CHIPRA Initial Core Set Technical Specifications Manual 2011

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Centers for Medicare & Medicaid Services

Center for Medicaid, CHIP and Survey & Certification

Children and Adults Health Programs Group

For NCQA measures in the CHIPRA Initial Core Set:

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CHIPRA Technical Specifications Manual

The CHIPRA Technical Specifications Manual is a resource for States that seek to voluntarily report the initial core set of quality measures for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Although the CHIPRA core measures are voluntary, the Centers for Medicare and Medicaid (CMS) encourages States to report on as many of the CHIPRA core set measures as feasible. The more States that collect and report the initial core set of measures, the greater the potential for States and others to benefit from this information. CMS is developing data information systems to standardize reporting and make access to quality data more available to States for comparison purposes. By having access to these data, States will have the opportunity to integrate quality data in designing and implementing their quality improvement initiatives.

This manual contains technical instructions for collecting and calculating the initial core set measures for Medicaid and CHIP programs. To get a full sense of what is needed to report the CHIPRA core measures to CMS, States should familiarize themselves with this technical specifications manual as well as with the process for submitting data to CMS via the CHIP Annual Reporting Template System (CARTS). If you would like information about using CARTS contact: Jeffrey Silverman (Jeffrey.Silverman@cms.hhs.gov) or Amy Lutzky (Amy.Lutzky@cms.hhs.gov).

I. Background

A study published in the New England Journal of Medicine indicated that children receive recommended care about half of the time.[1] Quality measures today are largely based on processes of care, and attempt to measure the degree to which evidence-based treatment guidelines are followed, where indicated, or outcomes measures which provide an assessment of results of care. The use of quality measurement helps strengthen accountability and support performance improvement initiatives at numerous levels (i.e., Federal, State, health plan, provider). State Medicaid and CHIP programs have been engaged in measuring and improving the quality of care for children in their programs for years. Many of those measures are submitted to CMS via various mechanisms, whether to demonstrate waiver outcomes, measurement for particular populations (i.e. CHIP beneficiaries) or through external quality review (EQR) reporting for managed care. However, the types of and methods for calculating the measures vary greatly across States.

CHIPRA Legislation

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Pub.L. 111-3) included broad mandates to strengthen the quality of care and health outcomes of children in Medicaid and CHIP. Section 401 of CHIPRA called for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish an initial core measure set of children's health care quality measures for voluntary use by State programs administered under titles XIX and XXI, health insurance

[1] Mangione-Smith R, DeCristofaro A, Setodji C, Keesey, J., Adams, J., Schuster, M.A., McGlynn, E.A. (2007). The Quality of Care Received by Children and Adolescents in the United States. *New England Journal of Medicine*, 357(15), 1515-1523.

issuers, managed care entities, and providers of items and services under Medicaid and CHIP. The legislation required the HHS Secretary to identify measures applicable to the duration of enrollment and health care coverage, preventive and health promotion services, as well as the treatment and management of acute and chronic conditions in children. The legislation also called for measures that could be used to assess families' experiences with health care, the availability of services, and care in the most integrated health settings. Ultimately, the core measure set will provide an estimate of the overall national quality of health care for children, facilitate comparative analyses across various dimensions of pediatric health care quality, and help identify racial, ethnic, and socioeconomic disparities.

Identifying the Initial Core Set

In 2009, under delegated authority of the Secretary of HHS, CMS began collaborating with the Agency for Healthcare Research and Quality (AHRQ) to identify a set of child-focused health care quality measures. In order to include a wide range of national expertise in identifying the initial core set of measures, AHRQ's National Advisory Council established a national Subcommittee (the SNAC) on Quality Measures for Children's Health care in Medicaid and CHIP Programs. The Subcommittee consisted of State Medicaid representatives, child health care quality experts, and family advocates. The Subcommittee evaluated which measures were best suited for the core set based on their validity, feasibility of use by Medicaid and CHIP, and importance to improving health outcomes for children.

The SNAC reviewed over 100 measures of children's health care quality, considering relevance to the legislative requirements, as well as meeting the goal of assessing the overall national quality of health care for children. In total, the SNAC recommended 25 measures for the initial core set of health care quality measures for children. CMS and AHRQ made additional refinements based on legislative intent and removed one of the SNAC-recommended measures. The initial core set includes measures of prevention and health promotion services, management of acute conditions, management of chronic conditions, oral health, and family experiences of care.

On December 29, 2009, the Secretary posted, for public comment in the Federal Register, an initial core set of children's health care quality measures for voluntary use by Medicaid and CHIP programs. AHRQ and CMS used feedback from the public comments to enhance the initial core measures and to target technical assistance accordingly. To ensure the availability of complete, tested and validated specifications for the measures and domains identified by the SNAC, AHRQ and CMS made technical clarifications and substitutions to a few of the measures.

Additional information about identification of the CHIPRA core set and other CHIPRA-related quality measurement activities can be found at the AHRQ website: www.ahrq.gov/chipra/

II. Reporting Measures to CMS

CMS has designated the CHIP Annual Reporting Template System (CARTS), a web-based data submission tool currently used by CHIP Programs, as the vehicle which all States choosing to report the initial core measures should use. States report the numerators, denominators, and rates for each measure in CARTS. CARTS also provides the option for States to describe quality improvement activities related to the measure as well as future quality improvement plans. CMS provided States with instructions for annual reporting in late fall of 2010 and held a webinar in December 2010 to demonstrate how to use CARTS. If you would like information on using CARTS contact: Jeffrey Silverman (Jeffrey.Silverman@cms.hhs.gov) or Amy Lutzky (Amy.Lutzky@cms.hhs.gov).

The reporting unit for each measure is the State as a whole. This means that States reporting any of the core measures should collect data across all of the health delivery systems used in their State Medicaid and/or CHIP program [e.g. Fee-For-Service (FFS), managed care organizations (MCOs), and primary care case management (PCCMs), insurers and institutions]. States must aggregate data from all these sources into one State rate prior to reporting the measurement data to CMS.

- **Options for Reporting by Medicaid and CHIP Programs:** States may use and report the core set measures data for their: Medicaid program only; CHIP program only; or combined Medicaid and CHIP programs. If a State has a separate Medicaid and CHIP program, it has the option of submitting measurement data into CARTS separately or combined.

- **Aggregating Information for State Level Reporting:** States should ensure that the rates reported are representative of the entire population enrolled in the Medicaid and CHIP programs. For a measure based on administrative data, all beneficiaries that meet the eligible population requirements for the measure should be included. For a measure based on a sampling methodology, States should ensure that the sample used to calculate the measures is representative of the entire eligible population requirements for the measure. If a State is developing a State or program-level rate based on rates reported by individual MCOs and other units of measurement, then the State will need to use statistical techniques to properly weight and adjust these rates by eligible population so that a State/program-wide performance rate can be developed.

- **Technical Assistance:** To help States understand how to collect, report, and use the core measures to drive quality improvement at the State level, CMS will provide technical assistance and analytic support. The overarching goals for providing technical assistance and analytic support are to increase the number of States consistently collecting and uniformly reporting the voluntary initial core measures set, and to help States understand how to use these data to improve the quality of care for children. As part of the technical assistance effort, CMS will share promising practices for collecting the core measures with States. The national technical assistance program will begin in 2011.

III. How the Initial Core Set will be Used

Implementation of a standardized set of health care quality measures will help CMS and States move towards a national system for measurement, reporting, and quality improvement. Part of building a national system for measuring health care quality across States may include benchmarking State performance against national averages to facilitate the identification of best practices and cross-state learning. The data collected from these measures will help CMS to better understand the quality of health care children receive through Medicaid and CHIP programs. As per the CHIPRA legislation, State data derived from the core measures will become part of the Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP. The Secretary's Annual Report, released every September, summarizes State-specific and national measurement information on the quality of health care furnished to children enrolled in Medicaid and CHIP programs. The first annual report is available at: http://www.cms.gov/MedicaidCHIPQualPrac/Downloads/secrep.pdf .

Aligning with the Electronic Health Record Incentive Program

Providers who participate in the Medicare & Medicaid Electronic Health record (EHR) Incentive Program may be eligible for incentive payments for "meaningful use" of measures and health information technology. The following four initial core measures are also part of the EHR incentive program:

- Childhood immunization status
- BMI Assessment for Children/Adolescents
- Chlamydia screening
- Appropriate testing for children with pharyngitis

For the first year of reporting, States collecting these overlapping measures may notice slight variations with the respective measure specifications. These variations can be largely attributed to the fact that the EHR Incentive Program and the CHIPRA initial core measures set may use a different version of the same measure (e.g., measure x for the EHR program is based on 2009 HEDIS specifications while the same CHIPRA core measure is based on 2010 HEDIS specifications). The CHIPRA initial core measures set will use the most recent available version of measure specifications (i.e., if HEDIS 2011 is available than that will be the version CMS will use). In rare instances, the methodology for calculating the measure may also differ slightly between the EHR Incentive Program and the CHIPRA core set measure, but it will not impact the data result.

For States reporting to CMS through CARTS on a CHIPRA core measure/EHR incentive measure, we ask that you indicate whether any information was extracted from electronic health records.

The technical specifications for measures in the Medicare and Medicaid Electronic Health Record Incentive Payment Program can be accessed at: http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.

IV. On the Horizon: The Pediatric Quality Measures Program

The initial core set of pediatric quality measures is the first step towards a national approach for measuring and improving the quality of care for children covered by Medicaid and CHIP. Over the next several years, the initial core set will be modified to better reflect children's health care quality across all Medicaid and CHIP programs, providers, consumers, and health plans. AHRQ, in collaboration with CMS, will launch a Pediatric Quality Measures Program (PQMP) consisting of seven Pediatric Centers of Excellence in Quality Measurement. The Centers will focus, in part, on methodological improvements to the initial core set of measures to make them more easily collected across State Medicaid and CHIP programs and delivery models (e.g., managed care, primary care case management, fee-for-service, etc.). Additionally, the PQMP will consider methods to increase States' and CMS' ability to rely on non-Medicaid and CHIP data sources through improvement in public health sector measurement (e.g., birth certificate data, immunization, surveys). Currently, few measures in the initial core set can be used to identify disparities by race, ethnicity, socioeconomic status and special health care needs. The PQMP will work to refine the core measures so that they can be used to identify a variety of disparities. As part of the modification process, the Centers will use incorporate feedback provided by States implementing of the initial core set.

While the initial core set covers a range of measures, gaps persist in several dimensions of pediatric quality measurement. As the Pediatric Quality Measures Program refines the initial core measures to make them more feasible for State collection and reporting, it will also develop new quality measures that will increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers. CMS will publish annual revisions to the CHIPRA Technical Specifications Manual to address updates to measure specifications and newly available CHIPRA core measures.

V. CHIPRA Initial Core Set Measures

Below are the measure stewards and general description of each CHIPRA core set measure for collection using Federal Fiscal Year 2010 data. The data sources for the measures are administrative, hybrid methodologies, medical record and survey as noted in the chart. Additional information may be found on the website of each measure steward.

Measure		Measure Steward[2]	Description	Data Source	Website
Prevention and Health Promotion					
1	Frequency of Ongoing Prenatal Care	NCQA/HEDIS	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of visits: < 21 percent of expected visits 21 percent – 40 percent of expected visits 41 percent – 60 percent of expected visits 61 percent – 80 percent of expected visits ≥ 81 percent of expected visits	Hybrid	www.ncqa.org
2	Prenatal and Postpartum Care:	NCQA/HEDIS	The percentage of deliveries of live	Hybrid	www.ncqa.org

[2] A measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

Measure		Measure Steward[2]	Description	Data Source	Website
	Timeliness of Prenatal Care		births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.		
3	Percent of live births weighing less than 2,500 grams	Centers for Disease Control and Prevention	The measure assesses the number of resident live births less than 2,500 grams as a percent of the number of resident live births in the State reporting period.	Medical Record Birth Certificate Data	www.cdc.gov/nchs
4	Cesarean rate for nulliparous singleton vertex	California Maternal Quality Care Collaborative	Percentage of women who had a cesarean section among women with first live singleton births [also known as nulliparous term singleton vertex (NTSV) births] at 37 weeks of gestation or later.	Birth Certificate Data Medical Record	www.cmqcc.org
5	Childhood Immunization Status	NCQA/HEDIS	Percentage of patients who turned 2 years old during the measurement year who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B,	Hybrid	www.ncqa.org

Measure		Measure Steward[2]	Description	Data Source	Website
			one chicken pox vaccine (VZV), four pneumococcal conjugate (PCV), two hepatitis (HepA), two or three rotavirus (RV);and two influenza vaccines by the child's second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.		
6	Immunizations for Adolescents	NCQA/HEDIS	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.	Hybrid	www.ncqa.org
7	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA/HEDIS	Percentage of children, 3 through 17 years of age, whose weight is classified based on body mass index percentile for age and gender.	Hybrid	www.ncqa.org

Measure		Measure Steward[2]	Description	Data Source	Website
8	Developmental Screening In the First Three Years of Life	Child and Adolescent Health Measurement Initiative (CAHMI) and NCQA	Assesses the extent to which children at various ages from 0-36 months were screened for social and emotional development with a standardized, documented tool or set of tools.	Hybrid	www.cahmi.org
9	Chlamydia Screening	NCQA/HEDIS	Percentage of women 16 through 20 who were identified as sexually active who had at least one test for Chlamydia during the measurement year.	Administrative	www.ncqa.org
10	Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS	Percentage of members who received zero, one, two, three, four, five, and six or more well child visits with a primary care practitioner during their first 15 months of life.	Hybrid	www.ncqa.org
11	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA/HEDIS	Percentage of members age 3 through 6 years old who received one or more well-child visits with a primary care practitioner during the measurement year.	Hybrid	www.ncqa.org
12	Adolescent Well-Care Visit	NCQA/HEDIS	Percentage of members age 12 through 21 years	Hybrid	www.ncqa.org

