MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: TEXAS-SPECIFIC REPORTING REQUIREMENTS

Effective as of March 1, 2015, Issued August 21, 2015

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Texas-Specific Reporting Requirements Appendix

Introduction

The measures in this appendix are required reporting for all MMPs in the Texas Dual Eligibles Integrated Care Demonstration Project. CMS and the state reserve the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model: Core Reporting Requirements, which can be found at the following web address:

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology.

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®[1] and HOS. CMS and the states will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

MMPs should contact the TX Help Desk at TXHelpDesk@norc.org with any questions about the Texas state-specific appendix or the data submission process.

Definitions

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: 1/1 – 3/31, 4/1 – 6/30, 7/1 – 9/30, and 10/1 – 12/31.

Calendar Year: All annual measures are reported on a calendar year basis. Calendar year 2015 (CY1) will be an abbreviated year, with data reported for the time period beginning March 1, 2015 and ending December 31, 2015. Calendar year 2016 (CY2) will represent January 1, 2016 through December 31, 2016.

[1] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).

Implementation Period: The period of time starting with the first effective enrollment date, March 1, 2015, until September 30, 2015.

Long Term Services and Supports (LTSS): Services to meet an individual's health or personal care needs over an extended period of time and may include nursing, assistance with bathing, toileting, dressing, eating, meal preparation, relief for caregivers, home modifications and repairs, transportation, adaptive aids, services at licensed facilities, and nutrition services such as home-delivered meals or meals at senior centers. LTSS are provided predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Primary Care Provider: A Provider who has agreed with the STAR+PLUS MMP to provide a Medical Home to Enrollees and who is responsible for providing initial and primary care to Enrollees, maintaining the continuity of care, and initiating referral for services.

Service Coordination: A specialized Care Management service that is performed by a Service Coordinator that includes but is not limited to: 1) identification of needs, including physical and behavioral health services, and LTSS, 2) development of and necessary updates to a Plan of Care to address those identified needs; 3) assistance to ensure timely and a coordinated access to an array of Providers and Covered Services; 4) attention to addressing unique, person-centered needs of Enrollees; 5) coordination of Covered Services with Non-Capitated Services, as necessary and appropriate; and 6) includes, for Enrollees who have been determined STAR+PLUS HCBS eligible, the development of an ISP with the Enrollee, family members, and Provider(s), as well as authorization of HCBS services.

Variation from the Core Document

Core 2.1 and Core 2.2

Under certain circumstances, Texas MMPs are permitted to count assessments previously completed by the MMP's affiliated STAR+PLUS and/or Medicare Advantage D-SNP product. As a result, there are some caveats to the reporting of the core measures that pertain to assessments (i.e., Core 2.1 and Core 2.2).

Only those assessments completed by a MMP's own sister product may be counted toward MMP requirements. In addition, the MMP must determine, through contact with the member or other means as appropriate, if the member has experienced any of the triggering events listed in Section 2.6.2.8.2 of the contract. If so, the MMP should conduct a new assessment and report that completion according to the specifications for Core 2.1 and Core 2.2.

In the absence of a triggering event as described in Section 2.6.2.8.2 of the contract, MMPs are not required to complete an additional assessment for

members who have previously received a comprehensive assessment in the MMP's sister product within the prior nine months. As such, for formerly STAR+PLUS and/or D-SNP members with a comprehensive assessment completed within nine months of their initial effective enrollment date in the MMP, MMPs are to report those assessments under Core 2.1 and Core 2.2 as having been completed as of the member's first effective enrollment date in the MMP. For example, if a member's first effective enrollment date was March 1, 2015 and the assessment for that member was previously completed on August 20, 2014, the MMP should report the assessment as if it were completed on March 1, 2015.

For Level 2 members who received a non-comprehensive assessment from the MMP's sister product within nine months of their initial effective enrollment date in the MMP, and who have not had a triggering event as described in Section 2.6.2.8.2 of the contract, MMPs are required to ask the additional required assessment questions within 90 days of the member's effective enrollment date in the MMP. MMPs are to report such assessments as completed as of the date on which the missing questions were asked and documented. Alternatively, the MMP may opt to complete a new assessment for the low-risk member using its new comprehensive tool (with the required questions added) within 90 days of the member's enrollment in the MMP. MMPs would report the completion of the new comprehensive assessment under Core 2.1 and Core 2.2 according to the actual date of completion.

Level 1 members who received a non-comprehensive assessment while enrolled in an MMP's sister product must have a new, comprehensive assessment within 90 days of enrollment. MMPs should report these new comprehensive assessments under Core 2.1 and Core 2.2 according to the actual date of completion.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period and who were still enrolled as of the last day of the reporting period. Members enrolled into the MMP on March 1, 2015 would reach their 90th day (which is equivalent to three full months) on May 31, 2015. Therefore, these members would be reported in the data submission for the May monthly reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e. March 1).

Core 2.3

For Core 2.3, members with an annual reassessment, MMPs should determine whether members are eligible for an annual reassessment using the actual date the initial assessment was completed, even if that date occurred when the member was enrolled in the MMP's sister product.

Core 9.2

The following section provides additional guidance about identifying individuals enrolled in the MMP as "nursing home certifiable," or meeting the nursing facility level of care (NF LOC), for the purposes of reporting Core 9.2.

Core 9.2 focuses on "nursing home certifiable" members, defined as "members living in the community, but requiring an institutional level of care" (see the 2015 Core Reporting Requirements, pages 75-76). TX STAR+PLUS MMPs should use risk group assignments, supplemented by claims or enrollment data, to categorize members as "nursing home certifiable." Members in the following risk groups should be included:

- Dually-eligible, STAR+PLUS Waiver
- Dually-eligible, Nursing Facility, for individuals residing in the nursing home no more than 100 days

In addition, MMPs may have members who, for a short period, may be in HCBS but not yet assigned to the appropriate risk group. MMPs should use information available in internal data systems wherever possible to identify whether these individuals should be included in reporting for Core 9.2.

Reporting on Assessments and Plans of Care Completed Prior To First Effective Enrollment Date

For MMPs that have requested and obtained CMS approval to do so, health risk assessments (HRAs) may be completed up to 20 days prior to the individual's coverage effective date for individuals who are passively enrolled. Early HRA outreach for opt-in members is permitted for all participating MMPs.

For purposes of reporting data on HRAs (Core 2.1 and Core 2.2), MMPs should report any HRAs completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the HRA for that member was completed on May 25, the MMP should report the HRA as if it were completed on June 1. As noted in the prior section, MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2.

MMPs must comply with contractually specified timelines regarding completion of Plans of Care within 90 days of enrollment. In the event that a Plan of Care is also finalized prior to the first effective enrollment date, MMPs should report completion of the Plan of Care (for measures TX1.1, TX1.2, and TX1.4) as if it were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the Plan of Care for that member

was completed on May 27, the MMP should report the Plan of Care as if it were completed on June 1.

Guidance on Assessments and Plans of Care for Members with a Break in Coverage

Health Risk Assessments

If a MMP already completed a Health Risk Assessment (HRA) for a member that was previously enrolled, the MMP is not necessarily required to conduct a new HRA if the member rejoins the same MMP within one year of his/her most recent HRA. Instead, the MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the HRA was conducted; and
2. Ask the member (or his/her authorized representative) and service coordinator if there has been a change in the member's health status or needs since the HRA was conducted.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or his/her authorized representative) and service coordinator to determine if there was a change in the member's health status or needs.

If a change is identified, the MMP must conduct a new HRA within the timeframe prescribed by the contract. If there are no changes, the MMP is not required to conduct a new HRA unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct HRAs on all re-enrollees regardless of status, it may continue to do so. The MMP must inform the member of his/her right to request a new HRA at any time.

Once the MMP has conducted a new HRA as needed or confirmed that the prior HRA is still accurate, the MMP can mark the HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these core measures, the MMP should count the 90 days from the member's most recent enrollment effective date, and should report the HRA based on the date the prior HRA was either confirmed to be accurate or a new HRA was completed.

If the MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the MMP may report that member as unable to be reached so long as the MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss his/her health status with the MMP, then the MMP may report that member as unwilling to participate in the HRA.

If the MMP did not complete an HRA for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's HRA was completed, the MMP is required to conduct a HRA for the member within the timeframe prescribed by the contract. The MMP must make the requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members that refused the HRA during their prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

Plans of Care

If the MMP conducts a new HRA for the re-enrolled member, the MMP must revise the Plan of Care accordingly in collaboration with the member or authorized representative within the timeframe prescribed by the contract. Once the Plan of Care is revised, the MMP may mark the Plan of Care as complete for the member's current enrollment. If the MMP determines that the prior HRA is still accurate and therefore no updates are required to the previously developed Plan of Care, the MMP may mark the Plan of Care as complete for the current enrollment at the same time that the HRA is marked complete. The MMP would then follow the applicable state-specific measure specifications for reporting the completion. Please note, for purposes of reporting, the Plan of Care for the re-enrolled member should be classified as an *initial* Plan of Care.

If the MMP did not complete a Plan of Care for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's Plan of Care was completed, the MMP is required to develop a Plan of Care for the member within the timeframe prescribed by the contract. The MMP must also follow the above guidance regarding reaching out to members that previously refused to participate or were not reached.

Annual Reassessments and Plan of Care Updates

The MMP must follow contract requirements regarding the completion of annual reassessments and updates to the Plan of Care. If the MMP determined that an HRA/Plan of Care from a member's prior enrollment was accurate and marked that HRA/Plan of Care as complete for the member's current enrollment, the MMP should count continuously from the date that the HRA/Plan of Care was completed in the prior enrollment period to determine the due date for the annual reassessment and Plan of Care update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the HRA was actually completed, even if that date was during the member's prior enrollment period.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: (ⁱ). This document only identifies Demonstration Year 1 (DY1) quality withhold measures. CMS and the state will update the reporting requirements to reflect quality withhold measures for subsequent demonstration years closer to the start of Demonstration Year 2 (DY2). Additional information on the withhold methodology and benchmarks will be provided at a later time.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMPs. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are ***not*** required to re-submit corrected data should you be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member's enrollment status.

Code Tables

The measure specifications in this document include references to code tables (TX-X) that will be used to determined data elements. These code tables can be found in Appendix A starting on page TX-84.

Texas's Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1.a			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	3-1-15 through 9-30-15	From the first effective enrollment date through September 30, 2015.
	Ongoing Period	3-1-15 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 1.b			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1st through the end of the third demonstration year.

Data Submission

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative (FAI) Data Collection System (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00p.m. ET on the applicable due date. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

(Note: Prior to the first use of the system, all MMPs will receive an email notification with the username and password that has been assigned to their plan. This information will be used to log in to the FAI system and complete the data submission.)

All MMPs will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through the Health Plan Management System (HPMS).

Please note, late submissions may result in compliance action from CMS.

