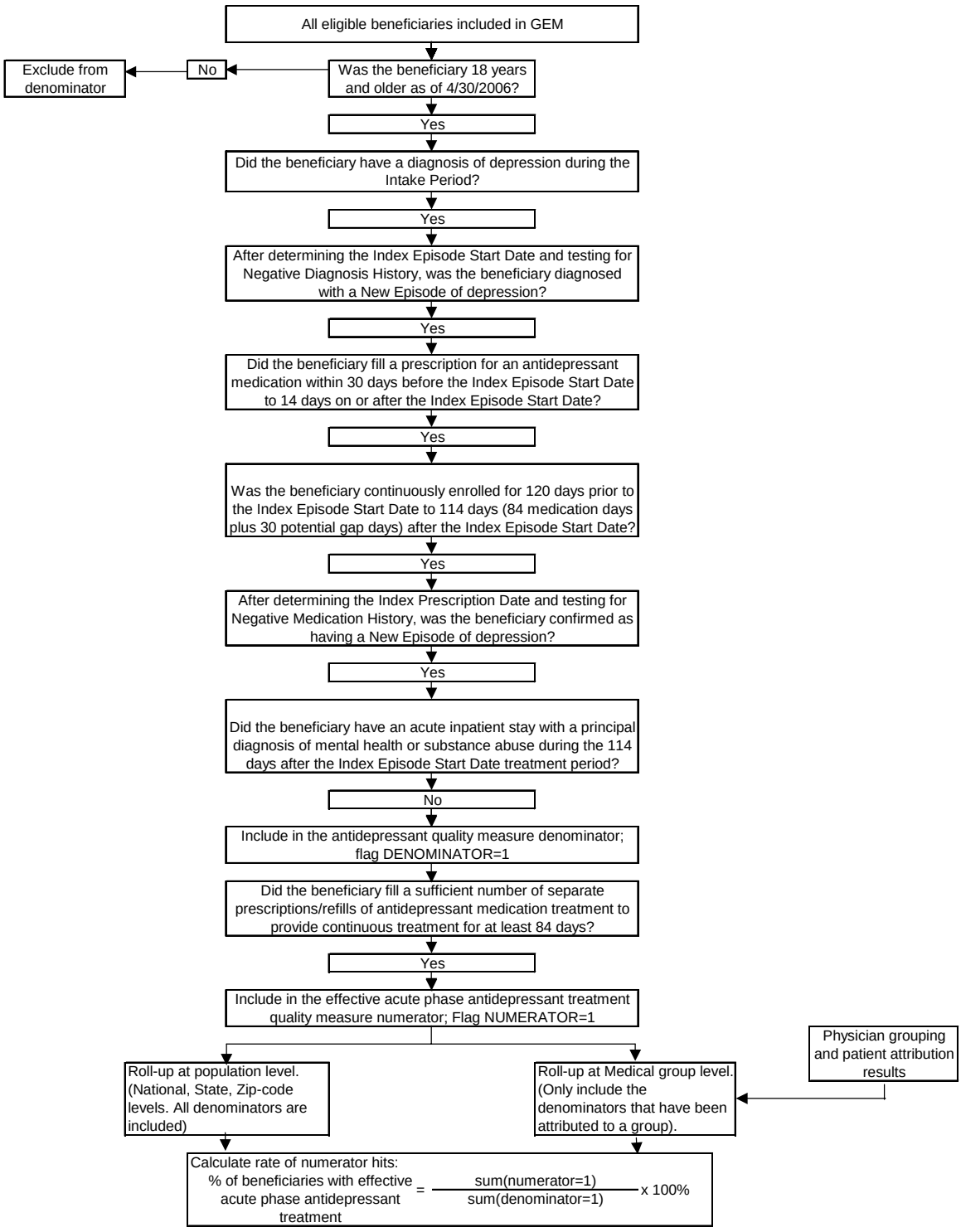
Measure Category	Description	SubCategory	Coding Scheme	Codes
Denominator Inclusion	Diagnosis	Major depression[1]	ICD-9-CM Diagnosis	296.2, 296.3, 298.0, 300.4, 309.1, 311
		Prior depressive episodes	ICD-9-CM Diagnosis	296.2-296.9, 298.0, 300.4, 309.0, 309.1, 309.28, 311
	Procedure	Outpatient, intensive outpatient and partial hospitalization	CPT	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99341-99397, 99401-99404, 99411, 99412, 99510
			CPT (used with POS)	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263
			POS	05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72
			HCPCS	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
			UB-92 Revenue	0510, 0513, 0515-0517, 0519,-0523, 0526-0529, 077x, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
		Emergency department	CPT	99281-99285
			UB-92 Revenue	045x, 0981
		Acute Inpatient	CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291
			UB-92 Revenue	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
		Nonacute inpatient	CPT	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337
			UB-92 Revenue	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x

Measure Category	Description	SubCategory	Coding Scheme	Codes
Denominator Exclusion	Diagnosis	Mental Health Utilization—Inpatient Discharges	ICD-9-CM Principal Diagnosis	290, 293-302, 306-316
			DRG	424-432 except discharges with ICD-9-CM principal diagnosis of 317-319
		Chemical Dependency Utilization—Inpatient Discharges	ICD-9-CM Principal Diagnosis	291-292, 303-305, 960-979 with a secondary diagnosis of chemical dependency (291-292, 303-305)*
			DRG	433, 521-523
Numerator Inclusion	Antidepressant Medications ▪ Tricyclic antidepressants (TCA) and other cyclic antidepressants; ▪ Selective serotonin reuptake inhibitors (SSRI) ▪ Monoamine oxidase inhibitors (MAOI) ▪ Serotonin-norepinephrine reuptake inhibitors (SNRI) ▪ Other antidepressants		NDC	Any NDC in "AMM_numerator.xls"[3]

[1] Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of that code). Additionally, other possible codes that could indicate depression diagnosis (296.4-296.9, 309.0, 309.28) are not included in this list because these codes are less specific in identifying eligible beneficiaries.

[3] The source of this table can be found in the "Antidepressant Medication Management (AMM)" link of the following NCQA website: www.ncqa.org/tabid/210/Default.aspx

Flowchart 8: Acute Phase Antidepressant Medication Management



GEM Measure Functional Specification Document

Performance Measure Name: Beta-Blocker Treatment After a Heart Attack (BBH)

Description: The percentage of members 35 years of age and older during 2006 who were hospitalized and discharged alive from January 1, 2006 to December 24, 2006 with a diagnosis of acute myocardial infarction (AMI) and who received an ambulatory prescription of beta-blockers upon discharge.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 35 years of age and older as of December 31, 2006 who had continuous enrollment for both medical services and pharmacy from the discharge date through 7 days after discharge. Beneficiaries are identified for the denominator by event/diagnosis. Additional rules follow as to how to count transfers and readmissions.