Measure		Measure Steward[2]	Description	Data Source	Website
			who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.		
13	Total Eligibles Who Received Preventive Dental Services	CMS	Total eligible children age 1 to 20 years who received preventive dental services.	Administrative	http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp
Availability					
14	Child and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS	Percentage of enrollees who are 12 months through 19 years of age who had a visit with a primary care practitioner (PCP). Four separate percentages are reported: • Children 12 through 24 months and 25 months through 6 years who had a visit with a PCP during the measurement year. • Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a PCP during the measurement year or the year	Administrative	www.ncqa.org

Measure		Measure Steward[2]	Description	Data Source	Website
			prior to the measurement year.		
Management of Acute Conditions					
15	Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	Percentage of patients who were diagnosed with pharyngitis, dispensed an antibiotic, and who received a group A streptococcus test for the episode.	Administrative	www.ncqa.org
16	Otitis media with effusion (OME) – avoidance of inappropriate use of systemic antimicrobials in children – ages 2 through 12	American Medical Association /PCPI[3]	Percentage of patients age 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	Administrative EHR	www.ama-assn.org
17	Total Eligibles who Received Dental Treatment Services	CMS	Total eligible children age 1 to 20 years who received dental treatment services.	Administrative	http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp
18	Ambulatory Care: Emergency Department Visits	NCQA/HEDIS	The number of visits per member per year as a function of all child and adolescent members enrolled and eligible during the measurement year.	Administrative	www.ncqa.org
19	Pediatric central-line associated blood stream infections – Neonatal Intensive	Centers for Disease Control and Prevention	Central line-associated blood stream infections (CLABSI) identified	Medical Record	

[3] Physician Consortium for Performance Improvement

Measure		Measure Steward[2]	Description	Data Source	Website
	Care Unit and Pediatric Intensive Care Unit		during periods selected for surveillance as a function of the number of central line catheter days selected for surveillance in pediatric and neonatal intensive care units.		
Management of Chronic Conditions					
20	Annual number of asthma patients 2 through 20 years old) with one or more asthma-related emergency room visits	Alabama Medicaid	Asthma emergency department utilization for all children 2 through 20 years of age diagnosed with asthma or treatment with at least 2 short-acting beta adrenergic agents during the measurement year with one or more asthma-related ED visit.	Administrative	
21	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS	Percentage of children newly prescribed ADHD medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed.	Administrative	www.ncqa.org
22	Annual Pediatric hemoglobin A1C	NCQA	Percentage of pediatric patients	Hybrid, EHR	www.ncqa.org

Measure		Measure Steward[2]	Description	Data Source	Website
	testing		with diabetes with a hemoglobin A1c test in a 12-month measurement period.		
23	Follow-up after hospitalization for mental illness	NCQA/HEDIS	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.	Administrative	www.ncqa.org
Family Experiences of Care					
24	CAHPS® 4.0 (child version including Medicaid and Children with chronic conditions supplemental items)	NCQA/HEDIS	Survey on an individual's experiences of care.	Survey	www.ncqa.org

VI. Data Collection and Reporting

The Technical Specifications listed on pages 22 -121 provide States detailed information on which data to collect for each measure. We also ask that you consider the following:

- **Deadline for Submission to CARTS:** With CARTS as the reporting vehicle, States are asked to report data on the CHIPRA core measures by December 31st of each year.

- **Data Collection Time Frames For Measures:** States should adhere to the measurement periods as identified in the technical specifications for each measure. Some measures are collected on a calendar year, while others are indexed to a specific date. When the option is not specified, data collection timeframes should align with the federal fiscal year (e.g., for 2009: 10/1/09 through 9/30/10).

- **Data Auditing:** In the first year of measure reporting, CMS will not expect certification or auditing of HEDIS or other measures. However, if there are current State mechanisms for accreditation, certification, and managed care external quality review reporting, we ask that you note these processes.

- **Small Numbers:** If a State is using a denominator that is smaller than 30 to calculate a measure (administrative or hybrid method), we ask that you note this in the CARTS template field entitled "*Other Comments About This Measure.*" Keep in mind that aggregating data to the State-level minimizes the chances for small numbers in the denominator. Always use the eligible population for the denominator. However, the numerator will be calculated differently depending on collection method. For administrative rates, use the administrative numerator. For hybrid rates, multiply the eligible population by the hybrid rate to get a suitable numerator.

- **Continuous Enrollment:** For HEDIS measures, an organization that applies a full month of eligibility criterion to Medicaid or CHIP beneficiaries and verifies enrollment prospectively in monthly intervals, the one gap in enrollment during the continuous enrollment period may not exceed 45 days. If the retroactive eligibility period exceeds the allowable gap requirement, the individual may be excluded from the measure.

- **Measures with Multiple Rates:** CARTS provides States only with the space needed to enter data for the component of the measure that is a part of the CHIPRA core set. For example, the HEDIS Prenatal and Postpartum Care measure (CHIPRA core measure #1) is comprised of one rate for *timeliness of prenatal care* and another rate for *postpartum care*. Since the CHIPRA core set only includes the *timeliness of prenatal care*, CARTS will only ask you to report data on this particular rate.

- **Weighted Average:** If States are developing State level rates based on rates reported by individual MCOs and other units of measurement (such as PCCM and FFS), statistical techniques

to appropriately weight these rates by eligible population should be taken so that a State level performance rates can be developed. For example, if a State level rate for a measure is to be developed from the rates of multiple MCOs, how much any one individual MCO will contribute to the weighted average is based on the size of its eligible population for the measure. This means that MCOs with larger eligible populations for the measure will contribute more towards the rate than MCOs with smaller eligible populations.

VII. Glossary/Definitions

Administrative data collection	Data that is collected for the eligible population using administrative data sources such as registries or transactional databases such as claims and encounters.
Continuous enrollment	The timeframe an enrollee must be eligible for benefits to be included in the measure denominator.
Eligible Population	Individuals that satisfy specified criteria.
Hybrid data collection	Data is collected from both administrative sources and the medical record in order to identify the eligible population. This method is based on sampling methodologies.
Measure steward	An organization responsible for maintaining a particular measure or measure set. Responsibilities include updating the codes that are tied to the technical specifications and adjusting measures as the clinical evidence changes.
Mental Health practitioner	A practitioner who provides mental health service and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry or if not certified who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the State of practice. • An individual who is licensed as a psychologist in his/her State of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of

Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the State of practice.

- A registered nurse who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist or who has a master's degree in nursing with a specialization in psychiatric/mental; health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the State of practice.

- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the State of practice or if licensure or certification is not required by the State of practice, who is eligible for clinical membership in the American Association of Marriage and Family Therapy.

- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the State of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors.

OB/GYN and other prenatal care practitioners

- Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology.
- Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).

Primary Care Physician	A physician or non-physician (e.g., physician assistant, nurse practitioner) who offers primary care medical services. Includes: • General of family practice physicians • Geriatricians • General internal medicine physicians • General pediatricians • Obstetricians/gynecologists (OB/GYN)

VIII. Technical Specifications

CHIPRA Measure 1: Prenatal and Postpartum Care: Timeliness of Prenatal Care

National Committee for Quality Assurance

Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.

Eligible Population

Age	None specified
Continuous Enrollment	43 days prior to delivery through 56 days after delivery
Allowable Gap	No allowable gap during the continuous enrollment period
Anchor Date	Date of delivery
Benefit	Medical
Event/Diagnosis	*Delivered a* live *birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Women who delivered in a birthing center should be included in this measure. Refer to Tables PPC-A and PPC-B for codes to identify live births. *Multiple births.* Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure

Definitions

Preterm*	A neonate whose birth occurs through the end of the last day of the 37th week (259th day) following the onset of the last menstrual period.
Post-term*	A neonate whose birth occurs from the beginning of the first day (295th day) of the 43rd week following the onset of the last menstrual period.
Start date of the last enrollment segment	For women with a gap in enrollment during pregnancy, the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date.

* These definitions are from the Guidelines for Perinatal Care, Fifth Edition. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Administrative Specification

Denominator

Follow the first two steps below to identify the eligible population.

Step 1

Identify live births. Use Method A and Method B below to identify all women with a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one to be included in the measure

Method A

Codes listed identify a delivery *and* indicate the outcome of the delivery was a live birth. Women who are identified through the codes listed in Method A are automatically included in the eligible population and require no further verification of the outcome.

Denominator Criteria

Codes to Identify Live Births

ICD-9-CM Diagnosis: 650, V27.0, V27.2, V27.3, V27.5, V27.6, V30-V37*, V39*

Method B

Identify deliveries and verify live births. Codes in Table PPC-B, step A, identify deliveries but do not indicate the outcome. The organization must use step B to eliminate deliveries that did not result in a live birth.

Denominator Criteria

Codes to Identify Deliveries and Verify Live Births

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure

* These definitions are from the Guidelines for Perinatal Care, Fifth Edition. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

* These codes are assigned to the infant and should only be used if the organization can link infant and mother records.

Step A: Identify deliveries	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.x1, 646.x1, 646.x2, 647.x1, 647.x2, 648.x1, 648.x2, 649.x1, 649.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.x2, 655.x1, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.x1, 665.x2, 666.x2, 667.x2, 668.x1, 668.x2, 669.x1, 669.x2, 670.02, 671.x1, 671.x2, 672.02, 673.x1, 673.x2, 674.x1, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2, 678.x1, 679.x1, 679.x2	72.0-73.99, 74.0-74.2, 74.4, 74.99
Step B: Exclude deliveries not resulting in a live birth		630-637, 639, 656.4, 768.0, 768.1, V27.1, V27.4, V27.7	

Step 2

Identify continuous enrollment. For women identified in step 1, determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

Numerator

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy. *Include only visits that occur while the member was enrolled.*

Step 3

Determine enrollment status during the first trimester. Determine if women identified in step 2 were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, go to step 4. For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 6.

Step 4

Determine continuous enrollment for the first trimester. Determine if women identified in step 3 were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]) with no gaps in enrollment. For these women, use one of the four decision rules in Table PPC-C to determine if there was a prenatal visit during the first trimester.[4] For women who were not continuously enrolled during the first trimester, proceed to step 5

Step 5

For women who had a gap between 176 and 280 days before delivery, proceed to step 6.

Step 6

For women identified in step 3 and step 5, determine the start date of the last enrollment segment.[5] For women not enrolled in the organization on or before 280 days before delivery (or EDD) and for women who had a gap between 176 and 280 days before delivery (step 5), determine the start date of the last enrollment segment.

For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 7. For women whose last enrollment started less than 219 days before delivery proceed to step 8.

Step 7

Determine numerator compliance if enrollment started on or between 219 and 279 days before delivery. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the numerator criteria in Table PPC-D and find a visit between the last enrollment start date and 176 days before delivery.[6]

Step 8

Determine numerator compliance if enrollment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery). If the last enrollment segment started less than 219 days before delivery, determine numerator compliance using Table PPC-D numerator criteria for a visit within 42 days after enrollment.

[4] If the member identified in step 3 was continuously enrolled for the first trimester (176–280 days before delivery with no gaps during this period), the organization has sufficient opportunity to provide prenatal care in the first trimester. The organization must use the Table PPC-C. Any enrollment gaps in the second and third trimesters are incidental. The organization must use the Table PPC-C.

[5] For women with a gap in enrollment during pregnancy, the last enrollment segment is the enrollment date during the pregnancy that is closest to the delivery date

[6] The 176 days before delivery includes the 42-day period after enrollment. For example, a member who had a last enrollment segment 225 days before delivery would have until the end of the first trimester (176 days before delivery) instead of the 183 days before delivery under the 42-day criteria. Table PPC-D allows more flexibility for identifying prenatal care visits occurring later in the pregnancy.

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Table PPC-C: Markers for Early Prenatal Care Obtainable From Administrative Data

Decision Rule 1
Marker Event
Any prenatal care visit to an OB practitioner, a midwife or family practitioner or other PCP with documentation of when prenatal care was initiated.
Administrative
Any one code: **CPT:** 59400*, 59425*, 59426*, 59510*, 59610*, 59618*[*] **CPT Category II:** 0500F, 0501F, 0502F

*****Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

Decision Rule 2		
Marker Event		
Any visit to an OB practitioner or midwife with one of the following: Obstetric panel TORCH antibody panel Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing) Ultrasound (echocardiography) of pregnant uterus Pregnancy-related diagnosis code		
Administrative		
The member must meet criteria in [Part A ***and*** (Part B ***or*** Part C)] ***or*** Part D. ***Part A:*** *Any one code.* **CPT:** 99201-99205, 99211-99215, 99241-99245, 99500 **UB Revenue:** 0514 ***Part B:*** *Any one code.* **CPT:** 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 80055 **ICD-9-CM Diagnosis:** 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28 **ICD-9-CM Procedure:** 88.78		
Part C: *One of the following.* **TORCH:** A code for each of the four infections must be present for this component	Cytomegalovirus	**CPT:** 86644 **LOINC:** 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6, 47307-4, 45326-6, 47363-7, 47430-4, 49539-0, 52976-8, 52984-2

[*] Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

	Herpes simplex	**CPT:** 86694, 86695, 86696 **LOINC:** 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6, 25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4, 43180-9, 44008-1, 44480-2, 44494-3, 44507-2, 45210-2, 47230-8, 48784-3, 49848-5, 50758-2, 51915-7, 51916-5, 52977-6, 52981-8, 53377-8, 53560-9, 57321-2

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Decision Rule 2 *continued*		
Administrative		
Part C: *One of the following.* **TORCH:** A code for each of the four infections must be present for this component ***continued***	Rubella	**CPT:** 86762 **LOINC:** 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7
	Toxoplasma	**CPT:** 86777 **LOINC:** 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23485-6, 23486-4, 23784-2, 24242-0, 25300-5, 25542-2, 33336-9, 34422-6, 35281-5, 35282-3, 40677-7, 40678-5, 40697-5, 40785-8, 40786-6, 41123-1, 41124-9, 42949-8, 47389-2, 47390-0, 56990-5, 56991-3
Marker Event		
Rubella/ABO/Rh: A code for Rubella ***and*** (ABO ***or*** Rh) must be present for this component	Rubella	CPT: 86762 LOINC: 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7
	ABO	CPT: 86900 LOINC: 883-9, 57743-7
	Rh	CPT: 86901 LOINC: 10331-7, 34961-3
	ABO and Rh	LOINC: 882-1, 884-7
Part D: *Any one code.* **HCPCS:** H1000-H1004, H1005*		