Resubmission of Data to the FAI Data Collection System or HPMS

MMPs must comply with the following steps to resubmit data after an established due date:

1. Email the TX HelpDesk (TXHelpDesk@norc.org) to request resubmission.
   - Specify in the email which measures need resubmission;
   - Specify for which reporting period(s) the resubmission is needed; and
   - Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the TX HelpDesk will notify the MMP once the FAI Data Collection System and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the TX HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

Section TXI. Care Coordination

TX1.1 Members with Plans of Care within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
TX1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of members who were documented as unwilling to complete a Plan of Care within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to complete a Plan of Care within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members the MMP was unable to reach, following five documented attempts within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to reach, following five documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	Total number of members with a Plan of Care completed within 90 days of enrollment.	Of the total reported in A, the number of members with a Plan of Care completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members whose 90th day of enrollment occurred within the reporting period:

- Who refused to have a Plan of Care completed within 90 days of enrollment.
- Who were unable to be reached to have a Plan of Care completed within 90 days of enrollment.
- Who had a Plan of Care completed within 90 days of enrollment.
- Who were willing to participate and who could be reached who had a Plan of Care completed within 90 days of enrollment.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's effective enrollment date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective enrollment date is the first date of the member's coverage through the MMP.
- MMPs should refer to the three-way contract for specific requirements pertaining to a Plan of Care.
- For data element B, MMPs should report the number of members who were unwilling to participate in the development of the Plan of Care if the member (or his or her authorized representative):
    - Affirmatively declines to participate in the Plan of Care. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the Plan of Care but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the Plan of Care within 90 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the Plan of Care, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the Plan of Care, but then declines to answer a majority of the questions in the Plan of Care.
- For data element C, MMPs should report the number of members the MMP was unable to reach after five attempts to contact the member. MMPs should refer to the TX three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.

- There may be certain circumstances that make it impossible or inappropriate to complete a Plan of Care within 90 days of the enrollment. For example, a member may become medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a Plan of Care. However, MMPs should not include such members in the counts for data elements B and C.
- If a Plan of Care was started but not completed within 90 days of enrollment, then the Plan of Care should not be considered completed and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A if the member's 90th day of enrollment occurred within the reporting period.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX1.2 Members with Plans of Care completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
TX1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period and who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of members who had a Plan of Care completed as of the end of the reporting period.	Of the total reported in A, the number of members who had a Plan of Care completed as of the end of the reporting period.	Field type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members enrolled for 90 days or longer as of the last day of the reporting period who had a Plan of Care completed as of the end of the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- The 90th day of enrollment should be based on each member's effective enrollment date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective enrollment date is the first date of the member's coverage through the MMP.
- The Plans of Care reported in data element B could have been completed at any time prior to the end of the reporting period, not necessarily during the reporting period.
- MMPs should refer to the three-way contract for specific requirements pertaining to a Plan of Care.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX1.3 Members with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
TX1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of hospital discharges.	Total number of hospital discharges during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Of the total reported in A, the number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the hospital.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all hospital discharges for Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all hospital discharges for members who meet the criteria outlined in Element A and who were continuously enrolled from the date of the hospital discharge through 30 days after the hospital discharge, regardless if they are disenrolled as of the end of the reporting period.
- The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period. For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.

- This measure will be due four months following the last day of the reporting period; therefore, MMPs will have sufficient time to collect and report data for discharges with a follow-up visit that occurred during the first month of the subsequent reporting period.
- The member needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment, to be included in this measure.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in **Table TX-1**.
- Codes to identify inpatient discharges are provided in **Table TX-2**.
- Exclude discharges in which the patient was readmitted within 30 days after discharge to an acute or non-acute facility.
- Exclude discharges due to death. Codes to identify patients who have expired are provided in **Table TX-3**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX1.4 Members whose Plan of Care is updated annually before the expiration date.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX1. Care Coordination	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions - details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members eligible for a Plan of Care annual update.	Total number of members eligible for a Plan of Care annual update during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members whose Plan of Care was updated annually before the expiration date.	Of the total reported in A, the number of members whose Plan of Care was updated annually before the expiration date during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established threshold for this measure.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members eligible for a Plan of Care annual update during the reporting period whose Plan of Care was updated annually before the expiration date during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

Section TXII. Enrollee Protections

TX2.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX2. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
TX2. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of critical incident and abuse reports per 1,000 members receiving LTSS.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should refer to the STAR+PLUS handbook for guidance on how to identify members classified as receiving LTSS.
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- For data elements A and B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless if the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider, and are not limited to only those providers defined as LTSS providers.
- Critical Event or Incident means an event or incident that may harm, or create the potential for harm, to an individual. Critical Events or Incidents include:
    - Abuse, neglect, or exploitation;
    - The unauthorized use of restraint, seclusion, or restrictive interventions;
    - Serious injuries that require medical intervention or result in hospitalization;
    - Criminal victimization;
    - Unexplained death;
    - Medication errors; and
    - Other events or incidents that involve harm or risk of harm to a member.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

Section TXIII. Organizational Structure and Staffing

TX3.1 Service coordinator training for supporting self-direction.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX3. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of new service coordinators who have been employed by the MMP for at least six months.	Total number of new service coordinators who have been employed by the MMP for at least six months during the reporting period.	Field Type: Numeric
B.	Total number of new service coordinators that have undergone State-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of new service coordinators that received State-based training for supporting self-direction under the demonstration.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.

- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of new service coordinators who have been employed by the MMP for at least six months that received State-based training for supporting self-direction.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should refer to the three-way contract for specific requirements pertaining to a service coordinator.
- MMPs should refer to the three-way contract for specific requirements pertaining to training for supporting self-direction. Additional guidance and training materials will be provided by HHSC.
- A service coordinator includes all full-time and part-time staff.
- If a service coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least six months during the reporting period, they should be included in this measure.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

Section TXIV. Performance and Quality Improvement

TX4.1 Diabetes short-term complications admission rate. (PQI #01)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for diabetes with short-term complications.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma).	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-9-CM diagnosis code for diabetes with short-term complications per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify diabetes with short-term complications are provided in **Table TX-4**.
- Cases to exclude:
  - Transfer from a hospital (different facility)
  - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.2 Diabetes long-term complications admission rate. (PQI #03)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for diabetes with long-term complications.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified).	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-9-CM diagnosis code for diabetes with long-term complications per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify diabetes with long-term complications are provided in **Table TX-5**.
- Exclude cases:
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).

- See Appendix B for codes to identify *Admission Codes for Transfers*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.3 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate. (PQI #05)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 40 and older.	Total number of member months during the reporting period for members age 40 and older.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of discharges for members age 40 years and older with either a principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis); a principal ICD-9-CM diagnosis code for asthma; or a principal ICD-9-CM diagnosis code for acute bronchitis and any secondary ICD-9-CM diagnosis code for COPD (excluding acute bronchitis).	Of the total reported in A, the number of discharges for members age 40 years and older with either a principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis); a principal ICD-9-CM diagnosis code for asthma; or a principal ICD-9-CM diagnosis code for acute bronchitis and any secondary ICD-9-CM diagnosis code for COPD (excluding acute bronchitis).	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 40 years and older with either a principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis); a principal ICD-9-CM diagnosis code for asthma; or a principal ICD-9-CM diagnosis code for acute bronchitis and any secondary ICD-9-CM diagnosis code for COPD per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- For data element A, use the members' age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an MMP tallies members on the 1st of each month and Ms. X turns 40 on April 3 and is enrolled for the entire year, then she contributes nine months to the 40 and older age group category.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify COPD (excluding acute bronchitis) are provided in **Table TX-6**.
- Codes to identify asthma are provided in **Table TX-7**.
- Codes to identify acute bronchitis are provided in **Table TX-8**.
- Exclude cases:
    - With any listed ICD-9-CM diagnosis code for cystic fibrosis and anomalies of the respiratory system (**Table TX-9**)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.4 Hypertension admission rate. (PQI #07)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for hypertension.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for hypertension.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-9-CM diagnosis code for hypertension per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify hypertension are provided in **Table TX-10**.
- Exclude cases:
    - With any listed ICD-9-CM procedure code for cardiac procedure
    - With any listed ICD-9-CM diagnosis code for Stage I-IV kidney disease (**Table TX-11**), only if accompanied by any listed ICD-9-CM procedure codes for dialysis access (**Table TX-12**).
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).

- See Appendix B for codes to identify *Admission Codes for Transfers*
- See Appendix C for codes to identify *Cardiac Procedure Codes*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.5 Heart failure admission rate. (PQI #08)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for heart failure.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for heart failure.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-9-CM diagnosis code for heart failure per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify heart failure are provided in **Table TX-13**.
- Exclude cases:
    - With any listed ICD-9-CM procedure codes for cardiac procedure
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).

- See Appendix B for codes to identify *Admission Codes for Transfers*
- See Appendix C for codes to identify *Cardiac Procedure Codes*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.6 Dehydration admission rate. (PQI #10)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of discharges for members age 21 years and older with either a principal ICD-9-CM diagnosis code for dehydration; or any secondary ICD-9-CM diagnosis code for dehydration and a principal ICD-9-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury.	Of the total reported in A, the number of discharges for members age 21 years and older with either a principal ICD-9-CM diagnosis code for dehydration; or any secondary ICD-9-CM diagnosis code for dehydration and a principal ICD-9-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with either a principal ICD-9-CM diagnosis code for dehydration; or any secondary ICD-9-CM diagnosis code for dehydration and a principal ICD-9-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify dehydration are provided in **Table TX-14**.
- Codes to identify hyperosmolality and/or hypernatremia are provided in **Table TX-15**.
- Codes to identify gastroenteritis are provided in **Table TX-16**.
- Codes to identify acute kidney injury are provided in **Table TX-17**.
- Exclude cases:
    - With any listed ICD-9-CM diagnosis codes for chronic renal failure (**Table TX-18**)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.7 Bacterial pneumonia admission rate. (PQI #11)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for bacterial pneumonia.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for bacterial pneumonia.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal

ICD-9-CM diagnosis code for bacterial pneumonia per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify bacterial pneumonia are provided in **Table TX-19**.
- Exclude cases:
    - With any listed ICD-9-CM diagnosis codes for sickle cell anemia or HB-s disease (**Table TX-20**)
    - With any listed ICD-9-CM diagnosis codes or any listed ICD-9-CM procedure codes for immunocompromised state
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*
- See Appendix D for codes to identify *Immunocompromised State Diagnosis and Procedure Codes*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.8 Urinary tract infection admission rate. (PQI #12)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for urinary tract infection.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for urinary tract infection.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-9-CM diagnosis code for urinary tract infection per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify urinary tract infection are provided in **Table TX-21**.
- Exclude cases:
    - With any listed ICD-9-CM diagnosis codes for kidney/urinary tract disorder (**Table TX-22**)
    - With any listed ICD-9-CM diagnosis codes or any listed ICD-9-CM procedure codes for immunocompromised state
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility

  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*
- See Appendix D for codes to identify *Immunocompromised State Diagnosis and Procedure Codes*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.9 Angina without procedure admission rate. (PQI #13)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for angina.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for angina.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-9-CM diagnosis code for angina per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify angina are provided in **Table TX-23**.
- Exclude cases:
    - With any listed ICD-9-CM procedure codes for cardiac procedure
    - Transfer from a hospital (different facility)

  - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*
- See Appendix C for codes to identify *Cardiac Procedure Codes*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.10 Uncontrolled diabetes admission rate. (PQI #14)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication.	Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-9-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-9-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.

- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify uncontrolled diabetes without mention of a short-term or long-term complication are provided in **Table TX-24**.
- Exclude cases:
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.11 Lower-extremity amputation among patients with diabetes admission rate. (PQI #16)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 21 and older.	Total number of member months during the reporting period for members age 21 and older.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with any listed ICD-9-CM procedure code for lower-extremity amputation and any ICD-9-CM diagnosis code for diabetes.	Of the total reported in A, the number of discharges for members age 21 years and older with any listed ICD-9-CM procedure code for lower-extremity amputation and any ICD-9-CM diagnosis code for diabetes.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with any listed ICD-9-CM procedure code for lower-extremity amputation and any ICD-9-CM diagnosis code for diabetes per 100,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify lower-extremity amputation are provided in **Table TX-25**.
- Codes to identify diabetes are provided in **Table TX-26**.
- Exclude cases:
    - With any listed ICD-9-CM procedure codes for traumatic amputation of the lower extremity (**Table TX-27**)
    - With any listed ICD-9-CM procedure codes for toe amputation (**Table TX-28**)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - MDC 14 (pregnancy, childbirth, and puerperium)
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See Appendix B for codes to identify *Admission Codes for Transfers*

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.12 Medication management for people with asthma.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members 21-50 years of age who were identified as having persistent asthma and who were dispensed appropriate medications.	Total number of members 21-50 years of age who were continuously enrolled during the previous reporting period and the current reporting period, and who were enrolled on December 31 of the current reporting period, who were identified as having persistent asthma and who were dispensed appropriate medications.	Field Type: Numeric
B.	Total number of members who achieved a proportion of days covered (PDC) of at least 50 percent for their asthma controller medications.	Of the total reported in A, the number of members who achieved a PDC of at least 50 percent for their asthma controller medications during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members who achieved a PDC of at least 75 percent for their asthma controller medications.	Of the total reported in A, the number of members who achieved a PDC of at least 75 percent for their asthma controller medications during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members 51-64 years of age who were identified as having persistent asthma and who were dispensed appropriate medications.	Total number of members 51-64 years of age who were continuously enrolled during the previous reporting period and the current reporting period, and who were enrolled on December 31 of the current reporting period, who were identified as having persistent asthma and who were dispensed appropriate medications.	Field Type: Numeric
E.	Total number of members who achieved a PDC of at least 50 percent for their asthma controller medications.	Of the total reported in D, the number of members who achieved a PDC of at least 50 percent for their asthma controller medications during the reporting period.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of members who achieved a PDC of at least 75 percent for their asthma controller medications.	Of the total reported in D, the number of members who achieved a PDC of at least 75 percent for their asthma controller medications during the reporting period.	Field Type: Numeric Note: Is a subset of D.

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of members 65 years of age and older who were identified as having persistent asthma and who were dispensed appropriate medications.	Total number of members 65 years of age and older who were continuously enrolled during the previous reporting period and the current reporting period, and who were enrolled on December 31 of the current reporting period, who were identified as having persistent asthma and who were dispensed appropriate medications.	Field Type: Numeric
H.	Total number of members who achieved a PDC of at least 50 percent for their asthma controller medications.	Of the total reported in G, the number of members who achieved a PDC of at least 50 percent for their asthma controller medications during the reporting period.	Field Type: Numeric Note: Is a subset of G.
I.	Total number of members who achieved a PDC of at least 75 percent for their asthma controller medications.	Of the total reported in G, the number of members who achieved a PDC of at least 75 percent for their asthma controller medications during the reporting period.	Field Type: Numeric Note: Is a subset of G.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.

- MMPs should validate that data elements B and C are less than or equal to data element A.
- MMPs should validate that data elements E and F are less than or equal to data element D.
- MMPs should validate that data elements H and I are less than or equal to data element G.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members 21-50 years of age who achieved a PDC of at least 50 percent for their asthma controller medications during the reporting period.
- Members 21-50 years of age who achieved a PDC of at least 75 percent for their asthma controller medications during the reporting period.
- Members 51-64 years of age who achieved a PDC of at least 50 percent for their asthma controller medications during the reporting period.
- Members 51-64 years of age who achieved a PDC of at least 75 percent for their asthma controller medications during the reporting period.
- Members 65 years of age and older who achieved a PDC of at least 50 percent for their asthma controller medications during the reporting period.
- Members 65 years of age and older who achieved a PDC of at least 75 percent for their asthma controller medications during the reporting period.
- Members 21 and older who achieved a PDC of at least 50 percent for their asthma controller medications during the reporting period.
- Members 21 and older who achieved a PDC of at least 75 percent for their asthma controller medications during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- The member must be enrolled during the current reporting period and the previous reporting period with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a 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).

- Due to continuous enrollment criteria this measure will be reported beginning CY2.
- The index prescription start date (IPSD) is the earliest prescription dispensing date for any asthma controller medication during the reporting period.
- The treatment period is the period of time beginning on the IPSD through the last day of the reporting period.
- The proportion of days covered (PDC) is the number of days that a member is covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period.
- The oral medication dispensing event is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). The MMP should allocate the dispensing events to the appropriate year based on the date when the prescription is filled.
- Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.
- The inhaler dispensing event is all inhalers (i.e., canisters) dispensed on the same calendar day count as one dispensing event, regardless if they are the same medication or a different medication. For example, two inhalers dispensed on the same day count as one dispensing event. Two inhalers dispensed on different dates of service count as two dispensing events. Allocate the dispensing events to the appropriate reporting period based on the date when the prescription was filled.
- For injection dispensing events, each injection counts as one dispensing event. Multiple dispensing events of the same medication or a different medication count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events. Allocate the dispensing events to the appropriate reporting period based on the date when the prescription was filled.
- To calculate the number of days covered for multiple prescriptions:
    - If multiple prescriptions for different medications are dispensed on the same day, calculate numbers of days covered by a controller medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

- If multiple prescriptions for different medications are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication (for the numerator). For example, three controller prescriptions for the same medications are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller. Subtract any days supply that extends beyond December 31 of the reporting period.
- Use the drug ID provided by the NCD to determine if the prescriptions are the same or different.

- Follow the steps below to identify the eligible population for this measure:

  Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the current reporting period and the year prior to the reporting period. Criteria need not be the same across both years.

  - At least one ED visit (**Table TX-29**, ED value set), with a principal diagnosis of asthma (**Table TX-66**).
  - At least one acute inpatient encounter (**Table TX-29**, Acute Inpatient value set), with a principal diagnosis of asthma (**Table TX-66**).
  - At least four outpatient visits (**Table TX-29**, Outpatient value set) or observation visits (**Table TX-29**, Observation value set) on different dates of service, with any diagnosis of asthma (**Table TX-66**) *and* at least two asthma medication dispensing events (**Table TX-30**). Visit type need not be the same for the four visits.
  - At least four asthma medication dispensing events (**Table TX-30**).
    i. MMPs should also reference the complete list of medications and NDC codes NCQA has posted to www.ncqa.org.

  Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (**Table TX-66**) during the same year as the

leukotriene modifier (i.e., the reporting period or the year prior to the reporting period).

Step 3: Required exclusions. Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the reporting period:
  - **Table TX-31**, Emphysema
  - **Table TX-32**, Other Emphysema
  - **Table TX-33**, COPD value set
  - **Table TX-34**, Obstructive Chronic Bronchitis
  - **Table TX-35**, Chronic Respiratory Conditions Due To Fumes/Vapors
  - **Table TX-36**, Cystic Fibrosis
  - **Table TX-37**, Acute Respiratory Failure
- Members who have no asthma controller medications (**Table TX-38**) dispensed during the reporting period.
  i. MMPs should also reference the complete list of medications and NDC codes NCQA has posted to www.ncqa.org.

- The following steps should be used to identify numerator compliance:

Step 1: Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication (**Table TX-38**) during the reporting period.

Step 2: To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the reporting period.

Step 3: Count the days covered by at least one prescription for an asthma controller medication (**Table TX-38**) during the treatment period. To ensure that days supply that extends beyond the reporting period is not counted, subtract any days supply that extends beyond December 31 of the reporting period.

Step 4: Calculate the member's PDC using the following equation. Round (using the .5 rule) to two decimal places.

$$\frac{\textbf{Total days covered by a controller medication in the treatment period (Step 3)}}{\textbf{Total days in treatment period (Step 2)}}$$

- To determine the 50 percent medication compliance, sum the number of members whose proportion of days covered (PDC) is ≥50 percent for the treatment period.
- To determine the 75 percent medication compliance, sum the number of members whose PDC is ≥75 for the treatment period.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.13 Cervical cancer screening.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of women 24-64 years old.	Total number of women 24-64 years old, who were continuously enrolled during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of women sampled that met inclusion criteria.	Of the total reported in A, the number of women sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of women who were appropriately screened for cervical cancer.	Of the total reported in B, the number of women who were appropriately screened for cervical cancer.	Field Type: Numeric Note: Is a subset of B.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of women 24-64 years old who were appropriately screened for cervical cancer.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members ages 24-64 regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included. A subset of all members that are eligible will be included in the sample.
- The member must be enrolled during the current reporting period and the previous reporting period with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a 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).
- Due to continuous enrollment criteria this measure will be reported beginning CY2.

Administrative Specifications

- The MMP should refer to the HEDIS® Value sets listed in steps 1 and 2 to identify numerator positive hits when using administrative data.
    - **Step 1**: Identify women 24-64 years of age as of December 31 of the reporting period who had a cervical cytology (**Table TX-39**) during the reporting period or the two years prior to the reporting period.
    - **Step 2**: From the women who did not meet step 1 criteria, identify women 30-64 years of age as of December 31 of the reporting period who had cervical cytology (**Table TX-39**) and a human papillomavirus (HPV) test (**Table TX-40**) with service dates four or less days apart during the reporting period or the four years prior to the reporting period. For example, if the service date for cervical cytology was December 1 of the reporting period, then the HPC text must include a service date on or between December 1 and December 5 of the reporting period.
    - **Step 3**: Sum the events from steps 1 and 2 to obtain the rate.
- Exclude hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (**Table TX-41**) any time during the member's history through December 31 of the reporting period.

Hybrid Specifications

- MMPs may elect to use a hybrid methodology for this measure.
- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.
- Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- The MMP should refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- When reviewing a members medical record, the following steps should be used to identify numerator compliance.
    - **Step 1**: Identify the number of women who were 24–64 years of age as of December 31 of the reporting period who had cervical cytology during the reporting period, or the two years prior to the reporting period. Documentation in the medical record must include both of the following:
        - A note indicating the date when the cervical cytology was performed.
        - The result or finding.

- Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Step 2: From the women who did <u>not</u> meet step 1 criteria, identify the number of women who were 35–64 years of age as of December 31 of the reporting period who had cervical cytology and an HPV test on the same date of service during the reporting period or the four years prior to the reporting period. Documentation in the medical record must include both of the following:
  - A note indicating the date when the cervical cytology and the HPV test were performed.
  - The result or finding.
- Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
- In administrative data, there is flexibility in the date of service to allow for a potential lag in claims.
- In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.
- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Step 3: Sum the events from Steps 1-2 to obtain the rate.

- Exclude the following (these are optional exclusions):
  - Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (**Table TX-41**) any time during the member's history through December 31 of the reporting period. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.

- Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.14 Avoidance of antibiotic treatment in adults with acute bronchitis.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members 21-64 years of age with a diagnosis of acute bronchitis.	Total number of members 21-64 years of age who were continuously enrolled one year prior to the Episode Date through seven days after the Episode Date with a diagnosis of acute bronchitis.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who were dispensed a prescription for antibiotic medication on the index episode start date (IESD) or within three days after the IESD.	Of the total reported in A, the number of members who were dispensed a prescription for antibiotic medication on the IESD or within three days after the IESD.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members 65 years of age and older with a diagnosis of acute bronchitis.	Total number of members 65 years of age and older who were continuously enrolled one year prior to the Episode Date through seven days after the Episode Date with a diagnosis of acute bronchitis.	Field Type: Numeric
D.	Total number of members who were dispensed a prescription for antibiotic medication on the IESD or within three days after the IESD.	Of the total reported in C, the number of members who were dispensed a prescription for antibiotic medication on the IESD or within three days after the IESD.	Field Type: Numeric Note: Is a subset of C.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

NOTE: This measure is reported as an inverted rate [1-(numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

CMS and the state will evaluate the percentage of:

- Members 21-64 years of age with a diagnosis of acute bronchitis who were not dispensed a prescription for antibiotic medication on the IESD or within three days after the IESD.
- Members 65 years of age and older with a diagnosis of acute bronchitis who were not dispensed a prescription for antibiotic medication on the IESD or within three days after the IESD.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- A member must be continuously enrolled for one year prior to the Episode Date through seven days after the Episode Date (inclusive).
- Due to continuous enrollment criteria this measure will be reported beginning CY2.
- No more than one gap in enrollment of up to 45 days is allowed from 365 days (1 year) prior to the Episode Date through 7 days after the Episode Date. To determine continuous enrollment for a 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).
- The Intake Period is January 1-December 24 of the reporting period. The Intake Period captures eligible episodes of treatment.
- The Episode Date is the date of service for any outpatient ED visit during the Intake Period with a diagnosis of acute bronchitis.
- The index episode start date (IESD) is the earliest Episode Date during the Intake Period that meets all of the following criteria:
    - A 30-day Negative Medication History prior to the Episode Date.
    - A 12-month Negative Comorbid Condition History prior to and including the Episode Date.
    - A negative competing diagnosis during the 30 days prior to the Episode Date through seven days after the Episode Date (inclusive).

  - The member was continuously enrolled one year prior to the Episode Date through seven days after the Episode Date.

- 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 that were filled more than 30 days prior to the Episode Date and 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 the date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.
- The Negative Comorbid Condition History is a period of 12 months prior to and including the Episode Date, when the member had no claims/encounters containing either a principle or secondary diagnosis for a comorbid condition.
- The Negative Competing Diagnosis is a period of 30 days prior to the Episode Date through seven days after the Episode Date (inclusive), when the member had no claims/encounters with any competing diagnosis.
- Follow the steps below to identify the eligible population:
  - **Step 1**: Identify all members who had an outpatient visit (**Table TX-29**, Outpatient value set), an observation visit (**Table TX-29**, Observation value set), or an ED visit (**Table TX-29**, ED value set), during the Intake Period, with a diagnosis of acute bronchitis (**Table TX-67**, Acute Bronchitis value set). Do not include ED visits that result in an inpatient admission.
  - **Step 2**: Determine all acute bronchitis Episode Dates. For each member identified in step one, determine all outpatient or ED claims/encounters with a diagnosis of acute bronchitis.
  - **Step 3**: Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with a diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:
    - **Table TX-42**, HIV
    - **Table TX-43**, Malignant Neoplasms
    - **Table TX-31**, Emphysema
    - **Table TX-33**, COPD

- **Table TX-36**, Cystic Fibrosis
- **Table TX-44**, Comorbid Conditions

Step 4: Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (**Table TX-45**) was filled 30 days prior to the Episode Date or was active on the Episode Date.

i. MMPs should also reference the complete list of medications and NDC codes NCQA has posted to www.ncqa.org.

Step 5: Test for negative competing diagnosis. Exclude Episode Dates where during the period 30 days prior to the Episode Date through seven days after the Episode Date (inclusive), the member had a claim/encounter with any competing diagnosis. A code from either of the following meets criteria for a competing diagnosis:

- **Table TX-46**,Pharyngitis
- **Table TX-47**,Competing diagnosis

Step 6: Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days (one year) prior to the Episode Date through seven days after the Episode Date.

Step 7: Select the IESD. This measure examines the earliest eligible episode per member.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.15 Use of appropriate medications for people with asthma.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	The number of members 21-50 years of age who were identified as having persistent asthma.	Total number of members 21-50 years of age who were continuously enrolled during the previous reporting period and the current reporting period, who were enrolled on December 31 of the current reporting period, who were identified as having persistent asthma.	Field Type: Numeric
B.	The number of members who were dispensed at least one prescription for an asthma controller medication.	Of the total reported in A, the number of members who were dispensed at least one prescription for an asthma controller medication during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	The number of members 51-64 years of age who were identified as having persistent asthma.	Total number of members 51-64 years of age who were continuously enrolled during the previous reporting period and the current reporting period, who were enrolled on December 31 of the current reporting period, who were identified as having persistent asthma.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	The number of members who were dispensed at least one prescription for an asthma controller medication.	Of the total reported in C, the number of members who were dispensed at least one prescription for an asthma controller medication during the reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	The number of members 65 years of age and older who were identified as having persistent asthma.	Total number of members 65 years of age and older who were continuously enrolled during the previous reporting period and the current reporting period, who were enrolled on December 31 of the current reporting period, who were identified as having persistent asthma.	Field Type: Numeric
F.	The number of members who were dispensed at least one prescription for an asthma controller medication.	Of the total reported in E, the number of members who were dispensed at least one prescription for an asthma controller medication during the reporting period.	Field Type: Numeric Note: Is a subset of E.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.

- MMPs should validate that data element F is less than or equal to data element E.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members 21-50 years of age who were identified as having persistent asthma who were dispensed at least one prescription for an asthma controller medication during the reporting period.
- Members 51-64 years of age who were identified as having persistent asthma who were dispensed at least one prescription for an asthma controller medication during the reporting period.
- Members 65 years of age and older who were identified as having persistent asthma who were dispensed at least one prescription for an asthma controller medication during the reporting period.
- Members 21 years of age and older who were identified as having persistent asthma who were dispensed at least one prescription for an asthma controller medication during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- The member must be enrolled during the current reporting period and the previous reporting period with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a 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).
- Due to continuous enrollment criteria this measure will be reported beginning CY2.
- The oral medication dispensing event is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). The MMP should allocate the dispensing events to the appropriate year based on the date when the prescription is filled.
- Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

  - *Two prescriptions* for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).
  - *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).
  - *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).
  - *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

- The inhaler dispensing event is all inhalers (i.e., canisters) dispensed on the same calendar day count as one dispensing event, regardless if they are the same medication or a different medication. For example, two inhalers dispensed on the same day count as one dispensing event. Two inhalers dispensed on different dates of service count as two dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
- For injection dispensing events, each injection counts as one dispensing event. Multiple dispensing events of the same medication or a different medication count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
- Follow the steps below to identify the eligible population for this measure:

  Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the reporting period and the year prior to the reporting period. Criteria need not be the same across both years.

  - At least one ED visit (**Table TX-29**, ED value set), with a principal diagnosis of asthma (**Table TX-7**).
  - At least one acute inpatient encounter (**Table TX-29**, Acute Inpatient value set), with a principal diagnosis of asthma (**Table TX-7**).
  - At least four outpatient visits (**Table TX-29**, Outpatient value set) or observation visits (**Table TX-29**, Observation value set) on different dates of service, with any diagnosis of

asthma (**Table TX-7**) and at least two asthma medication dispensing events (**Table TX-30**). Visit type need not be the same for the four visits.

- At least four asthma medication dispensing events (**Table TX-30**).

Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (**Table TX-7**) during the same year as the leukotriene modifier (i.e., the reporting period or the year prior to the reporting period).

Step 3: Required exclusions. Exclude members who met any of the following criteria:

- Member who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the reporting period:
  - **Table TX-31**, Emphysema
  - **Table TX-32**, Other Emphysema
  - **Table TX-33**, COPD
  - **Table TX-34**, Obstructive Chronic Bronchitis
  - **Table TX-35**, Chronic Respiratory Conditions Due To Fumes/Vapors
  - **Table TX-36**, Cystic Fibrosis
  - **Table TX-37**, Acute Respiratory Failure

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.16 Prenatal and postpartum care.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions - details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of live deliveries.	Total number of live deliveries for women who were continuously enrolled between 43 days prior to delivery and 56 days after delivery during the reporting period.	Field Type: Numeric
B.	Total number of deliveries sampled that met inclusion criteria.	Of the total reported in A, the number of deliveries sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of deliveries that received a prenatal visit in the first trimester or within 42 days of enrollment.	Of the total reported in B, the number of deliveries that received a prenatal visit in the first trimester or within 42 days of enrollment.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of deliveries that had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.	Of the total reported in B, the number of deliveries that had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.	Field Type: Numeric Note: Is a subset of B.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data elements C and D are less than or equal to data element B.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of deliveries that:

- Received a prenatal visit in the first trimester or within 42 days of enrollment.
- Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included. A subset of all members that are eligible will be included in the sample.
- A member must be continuously enrolled for 46 days prior to the delivery through 56 days after the delivery, with no gaps in enrollment to be included in this measure.
- Include all events for those members who delivered a live birth between November 6 of the prior reporting period and November 5 of the current reporting period.
- Include women who delivered in a birthing center.
- Include all women who had two separate deliveries (different dates of service) between November 6 of the year prior to the reporting period and November 5 of the current reporting period should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.
- For data element C, the prenatal visit depends on the date of enrollment in the MMP and the gaps in enrollment during the pregnancy. Include only visits that occur while the member was enrolled.

- For data element D, the postpartum visit should be documented through either administrative data or medical record review.
- Follow the steps below to identify the eligible population, which is the denominator for both rates:
    - **Step 1**: Identify deliveries. Identify all women with a delivery between November 6 of the year prior to the reporting period and November 5 of the reporting period. Either of the following meets criteria:
        - A delivery (**Table TX-48**)
        - A delivery on an infant claim (**Table TX-49**), where the MMP can link infant and mother records.
    - **Step 2**: Exclude non-live births (**Table TX-50**)
    - **Step 3**: Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

Administrative Specifications – Timeliness of Prenatal Care

- Follow the steps below to identify the numerator:
    - **Step 1**: Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women proceed to step 2.
        - 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 3.
    - **Step 2**: Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176-280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for *Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester* (see page TX-75).
        - For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.
    - **Step 3**: Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).
        - For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4. For women whose last

enrollment started less than 219 days before delivery, proceed to step 5.

Step 4: Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* (see page TX-76) and find a visit between the last enrollment start date and 176 days before delivery.

Step 5: Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During The First Trimester* (see page TX-76) and find a visit within 42 days after enrollment.

Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester

Decision Rule 1: Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria:

- A bundled service (**Table TX-51**) where the MMP can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (**Table TX-52**)

Decision Rule 2: Any of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner, meet criteria:

- A prenatal visit (**Table TX-53**), with an obstetric panel (**Table TX-54**).
- A prenatal visit (**Table TX-53**) with an ultrasound (echocardiography) of the pregnant uterus (**Table TX-55**).
- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**).
- A prenatal visit (**Table TX-53**) with all of the following:
  - **Table TX-57**, Toxoplasma
  - **Table TX-58**, Rubella
  - **Table TX-59**, Cytomegalovirus
  - **Table TX-60**, Herpes simplex

- A prenatal visit (**Table TX-53**) with rubella (**Table TX-58**) and ABO (**Table TX-61**).
- A prenatal visit (**Table TX-53**) with rubella (**Table TX-58**) and Rh (**Table TX-62**).
- A prenatal visit (**Table TX-53**) with rubella (**Table TX-58**) and ABO/Rh (**Table TX-63**).