Event/Diagnosis: Discharged alive from an acute inpatient setting with an AMI between January 1, 2006 through December 24, 2006. If a beneficiary has more than one episode of AMI from January 1, 2006 through December 24, 2006, include only the first discharge.

Transfers to acute facilities. Include hospitalizations in which the beneficiary was transferred directly to another acute care facility for any diagnosis. The discharge date from the facility to which the beneficiary was transferred must occur on or before December 24, 2006.

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

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

Denominator Exclusions:

The organization should exclude from the denominator beneficiaries who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction (i.e., intolerance) to beta-

[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:
(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*
(2) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf*

blocker therapy. The organization should look back as far bas as possible in the beneficiary's history through the end of the continuous enrollment period, defined as the discharge date through seven days after discharge (inclusive), for evidence of a contraindication or a previous adverse reaction to beta-blocker therapy.

Numerator Statement:

Beneficiaries who received an ambulatory prescription for beta-blockers within seven days (inclusive) after discharge as indicated by pharmacy or claims data. The date of discharge counts as day 0. Prescriptions rendered on an *ambulatory basis* while a patient is hospitalized for AMI through the seventh day after discharge count toward this measure. If the organization is unable to determine whether the prescription was rendered on an inpatient or ambulatory basis, it may only count prescriptions rendered after discharge. To account for beneficiaries who are on beta-blockers prior to admission, the organization may also count beta-blocker prescriptions that are active at the time of admission.

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

Transfers. If a beneficiary was directly transferred to another acute facility, identify that the prescription is active on the date of admission for the initial inpatient stay for AMI or that the beneficiary received a beta-blocker prescription within seven days after the discharge from the facility to which the beneficiary was transferred. For claims data, a code for "beta-blocker therapy prescribed" on or between the discharge date and seven days after discharge indicates the member is numerator compliant.

Deviation from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. In addition, the following criteria will be used to exclude beneficiaries:
    1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
    2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
    3) Beneficiaries cannot have any periods of Medicare secondary payer status.
    4) Beneficiaries cannot reside outside of the United States.
    5) Beneficiaries must have a record in the Medicare enrollment files.
    6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusions to be optional. However, for the GEM project, all optional denominator exclusion criteria specified in HEDIS were made mandatory. For the exclusion based on contraindications to beta-blockers, HEDIS specified that the diagnosis can occur at any time in the beneficiary's history through the end of the continuous enrollment period, defined as discharge date through 7 days after discharge (inclusive). GEM can exclude patients from the denominator if we can find a diagnosis of contraindications to beta-blockers in 2005 or 2006.

Algorithm Flowchart: See Flowchart 9.

Denominator and Numerator Codes

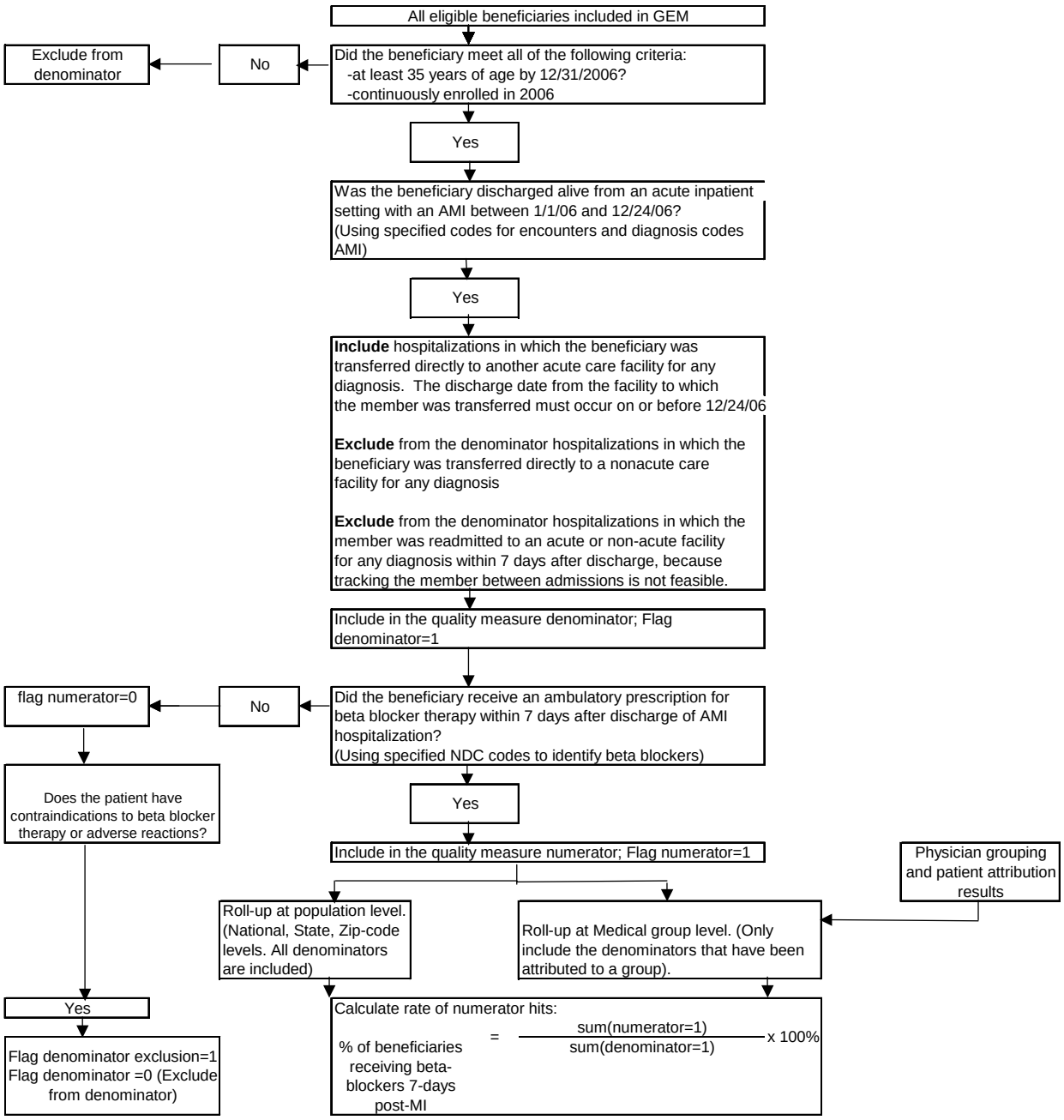
Measure Category	Description	Subcategory	Code Type	Codes
Denominator inclusions (event)	Diagnosis for AMI		ICD-9 CM Diagnosis	410.x1[1]
			DRG Code	121, 122, 516, 526
Denominator exclusion	Contraindications for beta-blocker therapy	History of asthma	NDC Codes	Any NDC in "BBH_Denominator_ Exclusions_07.xls"[2]
			ICD-9 CM Diagnosis	493
		Hypotension	ICD-9 CM Diagnosis	458
		Heart block > 1 degree	ICD-9 CM Diagnosis	426.0, 426.12, 426.13, 426.2-426.4, 426.51-426.54, 426.7
		Sinus bradycardia	ICD-9 CM Diagnosis	427.81
		COPD	ICD-9 CM Diagnosis	491.2, 496, 506.4
Numerator inclusion	Beta-blocker Medication • Acebutolol HCL • Atentolol • Betaxolol HCL • Bisoprolol fumarate • Carteolol HCL • Carvedilol • Labetolol HCL • Metoprolol succinate • Metoprolol tartrate • Nadolol • Penbutolol sulfate • Pindolol • Propanolol HCL • Sotalol HCL • Timolol maleate		NDC Codes	Any NDC in "BBH_Numerator_In clusions_07.xls"[2]
	Beta blocker therapy prescribed		CPT II	4006F