Decision Rule 3
Marker Event
Any visit to a family practitioner or other PCP with a pregnancy related ICD-9-CM Diagnosis code AND one of the following: *Obstetric panel* *TORCH antibody panel* *Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing)* *Ultrasound of the pregnant uterus*
*When using a visit to a family practitioner or other PCP, it is necessary to determine that prenatal care was rendered and that the member was not merely diagnosed as pregnant and referred to another practitioner for prenatal care.
Administrative
The member must meet criteria in Part A ***and*** (Part B ***or*** Part C). ***Part A:*** *Any CPT or UB revenue code* ***with*** *a ICD-9-CM Diagnosis code: (CPT with ICD-9-CM) or (UB with ICD-9-CM). The ICD-9-CM Diagnosis code must be on the same claim as the CPT or UB revenue code. Alternatively, an HCPCS code does not require a diagnosis code.* **CPT:** 99201-99205, 99211-99215, 99241-99245, 99500 **HCPCS:** H1000-H1004, H1005* **UB Revenue:** 0514 **ICD-9-CM Diagnosis:** 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28 ***Part B:*** *Any one code.* **CPT:** 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 80055 **ICD-9-CM Procedure:** 88.78

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Decision Rule 3 *continued*		
Administrative		
Part C: *One of the following.* **TORCH:** A code for each of the four infections must be present for this component	Cytomegalovirus	**CPT:** 86644 **LOINC:** 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6, 47307-4, 45326-6, 47363-7, 47430-4, 49539-0, 52976-8, 52984-2
	Herpes simplex	**CPT:** 86694, 86695, 86696 **LOINC:** 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6, 25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4, 43180-9, 44008-1, 44480-2, 44494-3, 44507-2, 45210-2, 47230-8, 48784-3, 49848-5, 50758-2, 51915-7, 51916-5, 52977-6, 52981-8, 53377-8, 53560-9, 57321-2
	Rubella	**CPT:** 86762 **LOINC:** 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7
	Toxoplasma	**CPT:** 86777 **LOINC:** 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23485-6, 23486-4, 23784-2, 24242-0, 25300-5, 25542-2, 33336-9, 34422-6, 35281-5, 35282-3, 40677-7, 40678-5, 40697-5, 40785-8, 40786-6, 41123-1, 41124-9, 42949-8, 47389-2, 47390-0, 56990-5, 56991-3
Rubella/ABO/Rh: A code for Rubella ***and*** (ABO ***or*** Rh) must be present for this component	Rubella	**CPT:** 86762 **LOINC:** 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7
	ABO	**CPT:** 86900 **LOINC:** 883-9, 57743-7
	Rh	**CPT:** 86901 **LOINC:** 10331-7, 34961-3
	ABO and Rh	**LOINC:** 882-1, 884-7

***H1005** is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

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Decision Rule 4
Marker Event
Any visit to a family practitioner or other PCP with diagnosis-based evidence of prenatal care in the form of a documented LMP or EDD with either a completed obstetric history or risk assessment and counseling/education.
Administrative
The member must meet criteria in (Part A ***and*** Part B) ***or*** Part C. ***Part A:*** *Any one code.* **CPT:** 99201-99205, 99211-99215, 99241-99245, 99500 **UB Revenue:** 0514 ***Part B:*** Any internal organization code for LMP or EDD with an obstetrical history Any internal organization code for LMP or EDD with risk assessment and counseling/education ***Part C:*** *Any one code.* **HCPCS:** H1000-H1004, H1005*

***H1005** is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

Table PPC- D: Markers for Prenatal Care Obtainable From Administrative Data

Marker Event
Any visit to an OB/GYN, family practitioner or other PCP with either an ultrasound or a principal diagnosis of pregnancy.
Administrative
The member must meet criteria in Part A ***or*** (Part B ***and*** Part C). ***Part A:*** *Any one code.* **CPT:** 59400*, 59425*, 59426*, 59510*, 59610*, 59618* **HCPCS:** H1000-H1004, H1005** **CPT Category II:** 0500F, 0501F, 0502F ***Part B:*** *Any one code.* **CPT:** 76801, 76805, 76811, 76813, 76815-76821, 76825-76828 **ICD-9-CM Diagnosis**: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28 **ICD-9-CM Procedure:** 88.78 ***Part C:*** *Any one code.* **CPT:** 99201-99205, 99211-99215, 99241-99245, 99500 **UB Revenue:** 0514 ***Note:*** *If using an ICD-9-CM Diagnosis code from Part B with a CPT or UB revenue code from Part C, the ICD-9-CM Diagnosis code must be on the same claim as the CPT or UB revenue code.*

***** Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

**** H1005** is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

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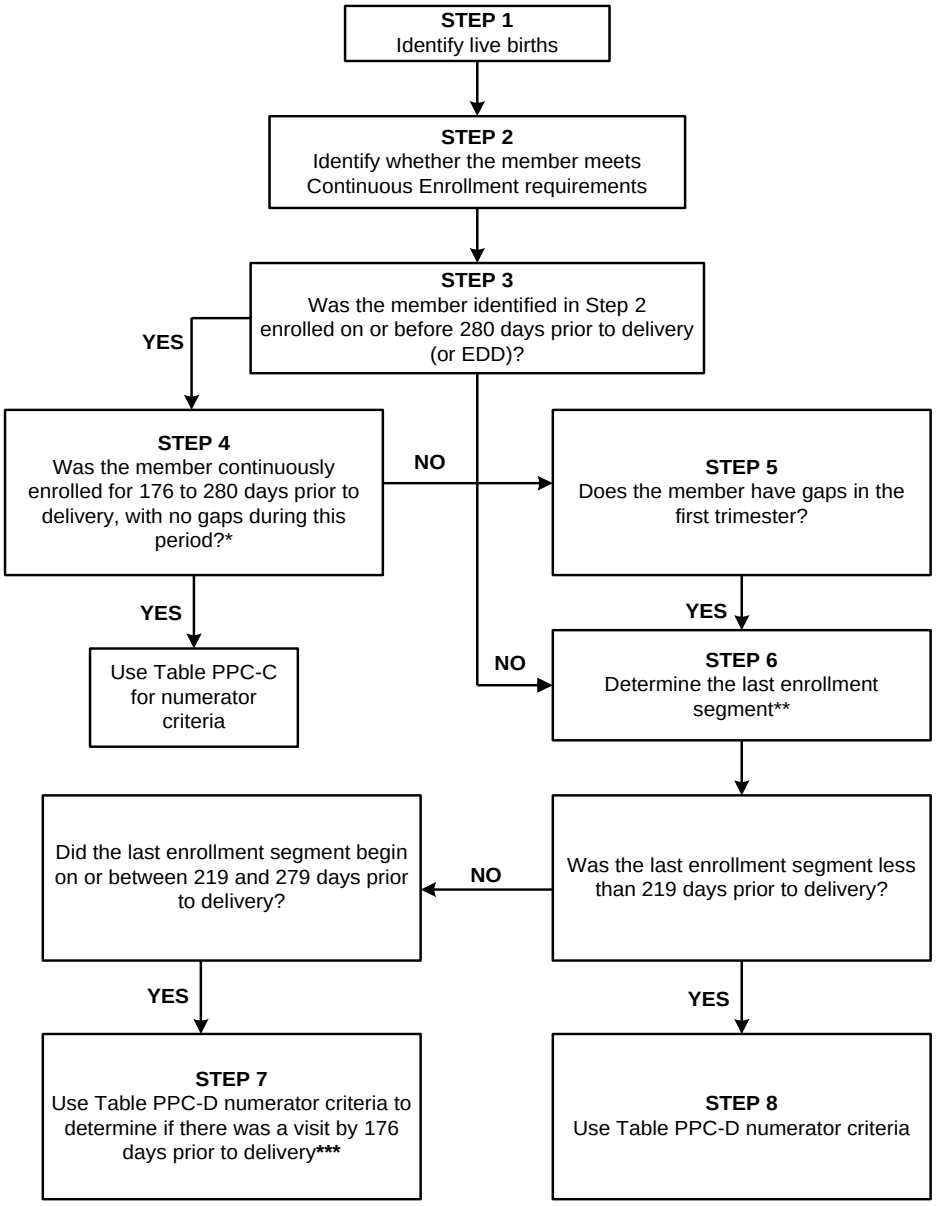
Prenatal and Postpartum Care
Timeliness of Prenatal Care Numerator



* If the member identified in step 3 was continuously enrolled for the first trimester (176–280 days before delivery), there is no need to look for gaps occurring during other times in the pregnancy. Use the criteria in Table PPC-C to determine numerator compliance. For example, if a member was enrolled during the first trimester, 176–280 days before delivery with a gap between the 125–150 days before delivery, the organization must still meet the PPC-C first trimester criteria for numerator compliance. The gap and last enrollment segment are incidental because the member meets the first trimester enrollment test.

** See the definition of **last enrollment segment.**

*** The 176 days before delivery includes the 42-day period following enrollment. For example, a member who had a last enrollment segment 225 days before delivery has until the end of the first trimester (176 days before delivery), instead of the 183 days before delivery under the 42-day criteria. Table PPC-D also has greater flexibility to identify a prenatal care visit.

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Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line. The organization may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81% indicator from Frequency of Ongoing Prenatal Care or the prior year's lowest audited product line-specific rate for these two indicators and the >81% indicator from Frequency of Ongoing Prenatal Care.

Numerator

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Include only visits that occurred while the member was enrolled.

Administrative

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

Medical Record

Prenatal care visit to an OB/GYN practitioner or midwife, family practitioner or other PCP. For visits to a family practitioner or PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:

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

Note: For members whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery), count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principal diagnosis of pregnancy.

Note

When counting prenatal visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses if a physician co signature is present, if required by State law.

Services that occur over multiple visits count toward this measure as long as all services are within the time frame established in the measure. Ultrasound and lab results alone should not be

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considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.

A pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant.

The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.

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CHIPRA Measure 2: Frequency of Ongoing Prenatal Care

National Committee for Quality Assurance

Description

The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits.

- <21 percent of expected visits
- 21 percent–40 percent of expected visits
- 41 percent–60 percent of expected visits
- 61 percent–80 percent of expected visits
- ≥81 percent of expected visits

This measure uses the same denominator as the *Prenatal and Postpartum Care* measure.

Eligible Population

Age	None specified
Continuous Enrollment	43 days prior to delivery through 56 days after delivery
Allowable Gap	No allowable gap during the continuous enrollment period
Anchor Date	Date of delivery
Benefit	Medical
Event/Diagnosis	*Delivered a* live *birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Women who delivered in a birthing center should be included in this measure. Refer to Tables PPC-A and PPC-B for codes to identify live births. *Multiple births.* Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure The organization must exclude members for whom a prenatal visit is not indicated. These exclusions are indicated by a dash (–) in Table FPC-A.

Administrative Specification

Denominator

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The Eligible Population

Numerator

Step 1

Identify the delivery date using hospital discharge data.

Step 2

Identify the date when the member enrolled in the organization and determine the stage of pregnancy at time of enrollment. If the member has gaps in enrollment during pregnancy, use the last enrollment segment to determine continuous enrollment in the organization. For members with a gap in enrollment any time during pregnancy (including a gap in the first trimester), the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date.

Use the following approach (or an equivalent method) to calculate the stage of pregnancy at time of enrollment. If gestational age is not available, assume a gestational age of 280 days (40 weeks).

Convert gestational age into days.

Subtract gestational age (in days) from the date of delivery (step 1).

Subtract the date obtained above from the date when the member enrolled in the organization to determine the stage of pregnancy at time of enrollment.

Divide the numbers of days the member was pregnant at enrollment (step 3) by 30. Round the resulting number according to the .5 rule to a whole number.

For example, delivery date is August 8, 2010; gestational age is 33 weeks; date of enrollment is May 6, 2010. Given these variables, the process is:

Gestational age in days is 231 days (33 weeks x 7 days/week).

Date of delivery – gestational age (in days) is December 22, 2009 (August 8, 2009 – 231 days).

Date when the member enrolled in the organization – date obtained in

Step 2 is 135 days (May 6, 2010 – December 22, 2009).

Month in which prenatal care began is 4.5 months (135 days/30 days) and then round up to 5 months using the 0.5 rule.

This member's stage of pregnancy at time of enrollment is 5 months.

Step 3

Use Table FPC-A to find the number of recommended prenatal visits by gestational age and stage of pregnancy at time of enrollment per the American College of Obstetricians and Gynecologists (ACOG). The chart subtracts the number of missed visits prior to the date the member enrolled from the number of recommended visits for a given gestational age.

ACOG recommends that women with an uncomplicated pregnancy receive visits every

4 weeks for the first 28 weeks of pregnancy, every 2–3 weeks until 36 weeks of pregnancy, and weekly thereafter. For example, ACOG recommends 14 visits for a 40-week pregnancy. If the

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member enrolled during her fourth month (3 missed visits prior to enrollment in the organization), the expected number of visits is 14 – 3 = 11.

For deliveries with a gestational age <28 weeks or >42 weeks, calculate the expected number of prenatal care visits using the date when the member enrolled and ACOG's recommended schedule of visits. For example, if gestational age is 26 weeks and the member enrolled during her second month of pregnancy, the expected number of prenatal care visits is 5 (6 expected visits [1 visit every 4 weeks or 6 visits in 24 weeks], less 1 visit missed in the first month).

If gestational age is 43 weeks and the member enrolled during her third month of pregnancy, the expected number of prenatal care visits is 15 (14 expected visits for a 40-week gestation plus 1 visit each additional week [17 total expected prenatal care visits], less 2 visits missed in the first and second months).

Step 4

Identify the number of prenatal care visits the member received during the course of her pregnancy and while enrolled in the organization using claims and encounter data. Use Table PPC-C to identify prenatal visits that occurred during the first trimester. The organization may use any of the four rules presented in the table to search for evidence of prenatal care; a woman's record only needs to satisfy one rule.