Decision Rule 3: Any of the following during the first trimester, where the practitioner type is PCP, meet criteria:

- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis (**Table TX-56**) and an obstetric panel (**Table TX-54**).
- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**) and an ultrasound (echocardiography) of the pregnant uterus (**Table TX-55**).
- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**).
- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**) and all of the following:
  - **Table TX-57**, Toxoplasma
  - **Table TX-58**, Rubella
  - **Table TX-59**, Cytomegalovirus
  - **Table TX-60**, Herpes simplex
- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**) and rubella (**Table TX-58**) and ABO (**Table TX-61**).
- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**) and rubella (**Table TX-58**) and Rh (**Table TX-62**).
- A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**) and rubella (**Table TX-58**) and ABO/Rh (**Table TX-63**).
- A prenatal visit (**Table TX-53**) with any internal MMP code for LMP or EDD with an obstetrical history.
- A prenatal visit (**Table TX-53**) with any internal MMP code for LMP or EDD with risk assessment and counseling/education.

- For criteria that require a prenatal visit code (**Table TX-53**) *and* a pregnancy-related diagnosis code (**Table TX-56**), the codes must be on the same claim.

Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester

- Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:

  - A bundled service (**Table TX-51**) where the MMP can identify the date when prenatal care was initiated (because bundled codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated.
  - A visit for prenatal care (**Table TX-52**).
  - A prenatal visit (**Table TX-53**) with an ultrasound (echocardiography) of the pregnant uterus (**Table TX-55**).
  - A prenatal visit (**Table TX-53**) with a pregnancy-related diagnosis code (**Table TX-56**).
- For criteria that require a prenatal visit code (**Table TX-53**) *and* a pregnancy-related diagnosis code (**Table TX-56**), the codes must be on the same claim.

Administrative Specifications – Postpartum Care

- Any of the following meet criteria:
  - A postpartum visit (**Table TX-64**).
  - Cervical Cytology (**Table TX-39**).
  - A bundled service (**Table TX-65**) where the MMP can identify the date when the postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the visit, these codes may be used only if the claim form indicates when postpartum care was rendered).
- The practitioner requirement only applies to the Hybrid Specification. The MMP is not required to identify practitioner type in administrative data.

Hybrid Specifications – Timeliness of Prenatal Care

- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.
- The MMP should refer to the *Administrative Specification* to identify positive numerator hits from administrative data.
- Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. MMPs may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81 percent 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 percent indicator from *Frequency of Ongoing Prenatal Care*. The sample size should be 411, plus oversample to allow for substitution.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- When reviewing a members medical record, the record should include a prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a 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 (standardized prenatal flow sheet must 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 white blood cell count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, red blood cell antibody screen, Rh 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.
  - Complete obstetrical history.

- For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principle diagnosis of pregnancy.

Hybrid Specifications – Postpartum Care

- The MMP should refer to the *Administrative Specification* to identify positive numerator hits from administrative data.
- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.
- Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. MMPs may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81 percent 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 percent indicator from *Frequency of Ongoing Prenatal Care*. The sample size should be 411, plus oversample to allow for substitution.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- When reviewing a members medical record, the record should include a postpartum visit to an OB/GYN practitioner or midwife,

family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts and abdomen.
  - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
- Notation of postpartum care, including but not limited to:
  - Notation of "postpartum care", "PP care", "PP check", "6-week check."
  - A preprinted "Postpartum Care" form in which information was documented during the visit.

Additional Notes:

- For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the MMP has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.
- Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.
  - For women whose last enrollment segment started on or between 219 and 279 days before delivery, the MMP has sufficient opportunity to provide prenatal care by the end of the first trimester.
  - For women whose last enrollment segment started less than 219 days before delivery, the MMP has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.
- The MMP must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the MMP must define a method to determine which EDD to use, and use that date consistently.
- 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 for either rate.
- An OB/GYN includes:
  - 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 as 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).
- The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.
- The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

Section TXV. Utilization

TX5.1 Members who went from community to hospital to nursing facility and remained in nursing facility.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX5. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions - details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who were admitted to the hospital from the community and who remained in the hospital for 30 days or less.	Total number of members who were admitted to the hospital from the community and who remained in the hospital for 30 days or less during the reporting period.	Field Type: Numeric
B.	Total number of members who were discharged to a nursing facility (NF) and remained in the NF for at least 100 continuous days.	Of the total reported in A, the number of members who were discharged to a NF and remained in the NF for at least 100 continuous days.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established threshold for this measure.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.

- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members who were admitted to the hospital from the community, remained in the hospital for 30 days or less during the reporting period, and who were discharged to a NF and remained in the NF for at least 100 continuous days.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The date of discharge must occur within the reporting period, but the amount of time spent in a nursing facility may not be in the same reporting period. For example, if the discharge occurs during the last three months of the reporting period, look to the first three months of the following reporting period to identify if a member remained in the nursing facility for at least 100 continuous days.
- The member needs to be enrolled from the date of the hospital admission through 100 days following the hospital discharge, with no gaps in enrollment, to be included in this measure.
- Nursing facility: A convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to Medicaid recipients
- An admission is a stay in a nursing facility longer than 100 continuous days.
- To determine members who were discharged to a NF and remained in the NF for at least 100 continuous days (i.e., data element B), the member must have no break in their stay in the NF. For example, if a member is discharged to the NF and remains there for 80 days, then transferred back to the hospital, or some other facility, and then is readmitted back to the NF, the first day back in the NF would count as day one (and not day 81). A transfer or discharge from the NF before the members 100th continuous day in the facility would disrupt the number of days the member remained in the NF. However, if a member was discharged or

transferred from the NF on day 102 of their NF stay, they would be counted in data element B.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- The data source for this measure is encounter data. HHSC will calculate the measure and provide it to CMS.

Appendix A – Texas Measure Tables

Table TX-1: Codes to Identify Ambulatory Health Services				
Description	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	9938-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Table TX-2: Codes to Identify Inpatient Discharges		
Principal ICD-9-CM Diagnosis		**MS-DRG**
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill	***OR***	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Table TX-3: Codes to Identify Patients who Expired
Discharge Status Code
20

Table TX-4: Codes to Identify Diabetes Short-Term Complications
ICD-9-CM
25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033

Table TX-5: Codes to Identify Diabetes Long-Term Complications
ICD-9-CM
25040, 25041, 25042, 25043, 25050, 25051, 25052, 25053, 25060, 25061, 25062, 25063, 25070, 25071, 25072, 25073, 25080, 25081, 25082, 25083, 25090, 25091, 25092, 25093

Table TX-6: Codes to Identify COPD (Excluding Acute Bronchitis)
ICD-9-CM
4910, 4911, 49120, 49121, 4918, 4919, 4920, 4928, 494, 4940, 4941, 496

Table TX-7: Codes to Identify Asthma
ICD-9-CM
49300, 49301, 49302, 49310, 49311, 49312, 49320, 49321, 49322, 49381, 49382, 49390, 49391, 49392

Table TX-8: Codes to Identify Acute Bronchitis
ICD-9-CM
466.0 and 490

Table TX-9: Codes to Identify Cystic Fibrosis and Anomalies of the Respiratory System
ICD-9-CM
27700, 27701, 27702, 27703, 27709, 51661, 51662, 51663, 51664, 51669, 74721, 7483, 7484, 7485, 74860, 74861, 74869, 7488, 7489, 7503, 7593, 7707

Table TX-10: Codes to Identify Hypertension
ICD-9-CM
4010, 4019, 40200, 40210, 40290, 40300, 40310, 40390, 40400, 40410, 40490

Table TX-11: Codes to Identify Stage I-IV Kidney Disease
ICD-9-CM
40300, 40310, 40390, 40400, 40410, 40490

Table TX-12: Codes to Identify Dialysis Access
ICD-9-CM
3895, 3927, 3929, 3942, 3943, 3993, 3994

Table TX-13: Codes to Identify Heart Failure
ICD-9-CM
39891, 40201, 40211, 40291, 40401, 40403, 40411, 40413, 40491, 40493, 4280, 4281, 42820, 42821, 42822, 42923, 42830, 42831, 42832, 42833, 42840, 42841, 42842, 42843, 4289

Table TX-14: Codes to Identify Dehydration
ICD-9-CM
2765, 27650, 27651, 27652

Table TX-15: Codes to Identify Hyperosmolality and/or Hypernatremia
ICD-9-CM
2760

Table TX-16: Codes to Identify Gastroenteritis
ICD-9-CM
00861, 00862, 00863, 00864, 00865, 00866, 00867, 00869, 0088, 0090, 0091, 0092, 0093, 5589

Table TX-17: Codes to Identify Acute Kidney Injury
ICD-9-CM
5845, 5846, 5847, 5848, 5849, 586, 9975

Table TX-18: Codes to Identify Chronic Renal Failure
ICD-9-CM
40300, 40301, 40310, 40311, 40390, 40391, 40400, 40401, 40402, 40403, 40410, 40411, 40412, 40413, 40490, 40491, 40492, 40493, 585, 5855, 5856

Table TX-19: Codes to Identify Bacterial Pneumonia
ICD-9-CM
481, 4822, 48230, 48231, 48232, 48239, 48241, 48242, 4829, 4830, 4831, 4838, 485, 486

Table TX-20: Codes to Identify Sickle Cell Anemia or HB-S Disease
ICD-9-CM
28241, 28242, 28260, 28261, 28262, 28263, 28264, 28268, 28269

Table TX-21: Codes to Identify Urinary Tract Infection
ICD-9-CM
59010, 59011, 5902, 5903, 59080, 59081, 5909, 5950, 5959, 5990

Table TX-22: Codes to Identify Kidney/Urinary Tract Disorder
ICD-9-CM
59000, 59001, 59370, 59371, 59372, 59373, 7530, 75310, 75311, 75312, 75313, 75314, 75315, 75316, 75317, 75319, 75320, 75321, 75322, 75323, 75329, 7533, 7534, 7535, 7536, 7538, 7539

Table TX-23: Codes to Identify Angina
ICD-9-CM
4111, 41181, 41189, 4130, 4131, 4139

Table TX-24: Codes to Identify Uncontrolled Diabetes
ICD-9-CM
25002, 25003

Table TX-25: Codes to Identify Lower-Extremity Amputation
ICD-9-CM
8410, 8412, 8413, 8414, 8415, 8416, 8417, 8418, 8419

Table TX-26: Codes to Identify Diabetes
ICD-9-CM
25000, 25001, 25002, 25003 , 25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033, 25040, 25041, 25042, 25043, 25050, 25051, 25052, 25053, 25060, 25061, 25062, 25063, 25070, 25071, 25072, 25073, 25080, 25081, 25082, 25083, 25090, 25091, 25092, 25093

Table TX-27: Codes to Identify Traumatic Amputation of the Lower Extremity
ICD-9-CM
8950, 8951, 8960, 8961, 8962, 8963, 8970, 8971, 8972, 8973, 8974, 8975, 8976, 8977