[1] An organization that does not have a 5th digit specificity must develop a methodology to ensure that only the first eligible episode of an AMI is included in the measure

[2] The source of this table can be found in the "Beta-Blocker Treatment After a Heart Attack (BBH) - Exclusions" link of the following NCQA website: http://www.ncqa.org/tabid/210/default.aspx

[3] The source of this table can be found in the "Beta-Blocker Treatment After a Heart Attack (BBH) - Numerator" link of the following NCQA website: http://www.ncqa.org/tabid/210/default.aspx

Flowchart 9: Beta Blocker Treatment After a Heart Attack (BBH)



GEM Measure Functional Specification Document

Performance Measure Name: Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)

Description: This measure assesses whether patients diagnosed with rheumatoid arthritis have had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug (DMARD).

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Include beneficiaries 18 years of age and older as of December 31, 2006 who had continuous enrollment for both medical service and pharmacy during 2006. Beneficiaries are identified for the denominator by event/diagnosis.

Event/Diagnosis: Two face-to-face physician encounters with different dates of service in an outpatient or non-acute inpatient setting on or between January 1 and November 30, 2006 with any diagnosis of rheumatoid arthritis. A valid diagnosis code must be found in conjunction with a valid visit code on the same date.

Denominator Exclusions:

Exclude from the denominator beneficiaries who have a diagnosis code for pregnancy during the measurement year.

Exclude from the denominator beneficiaries who have been diagnosed with HIV. The organization should use administrative data to look for evidence of HIV diagnosis as far back as possible in the beneficiary's history.

Numerator Statement:

Include beneficiaries who had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug (DMARD) during 2006.

Deviation from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:

(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*

(2) National Committee for Quality Assurnace (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf

2. In addition, the following criteria will be used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
   3) Beneficiaries cannot have any periods of Medicare secondary payer status.
   4) Beneficiaries cannot reside outside of the United States.
   5) Beneficiaries must have a record in the Medicare enrollment files.
   6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusion to be optional. However, for the GEM project, the optional denominator exclusion criteria specified in HEDIS was made mandatory. For evidence of HIV, HEDIS specifies to look as far back as possible in the beneficiary's history. GEM can exclude patients from the denominator if we can find evidence of HIV in 2005 or 2006.

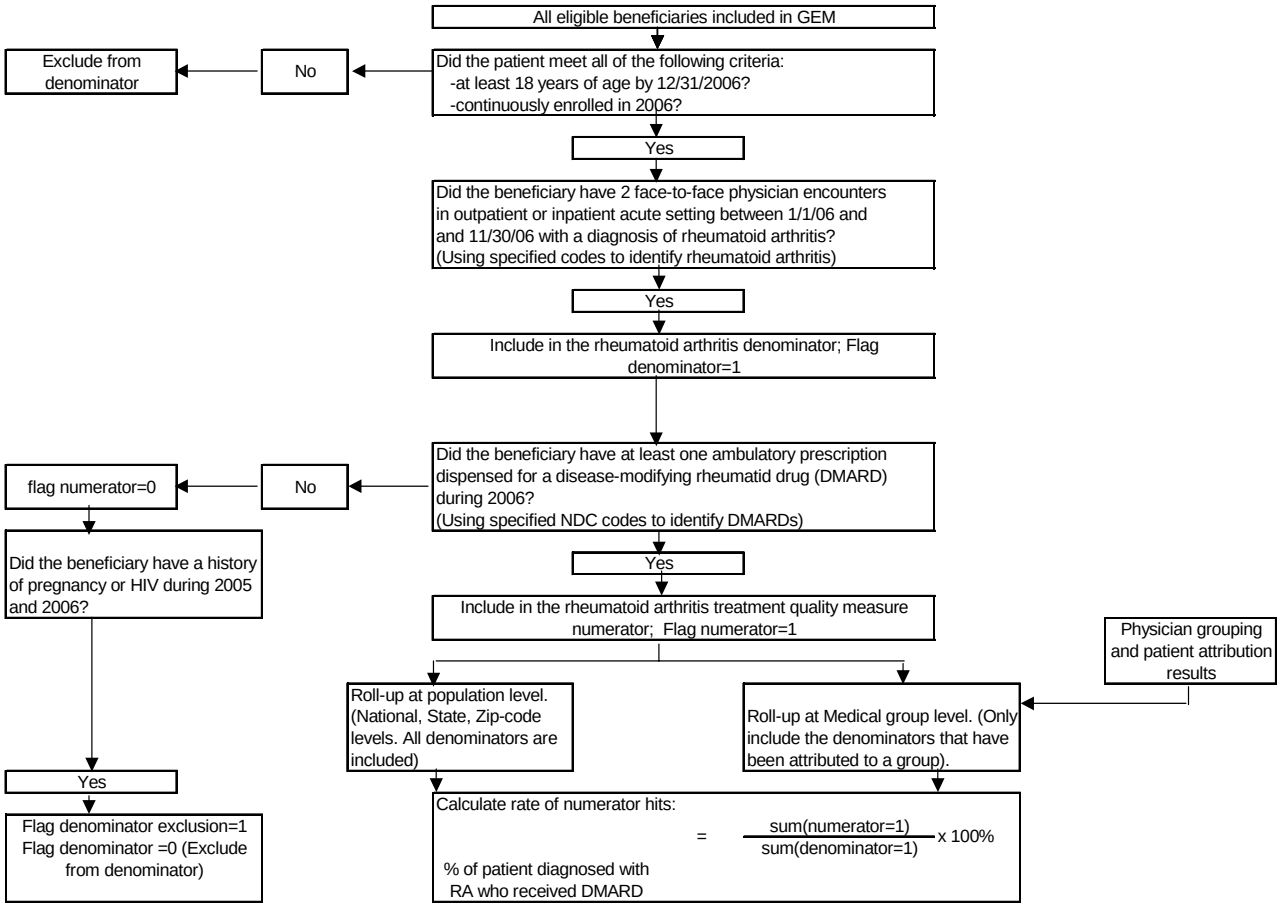
Algorithm Flowchart: See Flowchart 10.