Use Table PPC-D to identify prenatal visits that occurred during the second and third trimester. Visits that occur on the date of delivery and meet the prenatal visit criteria count toward the measure.

Count as a single visit, a HCPCS code that falls on the same date of service as a CPT or UB Revenue code. Using Table PPC-C, Decision Rule 2 as an example, count as a single visit, HCPCS H1004, CPT 99201 and ICD-9-CM Diagnosis code 651.03 that fall on the same date of service.

If the member had a gap in enrollment, count only the visits received during the last enrollment segment.

Step 5

Calculate the ratio of observed visits (step 4) over expected visits (step 3).

Step 6

Report each woman in the appropriate category.

<21 percent

21 percent–40 percent

41 percent–60 percent

61 percent–80 percent

≥81 percent of expected visits

Note

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Ultrasound and lab results alone should not be considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.

Hybrid Specification

Denominator

A systematic sample of members drawn from the eligible population. If the organization collects this measure and the Prenatal and Postpartum Care measure, it must use the same systematic sample for both. The organization may reduce the sample size using the current year's lowest product-line-specific administrative rate for the rate of women who received ≥ 81 percent of expected prenatal care visits and the two rates from Prenatal and Postpartum Care. It may also use the prior year's lowest audited product-line-specific rates for the rate of women who received ≥ 81 percent of expected prenatal care visits and the two rates from Prenatal and Postpartum Care.

Numerator

Women who had an unduplicated count of the number of expected visits that was <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. The visits may be identified through either administrative data or medical record review.

The numerator is calculated retroactively from date of delivery or EDD.

Administrative

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

Medical Record

Use the medical record documentation requirements in the Prenatal and Postpartum Care measure to identify prenatal visits that occur during the first, second and third trimesters.

Identify gestational age at birth from the hospital record (e.g., admission write-ups, histories and physicals, discharge summaries or labor and delivery records) or birth certificate. Gestational age is the number of completed weeks that elapsed between the first day of the last normal menstrual period and the date of delivery. If gestational age is not available, assume a gestational age of 280 days (40 weeks).

Methods recommended to determine gestational age are as follows.

Physician ascertainment using ultrasound or Dubowitz assessment.

Last menstrual period (LMP) calculation (date of LMP – date of delivery) ÷ 7.

If gestational age is recorded or calculated in fractions of a week, round down to the lower whole number.

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For visits after 219 days prior to delivery, count any documentation of a visit to an OB/GYN practitioner or midwife, family practitioner or other PCP with a principal diagnosis of pregnancy.

Note

This measure is based on deliveries. Members who have multiple deliveries from a single pregnancy should be counted once. Include each pregnancy for members who have multiple deliveries from different pregnancies.

When counting prenatal visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses if a physician co signature is present, if required by State law.

If the organization collects both Prenatal and Postpartum Care and Frequency of Ongoing Prenatal Care for reporting using the Hybrid Method, it must use the same sample for collection. If the organization uses the Hybrid Method, it may not use a combination of administrative data and medical record review to identify prenatal care visits for an individual in the denominator. For example, for one member, the organization may not count two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) for one member, even if each visit shows a different date of service.

Month of Pregnancy Member Enrolled in the Organization*

Gestational Age in Weeks	0-1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month
28	6	5	4	3	1	1	-	-
29	6	5	4	3	1	1	-	-
30	7	6	5	4	2	1	1	-
31	7	6	5	4	2	1	1	-
32	8	7	6	5	3	2	1	-
33	8	7	6	5	3	2	1	-
34	9	8	7	6	4	3	2	1
35	9	8	7	6	4	3	2	1

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36	10	9	8	7	5	4	3	1
37	11	10	9	8	6	5	4	2
38	12	11	10	9	7	6	5	3
39	13	12	11	10	8	7	6	4
40	14	13	12	11	9	8	7	5
41	15	14	13	12	10	9	8	6
42	16	15	14	13	11	10	9	7

* Members who enroll during their 9th month of pregnancy would not be eligible for this measure, given the continuous enrollment criterion of 43 days prior to delivery through 56 days after delivery.

Source: Guidelines for Perinatal Care, Fifth Edition. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

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CHIPRA Measure 3: Percentage of Live Births Weighing Less Than 2,500 grams

Centers for Disease Control and Prevention (National Center for Health Statistics)

Description

The measure assesses the number of resident live births less than 2,500 grams as a percent of the number of resident live births in the State reporting period.

Eligible Population

Deliveries where principal source of payment for delivery is Medicaid and CHIP

Numerator

Number of resident live births less than 2,500 grams with Medicaid and/or CHIP payer source

Denominator

Number resident live births in the State in the reporting period with Medicaid and/or CHIP payer source

Units: Report as a Percentage

Data Source

State vital records and census data

CHIPRA Measure 4: Cesarean rate for Nulliparous Singleton Vertex

(Also known as Cesarean rate for low-risk first birth women)

California Maternal Quality Care Collaborative

Description

Cesarean Rate for low-risk first birth women (aka NTSV CS rate: nulliparous, term, singleton, vertex) identifies the portion of cesarean births that has the most variation among practitioners, hospitals, regions and States. This measure focuses attention on the proportion of cesarean births that is affected by elective medical practices such as induction and early labor admission. Furthermore, the success (or lack thereof) of management of the first labor directly impacts the remainder of the woman's reproductive life especially given the current high rate of repeat cesarean births. This is also the measure used in Healthy Person 2010 (Objective 16.9a, US DHS, 2000) and previously received endorsement from the American College of Obstetricians and Gynecologists (American College of Obstetricians and Gynecologists: Task Force on Cesarean Delivery, 2000).

Eligible Population

Medicaid and CHIP Births

Numerator

The proportion of the denominator that had a cesarean birth

Denominator

Live births at or beyond 37 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions). Parameters are available in administrative data sets

Data Source and Data Collection Methods:

Vital Records (Birth Certificate) either alone or merged with discharge diagnosis data set (see below)

Discharge Data Set Specification:

NUMERATOR: Those in the denominator with a Cesarean Delivery

DENOMINATOR:

Parity=0
Fetal Presentation= Vertex or cephalic
Gestational age at delivery =/> 37.0

Plurality (number of fetuses) =1 (i.e. a singleton)

Patient Discharge Data Set (ICD9)
Primary Cesarean Delivery Rate (IQI 33) methodology below uses patient discharge data (ICD9), and can be used as a start but lacks the ability to identify parity=0 (i.e. first pregnancy). This is the most important risk factor for initial cesarean birth. This data is found in the birth certificate (vital stats) data and may be linked to the discharge data files. It is easier to use vital records (see above) as is done in many States and by NCHS.

NUMERATOR

Number of Cesarean deliveries, identified by DRG, or by ICD-9-CM procedure codes if they are reported without a 7491 hysterectomy procedure.

Cesarean delivery DRGs:

370	CESAREAN SECTION W CC
371	CESAREAN SECTION W/O CC

ICD-9-CM Cesarean delivery procedure codes:

740	CLASSICAL C-SECTION
741	LOW CERVICAL C-SECTION
742	EXTRAPERITONEAL C-SECT
744	CESAREAN SECTION NEC
7499	CESAREAN SECTION NOS

Exclusions
ICD-9-CM procedure codes:

7491	HYSTEROTOMY TO TERMIN PG

DENOMINATOR:

All deliveries.
All delivery DRGs:

370	CESAREAN SECTION W CC
371	CESAREAN SECTION W/O CC
372	VAGINAL DELIVERY W COMPL
373	VAG DELIVERY W/O COMPL
374	VAG DELIV W STERIL OR DC
375	VAG DELIV W OTH OR PROC

Exclusions:

Patients with abnormal presentation, preterm delivery, fetal death, multiple gestation diagnosis codes, breech procedure codes, or a previous Cesarean delivery diagnosis in any diagnosis field.

ICD-9-CM abnormal presentation, preterm, fetal death and multiple gestation diagnosis codes:

65130	TWINS W FETAL LOSS-UNSP
65131	TWINS W FETAL LOSS-DEL

65133	TWINS W FETAL LOSS-ANTE
65140	TRIPLETS W FET LOSS-UNSP
65141	TRIPLETS W FET LOSS-DEL
65143	TRIPLETS W FET LOSS-ANTE
65150	QUADS W FETAL LOSS-UNSP
65151	QUADS W FETAL LOSS-DEL
65153	QUADS W FETAL LOSS-ANTE
65160	MULT GES W FET LOSS-UNSP
65161	MULT GES W FET LOSS-DEL
65163	MULT GES W FET LOSS-ANTE
65180	MULTI GESTAT NEC-UNSPEC
65181	MULTI GESTAT NEC-DELIVER
65183	MULTI GEST NEC-ANTEPART
65190	MULTI GESTAT NOS-UNSPEC
65191	MULT GESTATION NOS-DELIV
65193	MULTI GEST NOS-ANTEPART

65220	BREECH PRESENTAT-UNSPEC
65221	BREECH PRESENTAT-DELIVER
65223	BREECH PRESENT-ANTEPART
66960	BREECH EXTR NOS-UNSPEC
66961	BREECH EXTR NOS-DELIVER
65230	TRANSV/OBLIQ LIE-UNSPEC
65231	TRANSVER/OBLIQ LIE-DELIV
65233	TRANSV/OBLIQ LIE-ANTEPAR
65240	FACE/BROW PRESENT-UNSPEC
65241	FACE/BROW PRESENT-DELIV
65243	FACE/BROW PRES-ANTEPART
65260	MULT GEST MALPRESEN-UNSP
65261	MULT GEST MALPRES-DELIV
65263	MULT GES MALPRES-ANTEPAR
64420	EARLY ONSET DELIV-UNSPEC
64421	EARLY ONSET DELIVERY-DEL
65640	INTRAUTERINE DEATH-UNSP
65641	INTRAUTER DEATH-DELIVER
65643	INTRAUTER DEATH-ANTEPART
V271	DELIVER-SINGLE STILLBORN
V273	DEL-TWINS, 1 NB, 1 SB
V274	DELIVER-TWINS, BOTH SB
V276	DEL-MULT BRTH, SOME LIVE
V277	DEL-MULT BIRTH, ALL SB
65100	TWIN PREGNANCY-UNSPEC
65101	TWIN PREGNANCY-DELIVERED
65103	TWIN PREGNANCY-ANTEPART
65110	TRIPLET PREGNANCY-UNSPEC
65111	TRIPLET PREGNANCY-DELIV
65113	TRIPLET PREG-ANTEPARTUM
65120	QUADRUPLET PREG-UNSPEC
65121	QUADRUPLET PREG-DELIVER

65123	QUADRUPLET PREG-ANTEPART
66050	LOCKED TWINS-UNSPECIFIED
66051	LOCKED TWINS-DELIVERED
66053	LOCKED TWINS-ANTEPARTUM
66230	DELAY DEL 2ND TWIN-UNSP
66231	DELAY DEL 2ND TWIN-DELIV
66233	DELAY DEL 2 TWIN-ANTEPAR
7615	MULT PREGNANCY AFF NB
V272	DELIVER-TWINS, BOTH LIVE
V275	DEL-MULT BIRTH, ALL LIVE

ICD-9-CM breech procedure codes:

7251 PART BRCH EXTRAC W FORCP
7252 PART BREECH EXTRACT NEC
7253 TOT BRCH EXTRAC W FORCEP
7254 TOT BREECH EXTRAC NEC

ICD-9-CM previous cesarean delivery diagnosis codes:

65420	PREV C-SECT NOS-UNSPEC
65421	PREV C-SECT NOS-DELIVER
65423	PREV C-SECT NOS-ANTEPART

Risk Adjustment (Maternal Age)

Maternal age is a significant risk factor for primary cesarean rates with a continuous effect from age 19 through age 45 in both hospital level data and national data sets (Main, 2000; Menacker, 2005; Main, 2006).

Main DM, Main EK, Moore DH. The relationship between maternal age and uterine dysfunction: a continuous effect throughout reproductive life. Am J Obstet Gynecol. 2000 Jun;182(6):1312-20.

Main EK, Moore D, Farrell B, Schimmel LD, Altman RJ, Abrahams C, Bliss MC, Polivy L, Sterling J. Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. Am J Obstet Gynecol 2006; 194:1644-51.

Menacker F. Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990-2003. Nat Vital Stat Rep 2005; 54(4): 1-5.

CHIPRA Measure 5: Childhood Immunization Status

National Committee for Quality Assurance

Description

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

Eligible Population

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

Administrative Specification

Denominator

The eligible population

Numerators

For MMR, hepatitis B, VZV and hepatitis A, count any of the following:

Evidence of the antigen or combination vaccine, or

Documented history of the illness, or

A seropositive test result for each antigen

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For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count only:

Evidence of the antigen or combination vaccine.

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

DTaP

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

IPV

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

MMR

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

HiB

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

Hepatitis B

At least three hepatitis B vaccinations, with different dates of service on or before the child's second birthday.

VZV

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

Pneumococcal conjugate

At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis A

Two hepatitis A vaccinations, with different dates of service on or before the child's second birthday.

Rotavirus

The child must receive the required number of rotavirus vaccinations on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth. The following vaccine combinations are compliant:

Two doses of the two-dose vaccine, or

One dose of the two-dose vaccine and two doses of the three-dose vaccine, or

Three doses of the three-dose vaccine.

The vaccines are identified by different CPT codes (Table CIS-A).

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Influenza Two influenza vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.