Table TX-28: Codes to Identify Toe Amputation
ICD-9-CM
8411

Table TX-29: Codes to Identify Visits			
Value Set	**CPT**	**HCPCS**	**UB Revenue**
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0402, G0438, G0439, G0463, T1015	051x, 0520-0523, 0526-0529, 0982, 0983
Observation	99217-99220		
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291		010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 0987
ED	99281-99285		045x, 0981

Table TX-30: Asthma Medications			
Description	**Prescriptions**		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guiafenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticansone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone	• Triamcinolone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Long-acting, inhaled beta-2 agonists	• Arformoterol	• Salmeterol	• Formoterol
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline	• Theophylline	• Dyphylline
Short-acting, inhaled beta-2 agonists	• Albuterol • Levalbuterol	• Pirbuterol	

Table TX-31: Codes to Identify Emphysema
ICD-9-CM
492.0, 492.8

Table TX-32: Codes to Identify Other Emphysema
ICD-9-CM
518.1, 518.2

Table TX-33: Codes to Identify COPD
ICD-9-CM
493.20, 493.21, 493.22, 496

Table TX-34: Codes to Identify Obstructive Chronic Bronchitis
ICD-9-CM
491.20, 491.21, 491.22

Table TX-35: Codes to Identify Chronic Respiratory Conditions due to Fumes/Vapors
ICD-9-CM
506.4

Table TX-36: Codes to Identify Cystic Fibrosis
ICD-9-CM
277.00, 277.01, 277.02, 277.03, 277.09

Table TX-37: Codes to Identify Acute Respiratory Failure
ICD-9-CM
518.81

Table TX-38: Asthma Controller Medications			
Description	**Prescriptions**		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guiafenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticansone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone	• Triamcinolone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Long-acting, inhaled beta-2 agonists	• Arformoterol	• Salmeterol	• Formoterol
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline	• Theophylline	• Dyphylline
Short-acting, inhaled beta-2 agonists	• Albuterol • Levalbuterol	• Pirbuterol	

Table TX-39: Codes to Identify Cervical Cytology			
CPT	**HCPCS**	**UB Revenue**	**LOINC**
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Table TX-40: Codes to Identify HPV Test	
CPT	**LOINC**
87620-87622	21440-3, 30167-1, 38372-9, 49896-4, 59420-0

Table TX-41: Codes to Identify Exclusions due to Absence of Cervix		
CPT	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure**
51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, V88.01, V88.03, 752.43	68.41, 68.49, 68.51, 68.59, 68.61, 68.69, 68.71, 68.79, 68.8

Table TX-42: Codes to Identify HIV
ICD-9-CM
042, V08

Table TX-43: Codes to Identify Malignant Neoplasms
ICD-9-CM
1400, 1401, 1403, 1404, 1405, 1406, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1418, 1419, 1420, 1421, 1422, 1428, 1429, 1430, 1431, 1438, 1439, 1440, 1441, 1448, 1449, 1450, 1451, 1452, 1453, 1454, 1455, 1456, 1458, 1459, 1460, 1461, 1462, 1463, 1464, 1465, 1466, 1467, 1468, 1469, 1470, 1471, 1472, 1473, 1478, 1479, 1480, 1481, 1482, 1483, 1488, 1489, 1490, 1491, 1498, 1499, 1500, 1501, 1502, 1503, 1504, 1505, 1508, 1509, 1510, 1511, 1512, 1513, 1514, 1515, 1516, 1518, 1519, 1520, 1521, 1522, 1523, 1528, 1529, 1530, 1531, 1532, 1533, 1534, 1535, 1536, 1537, 1538, 1539, 1540, 1541, 1542, 1543, 1548, 1550, 1551, 1552, 1560, 1561, 1562, 1568, 1569, 1570, 1571, 1572, 1573, 1574, 1578, 1579, 1580, 1588, 1589, 1590, 1591, 1598, 1599, 1600, 1601, 1602, 1603, 1604, 1605, 1608, 1609, 1610, 1611, 1612, 1613, 1618, 1619, 1620, 1622, 1623, 1624, 1625, 1628, 1629, 1630, 1631, 1638, 1639, 1640, 1641, 1642, 1643, 1648, 1649, 1650, 1658, 1659, 1700, 1701, 1702, 1703, 1704, 1705, 1706, 1707, 1708, 1709, 1710, 1712, 1713, 1714, 1715, 1716, 1717, 1718, 1719, 1720, 1721, 1722, 1723, 1724, 1725, 1726, 1727, 1728, 1729, 17300, 17301, 17302, 17309, 17310, 17311, 17312, 17319, 17320, 17321, 17322, 17329, 17330, 17331, 17332, 17339, 17340, 17341, 17342, 17349, 17350, 17351, 17352, 17359, 17360, 17361, 17362, 17369, 17370, 17371, 17372, 17379, 17380, 17381, 17382, 17389, 17390, 17391, 17392, 17399, 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 1750, 1759, 1760, 1761, 1762, 1763, 1764, 1765, 1768, 1769, 179, 1800, 1801, 1808, 1809, 181, 1820, 1821, 1828, 1830, 1832, 1833, 1834, 1835, 1838, 1839, 1840, 1841, 1842, 1843, 1844, 1848, 1849, 185, 1860, 1869, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, 1879, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888, 1889, 1890, 1891, 1892, 1893, 1894, 1898, 1899, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1928, 1929, 193, 1940, 1941, 1943, 1944, 1945, 1946, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1958, 1960, 1961, 1962, 1963, 1965, 1966, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 19881, 19882, 19889, 1990, 1991, 1992, 20000, 20001, 20002, 20003, 20004, 20005, 20006, 20007, 20008, 20010, 20011, 20012, 20013, 20014, 20015, 20016, 20017, 20018, 20020, 20021, 20022, 20023, 20024, 20025, 20026, 20027, 20028, 20030, 20031, 20032, 20033, 20034, 20035, 20036, 20037, 20038, 20040, 20041, 20042, 20043, 20044, 20045, 20046, 20047, 20048, 20050, 20051, 20052, 20053, 20054, 20055, 20056, 20057, 20058, 20060, 20061, 20062, 20063, 20064, 20065, 20066, 20067, 20068, 20070, 20071, 20072, 20073, 20074, 20075, 20076, 20077, 20078, 20080, 20081, 20082, 20083, 20084, 20085, 20086, 20087, 20088, 20100, 20101, 20102, 20103, 20104, 20105, 20106, 20107, 20108, 20110, 20111, 20112, 20113, 20114, 20115, 20116, 20117, 20118, 20120, 20121, 20122, 20123, 20124, 20125, 20126, 20127, 20128, 20140, 20141, 20142, 20143, 20144, 20145, 20146, 20147, 20148, 20150, 20151, 20152, 20153, 20154, 20155, 20156, 20157, 20158, 20160, 20161, 20162, 20163, 20164, 20165, 20166, 20167, 20168, 20170, 20171, 20172, 20173, 20174, 20175, 20176, 20177, 20178, 20190, 20191, 20192, 20193, 20194, 20195, 20196, 20197, 20198, 20200, 20201, 20202, 20203, 20204, 20205, 20206, 20207, 20208, 20210, 20211, 20212, 20213, 20214, 20215, 20216, 20217, 20218, 20220, 20221, 20222, 20223, 20224, 20225, 20226, 20227, 20228, 20230, 20231, 20232, 20233, 20234, 20235, 20236, 20237, 20238, 20240, 20241, 20242, 20243, 20244, 20245, 20246, 20247, 20248, 20250, 20251, 20252, 20253, 20254, 20255, 20256, 20257, 20258, 20260, 20261, 20262, 20263, 20264, 20265, 20266, 20267, 20268, 20270, 20271, 20272, 20273, 20274, 20275, 20276, 20277, 20278, 20280, 20281, 20282, 20283, 20284, 20285, 20286, 20287, 20288, 20290, 20291, 20292, 20293, 20294, 20295, 20296, 20297, 20298, 20300, 20301, 20302, 20310, 20311, 20312, 20380, 20381, 20382, 20400, 20401, 20402, 20410, 20411, 20412, 20420, 20421, 20422, 20480, 20481, 20482, 20490, 20491, 20492, 20500, 20501, 20502, 20510, 20511, 20512, 20520, 20521, 20522, 20530, 20531, 20532, 20580, 20581, 20582, 20590, 20591, 20592, 20600, 20601, 20602, 20610, 20611, 20612, 20620, 20621, 20622, 20680, 20681, 20682, 20690, 20691, 20692, 20700, 20701, 20702, 20710, 20711, 20712, 20720, 20721, 20722, 20780, 20781, 20782, 20800, 20801, 20802, 20810, 20811, 20812, 20820, 20821, 20822, 20880, 20881, 20882, 20890, 20891, 20892, 20900, 20901, 20902, 20903, 20910, 20911, 20912, 20913, 20914, 20915, 20916, 20917, 20920, 20921, 20922, 20923, 20924, 20925, 20926, 20927, 20929, 20930, 20931, 20932, 20933, 20934, 20935, 20936, 20940, 20941, 20942, 20943, 20950, 20951, 20952, 20953, 20954, 20955, 20956, 20957, 20960, 20961, 20962, 20963, 20964, 20965, 20966, 20967, 20969, 20970, 20971, 20972, 20973, 20974, 20975, 2097