Denominator and Numerator Codes

Measure Category	Description		Code Type	Codes
Denominator inclusions	Rheumatoid Arthritis diagnosis		ICD-9 CM Diagnosis	714.0, 714.1, 714.2, 714.81
	Procedure	Outpatient visit	CPT	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499
			UB-92 Revenue	051x, 0520 – 0523, 0526 - 0529, 057x-059x, 077x, 0982, 0983
		Non-acute inpatient	CPT	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337
			UB-92 Revenue	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x, 0524, 0525
Denominator exclusion	HIV		ICD-9 CM Diagnosis	042, V08
	Pregnancy		ICD-9 CM Diagnosis	630-677, V22, V23, V28
Numerator inclusion	DMARDs • Abatacept • Adalimumab • Anakinra • Azathioprine • Cyclophosphamide) • Cyclosporine • Etanercept • Gold (oral or intramuscular) • Hydroxychloroquine • Infliximab) • Leflunomide • Methotrexate • Minocycline • Penicillamine • Rituximab • Staphyloccal Protein A • Sulfasalazine		NDC	Any NDC in "ART_C_07.xls"[1]
	DMARD Infused Medications		J code	J7501, J9070, J9080, J9090-J9096, J1438, J1745

[1]The source of this table can be found in the "Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)" link of the following NCQA website: http://www.ncqa.org/tabid/210/default.aspx

Flowchart 10: Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)



GEM Measure Functional Specification Document

Performance Measure Name: Colorectal Cancer Screening

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

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 51 – 80 years of age as of December 31, 2006 who had continuous enrollment during 2006 and 2005.

Denominator Exclusion Statements:

Beneficiaries with a diagnosis of colorectal cancer or total colectomy. The organization should look for evidence of colorectal cancer or total colectomy as far back as possible in the beneficiary's history.

Numerator Statement:

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

- Fecal occult blood test (FOBT) during 2006.
- Flexible sigmoidoscopy during the 2005 or 2006.
- Double contrast barium enema (DCBE) during 2005 or 2006.
- Colonoscopy during 2005 or 2006.

Deviation from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. In addition, the following criteria will be used to exclude beneficiaries:
    1) Beneficiaries cannot have any months of Medicare Advantage enrollment.

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:
(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*
(2) National Committee for Quality Assurnace (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* *http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf*

2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
3) Beneficiaries cannot have any periods of Medicare secondary payer status.
4) Beneficiaries cannot reside outside of the United States.
5) Beneficiaries must have a record in the Medicare enrollment files.
6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusion to be optional. However, for the GEM project, the optional denominator exclusion criteria specified in HEDIS was made mandatory. For evidence of colorectal cancer or total colectomy, HEDIS specifies to look as far back as possible in the beneficiary's history. GEM can exclude patients from the denominator if we can find evidence of either colorectal cancer or total colectomy in 2005 or 2006.

4. HEDIS requires a look back period of 4 years for flexible sigmoidoscopy, 4 years for double contrast barium enema (DCBE), and 9 years for colonoscopy. Due to the data availability for GEM, we will look back only 1 year for above screenings, and therefore may underestimate the rate of numerator compliance.

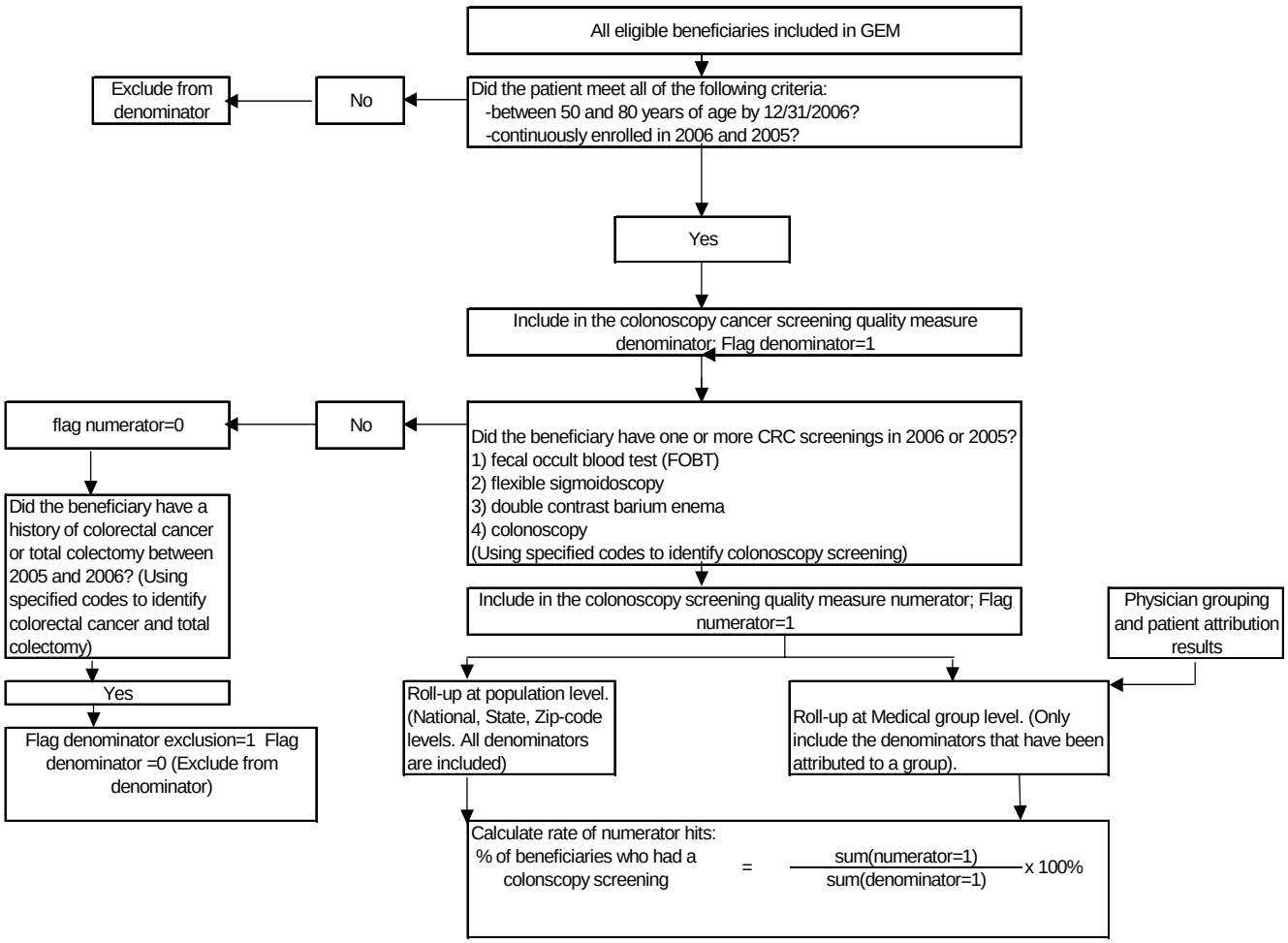
Algorithm Flowchart: See Flowchart 11.