Combination rates

Calculate the following rates for Combination 2–Combination 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 2	x	x	x	x	x	x				
Combination 3	x	x	x	x	x	x	x			
Combination 4	x	x	x	x	x	x	x	x		
Combination 5	x	x	x	x	x	x	x		x	
Combination 6	x	x	x	x	x	x	x			x
Combination 7	x	x	x	x	x	x	x	x	x	
Combination 8	x	x	x	x	x	x	x	x		x
Combination 9	x	x	x	x	x	x	x		x	x
Combination 10	x	x	x	x	x	x	x	x	x	x

Table CIS-A: Codes to Identify Childhood Immunizations

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
DTaP	90698, 90700, 90721, 90723			99.39
IPV	90698, 90713, 90723			99.41
MMR	90707, 90710			99.48
Measles and rubella	90708			
Measles	90705		055	99.45
Mumps	90704		072	99.46
Rubella	90706		056	99.47
HiB	90645-90648, 90698, 90721, 90748			
Hepatitis B**	90723, 90740, 90744, 90747, 90748	G0010	070.2, 070.3, V02.61	

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VZV	90710, 90716		052, 053	
Pneumococcal conjugate	90669, 90670	G0009		
Hepatitis A	90633		070.0, 070.1	
Rotavirus (two dose schedule)	90681			
Rotavirus (three dose schedule)	90680			
Influenza	90655, 90657, 90661, 90662	G0008		99.52

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

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

Exclusion (optional)

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

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Table CIS-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.4
DTaP	Encephalopathy	323.51 with (E948.4 or E948.5 or E948.6)
	Progressive neurologic disorder, including infantile spasm, uncontrolled epilepsy	
IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin	
MMR, VZV and influenza	Immunodeficiency, including genetic (congenital) immuno-deficiency syndromes	279
	HIV disease; asymptomatic HIV	042, V08
	Cancer of lymphoreticular or histiocytic tissue	200-202
	Multiple myeloma	203
	Leukemia	204-208
	Anaphylactic reaction to neomycin	
Hepatitis B	Anaphylactic reaction to common baker's yeast	

Hybrid Specification

Denominator

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

Numerators

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

Evidence of the antigen or combination vaccine, or

Documented history of the illness, or

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A seropositive test result

For DTaP, HiB, IPV, pneumococcal conjugate, rotavirus and influenza, count only:

Evidence of the antigen or combination vaccine.

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

Administrative

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

Medical Record

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

A note indicating the name of the specific antigen and the date of the immunization, or

A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

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

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

Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

Exclusion (Optional)

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

Note

This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.

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CHIPRA Measure 6: Immunizations for Adolescents

National Committee for Quality Assurance

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Eligible Population

Age	Adolescents who turn 13 years of age during the measurement year
Continuous enrollment	12 months prior to the member's 13th birthday
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months (60 days) is not continuously enrolled
Benefit	Medical
Event/Diagnosis	None

Administrative Specifications

Denominator

The eligible population.

Numerators

For meningococcal and Tdap or Td, count *only* evidence of the antigen or combination vaccine.

Meningococcal

One meningococcal conjugate or meningococcal polysaccharide vaccine on or between the member's 11th and 13th birthdays.

Tdap/Td

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One tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the member's 10th and 13th birthdays.

Combination 1 (Meningococcal, Tdap/Td)

Adolescents who received one meningococcal vaccine on or between the members 11th and 13th birthday and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the member's 10th and 13th birthdays.

Table IMA-A: Codes to Identify Adolescent Immunizations

Immunization	CPT	ICD-9-CM Procedure
Meningococcal	90733, 90734	
Tdap	90715	99.39
Td	90714, 90718	
Tetanus	90703	99.38
Diphtheria	90719	99.36

Exclusion (optional)

Adolescents who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. An organization that excludes contraindicated adolescents may do so only for adolescents where the administrative data do not indicate that the contraindicated immunization was rendered.

The exclusion must have occurred by the member's 13th birthday. The organization should look for exclusions as far back as possible in the member's history and use the codes in Table IMA-B to identify exclusions.

Table IMA-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.4

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative result or the prior year's audited, product line-specific rate.

Numerators

For meningococcal conjugate or polysaccharide and Tdap or Td, count *only* the evidence of the antigen or combination vaccine.

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Administrative

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

Medical Record

For immunization information obtained from the medical record, the organization may count members where there is evidence that the antigen was rendered from:

A note indicating the name of the specific antigen and the date of the immunization, or

A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

Exclusion (optional)

Refer to Administrative Specification for exclusion criteria. The exclusion must have occurred by the member's 13th birthday.

Note

NCQA follows the CDC and ACIP guidelines for immunizations. HEDIS implements the guidelines after three years to account for the measure's look-back period and to allow the industry time to adapt to the new guidelines

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CHIPRA Measure 7: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents

National Committee for Quality Assurance

Description

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Definitions

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI Percentile	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same sex and age.

Eligible Population

Age	3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators. 3–11 years 12–17 years Total The total is the sum of the two age stratifications.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year
Benefit	Medical
Event/Diagnosis	*An outpatient visit (Table WCC-A) with a PCP or an OB/GYN during*

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	the measurement year

Table WCC-A: Codes to Identify Outpatient Visits

CPT	ICD-9-CM Diagnosis	UB Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	051x, 0520-0523, 0526-0529, 0982, 0983

Administrative Specification

Denominator

The eligible population

Numerator

BMI percentile (Table WCC-B) during the measurement year.

Table WCC-B: Codes to Identify BMI Percentile

Description	CPT	ICD-9-CM Diagnosis	HCPCS
BMI Percentile		V85.5	

Exclusions (optional)

Members who have a diagnosis of pregnancy (Table WCC-C) during the measurement year.

ICD-9-CM Diagnosis: Pregnancy 630-679, V22, V23, V28

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for the Total age band (3–17 years). The Total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.

The organization may reduce the sample size using current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the Total age band. Refer to the NCQA Guidelines for Calculations and Sampling for information on reducing the sample size.

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Numerator

BMI percentile during the measurement year as identified by administrative data or medical record review.

Administrative

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

Medical Record

Documentation must include a note indicating the date on which the BMI percentile was documented and evidence of either of the following.

BMI percentile, or

BMI percentile plotted on age-growth chart

For members who are younger than 15 years of age on the date of service, only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. A BMI value is not acceptable for this age range.

For adolescents 16–17 years on the date of service, documentation of a BMI value expressed as kg/m2 is acceptable.

Exclusions (optional)

Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year.

Note

The following notations or examples of documentation do not count as numerator compliant:

- BMI or BMI percentile documented in medical record or plotted on age-growth chart
- Notation of height and weight only
- BMI or BMI percentile noted before or after the measurement year

A member-reported BMI may be used if it is part of a disease management system or obtained by a provider or clinician while taking the patient's history.

Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit.

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CHIPRA Measure 8: Developmental Screening in the First Three Years of Life

Child and Adolescent Health Measurement Initiative (CAHMI) and National Committee for Quality Assurance

Description

The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Eligible Population

Age	12 months through 36 months
Continuous Enrollment	Children who are enrolled continuously for 12 months
Benefit	Medical

Numerator

The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening over the first three years. The measure is based on three, age-specific indicators.

Indicator 1: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 12 months of age

Indicator 2: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 24 months of age

Indicator 3: Children who screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 36 months of age.

Data Source

Claims Data, Medical Record

Administrative Specifications

Claims data: CPT codes 96110 (Developmental testing, with interpretation and report)

Important Note About Appropriate Use of Claims Data: This measure is anchored to standardized tools that meet four criterion specified above. States who have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

Claims NOT Included in This Measure: It is important to note that modified 96110 claims [e.g. modifiers added to claim indicating standardized screening for a specific domain of development (e.g. social emotional screening via the ASQ-SE, autism screening] should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

Medical Record

Documentation in the medical record must include:
- A note indicating the date on which the test was performed, and
- The standardized tool used (see below), and
- Evidence of a screening result or screening score

Tools must meet the following criteria:

1) Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2) Established Reliability: Reliability scores of approximately 0.70 or above.
3) Established Findings Regarding the Validity:

   Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

4) Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Current recommended tools that meet these criteria:
Ages and Stages Questionnaire (ASQ) - 2 months – 5 years
Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth – 95 months
Bayley Infant Neuro-developmental Screen (BINS) - 3 months – 2 years
Brigance Screens-II – Birth – 90 months
Child Development Inventory (CDI) - 18 months–6 years
Child Development Review-Parent Questionnaire (CDR-PQ) - 18 months – 5 years
Infant Development Inventory – Birth – 18 months
Parents' Evaluation of Developmental Status (PEDS) – Birth – 8 years

Tools NOT Included in This Measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

Denominator

Indicator 1: Members who turn 12 months of age between January 1 of the measurement year and December 31 of the measurement year

Indicator 2: Members who turn 24 months of age between January 1 of the measurement year and December 31 of the measurement year

Indicator 3: Members who turn 36 months years of age between January 1 of the measurement year and December 31 of the measurement year

Exclusions

None

Calculation Algorithm

Step 1:

Determine the denominator
Identify the denominator for each age-specific indicator:

- Indicator 1: Members who turn 12 months of age between January 1 of the measurement year and December 31 of the measurement year
- Indicator 2: Members who turn 24 months of age between January 1 of the measurement year and December 31 of the measurement year
- Indicator 3: Members who turn 36 months of age between January 1 of the measurement year and December 31 of the measurement year

Step 2:

Determine the numerator

Claims Data:
Children for whom a claim of 96110 was submitted during the measurement year.

Medical Chart:
Children who had documentation in the medical record of developmental screening using a standardized validated tool during the measurement year.

Documentation must include a note indicating the standardized tool that was used, the date of screening and evidence that the tool was completed and scored.

Step 3:

Calculate the age-specific indicators (1-3) by dividing the numerator by the denominator and multiplying by 100 to get a percentage.

Step 4:

Create the measure of screening based on the age-specific measures.
Numerator: Numerator for Indicator 1 + Numerator for Indicator 2+ Numerator for Indicator3
Denominator: Denominator for Indicator 1 + Denominator for Indicator 2+ Denominator for Indicator 3

Step 5:

Multiply by 100 to get the percentage.

Comparison of proportions and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance.

Sampling Methodology

If administrative data are used, the entire population is used for the denominator. For hybrid measures (administrative plus chart review data sources), a random sample can be drawn. Preferred sample size would be 411.

CHIPRA Measure 9: Chlamydia Screening

National Committee for Quality Assurance

Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

Eligible Population

Age	Women 16–20 years as of December 31 of the measurement year.
Continuous Enrollment	The measurement year
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year
Benefit	Medical
Event/Diagnosis	Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure. Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (Table CHL-A).

Table CHL-A: Prescriptions to Identify Contraceptives

Description	Prescription	
Contraceptives	desogestrel-ethinyl estradiol drospirenone-ethinyl estradiol estradiol-medroxyprogesterone ethinyl estradiol-ethynodiol ethinyl estradiol-etonogestrel ethinyl estradiol-levonorgestrel ethinyl estradiol-norelgestromin ethinyl estradiol-norethindrone	ethinyl estradiol-norgestimate ethinyl estradiol-norgestrel etonogestrel levonorgestrel medroxyprogesterone mestranol-norethindrone norethindrone
iaphragm	diaphragm	
Spermicide	nonxynol 9	

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Note

NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November

Claim/encounter data. Members who had at least one encounter during the measurement year with any code in Table CHL-B. 15, 2010.
http://www.ncqa.org/

Table CHL-B: Codes to Identify Sexually Active Women

Description	Codes
CPT	11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84704, 86592, 86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87660, 87808, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269
HCPCS	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0199, S4981, S8055
ICD-9-CM Diagnosis	042, 054.10, 054.11, 054.12, 054.19, 078.11, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 339.82, 614, 615, 622.3, 623.4, 626.7, 628, 630-679, 795.0, 795.1, 796.7, 996.32, V01.6, V02.7, V02.8, V08, V15.7, V22-V28, V45.5, V61.5-V61.7, V69.2, V72.3, V72.4, V73.81, V73.88, V73.98, V74.5, V76.2
ICD-9-CM Procedure	69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 88.78, 97.24, 97.71, 97.73
UB Revenue	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925
LOINC	557-9, 560-3, 660-1, 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 1832-5, 1834-1, 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 4993-2, 5028-6, 5291-0, 5292-8, 5392-6, 5393-4, 5394-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 6487-3, 6488-1, 6489-9, 6510-2, 6511-0, 6514-4, 6516-9, 6561-5, 6562-3, 7975-6, 8041-6, 10524-7, 10705-2, 11083-3, 11084-1, 11481-9, 11597-2, 12222-6, 12223-4, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 14509-4, 14510-2, 14513-6, 15019-3, 16280-0, 16600-9, 16601-7, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 18500-9, 19080-1, 19171-8, 19176-7, 19177-5, 19180-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 20403-2, 20404-0, 20415-6, 20507-0, 20508-8, 20994-0, 21189-6, 21190-4, 21191-2, 21192-0, 21198-7, 21414-8, 21415-5, 21416-3, 21440-3, 21441-1, 21613-5, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 23838-6, 24110-9, 24111-7, 24312-1, 25372-4, 25373-2, 26009-1, 29311-8, 30167-1, 31147-2, 31771-9, 31772-7, 31775-0, 31777-6, 31905-3, 31906-1, 31993-9, 32198-4, 32199-2, 32705-6, 33717-0, 33773-3, 34147-9, 34382-2, 34493-7, 34656-9, 34670-0, 34718-7, 35457-1, 36902-5, 36903-3, 38372-9, 40679-3, 40680-1, 41273-4, 41274-2, 42316-0, 42481-2, 42931-6, 43304-5, 43305-2, 43403-5, 43404-3, 43406-8, 43798-8, 44543-7, 44544-5, 44546-0, 44547-8, 44549-4, 44550-2, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 45327-4, 45331-6, 45332-4, 46731-6, 46989-0, 47211-8, 47212-6, 47236-5, 47237-3, 47238-1, 47387-6, 47527-7, 47528-5, 48030-1, 48039-2, 48560-7, 48781-9, 49096-1, 49246-2, 49318-9, 49891-5, 49896-4, 50387-0, 50388-8, 50690-7, 51838-1, 51839-9, 53605-2, 53762-1, 53879-3, 53925-4, 53926-2, 53927-0, 55299-2, 55869-2, 55870-0, 56497-1, 57032-5

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Administrative Specification

Denominator

The eligible population

Numerator

At least one Chlamydia test during the measurement year as documented through administrative data. A woman is counted as having had a test if she had a claim/ encounter with a service date during the measurement year with one or more of the codes in Table CHL-C.