Table TX-44: Codes to Identify Comorbid Conditions
ICD-9-CM
01000, 01001, 01002, 01003, 01004, 01005, 01006, 01010, 01011, 01012, 01013, 01014, 01015, 01016, 01080, 01081, 01082, 01083, 01084, 01085, 01086, 01090, 01091, 01092, 01093, 01094, 01095, 01096, 01100, 01101, 01102, 01103, 01104, 01105, 01106, 01110, 01111, 01112, 01113, 01114, 01115, 01116, 01120, 01121, 01122, 01123, 01124, 01125, 01126, 01130, 01131, 01132, 01133, 01134, 01135, 01136, 01140, 01141, 01142, 01143, 01144, 01145, 01146, 01150, 01151, 01152, 01153, 01154, 01155, 01156, 01160, 01161, 01162, 01163, 01164, 01165, 01166, 01170, 01171, 01172, 01173, 01174, 01175, 01176, 01180, 01181, 01182, 01183, 01184, 01185, 01186, 01190, 01191, 01192, 01193, 01194, 01195, 01196, 01200, 01201, 01202, 01203, 01204, 01205, 01206, 01210, 01211, 01212, 01213, 01214, 01215, 01216, 01220, 01221, 01222, 01223, 01224, 01225, 01226, 01230, 01231, 01232, 01233, 01234, 01235, 01236, 01280, 01281, 01282, 01283, 01284, 01285, 01286, 01300, 01301, 01302, 01303, 01304, 01305, 01306, 01310, 01311, 01312, 01313, 01314, 01315, 01316, 01320, 01321, 01322, 01323, 01324, 01325, 01326, 01330, 01331, 01332, 01333, 01334, 01335, 01336, 01340, 01341, 01342, 01343, 01344, 01345, 01346, 01350, 01351, 01352, 01353, 01354, 01355, 01356, 01360, 01361, 01362, 01363, 01364, 01365, 01366, 01380, 01381, 01382, 01383, 01384, 01385, 01386, 01390, 01391, 01392, 01393, 01394, 01395, 01396, 01400, 01401, 01402, 01403, 01404, 01405, 01406, 01480, 01481, 01482, 01483, 01484, 01485, 01486, 01500, 01501, 01502, 01503, 01504, 01505, 01506, 01510, 01511, 01512, 01513, 01514, 01515, 01516, 01520, 01521, 01522, 01523, 01524, 01525, 01526, 01550, 01551, 01552, 01553, 01554, 01555, 01556, 01560, 01561, 01562, 01563, 01564, 01565, 01566, 01570, 01571, 01572, 01573, 01574, 01575, 01576, 01580, 01581, 01582, 01583, 01584, 01585, 01586, 01590, 01591, 01592, 01593, 01594, 01595, 01596, 01600, 01601, 01602, 01603, 01604, 01605, 01606, 01610, 01611, 01612, 01613, 01614, 01615, 01616, 01620, 01621, 01622, 01623, 01624, 01625, 01626, 01630, 01631, 01632, 01633, 01634, 01635, 01636, 01640, 01641, 01642, 01643, 01644, 01645, 01646, 01650, 01651, 01652, 01653, 01654, 01655, 01656, 01660, 01661, 01662, 01663, 01664, 01665, 01666, 01670, 01671, 01672, 01673, 01674, 01675, 01676, 01690, 01691, 01692, 01693, 01694, 01695, 01696, 01700, 01701, 01702, 01703, 01704, 01705, 01706, 01710, 01711, 01712, 01713, 01714, 01715, 01716, 01720, 01721, 01722, 01723, 01724, 01725, 01726, 01730, 01731, 01732, 01733, 01734, 01735, 01736, 01740, 01741, 01742, 01743, 01744, 01745, 01746, 01750, 01751, 01752, 01753, 01754, 01755, 01756, 01760, 01761, 01762, 01763, 01764, 01765, 01766, 01770, 01771, 01772, 01773, 01774, 01775, 01776, 01780, 01781, 01782, 01783, 01784, 01785, 01786, 01790, 01791, 01792, 01793, 01794, 01795, 01796, 01800, 01801, 01802, 01803, 01804, 01805, 01806, 01880, 01881, 01882, 01883, 01884, 01885, 01886, 01890, 01891, 01892, 01893, 01894, 01895, 01896, 27900, 27901, 27902, 27903, 27904, 27905, 27906, 27909, 27910, 27911, 27912, 27913, 27919, 2792, 2793, 27941, 27949, 27950, 27951, 27952, 27953, 2798, 2799, 4910, 4911, 49120, 49121, 49122, 4918, 4919, 4940, 4941, 4950, 4951, 4952, 4953, 4954, 4955, 4956, 4957, 4958, 4959, 500, 501, 502, 503, 504, 505, 5060, 5061, 5062, 5063, 5064, 5069, 5070, 5071, 5078, 5080, 5081, 5082, 5088, 5089, 5100, 5109, 5110, 5111, 51181, 51189, 5119, 5120, 5121, 5122, 51281, 51282, 51283, 51284, 51289, 5130, 5131, 514, 515, 5160, 5161, 5162, 51630, 51631, 51632, 51633, 51634, 51635, 51636, 51637, 5164, 5165, 51661, 51662, 51663, 51664, 51669, 5168, 5169, 5171, 5172, 5173, 5178, 5180, 5181, 5182, 5183, 5184, 51851, 51852, 51853, 5186, 5187, 51881, 51882, 51883, 51884, 51889, 51900, 51901, 51902, 51909, 51911, 51919, 5192, 5193, 5194, 5198, 5199

Table TX-45: Antibiotic Medications			
Description	**Prescriptions**		
Aminoglycosides	• Amikacin • Gentamicin	• Kanamycin • Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Antipseudomonal penicillins	• Piperacillin		
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam • Ticarcillin-clavulanate	
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin • Erythromycin ethylsuccinate	• Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Erythromycin-sulfisoxazole • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Norfloxacin • Ofloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefprozil • Cefuroxime	• Cefotetan • Cefoxitin	
Sulfonamides	• Sulfamethoxazole-trimethoprim	• Sulfadiazine	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Table TX-46: Codes to Identify Pharyngitis
ICD-9-CM
034.0, 462, 463

Table TX-47: Codes to Identify Competing Diagnosis
ICD-9-CM
0010, 0011, 0019, 0020, 0021, 0022, 0023, 0029, 0030, 0031, 00320, 00321, 00322, 00323, 00324, 00329, 0038, 0039, 0040, 0041, 0042, 0043, 0048, 0049, 0050, 0051, 0052, 0053, 0054, 00581, 00589, 0059, 0060, 0061, 0062, 0063, 0064, 0065, 0066, 0068, 0069, 0070, 0071, 0072, 0073, 0074, 0075, 0078, 0079, 00800, 00801, 00802, 00803, 00804, 00809, 0081, 0082, 0083, 00841, 00842, 00843, 00844, 00845, 00846, 00847, 00849, 0085, 00861, 00862, 00863, 00864, 00865, 00866, 00867, 00869, 0088, 0090, 0091, 0092, 0093, 0330, 0331, 0338, 0339, 0419, 07888, 07988, 07998, 0880, 08881, 08882, 08889, 0889, 0900, 0901, 0902, 0903, 09040, 09041, 09042, 09049, 0905, 0906, 0907, 0909, 0910, 0911, 0912, 0913, 0914, 09150, 09151, 09152, 09161, 09162, 09169, 0917, 09181, 09182, 09189, 0919, 0920, 0929, 0930, 0931, 09320, 09321, 09322, 09323, 09324, 09381, 09382, 09389, 0939, 0940, 0941, 0942, 0943, 09481, 09482, 09483, 09484, 09485, 09486, 09487, 09489, 0949, 0950, 0951, 0952, 0953, 0954, 0955, 0956, 0957, 0958, 0959, 096, 0970, 0971, 0979, 0980, 09810, 09811, 09812, 09813, 09814, 09815, 09816, 09817, 09819, 0982, 09830, 09831, 09832, 09833, 09834, 09835, 09836, 09837, 09839, 09840, 09841, 09842, 09843, 09849, 09850, 09851, 09852, 09853, 09859, 0986, 0987, 09881, 09882, 09883, 09884, 09885, 09886, 09889, 0990, 0991, 0992, 0993, 09940, 09941, 09949, 09950, 09951, 09952, 09953, 09954, 09955, 09956, 09959, 0998, 0999, 13100, 13101, 13102, 13103, 13109, 1318, 1319, 38200, 38201, 38202, 3821, 3822, 3823, 3824, 3829, 38300, 38301, 38302, 3831, 38320, 38321, 38322, 38330, 38331, 38332, 38333, 38381, 38389, 3839, 4610, 4611, 4612, 4613, 4618, 4619, 46410, 46411, 46420, 46421, 46430, 46431, 4730, 4731, 4732, 4733, 4738, 4739, 47400, 47401, 47402, 47410, 47411, 47412, 4742, 4748, 4749, 47821, 47822, 47824, 47829, 47871, 47879, 4789, 481, 4820, 4821, 4822, 48230, 48231, 48232, 48239, 48240, 48241, 48242, 48249, 48281, 48282, 48283, 48284, 48289, 4829, 4830, 4831, 4838, 4841, 4843, 4845, 4846, 4847, 4848, 485, 486, 59000, 59001, 59010, 59011, 5902, 5903, 59080, 59081, 5909, 5950, 5951, 5952, 5953, 5954, 59581, 59582, 59589, 5959, 5990, 6010, 6011, 6012, 6013, 6014, 6018, 6019, 6140, 6141, 6142, 6143, 6144, 6145, 6146, 6147, 6148, 6149, 6150, 6151, 6159, 6160, 61610, 61611, 6162, 6163, 6164, 61650, 61651, 61681, 61689, 6169, 68100, 68101, 68102, 68110, 68111, 6819, 6820, 6821, 6822, 6823, 6824, 6825, 6826, 6827, 6828, 6829, 683, 684, 68600, 68601, 68609, 6861, 6868, 6869, 7060, 7061, 73000, 73001, 73002, 73003, 73004, 73005, 73006, 73007, 73008, 73009, 73010, 73011, 73012, 73013, 73014, 73015, 73016, 73017, 73018, 73019, 73020, 73021, 73022, 73023, 73024, 73025, 73026, 73027, 73028, 73029, 73030, 73031, 73032, 73033, 73034, 73035, 73036, 73037, 73038, 73039, 73070, 73071, 73072, 73073, 73074, 73075, 73076, 73077, 73078, 73079, 73080, 73081, 73082, 73083, 73084, 73085, 73086, 73087, 73088, 73089, 73090, 73091, 73092, 73093, 73094, 73095, 73096, 73097, 73098, 73099, V016, V027, V028

Table TX-48: Codes to Identify Deliveries		
CPT	**ICD-9-CM**	**ICD-9-PCS**
59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	64001, 64081, 64091, 64101, 64111, 64121, 64131, 64181, 64191, 64201, 64202, 64211, 64212, 64221, 64222, 64231, 64232, 64241, 64242, 64251, 64252, 64261, 64262, 64271, 64272, 64291, 64292, 64301, 64311, 64321, 64381, 64391, 64421, 64511, 64521, 64601, 64611, 64612, 64621, 64622, 64631, 64641, 64642, 64651, 64652, 64661, 64662, 64671, 64681, 64682, 64691, 64701, 64702, 64711, 64712, 64721, 64722, 64731, 64732, 64741, 64742, 64751, 64752, 64761, 64762, 64781, 64782, 64791, 64792, 64801, 64802, 64811, 64812, 64821, 64822, 64831, 64832, 64841, 64842, 64851, 64852, 64861, 64862, 64871, 64872, 64881, 64882, 64891, 64892, 64901, 64902, 64911, 64912, 64921, 64922, 64931, 64932, 64941, 64942, 64951, 64961, 64962, 64971, 64981, 64982, 650, 65101, 65111, 65121, 65131, 65141, 65151, 65161, 65171, 65181, 65191, 65201, 65211, 65221, 65231, 65241, 65251, 65261, 65271, 65281, 65291, 65301, 65311, 65321, 65331, 65341, 65351, 65361, 65371, 65381, 65391, 65401, 65402, 65411, 65412, 65421, 65431, 65432, 65441, 65442, 65451, 65452, 65461, 65462, 65471, 65472, 65481, 65482, 65491, 65492, 65501, 65511, 65521, 65531, 65541, 65551, 65561, 65571, 65581, 65591, 65601, 65611, 65621, 65631, 65651, 65661, 65671, 65681, 65691, 65701, 65801, 65811, 65821, 65831, 65841, 65881, 65891, 65901, 65911, 65921, 65931, 65941, 65951, 65961, 65971, 65981, 65991, 66001, 66011, 66021, 66031, 66041, 66051, 66061, 66071, 66081, 66091, 66101, 66111, 66121, 66131, 66141, 66191, 66201, 66211, 66221, 66231, 66301, 66311, 66321, 66331, 66341, 66351, 66361, 66381, 66391, 66401, 66411, 66421, 66431, 66441, 66451, 66461, 66481, 66491, 66501, 66511, 66522, 66531, 66541, 66551, 66561, 66571, 66572, 66581, 66582, 66591, 66592, 66602, 66612, 66622, 66632, 66702, 66712, 66801, 66802, 66811, 66812, 66821, 66822, 66881, 66882, 66891, 66892, 66901, 66902, 66911, 66912, 66921, 66922, 66932, 66941, 66942, 66951, 66961, 66971, 66981, 66982, 66991, 66992, 67002, 67101, 67102, 67111, 67112, 67121, 67122, 67131, 67142, 67151, 67152, 67181, 67182, 67191, 67192, 67202, 67301, 67302, 67311, 67312, 67321, 67322, 67331, 67332, 67381, 67382, 67401, 67402, 67412, 67422, 67432, 67442, 67451, 67452, 67482, 67492, 67501, 67502, 67511, 67512, 67521, 67522, 67581, 67582, 67591, 67592, 67601, 67602, 67611, 67612, 67621, 67622, 67631, 67632, 67641, 67642, 67651, 67652, 67661, 67662, 67681, 67682, 67691, 67692, 67801, 67811, 67901, 67902, 67911, 67912, V270, V272, V273, V275, V276	720, 721, 7221, 7229, 7231, 7239, 724, 7251, 7252, 7253, 7254, 726, 7271, 7279, 728, 729, 7301, 7309, 731, 7321, 7322, 733, 734, 7351, 7359, 736, 738, 7391, 7392, 7393, 7394, 7399, 740, 741, 742, 744, 7499