Denominator and Numerator Codes

Measure Category	Description	Coding Scheme	Codes
Denominator Exclusions	Colorectal cancer	HCPCS	G0213-G0215, G0231
		ICD-9 CM diagnosis	153, 154.0, 154.1, 197.5, V10.05
	Total colectomy	CPT Codes	44150-44153, 44155-44156, 44210-44212
		ICD-9 CM procedure	45.8
Numerator Inclusion	FOBT	CPT Codes	82270, 82274
		LOINC[1]	2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3
		HCPCS	G0107, G0328
		ICD-9-CM Diagnosis	V76.51
	Flexible sigmoidoscopy	CPT Codes	45330-45335, 45337-45342, 45345
		HCPCS	G0104
		ICD-9 CM Procedure	45.24, 45.42
	DCBE	CPT codes	74280
	Colonoscopy	CPT codes	44388-44394, 44397, 45355, 45378-45387, 45391, 45392
		HCPCS	G0105, G0121
		ICD-9 CM Procedure	45.22, 45.23, 45.25, 45.43

[1] LOINC codes are not available in the Medicare claims data.

Flowchart 11: Colorectal Cancer Screening



GEM Measure Functional Specification Document

Performance Measure Name: Medical Attention for Nephropathy for Beneficiaries with Diabetes

Description: The percentage of beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 18–75 years as of December 31, 2006 who had continuous enrollment for both medical service and pharmacy during 2006.

There are two methods for identifying diabetic beneficiaries:

- Pharmacy data
- Claim/encounter data

The organization must use *both* methods to identify the eligible population; however, to be included in the measure, a beneficiary needs to be identified in only one method. Beneficiaries may be identified as having diabetes during 2006 or 2005.

(1) Pharmacy data. Beneficiaries who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during 2006 or 2005 on an ambulatory basis.

(2) Claim/encounter data. Beneficiaries who had *two* face-to-face encounters with different dates of service in an outpatient setting or nonacute inpatient setting or *one* face-to-face encounter in an acute inpatient or emergency department (ED) setting during 2006 or 2005 with a diagnosis of diabetes. The organization may count services that occur over both years.

Denominator Exclusion Statement:

(1) Exclude beneficiaries with a diagnosis of polycystic ovaries who did not have any face-to-face encounters with the diagnosis of diabetes, in any setting, during 2006 or 2005. Diagnosis of polycystic ovaries can occur at any time in the beneficiary's history, but must have occurred by December 31, 2006.

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:

(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*

(2) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* *http://ncqa.org/Portals/0/PolicyUpdates/HEDIS%20Technical%20Updates/2007_Vol2_Technical_Update.pdf*

(2) Exclude beneficiaries with gestational diabetes or steroid-induced diabetes, who did not have any face-to-face encounters with the diagnosis of diabetes (in any setting), during 2006 or 2005. Diagnosis of gestational diabetes or steroid-induced diabetes can occur during 2006 or 2005, but must have occurred by December 31, 2006.

Numerator Statement:

A nephropathy screening test ***or*** evidence of nephropathy:

(1) A nephropathy screening test as documented through administrative data.

(2) Any of the following meet criteria for evidence of nephropathy.

- A claim/encounter with a code to indicate evidence of nephropathy during 2006.
- A nephrologist visit during 2006, as identified by the organization's specialty-provider codes (no restriction on the diagnosis or procedure code submitted).
- A *positive* urine macroalbumin test in 2006, as documented by claim/encounter or automated laboratory data. "Trace" urine macroalbumin test results are not considered numerator-compliant.
- Evidence of ACE inhibitor/ARB therapy during 2006. Beneficiaries who had a claim indicating therapy, or who received an ambulatory prescription or were dispensed an ambulatory prescription for ACE inhibitors or ARBs during 2006 are compliant.

Deviation(s) from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. The following criteria will be used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
   3) Beneficiaries cannot have any periods of Medicare secondary payer status.
   4) Beneficiaries cannot reside outside of the United States.
   5) Beneficiaries must have a record in the Medicare enrollment files.
   6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusions to be optional. However, for the GEM project, all optional denominator exclusion criteria specified in HEDIS were made mandatory. For the exclusion based on a diagnosis of polycystic ovaries, HEDIS specifies that the diagnosis can occur at any time in the beneficiary's history, as long as it occurred by December 31, 2006. GEM can exclude patients from the denominator if we can find a diagnosis of polycystic ovaries in 2005 or 2006.

4. Part D (pharmacy) coverage began only in 2006 and was not universal and equal for all Medicare beneficiaries in this project. Therefore, identification of patients in the denominator for the GEM project through Part D data alone will cover only a portion of patients who may otherwise have been dispensed oral hypoglycemics/ antihyperglycemics.

5. As one of the numerator compliance criteria requires pharmacy data, this measure must be restricted to those beneficiaries that have Part D coverage in 2006; note that the denominator counts in this measure will differ from all other diabetes related measures.