Table CHL-C: Codes to Identify Chlamydia Screening

CPT	LOINC
87110, 87270, 87320, 87490-87492 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2

Exclusion (optional)

Members who had a pregnancy test during the measurement year, followed within seven days (inclusive) by either a prescription for isotretinoin (Accutane) or an x-ray. This exclusion does not apply to members who qualify for the denominator based on services other than the pregnancy test alone. Refer to Table CHL-D and Table CHL-E to identify exclusions.

Table CHL-D: Codes to Identify Exclusions

Description	CPT	UB Revenue	LOINC
Pregnancy test	81025, 84702, 84703	0925	2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0, 55869-2, 55870-0, 56497-1
WITH			
Diagnostic radiology	70010-76499	032x	

Table CHL-E: Medications to Identify Exclusions

Description	Prescription
Retinoid	isotretinoin

Note: *An NDC list for isotretinoin will be available on [www.ncqa.orghttp://www.ncqa.org/](http://www.ncqa.org/) by November 15, 2010.*

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CHIPRA Measure 10: Well-Child Visits in the First 15 Months of Life

National Committee for Quality Assurance

Description

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life.

- No well-child visits
- One well-child visit
- Two well-child visits
- Three well-child visits
- Four well-child visits
- Five well-child visits

Eligible Population

Age	15 months old during the measurement year
Continuous Enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2009, and included in the rate of "six or more well-child visits" must have had six well-child visits by April 9, 2010
Allowable Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	Day the child turns 15 months old
Benefit	Medical
Event/Diagnosis	None

Administrative Specification

Denominator

The eligible population

Numerators

Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a PCP during their first 15 months of life.

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The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. A child who had a claim/encounter with a code listed in Table W15-A is considered to have received a well-child visit.

Table W15-A: Codes to Identify Well-Child Visits

CPT	ICD-9-CM Diagnosis
99381, 99382, 99391, 99392, 99432, 99461	V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70 .8, V70.9

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for the Medicaid product line. The organization may reduce its sample size using the current year's administrative rate for six or more visits, or the prior year's audited rate for six or more visits.

Numerator

Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a PCP during their first 15 months of life.
The well-child visit must occur with a PCP.

Administrative

Refer to Administrative Specification to identify positive numerator hits from administrative data

Medical Record

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following.

A health and developmental history (physical and mental)

A physical exam

Health education/anticipatory guidance

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure

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Note

This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more detailed information on what constitutes a well-child visit

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CHIPRA Measure 11: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

National Committee for Quality Assurance

Description

The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.

Eligible Population

Age	3–6 years as of December 31 of the measurement year
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	Date of delivery
Benefit	Medical
Event/Diagnosis	None

Administrative Specification

Denominator

The eligible population

Numerator

At least one well-child visit with a PCP during the measurement year.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. A child who had a claim/encounter with a code listed in Table W34-A is considered to have received a well-child visit.

Table W34-A: Codes to Identify Well-Child Visits

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

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Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for the Medicaid product line. The organization may reduce its sample size using the current year's administrative rate or the prior year's audited rate.

Numerator

At least one well-child visit with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

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

Medical Record

Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance
- Do not include services rendered during an inpatient or ED visit.
- Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.
- Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available. The PCP does not have to be assigned to the member.
- The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

Note

This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits.

Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more detailed information on what constitutes a well-child visit.

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CHIPRA Measure 12: Adolescent Well-Care Visits

National Committee for Quality Assurance

Description

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Eligible Population

Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator

The eligible population.

Numerator

At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

The PCP does not have to be assigned to the member. Adolescents who had a claim/encounter with a code listed in Table AWC-A are considered to have received a comprehensive well-care visit.

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

CPT	ICD-9-CM Diagnosis
99383-99385, 99393-99395	V20.2, V70.0, V7 0.3, V70.5, V70.6, V70.8, V70.9

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for the Medicaid product line. The organization may reduce its sample size using the current year's administrative rate or the prior year's audited rate.

Numerator

Administrative

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

Medical Record

- Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following.
- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance
- Do not include services rendered during an inpatient or ED visit.
- Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.
- Visits to school-based clinics with practitioner whom the organization would consider PCPs may be counted if documentation that a well-care exam occurred is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.
- The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

Note

This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at

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www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more detailed information on what constitutes a well-care visit.

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CHIPRA Measure 13: Total Eligibles Who Received Preventive Dental Services

Centers for Medicare & Medicaid Services

Description

The total number of children age one to twenty years who are eligible for Medicaid and/or CHIP and enrolled who received preventive dental services

Eligible Population

Age	Children age 1 through 20 years
Continuous Enrollment	Eligible for EPSDT for at least 90 Continuous Days

Definitions

Unduplicated	A child may only be counted once for each line of data.

Administrative Specifications

Numerator

The unduplicated number of children receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 - (CDT codes D1000 - D1999).

Denominator

The total unduplicated number of individuals age one through 20 who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 days and determined to be eligible for EPSDT services.

Services provided under both fee-for-service and managed care arrangements and through any other private health plans that contract with the State

Exclusions

Do not include in this count the following groups of individuals:

1) Medically needy individuals age 1 through 20 if you do not provide EPSDT services for the medically needy population;

2) Individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available;
3) Undocumented aliens who are eligible only for emergency Medicaid services;
4) Groups of individuals age 1 through 20 who are eligible only for limited services as part of their Medicaid eligibility (i.e., pregnancy-related services).

CHIPRA Measure 14: Children and Adolescents' Access to Primary Care Practitioners

National Committee for Quality Assurance

Description

The percentage of members 12 months –19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year

Eligible Population

Age	12 months–19 years as of December 31 of the measurement year. Report four age stratifications. 12–24 months as of December 31 of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 31, 2009, and December 1, 2008). 25 months–6 years as of December 31 of the measurement year. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between November 30, 2008, and January 1, 2004). 7–11 years as of December 31 of the measurement year. 12–19 years as of December 31 of the measurement year.
Continuous Enrollment	*For 12–24 months, 25 months–6 years:* The measurement year. *For 7–11 years, 12–19 years:* The measurement year and the year prior to the measurement year.

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Allowable gap	*For 12–24 months, 25 months–6 years:* No more than one gap in enrollment of up to 45 days during the measurement year. *For 7–11 years, 12–19 years:* No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical
Event/Diagnosis	None

Administrative Specification

Denominator

The eligible population.

Numerators

- For 12–24 months, 25 months–6 years: One or more visits with a PCP during the measurement year.

- For 7–11 years, 12–19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year.

- The organization should count all members who had an ambulatory or preventive care visit to any PCP, as defined by the organization, with a CPT or ICD-9-CM code listed in Table CAP-A. Exclude specialist visits.

Table CAP-A: Codes to Identify Ambulatory or Preventive Care Visits

Description	CPT	ICD-9-CM Diagnosis
Office or other outpatient services	99201-99205, 99211-99215, 992 41-99245	
Home services	99341-99345, 99347-99350	
Preventive medicine	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429	
General medical examination		V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

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CHIPRA Measure 15: Appropriate Testing for Children With Pharyngitis

National Committee for Quality Assurance

Description

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

Definitions

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 captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient or ED visit (Table CWP-B) during the Intake Period with only a diagnosis of pharyngitis (Table CWP-A). Exclude claims/encounters with more than one diagnosis.
IESD	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria. Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date A 30-day Negative Medication History prior to the Episode Date The member was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date
Negative Medication History	To qualify for Negative Medication History, the following criteria must be met. A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date A prescription is considered **active** if the "days supply" indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Eligible Population

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Ages	Children 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
Continuous enrollment	30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	Episode Date.
Benefits	Medical and pharmacy.
Event/ diagnosis	Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period. Follow the steps below to identify the eligible population.
Step 1	Identify all members who had an outpatient or ED visit (Table CWP-B) with only a diagnosis of pharyngitis (Table CWP-A) during the Intake Period. Exclude claims/ encounters with more than one diagnosis.

Step 1

Identify all members who had an outpatient or ED visit (Table CWP-B) with only a diagnosis of pharyngitis (Table CWP-A) during the Intake Period. Exclude claims/ encounters with more than one diagnosis.

Table CWP-A: Codes to Identify Pharyngitis

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

Table CWP-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 0982, 0983
ED*	99281-99285	045x, 0981

*Do not include ED visits that result in an inpatient admission.

Step 2

Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with only a diagnosis of pharyngitis.

Step 3

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

Table CWP-C: Antibiotic Medications

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

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 15, 2010.*

Step 4

Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date

Step 5

Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date

Step 6

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

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Administrative Specification

Denominator

The eligible population

Numerator

A group A streptococcus test (Table CWP-D) in the seven-day period from three days prior to the IESD through three days after the IESD

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

CPT	LOINC
87070, 87071, 87081, 87430, 87650-87652, 87880	626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 17656-0, 18481-2, 31971-5, 49610-9

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CHIPRA Measure 16: Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials

American Medical Association/Physician Consortium for Performance Improvement

Description

Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.

Numerator

Patients who were not prescribed systemic antimicrobials

Denominator

All patients aged 2 months through 12 years with a diagnosis of OME

Exclusions
Documentation of medical reason(s) for prescribing systemic antimicrobials

Administrative Specification

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rated based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

(Note: The specifications listed below are those needed for performance calculation.)

Denominator

(Eligible Population): All patients aged 2 months through 12 years with a diagnosis of OME

ICD-9 diagnosis codes: 381.10, 381.19, 381.20, 381.29, 381.3, 381.4

AND

CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244,
99245, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394

Denominator Exclusion:
Documentation of medical reason(s) for prescribing systemic antimicrobials

• **Append modifier to CPT Category II code: 4131F-1P**
Numerator Patients who were not prescribed systemic antimicrobials

Electronic Health Records Specifications
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Denominator

All patients aged 2 months through 12 years with a diagnosis of OME

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and ICD-9 (I9) codes for inclusion:

ENCOUNTER CODE
(C4)
99201-99205, 99212-99215,
99241-99245, 99381-99384,
99391-99394
AND

DX CODE
(I9)
381.10, 381.19, 381.20,
381.29, 381.3, 381.4

Numerator
Patients who were not prescribed systemic antimicrobials
Numerator Inclusion
Patients who were not prescribed systemic antimicrobials.
TOPIC_EVALUATION_CODES Table lists an applicable CPT Category II (C4) code for inclusion:
NO ANTIMICROB RX CODE
(C4)
4132F

OTITIS MEDIA WITH EFFUSION (OME)
Algorithm for Measures Calculation – EHRS
(Analytic Narrative and Data Elements)
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Denominator Exclusions
TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for a medical reason for exclusion:
Other medical reason(s) documented for prescribing systemic antimicrobials

MEDICAL REASON CODE
(C4)
4131F 1P

EHR DATA ELEMENTS

TOPIC TYPE Topic that is being reported on
TOPIC INDICATOR The specific indicator or measure
BIRTHDATE Birth date
MEASURE START DATE Date the measurement period begins
MEASURE END DATE Date the measurement period ends
ENCOUNTER CODING SYSTEM

Type of coding system applicable to face-to-face office visit (CPT4)
ENCOUNTER CODE Code used for encounter
ENCOUNTER DATE Date of encounter
DX CODING SYSTEM
Type of coding system applicable to the diagnosis code (ICD9)
DX CODE Diagnosis code
DX DATE Date of diagnosis

NO ANTIMICROB RX CODING SYSTEM - Type of coding system applicable for not prescribing a systemic antimicrobial drug code (CPT Category II)

NO ANTIMICROB RX CODE – Code used for not prescribing a systemic antimicrobial drug

NO ANTIMICROB RX DATE - Date of documentation that a systemic antimicrobial was not prescribed

MEDICAL REASON CODING SYSTEM - Type of coding system applicable for a medical reason code (CPT Category II)
MEDICAL REASON CODE Code used for medical reason
MEDICAL REASON DATE Date medical reason was documented

CHIPRA Measure 17: Total Eligibles Who Received Dental Treatment Services

Centers for Medicare & Medicaid Services

Description

The total number of children age one to twenty years who are eligible for Medicaid and/or CHIP who received dental treatment services

Eligible Population

Age	Children age 1 through 20 years
Continuous Enrollment	Eligible for EPSDT for at least 90 Continuous Days

Definitions

Unduplicated	A child may only be counted once for each line of data.

Administrative Specifications

Numerator

Enter the unduplicated number of children receiving at least one treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (CDT codes D2000 - 09999).

Denominator

The total unduplicated number of individuals age 1 through 20 who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 days and determined to be eligible for EPSDT services.

Services provided under both fee-for-service and managed care arrangements and through any other private health plans that contract with the State

Exclusions

Do not include in this count the following groups of individuals:

1) Medically needy individuals age 1 through 20 if you do not provide EPSDT services for the medically needy population;
2) Individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available;
3) Undocumented aliens who are eligible only for emergency Medicaid services;

4) Groups of individuals age 1 through 20 who are eligible only for limited services as part of their Medicaid eligibility (i.e., pregnancy-related services).

CHIPRA Measure 18: Ambulatory Care: Emergency Department Visits

National Committee for Quality Assurance

Description

This measure summarizes utilization of ambulatory care for ED Visits. The number of visits per member per year as a function of all child and adolescent members enrolled and eligible during the measurement year

Eligible Population

Age	Children under the age of 21 years

Administrative Specifications

Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

CPT : 99281-99285

UB Revenue: 045x, 0981

OR

CPT 10040-69979 AND POS 23

Exclusions (required)

The measure does not include mental health or chemical dependency services. Exclude (from all categories) claims and encounters that contain any code below

CPT: 90801-90899

Principal ICD-9-CM Diagnosis: 290-316

ICD-9-CM Procedure: 94.26, 94.27, 94.6

Principal ICD-9-CM Diagnosis: 960-979 with Secondary ICD-9-CM Diagnosis: 291-292, 303-305

Note

The measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.

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Age	Member Months
<1	_____
1-9	_____
10-20	_____
Total:	_____

Age	Visits	Visits/1,000 Member Years
<1	_____	_____
1-9	_____	_____
10-20	_____	_____
Total:	_____	_____

CHIPRA Measure 19: Pediatric Central-Line Associated Bloodstream Infections

Centers for Disease Control and Prevention

Description

The rate of central line-associated blood stream infections (CLABSI) identified during periods selected for surveillance as a function of the number of central line catheter days selected for surveillance in pediatric and neonatal intensive care units. The central line associated bloodstream infection is an infection in a patient that had a central line inserted within the 48-hour period before the onset of infection.

Definitions

Intensive Care Unit	A nursing care area in which at least 80% of the patients require intensive observation, diagnosis, and therapeutic procedures.
Central line	An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting central-line BSI and counting central-line days: Aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, common femoral veins, and in neonates, the umbilical artery/vein. NOTE: Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of these vessels or in or near the heart to qualify as a central line
Infusion	The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.
Umbilical catheter	A central vascular device inserted through the umbilical artery or vein in a neonate
Temporary central line	A non-tunneled catheter
Permanent central line	Includes tunneled catheters, including certain dialysis catheters and Implanted catheters (including ports)

Exclusions

Hospitals with fewer than 50 central line days a year

Specifications

Anchor Date

Cases of they are healthcare-associated and their infection dates are during the timeframe of selected surveillance

Numerator

Total number of observed healthcare-associated CLABSI among patients in ICUs and NICUs

CLABSI Criteria:

• Laboratory-confirmed bloodstream infection (LCBI):

Must meet one for the following criteria:

Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures and organism cultured from blood is not related to an infection at another site.

Criterion 2: Patient has at least one of the following signs or symptoms: fever (>38 degrees Celsius), chills, or
hypotension and signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B.anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.

Criterion 3: Patient < 1 year of age has at least one of the following signs or symptoms: fever (>38 degrees Celsius core) hypothermia (<36 degrees Celsius core), apnea, or bradycardia and signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.

Denominator

Total number of expected CLABSIs, calculated by multiplying the number of central line device days for

each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of

locations obtained from the standard population. Central line device- day denominator data that are

collected differ according to the location of the patients being monitored..

1. Number of appropriate device days for locations under CLABSI surveillance during the period

2. CLABSI rate per 1000 device days for the same location types from the identified population

3. Definition of device days: Device days are used for denominators. Device day denominator data

that are collected differ according to the location of the patients being monitored.

a. For ICUs, the number of patients with one or more central lines of any type is collected daily, at

the same time each day during the month. The totals for the month are entered.

b. In NICUs, because of differing infection risks, the number of patients with central lines and those

with umbilical catheters is collected daily, at the same time each day, during the month. If a patient had

both an umbilical catheter and a central line, count the day only as an umbilical catheter day. For the

NICU infants, patients are further stratified by birth weight in five categories since risk of BSI also varies by birthweight.

The ratio is calculated as follows:

1. Identify the number of CLABSI in each location type

2. Total these numbers for an observed number of CLABSIs

3. Obtain the number of expected number of CLABSIs in the same location types for a standard

population using the NHSN data report (http://www.cdc.gov/nhsn/PDFs/dataStat/2009NHSNReport.PDF)

4. Identify the number of expected CLABSIs for the facility based on its location types and numbers of central line device days:

a. For each location type, multiply the number of central line device days experienced, by the

expected CLABSI rate for that location

b. Sum the number of expected CLABSIs from all locations

5. Divide the total number of observed CLABSI events (“2” above) by the “expected” number of

CLABSI rates (“4.c.” above).

6. Result = rate

(The NHSN analysis tool will perform the calculations once the patient infection data and denominator

information are entered into the system.)

Tests of significance are needed to tell us whether the number of infections in a hospital is unusually high or low relative to the number of infections in a reference group (all NHSN hospitals reporting the same procedure). A p-value provides one method for significance testing. The p-value is a probability that weighs the evidence for determining whether an infection rate is unusually high or low in comparison to the reference group. If the p-value is small (less than .05), there is sufficient evidence to suggest that the infection rates are either higher or lower than the average for all NHSN hospitals. If the p-value is greater than .05, then there is not enough evidence to conclude the hospital's infection rate is different from the average for all NHSN hospitals.

CHIPRA Measure 20: Annual Number of Asthma Patients with > 1 asthma-related Emergency Room Visit

Alabama Medicaid

Description

Percentage of pediatric patients with an asthma diagnosis who have ≥1 ED visit during a calendar year

Eligible Population

Age	Children age two through twenty years old
Measurement Period	one year
Event/Diagnosis	diagnosis of with asthma or on at least two short acting beta adrenergic agents during the measurement period.

Administrative Specifications

Denominator will include recipients with any claims with ICD-9-CM codes :
493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92

Exclusions

493.20, 493.21 and 493.22

OR

A prescription for two or more short acting beta adrenergic agents
(Generic Code Number Sequence Numbers (GSN) of 04963, 04964, 04966, 04967, 04968, 05032, 05033, 05034, 05037, 05039, 05040, 16033, 22230, 28090, 41848, 41849, 48698, 48699, 49871, 51197, 51198, 54687, 57879, and 58890) within a twelve month timeframe

Emergency Department Visits
Numerator is patients with ≥ 1 asthma related ED visits as identified via ED visit codes (procedure codes 99281-99285) **AND** also has an asthma diagnosis code ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92 as the primary diagnosis on the emergency room claim during the measurement period.). Input the table name into the query SQL.

Use table of denominator recipient IDs to pull all recipients that have received claims described above.

CHIPRA Measure 21: Follow-Up Care for Children Prescribed ADHD Medication

National Committee for Quality Assurance

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

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

Definitions

Intake Period	The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD, during which time the member had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation Phase	The 30 days following the IPSD.
C&M Phase	The 31–300 days following the IPSD (9 months).
New Episode	The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous Medication Treatment	The number of medication treatment days during the 10-month follow-up period must be ≥210 days (i.e., 300 treatment days – 90 gap days).
Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

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Eligible Population: Rate 1 – Initiation Phase

Ages	Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year
Continuous enrollment	Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD through 30 days (1 month) after the IPSD
Allowable gap	None
Anchor date	None
Benefits	Medical and pharmacy.
Event/ diagnosis	The organization should follow the steps below to identify the eligible population for the Initiation Phase.

Step 1

Identify all children in the specified age range who were dispensed an ADHD medication during the 12-month Intake Period:

CNS stimulants: amphetamine-dextroamphetamine; atomoxetine; dexmethylphenidate; dextroamphetamine; guanfacine; Lisdexamfetamine; ethamphetamine; methylphenidate

Note

NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 15, 2010.

Step 2

Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3

Calculate continuous enrollment. Members must be continuously enrolled for 120 days prior to the IPSD through 30 days after the IPSD.

Step 4

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Exclude members who had an acute inpatient claim/encounter with a principal diagnosis or DRG for mental health or substance abuse (codes below) during the 30 days after the IPSD

Codes to Identify Mental Health Diagnosis:

ICD-9-CM Diagnosis:290, 293-302, 306-316

Codes to Identify Inpatient Services:

MS-DRG:876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Substance Abuse Codes:

Principal ICD-9-CM Diagnosis: 291-292, 303-305

Principal ICD-9-CM Diagnosis: 960-979 with Secondary ICD-9-CM Diagnosis: 291-292, 303-304, 305.0, 305.2-305.9, 535.3, 571.1

Administrative Specification: Rate 1 – Initiation Phase

Denominator

The Rate 1 eligible population

Numerator

One face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Use Table ADD-C to identify the follow-up visit.

Note:

Do not count a visit on the IPSD as the Initiation Phase visit

Table ADD-C: Codes to Identify Follow-Up Visits

CPT	HCPCS	UB Revenue	
90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983	
CPT			POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876		***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255		***WITH***	52, 53

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Eligible population: Rate 2 – Continuation and Maintenance Phase

Ages	Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year
Continuous enrollment	Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. Members who switch product lines between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1.
Allowable gap	One 45-day gap in enrollment between 31 days and 300 days after the IPSD. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	None
Benefits	Medical and pharmacy.
Event/ diagnosis	The organization should follow the steps below to identify the eligible population for the C&M Phase

Administrative Specification: Rate 2 – Continuation and Maintenance

Denominator

The Rate 2 eligible population

Numerator

Identify all members who meet the following criteria.

An Initiation Phase Visit in the first 30 days, and

At least two follow-up visits from 31–300 days after the IPSD

One of the two visits (during days 31–300) may be a telephone visit with practitioner. Refer to Table ADD-C for codes to identify follow-up visits.

Codes to identify telephone visits:

CPT Codes: 98966-98968, 99371-99373, 99441-99443

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Exclusions (optional)

Members diagnosed with narcolepsy at any point in their medical history.
ICD-9-CM Diagnosis: 347

Note

Members who have multiple overlapping prescriptions should count the overlap days once toward the days supply (regardless of whether the overlap is for the same drug or for a different drug).

Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).

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CHIPRA Measure 22: Annual Pediatric Hemoglobin (HbA1c) Testing and Control

National Committee for Quality Assurance

Description

Patients with annual diabetes testing and glycemic control.

Eligible Population

Age	Pediatric patients (5–17 years of age)
Continuous Enrollment	Has been under the care of the applicant clinician or group practice for at least 12 months. This is defined by documentation of a face-to-face visit for diabetes care between the clinician and the patient that predates the most recent visit by at least 12 months.
Benefit	Medical
Event/Diagnosis	Has had a diagnosis of diabetes (as defined in Table 1 below) or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics (as defined in Table 2 below) for at least 12 months.

Numerator

The number of patients in the sample who have documentation of date and result for the most recent HbA1c test during the 12-month abstraction period

Denominator

The total patient sample

Exclusions

The following is not acceptable documentation of HbA1c testing.

Fructosamine

Hgb

Hemoglobin

Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c”

Table 1. Codes and Descriptions to Identify a Patient With a Diagnosis of Diabetes

ICD-9 Code and Criteria	Definition	Synonyms	Exclusions
250 or 648.0	The need for diet	Insulin-dependent diabetes mellitus	Documentation of a family history

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Diabetes mellitus	management, insulin or oral hypoglycemic agent, report of home urine or home blood glucose testing or the presence of an insulin pump anywhere in the medical record	(IDDM), non-insulin dependent diabetes (NIDDM), Type I, Type II, DM, AODM, sugar diabetes, maturity onset diabetes, diet controlled diabetes	of diabetes without personal diagnosis, steroid-induced diabetes, gestational diabetes (ICD-9 code 648.8), R/O diabetes, diabetes insipidus, questionable or "?" diabetes mellitus, or hyperglycemia, glucose intolerance, borderline diabetes
357.2 **Diabetic polyneuropathy**	Any mention of a diagnosis of diabetic polyneuropathy in the medical record	Neuropathy or peripheral neuropathy, decreased or altered sensation, extremity numbness or tingling, paresthesia in the lower extremity, foot ulcers, distal symmetric polyneuropathy, loss of sensation (vibration/touch) in the feet, loss of ankle reflexes, Charcot's joints, malperforans	Rule out or R/O neuropathy, extremity weakness, or probable or "?" neuropathy
		ulcer, loss of light touch and pin prick, knife-like or burning pain of feet, sensory loss or pain in hands, or mononeuropathy	

Table 1. Codes and Descriptions to Identify a Patient With a Diagnosis of Diabetes *(continued)*

ICD-9 Code and Criteria	Definition	Synonyms	Exclusions
362.0 **Diabetic retinopathy**	Any mention of a diagnosis of diabetic retinopathy in the medical record	Diabetic eye changes: Proliferative diabetic retinopathy New vessels on the disc (NVD) New vessels elsewhere in iris or retina Preretinal or vitreous hemorrhage Fibrosis rubeosis diabetic retinal changes Macular lesion Background retinopathy Preproliferative retinopathy Venous beading/looping Large retinal blot hemorrhages Multiple cotton wool spots Multi-preintroretinal microvascular abnormalities Diabetic macular edema Nonproliferative diabetic retinopathy Microaneurysms Blot hemorrhage Hard exudates 1-2 soft exudates	Rule out or R/O diabetic retinopathy
366.41 **Diabetic cataract**	Any mention of a diagnosis of diabetic cataract in the medical record	NA	Patients with congenital cataract, senile cataract, traumatic cataract, cataract secondary to ocular disorders or after-cataract

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Table 2: Descriptions to Identify Patients With Notation of Prescribed Insulin or Oral Hypoglycemics/Antihyperglycemics

Criteria	Definition	Synonyms	Exclusions
Insulin	Any mention of routine insulin use during the past 12 months in the medical record	Any insulin, including regular insulin, insulin pump, insulin pen, 70/30, CSII (continuous subcutaneous infusion of insulin), Humalog, Humulin, Lente, Lispro, MDI (multiple daily injections), Novolin, Novolin Penfill, NPH Novo Nordisk, Semilente, Ultralente, Velosulin	Insulin given only during hospitalization, or briefly to help a patient through an acute illness, such as with steroid treatment or active infection does not constitute documentation of insulin use for diabetes
Oral hypoglycemics/anti-hyperglycemics	Any mention of oral hypoglycemic or antihyper-glycemic use during the past 12 months in the medical record	Acarbose, Acetohexamide, Amaryl, Chlorpropamide, Diabeta, Diabinase, Dymelor, Glipizide, Glipizide XL, Glucamide, Glucotrol, Glucotrol XL, Glyburide, Glynase, Micronase, Orinase, Orimide, Prandin (Repaglinide), Precose, Tolazamide, Tolamide, Tolbutamide, Tolinase, Troglitazone	NA

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CHIPRA Measure 23: Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

- The percentage of members who received follow-up within 30 days of discharge
- The percentage of members who received follow-up within 7 days of discharge

Eligible Population

Ages	6 years and older as of the date of discharge
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None
Benefits	Medical and mental health (inpatient and outpatient).
Event/ diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

Codes to Identify Mental Health Diagnosis:

ICD-9-CM Diagnosis: 295–299 , 300.3, 300.4, 301, 308, 309, 311–314

Mental Health Readmission or Direct Transfer

If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

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Exclude discharges followed by readmission or direct transfer to a nonacute facility for a mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify nonacute care.