6. Identifying numerator compliance through the use of LOINC codes is not expected in Medicare claims data.

Algorithm Flowchart: See Flowchart 12.

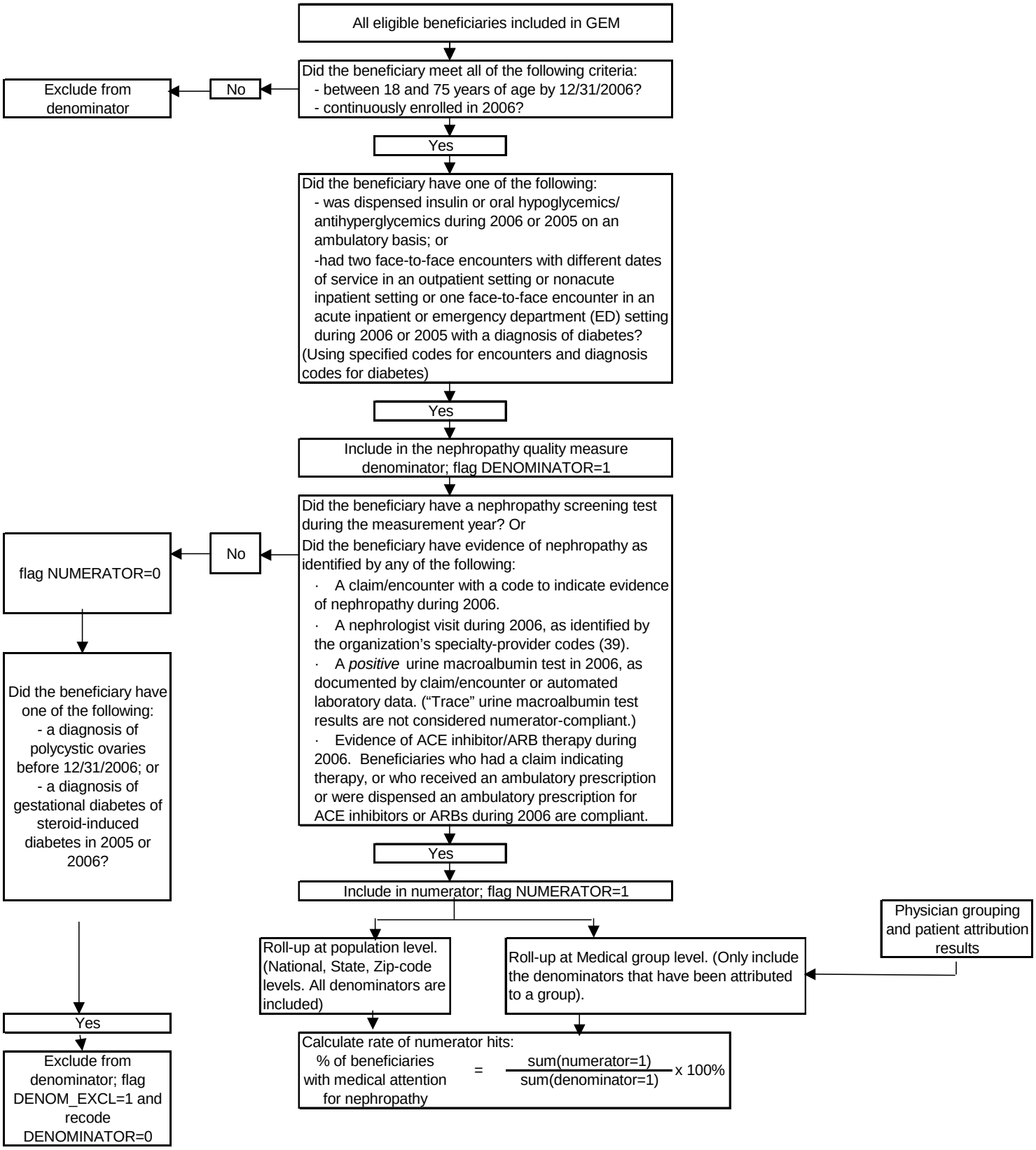
Denominator and Numerator Codes

Measure Category	Description	Sub-Category	Coding Scheme	Codes
Denominator Inclusion	Diagnosis for diabetes		ICD-9-CM Diagnosis	250, 357.2, 362.0, 366.41, 648.0
			DRG	294, 295
	Procedure (Two face-to-face encounters with different dates of service)	Outpatient	CPT	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
			UB-92 Revenue	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
		Nonacute inpatient	CPT	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337
			UB-92 Revenue	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x, 0524, 0525
	Procedure (One face-to-face encounter)	Acute inpatient	CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291
			UB-92 Revenue	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
		Emergency department	CPT	99281-99285
			UB-92 Revenue	045x, 0981
	Drug class for diabetes (Insulin; Oral hypoglycemic/antihyperglycemic)		NDC	Any NDC in "CDC_A_Denominator_07.xls"[1]
Denominator Exclusion	Diagnosis of polycystic ovaries		ICD-9-CM Diagnosis	256.4
	Diagnosis of steroid-induced diabetes		ICD-9-CM Diagnosis	251.8, 962.0
	Diagnosis of gestational diabetes		ICD-9-CM Diagnosis	648.8

Measure Category	Description	Sub-Category	Coding Scheme	Codes
Numerator Inclusion	Nephropathy screening test		CPT	82042, 82043, 82044, 84156
			CPT II	3060F, 3061F
			LOINC[2]	11218-5, 14956-7, 14957-5, 14958-3, 14959-1, 30000-4, 30001-2, 30003-8, 1753-3, 1754-1, 1755-8, 9318-7, 13705-9, 14585-4, 20621-9, 21059-1, 32294-1, 2887-8, 2888-6, 2889-4, 2890-2, 12842-1, 13801-6, 18373-1, 21482-5, 26801-1, 27298-9, 32209-9, 32551-4, 34366-5, 35663-4
	Urine macro-albumin test[3]		CPT	81000-81003, 81005
			CPT II	3062F
			LOINC[2]	5804-0, 20454-5, 24356-8, 24357-6
	Evidence of treatment for nephropathy		CPT	36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512
			CPT II	3066F
			HCPCS	G0257, G0314-G0319, G0322, G0323, G0326, G0327, S9339
			ICD-9-CM Diagnosis	250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0**,** V42.0, V45.1, V56
			ICD-9-CM Procedure	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6
			UB-92 Revenue	0367, 080x, 082x-085x, 088x
			DRG	316, 317
	ACE inhibitor/ARB therapy		CPT II	4009F
			NDC	Any NDC in "CDC_ACEARB_07.xls"[3]
	Nephrologist visit as identified by the organization's specialty-provider codes (no restriction on the diagnosis or procedure code submitted)		Specialty Code	39

[1]The source of this table can be found in the "Comprehensive Diabetes Care (CDC) ACE/ARB" link of the following NCQA website: www.ncqa.org/tabid/210/Default.aspx.
[2] LOINC codes are not available in the Medicare claims data.
[3]A CPT Category II code indicates a positive result for urine macroalbumin; the organization must use automated laboratory data to confirm a positive result for tests identified by CPT or LOINC codes.