Codes to Identify Mental Health Diagnosis:

ICD-9-CM Diagnosis:290, 293-302, 306-316

Codes to Identify Inpatient Services:

MS-DRG:876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Non-mental Health Readmission or Direct Transfer

Exclude 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. This includes an ICD-9-CM Diagnosis code or DRG code other than those identified above. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

FUH-B: Codes to Identify Hospitalizations

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment Center	T2048, H0017-H0019	100		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Administrative Specifications

Denominator

The eligible population

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Numerators

- 30 Day Follow-up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge
- An outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge

Table FUH-C: Codes to Identify Visits

CP T		HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.		
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510		G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
CPT		**POS**
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

Note

Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

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CHIPRA Measure 24: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0H, Child Version

National Committee for Quality Assurance

Description

This measure provides information on parents' experience with their child's health plan. Results summarize member experiences through ratings, composites and individual question summary rates.
Four global rating questions reflect overall satisfaction.
1. Rating of All Health Care
2. Rating of Personal Doctor
3. Rating of Specialist Seen Most Often
4. Rating of Health Plan

Five composite scores summarize responses in key areas.
1. Customer Service
2. Getting Care Quickly
3. Getting Needed Care
4. How Well Doctors Communicate
5. Shared Decision Making

Children With Chronic Conditions (CCC)

Description

This measure provides information on parents' experience with their child's health plan for the population of children with chronic conditions.
Results include the same ratings, composites and individual question summary rates as those reported for the CAHPS Health Plan Survey 4.0H, Child Version. In addition, three CCC composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions.
1. Access to Specialized Services
2. Family Centered Care: Personal Doctor Who Knows Child
3. Coordination of Care for Children With Chronic Conditions

Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:
1. Access to Prescription Medicines
2. Family Centered Care: Getting Needed Information

Implementing the CAHPS Survey

Data Collection	
Administration	Survey must be conducted by a third party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol.
Collection mode	Mail, telephone, or mixed mode protocols are recommended. Internet enhancement is accepted.
Sample size	The sample needs to be large enough to yield 300 completed surveys per health plan product, a cost-effective method shown to produce statistically valid survey comparisons.
Response rates	Target rates are 60 percent for commercial health plans and 50 percent for Medicaid, but lower rates are accepted.
Completion criteria	A questionnaire is complete if it has responses for 10 or more of the key items. (See Table 1 for more information).
Data Analysis	
Case-mix adjustment	Data should be adjusted for age, education, and self-reported health status. Sponsors have the option of adjusting the case mix for other factors as well.

Table 1: Key questions to determine a completed survey

Key questions from the CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire[6] Item	Question Wording
1.	Our records show that your child is in {INSERT HEALTH PLAN NAME}. Is that right?
3.	In the last 6 months, did your child have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?
5.	In the last 6 months, **not** counting the times your child needed care right away, did you make any appointments for your child's health care at a doctor's office or clinic?
7.	In the last 6 months, **not** counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?
9,	A personal doctor is the one your child would see if he or she needs a check-up or gets sick or hurt. Does your child have a personal doctor?
19.	Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you try to make any appointments for your child to see a specialist?
23.	In the last 6 months, did you try to get any kind of care, tests, or treatment

	for your child through his or her health plan?
25.	In the last 6 months, did you try to get information or help from customer service at your child's health plan?
28.	In the last 6 months, did your child's health plan give you any forms to fill out?
30.	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?
31.	In general, how would you rate your child's overall health?
32.	What is **your child's** age?
33.	Is your child male or female?
34.	Is your child of Hispanic or Latino origin or descent?
35.	What is your child's race? Please mark one or more.
36.	What is **your** age?
37.	Are you male or female?
38.	What is the highest grade or level of school that you have completed?
39.	How are you related to the child?
40.	Did someone help you complete this survey?

CAHPS® Health Plan Survey 4.0

Version: Child Medicaid Questionnaire

Language: English

Collecting Information about Children with Chronic Conditions. This version of the Child Medicaid Questionnaire includes the 4.0 version of the Children with Chronic Conditions Item Set. The updated items have been incorporated into the core items; **for easy identification, they are numbered as CC1-CC38**.

- If you would like to field this set of items, please delete the highlighting and renumber the questions and skip instructions.
- If you do not want to use these items, simply delete the highlighted items.

If you have any questions about the use of these items, contact the CAHPS Help Line at cahps1@ahrq.gov.

Instructions for Front Cover

- Replace the cover of this document with your own front cover. Include a user-friendly title and your own logo.
- Include this text regarding the confidentiality of survey responses:

  Your Privacy is Protected. All information that would let someone identify you or your family will be kept private. {VENDOR NAME} will not share your personal information with anyone without your OK. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders.

  Your Participation is Voluntary. You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get.

  What To Do When You're Done. Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the envelope to [INSERT VENDOR ADDRESS].

  If you want to know more about this study, please call XXX-XXX-XXXX.

Instructions for Format of Questionnaire

Proper formatting of a questionnaire improves response rates, the ease of completion, and the accuracy of responses. The CAHPS team's recommendations include the following:

- If feasible, insert blank pages as needed so that the survey instructions (see next page) and the first page of questions start on the right-hand side of the questionnaire booklet.
- Maximize readability by using two columns, serif fonts for the questions, and ample white space.
- Number the pages of your document, but remove the headers and footers inserted to help sponsors and vendors distinguish among questionnaire versions.

Additional guidance is available in **Preparing a Questionnaire Using the CAHPS Health Plan Survey**:
https://www.cahps.ahrq.gov/cahpskit/files/1012_Preparing_Questionnaire_HP40.pdf

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Survey Instructions

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes → **If Yes, go to #1 on page 1**
☐ No

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. Our records show that your child is now in {INSERT HEALTH PLAN NAME}. Is that right?

[1] ☐ Yes → **If Yes, go to #3**
[2] ☐ No

2. What is the name of your child's health plan?

Please print: _____

_____

Your Child's Health Care in the Last 6 Months

These questions ask about your child's health care. Do **not** include care your child got when he or she stayed overnight in a hospital. Do **not** include the times your child went for dental care visits.

3. In the last 6 months, did your child have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?

[1] ☐ Yes
[2] ☐ No → **If No, go to #5**

4. In the last 6 months, when your child **needed care right away**, how often did your child get care as soon as you thought he or she needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

5. In the last 6 months, **not** counting the times your child needed care right away, did you make any appointments for your child's health care at a doctor's office or clinic?

[1] ☐ Yes
[2] ☐ No → **If No, go to #7**

6. In the last 6 months, **not** counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

7. In the last 6 months, **not** counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?

- ☐ None → **If None, go to #9 on page 4 [If items CC5-CC7 or CC5-CC18 are included: go to #CC5; if only items CC8-CC18 are included: go to #CC8]**
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more

CC1. In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

CC2. Choices for your child's treatment or health care can include choices about medicine, surgery, or other treatment. In the last 6 months, did your child's doctor or other health provider tell you there was more than one choice for your child's treatment or health care?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #8**

CC3. In the last 6 months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?

- [1] ☐ Yes
- [2] ☐ No

CC4. In the last 6 months, when there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice was best for your child?

- [1] ☐ Yes
- [2] ☐ No

8. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?

- ☐ 0 Worst health care possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best health care possible

CC5. Is your child now enrolled in any kind of school or daycare?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #9 on page 4 [*If items CC8-CC18 are included:* go to #CC8]**

CC6. In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?

[1] ☐ Yes
[2] ☐ No → **If No, go to #9 on page 4 [*If items CC8-CC18 are included:* go to #CC8]**

CC7. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?

[1] ☐ Yes
[2] ☐ No

Option: Insert additional questions about general health care here.

Specialized Services

CC8. Special medical equipment or devices include a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment. In the last 6 months, did you get or try to get any special medical equipment or devices for your child?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC11**

CC9. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC10. Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?

[1] ☐ Yes
[2] ☐ No

CC11. In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?

1 ☐ Yes
2 ☐ No → **If No, go to #CC14**

CC12. In the last 6 months, how often was it easy to get this therapy for your child?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

CC13. Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?

1 ☐ Yes
2 ☐ No

CC14. In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?

1 ☐ Yes
2 ☐ No → **If No, go to #CC17**

CC15. In the last 6 months, how often was it easy to get this treatment or counseling for your child?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

CC16. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?

1 ☐ Yes
2 ☐ No

CC17. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?

1 ☐ Yes
2 ☐ No → **If No, go to #9**

CC18. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

1 ☐ Yes
2 ☐ No

Your Child's Personal Doctor

9. A personal doctor is the one your child would see if he or she needs a check-up or gets sick or hurt. Does your child have a personal doctor?

1 ☐ Yes
2 ☐ No → **If No, go to #19 on page 6**

10. In the last 6 months, how many times did your child visit his or her personal doctor for care?

- ☐ None → **If None, go to #18**
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more

11. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy to understand?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

12. In the last 6 months, how often did your child's personal doctor listen carefully to you?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

13. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

14. Is **your child** able to talk with doctors about his or her health care?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #16**

15. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for **your child** to understand?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

16. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

17. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

- [1] ☐ Yes
- [2] ☐ No

18. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?

- ☐ 0 Worst personal doctor possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best personal doctor possible

CC19. Does your child have any medical, behavioral, or other health conditions that have lasted for more than **3 months**?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #19**

CC20. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

- [1] ☐ Yes
- [2] ☐ No

CC21. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your **family's** day-to-day life?

- [1] ☐ Yes
- [2] ☐ No

Option: Insert additional questions about personal doctor here.

Getting Health Care From a Specialist

When you answer the next questions, do **not** include dental visits or care your child got when he or she stayed overnight in a hospital.

19. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you try to make any appointments for your child to see a specialist?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #23**

20. In the last 6 months, how often was it easy to get appointments for your child with specialists?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

21. How many specialists has your child seen in the last 6 months?

- [0] ☐ None → **If None, go to #23**
- [1] ☐ 1 specialist
- [2] ☐ 2
- [3] ☐ 3
- [4] ☐ 4
- [5] ☐ 5 or more specialists

22. We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

- ☐ 0 Worst specialist possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best specialist possible

Option: Insert additional questions about specialist care here.

Your Child's Health Plan

The next questions ask about your experience with your child's health plan.

23. In the last 6 months, did you try to get any kind of care, tests, or treatment for your child through his or her health plan?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #25**

24. In the last 6 months, how often was it easy to get the care, tests, or treatment you thought your child needed through his or her health plan?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

25. In the last 6 months, did you try to get information or help from customer service at your child's health plan?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #28**

26. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

27. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

28. In the last 6 months, did your child's health plan give you any forms to fill out?

[1] ☐ Yes
[2] ☐ No → **If No, go to #30**

29. In the last 6 months, how often were the forms from your child's health plan easy to fill out?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

30. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?

☐ 0 Worst health plan possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best health plan possible

Option: Insert additional questions about the health plan here.

Prescription Medicines

CC22. In the last 6 months, did you get or refill any prescription medicines for your child?

[1] ☐ Yes
[2] ☐ No → **If No, go to #31**

CC23. In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC24. Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

[1] ☐ Yes
[2] ☐ No

About Your Child and You

31. In general, how would you rate your child's overall health?

[1] ☐ Excellent
[2] ☐ Very Good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

CC25. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC28**

CC26. Is this because of any medical, behavioral, or other health condition?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC28**

CC27. Is this a condition that has lasted or is expected to last for at least 12 months?

[1] ☐ Yes
[2] ☐ No

CC28. Does your child need or use more medical care, more mental health services, or more educational services than is usual for most children of the same age?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC31**

CC29. Is this because of any medical, behavioral, or other health condition?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC31**

CC30. Is this a condition that has lasted or is expected to last for at least 12 months?

[1] ☐ Yes
[2] ☐ No

CC31. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC34**

CC32. Is this because of any medical, behavioral, or other health condition?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC34**

CC33. Is this a condition that has lasted or is expected to last for at least 12 months?

[1] ☐ Yes
[2] ☐ No

CC34. Does your child need or get special therapy such as physical, occupational, or speech therapy?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC37**

CC35. Is this because of any medical, behavioral, or other health condition?

[1] ☐ Yes
[2] ☐ No → **If No, go to #CC37**

CC36. Is this a condition that has lasted or is expected to last for at least 12 months?

[1] ☐ Yes
[2] ☐ No

CC37. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?

[1] ☐ Yes
[2] ☐ No → **If No, go to #32**

CC38. Has this problem lasted or is it expected to last for at least 12 months?

[1] ☐ Yes
[2] ☐ No

32. What is **your child's** age?

[1] ☐ Less than 1 year old

_____ YEARS OLD *(write in)*

33. Is your child male or female?

- [1] ☐ Male
- [2] ☐ Female

34. Is your child of Hispanic or Latino origin or descent?

- [1] ☐ Yes, Hispanic or Latino
- [2] ☐ No, not Hispanic or Latino

35. What is your child's race? Please mark one or more.

- [1] ☐ White
- [2] ☐ Black or African-American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or other Pacific Islander
- [5] ☐ American Indian or Alaska Native
- [6] ☐ Other

36. What is **your** age?

- [0] ☐ Under 18
- [1] ☐ 18 to 24
- [2] ☐ 25 to 34
- [3] ☐ 35 to 44
- [4] ☐ 45 to 54
- [5] ☐ 55 to 64
- [6] ☐ 65 to 74
- [7] ☐ 75 or older

37. Are you male or female?

- [1] ☐ Male
- [2] ☐ Female

38. What is the highest grade or level of school that you have completed?

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

39. How are you related to the child?

- [1] ☐ Mother or father
- [2] ☐ Grandparent
- [3] ☐ Aunt or uncle
- [4] ☐ Older sibling
- [5] ☐ Other relative
- [6] ☐ Legal guardian

40. Did someone help you complete this survey?

- [1] ☐ Yes
- [2] ☐ No → **Thank you. Please return the completed survey in the postage-paid envelope.**

41. How did that person help you? Mark all that apply.

[1] ☐ Read the questions to me
[2] ☐ Wrote down the answers I gave
[3] ☐ Answered the questions for me
[4] ☐ Translated the questions into my language
[5] ☐ Helped in some other way

Please print: _____

_____

_____

Option: Insert other child-specific, member-specific, or other general questions here.

Thank you.

Please return the completed survey in the postage-paid envelope.