Flowchart 12: Medical Attention for Nephropathy



GEM Measure Functional Specification Document

Performance Measure Name: Breast Cancer Screening

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

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Women 42–69 years as of December 31, 2006 who were continuously enrolled during 2006 and 2005.

Denominator Exclusion Statement:

Exclude women who had a bilateral mastectomy and for whom administrative data do not indicate that a mammogram was performed. The organization should look for evidence of a bilateral mastectomy as far back as possible in the member's history. If the organization finds evidence of two separate mastectomies, it may exclude the member from the measure. The bilateral mastectomy must have occurred by December 31, 2006.

Numerator Statement:

One or more mammograms during 2006 or 2005. A woman had a mammogram if a submitted claim/encounter contains any one of the codes in the table below.

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

Deviation from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. The following addition criteria are also used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:
(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*
(2) National Committee for Quality Assurnace (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf*

3) Beneficiaries cannot have any periods of Medicare secondary payer status.
4) Beneficiaries cannot reside outside of the United States.
5) Beneficiaries must have a record in the Medicare enrollment files.
6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusion to be optional. However, for the GEM project, the optional denominator exclusion criteria specified in HEDIS was made mandatory. For evidence of a bilateral mastectomy, HEDIS specifies to look as far back as possible in the member's history. GEM can exclude patients from the denominator if we can find evidence of a bilateral mastectomy in 2005 or 2006.

4. HEDIS specifies reporting two age stratifications (42-51 years, and 52-69 years) in addition to the overall rate. For the GEM project, we will report only the overall rate.

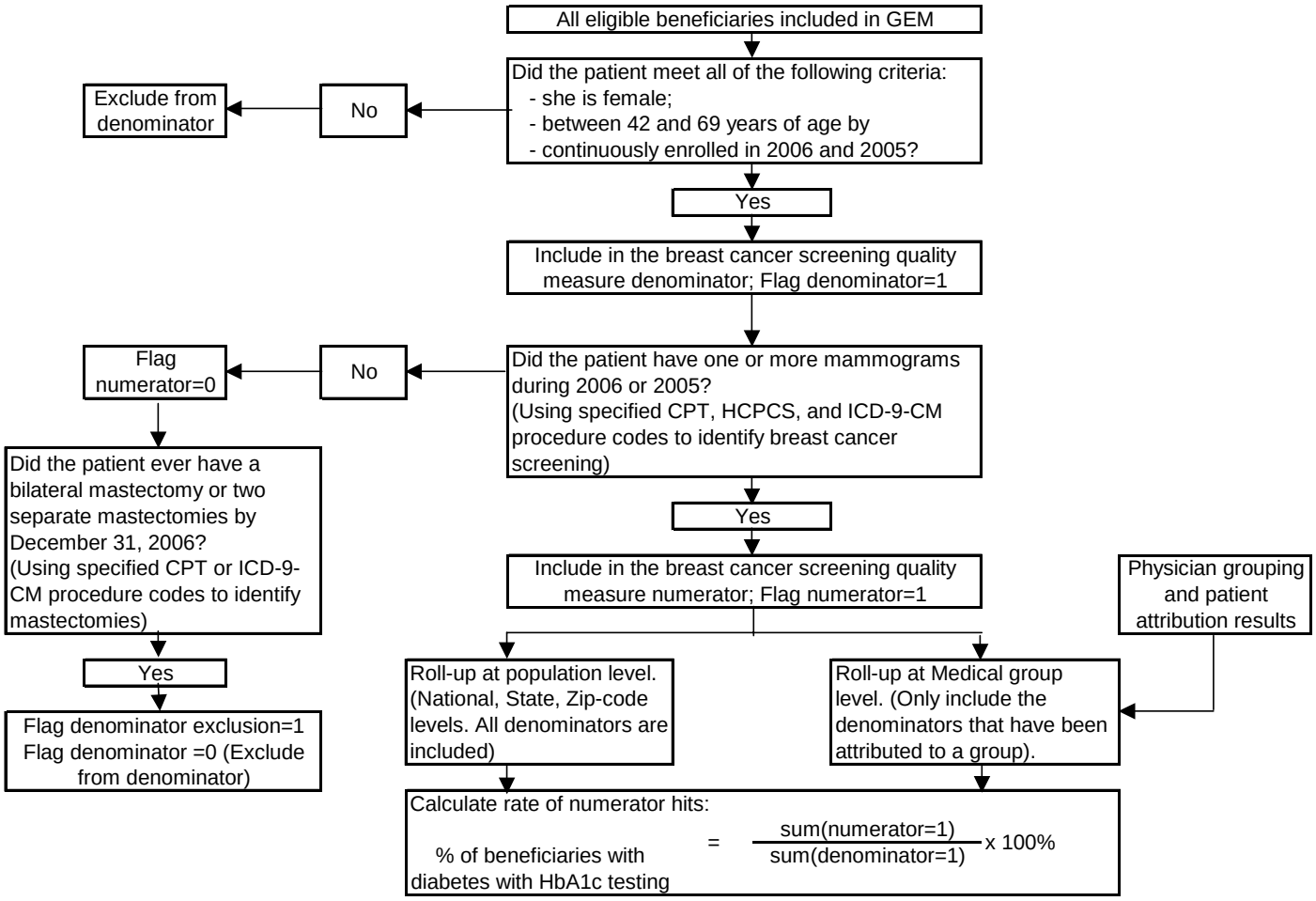
Algorithm Flowchart: See Flowchart 1.

Denominator and Numerator Codes

Measure Category	Description	Coding Scheme	Codes
Denominator Exclusion	Bilateral mastectomy	ICD-9-CM Procedure	85.42, 85.44, 85.46, 85.48
		CPT	19180.50 ***or*** (19180 with modifier code 09950[1]) 19200.50 ***or*** (19200 with modifier code 09950[1]) 19220.50 ***or*** (19220 with modifier code 09950[1]) 19240.50 ***or*** (19240 with modifier code 09950[1])
	Unilateral mastectomy (beneficiaries must have 2 separate occurrences on 2 different dates of service)	ICD-9-CM Procedures	85.41, 85.43, 85.45, 85.47
		CPT	19180, 19200, 19220, 19240
Numerator Inclusion	Mammogram	CPT	76083, 76090-76092
		HCPCS	G0202
		ICD-9 CM Procedure	87.36, 87.37
		ICD-9 CM Diagnosis	V76.11, V76.12
		UB-92 Revenue codes	0403

[1].50 and 09950 modifier codes indicate the procedure was bilateral and performed during the same operative session.

Flowchart 1: Breast Cancer Screening



GEM Measure Functional Specification Document

Performance Measure Name: LDL-C Screening Performed for Beneficiaries with Diabetes

Description: The percentage of beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who had LDL-C screening performed.

Source of Measure: Health Plan HEDIS® 2007[1]

Denominator Statement:

Beneficiaries 18–75 years as of December 31, 2006 who had continuous enrollment during 2006.

There are two methods for identifying diabetic beneficiaries:

- Pharmacy data
- Claim/encounter data

The organization must use *both* methods to identify the eligible population; however, to be included in the measure, a beneficiary needs to be identified in only one method. Beneficiaries may be identified as having diabetes during 2006 or 2005.

(1) Pharmacy data. Beneficiaries who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during 2006 or 2005 on an ambulatory basis.

(2) Claim/encounter data. Beneficiaries who had *two* face-to-face encounters with different dates of service in an outpatient setting or nonacute inpatient setting or *one* face-to-face encounter in an acute inpatient or emergency department (ED) setting during 2006 or 2005 with a diagnosis of diabetes. The organization may count services that occur over both years.

Denominator Exclusion Statement:

(1) Exclude beneficiaries with a diagnosis of polycystic ovaries who did not have any face-to-face encounters with the diagnosis of diabetes, in any setting, during 2006 or 2005. Diagnosis of polycystic ovaries can occur at any time in the beneficiary's history, but must have occurred by December 31, 2006.

(2) Exclude beneficiaries with gestational diabetes or steroid-induced diabetes, who did not have any face-to-face encounters with the diagnosis of diabetes (in any setting), during 2006

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[1] Referred to as "HEDIS" in this document. The sources include both the original technical specifications and the subsequent technical update:

(1) National Committee for Quality Assurance (2006). *HEDIS 2007, Volume 2: Technical Specifications. Washington, DC.*

(2) National Committee for Quality Assurnace (2006). *HEDIS 2007, Volume 2: Technical Update. September 29, 2006. Retrieved February 22, 2008, from* http://www.ncqa.org/Portals/0/PolicyUpdates/HEDIS_Technical Updates/2007_Vol2_Technical_Update.pdf

or 2005. Diagnosis of gestational diabetes or steroid-induced diabetes can occur during 2006 or 2005, but must have occurred by December 31, 2006.

Numerator Statement:

An LDL-C test performed during 2006, as identified by claim/ encounter or automated laboratory data.

Deviation(s) from HEDIS:

1. Unlike the 45-day allowable gap in enrollment in the HEDIS specifications, all beneficiaries in the GEM project must be both Part A and Part B enrolled for the full 12 months of 2006.

2. The following addition criteria are also used to exclude beneficiaries:
   1) Beneficiaries cannot have any months of Medicare Advantage enrollment.
   2) Beneficiaries cannot have any months of Medicare Part A only or Part B only enrollment (must have 12 months of both Medicare Part A and Part B enrollment).
   3) Beneficiaries cannot have any periods of Medicare secondary payer status.
   4) Beneficiaries cannot reside outside of the United States.
   5) Beneficiaries must have a record in the Medicare enrollment files.
   6) Beneficiaries cannot have any months of Hospice coverage.

3. HEDIS allows the denominator exclusions to be optional. However, for the GEM project, all optional denominator exclusion criteria specified in HEDIS were made mandatory. For the exclusion based on a diagnosis of polycystic ovaries, HEDIS specifies that the diagnosis can occur at any time in the beneficiary's history, as long as it occurred by December 31, 2006. GEM can exclude patients from the denominator if we can find a diagnosis of polycystic ovaries in 2005 or 2006.

4. Part D (pharmacy) coverage began only in 2006 and was not universal and equal for all Medicare beneficiaries in this project. Therefore, identification of patients in the denominator for the GEM project through Part D data alone will cover only a portion of patients who may otherwise have been dispensed oral hypoglycemics/antihyperglycemics.

5. Identifying numerator compliance through the use of LOINC codes is not expected in Medicare claims data.

Algorithm Flowchart: See Flowchart 2.

Denominator and Numerator Codes

Measure Category	Description	SubCategory	Coding Scheme	Codes
Denominator Inclusion	Diagnosis for diabetes		ICD-9-CM Diagnosis	250, 357.2, 362.0, 366.41, 648.0
			DRG	294, 295
	Procedure (Two face-to-face encounters with different dates of service)	Outpatient	CPT	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
			UB-92 Revenue	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
		Nonacute inpatient	CPT	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337
			UB-92 Revenue	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x, 0524, 0525.
	Procedure (One face-to-face encounter)	Acute inpatient	CPT	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291
			UB-92 Revenue	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
		Emergency department	CPT	99281-99285
			UB-92 Revenue	045x, 0981
	Drug class for diabetes (Insulin; Oral hypoglycemic/antihyperglycemic)		NDC	Any NDC in "CDC_A_Denominator_07.xls"[1]
Denominator Exclusion	Diagnosis of polycystic ovaries		ICD-9-CM Diagnosis	256.4
	Diagnosis of steroid-induced diabetes		ICD-9-CM Diagnosis	251.8, 962.0
	Diagnosis of gestational diabetes		ICD-9-CM Diagnosis	648.8
Numerator Inclusion	LDL-C test		CPT	80061, 83700, 83701, 83704, 83715, 83716, 83721
			CPT II	3048F, 3049F, 3050F
			LOINC[2]	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 24331-1, 39469-2

[1] The source of this table can be found in the "Comprehensive Diabetes Care (CDC) Denominator" link of the following NCQA website: www.ncqa.org/tabid/210/Default.aspx

[2] LOINC codes are not available in the Medicare claims data.

Flowchart 2: LDL-C Screening Performed for Beneficiaries with Diabetes