Table TX-49: Codes to Identify A Delivery on an Infant Claim
ICD-9-CM
V30.00, V30.01, V30.1, V30.2, V31.00, V31.01, V31.1, V31.2, V32.00, V32.01, V32.1, V32.2, V33.00, V33.01, V33.1, V33.2, V34.00, V34.01, V34.1, V34.2, V35.00, V35.01, V35.1, V35.2, V36.00, V36.01, V36.1, V36.2, V37.00, V37.01, V37.1, V37.2, V39.00, V39.01, V39.1, V39.2

Table TX-50: Codes to Identify Non-live Births
ICD-9-CM
630, 6310, 6318, 632, 63300, 63301, 63310, 63311, 63320, 63321, 63380, 63381, 63390, 63391, 63400, 63401, 63402, 63410, 63411, 63412, 63420, 63421, 63422, 63430, 63431, 63432, 63440, 63441, 63442, 63450, 63451, 63452, 63460, 63461, 63462, 63470, 63471, 63472, 63480, 63481, 63482, 63490, 63491, 63492, 63500, 63501, 63502, 63510, 63511, 63512, 63520, 63521, 63522, 63530, 63531, 63532, 63540, 63541, 63542, 63550, 63551, 63552, 63560, 63561, 63562, 63570, 63571, 63572, 63580, 63581, 63582, 63590, 63591, 63592, 63600, 63601, 63602, 63610, 63611, 63612, 63620, 63621, 63622, 63630, 63631, 63632, 63640, 63641, 63642, 63650, 63651, 63652, 63660, 63661, 63662, 63670, 63671, 63672, 63680, 63681, 63682, 63690, 63691, 63692, 63700, 63701, 63702, 63710, 63711, 63712, 63720, 63721, 63722, 63730, 63731, 63732, 63740, 63741, 63742, 63750, 63751, 63752, 63760, 63761, 63762, 63770, 63771, 63772, 63780, 63781, 63782, 63790, 63791, 63792, 6390, 6391, 6392, 6393, 6394, 6395, 6396, 6398, 6399, 65640, 65641, 65643, 7680, 7681, V271, V274, V277

Table TX-51: Codes to Identify Prenatal Bundled Services	
HCPCS	**CPT**
H1005	59400, 59425, 59426, 59510, 59610, 59618

Table TX-52: Codes to Identify Stand Alone Prenatal Visits	
HCPCS	**CPT**
H1000, H1001, H1002, H1003, H1004	0500F, 0501F, 0502F, 99500

Table TX-53: Codes to Identify Prenatal Visits		
UB Revenue	**HCPCS**	**CPT**
0514	T1015, G0463	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Table TX-54: Codes to Identify Obstetric Panel
CPT
80055

Table TX-55: Codes to Identify Prenatal Ultrasound	
CPT	**ICD-9-PCS**
76801, 76805, 76811, 76813, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828	88.78

Table TX-56: Codes to Identify Pregnancy Diagnosis
ICD-9-CM
64003, 64083, 64093, 64103, 64113, 64123, 64133, 64183, 64193, 64203, 64213, 64223, 64233, 64243, 64253, 64263, 64273, 64293, 64303, 64313, 64323, 64383, 64393, 64403, 64413, 64513, 64523, 64603, 64613, 64623, 64633, 64643, 64653, 64663, 64673, 64683, 64693, 64703, 64713, 64723, 64733, 64743, 64753, 64763, 64783, 64793, 64803, 64813, 64823, 64833, 64843, 64853, 64863, 64873, 64883, 64893, 64903, 64913, 64923, 64933, 64943, 64953, 64963, 64973, 65103, 65113, 65123, 65133, 65143, 65153, 65163, 65173, 65183, 65193, 65203, 65213, 65223, 65233, 65243, 65253, 65263, 65273, 65283, 65293, 65303, 65313, 65323, 65333, 65343, 65353, 65363, 65373, 65383, 65393, 65403, 65413, 65423, 65433, 65443, 65453, 65463, 65473, 65483, 65493, 65503, 65513, 65523, 65533, 65543, 65553, 65563, 65573, 65583, 65593, 65603, 65613, 65623, 65633, 65643, 65653, 65663, 65673, 65683, 65693, 65703, 65803, 65813, 65823, 65833, 65843, 65883, 65893, 65903, 65913, 65923, 65933, 65943, 65953, 65963, 65973, 65983, 65993, 67803, 67813, 67903, 67913, V220, V221, V222, V230, V231, V232, V233, V2341, V2342, V2349, V235, V237, V2381, V2382, V2383, V2384, V2385, V2386, V2387, V2389, V239, V280, V281, V282, V283, V284, V285, V286, V2881, V2882, V2889, V289

Table TX-57: Codes to Identify Toxoplasma Antibody	
LOINC	**CPT**
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, 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 56990-5, 56991-3, 8039-0, 8040-8,	86777

Table TX-58: Codes to Identify Rubella Antibody	
LOINC	**CPT**
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, 5330-6, 5331-4, 5332-2, 5330-0, 5334-8, 5335-5, 63462-6, 8013-5, 8014-3, 8015-0	86762

Table TX-59: Codes to Identify Cytomegalovirus Antibody	
LOINC	**CPT**
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, 45326-6, 47307-4, 47363-7, 47430-4, 49539-0, 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 52976-8, 52984-2, 59838-3, 7851-9, 7852-7, 7853-5, 9513-3	86644

Table TX-60: Codes to Identify Herpes Simplex Antibody	
LOINC	**CPT**
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, 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 52977-6, 52981-8, 53377-8, 53560-9, 57321-2, 73559-7, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7	86694, 86695, 86696

Table TX-61: Codes to Identify ABO	
LOINC	**CPT**
883-9, 57743-7	86900

Table TX-62: Codes to Identify Rh	
LOINC	**CPT**
972-0, 978-7, 1305-2, 10331-7, 34961-3	86901

Table TX-63: Codes to Identify ABO and Rh
LOINC
882-1, 884-7

Table TX-64: Codes to Identify Postpartum Visits			
CPT	**HCPCS**	**ICD-9-CM**	**ICD-9-PCS**
0503F, 57170, 58300, 59430, 99501	G0101	V24.1, V24.2, V25.11, V25.12, V25.13, V72.31, V72.32, V76.2	89.26

Table TX-65: Codes to Identify Postpartum Bundled Services
CPT
59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

Table TX-66: Codes to Identify Asthma
ICD-9-CM
49300, 49301, 49302, 49310, 49311, 49312, 49381, 49382, 49390, 49391, 49392

Table TX-67: Codes to Identify Acute Bronchitis
ICD-9-CM
466.0

Appendix B – Admission Codes for Transfers

This appendix is posted at:
http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%20Appendices.pdf.

Note: This appendix is named Appendix A instead of Appendix B on the AHRQ website.

SID ASOURCE Codes

2 - Another hospital
3 - Another facility, including long-term care

POINTOFORIGINUB04 Codes

4 - Transfer from a hospital
5 - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6 - Transfer from another health care facility

If Admission Type is newborn (ATYPE=4), POINTOFORIGINUB04 codes are as follows:
5 - Born inside this hospital
6 - Born outside of this hospital

Appendix C – Cardiac Procedure Codes

This appendix is posted at *http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%20Appendices.pdf.*

Note: This appendix is named Appendix B instead of Appendix C on the AHRQ website.

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ICD-9-CM Cardiac procedure codes:

0050	IMPL CRT PACEMAKER SYS
0051	IMPL CRT DEFIBRILLAT
0052	IMP/REP LEAD LF VEN SYS
0053	IMP/REP CRT PACEMKR
0054	GEN IMP/REP CRT DEFIB
0056	GENAT INS/REP SENS-
0057	CRD/VSL MTR
0066	IMP/REP SUBCUE CARD
1751	IMPLANT CCM,TOTAL SYSTEM
1752	IMPLANT CCM PULSE GENRTR
1755	TRANSLUM COR ATHERECTOMY
3500	CLOSED VALVOTOMY NOS
3501	CLOSED AORTIC VALVOTOMY
3502	CLOSED MITRAL VALVOTOMY
3503	CLOSED PULMON VALVOTOMY
3504	CLOSED TRICUSP VALVOTOMY
3505	ENDOVAS REPL AORTC VALVE
3506	TRNSAPCL REP AORTC VALVE
3507	ENDOVAS REPL PULM VALVE
3508	TRNSAPCL REPL PULM VALVE
3509	ENDOVAS REPL UNS HRT VLV
3510	OPEN VALVULOPLASTY NOS
3511	OPN AORTIC VALVULOPLASTY
3512	OPN MITRAL VALVULOPLASTY
3513	OPN PULMON VALVULOPLASTY
3514	OPN TRICUS VALVULOPLASTY
3520	OPN/OTH REP HRT VLV NOS
3521	OPN/OTH REP AORT VLV-TIS
3522	OPN/OTH REP AORTIC VALVE
3523	OPN/OTH REP MTRL VLV-TIS
3524	OPN/OTH REP MITRAL VALVE
3525	OPN/OTH REP PULM VLV-TIS
3526	OPN/OTH REPL PUL VALVE
3527	OPN/OTH REP TCSPD VLV-TS
3528	OPN/OTH REPL TCSPD
3531	VALVE PAPILLARY MUSCLE
3532	CHORDAE TENDINEAE OPS
3533	ANNULOPLASTY
3534	INFUNDIBULECTOMY
3535	TRABECUL CARNEAE CORD OP
3539	TISS ADJ TO VALV OPS NEC
3541	ENLARGE EXISTING SEP DEF
3542	CREATE SEPTAL DEFECT
3550	PROSTH REP HRT SEPTA NOS
3551	PROS REP ATRIAL DEF-OPN
3552	PROS REPAIR ATRIA DEF-
3553	PROS REP VENTRIC DEF-OPN
3554	PROS REP ENDOCAR CUSHION
3555	PROS REP VENTRC DEF-CLOS
3582	TOTAL REPAIR OF TAPVC
3583	TOT REP TRUNCUS ARTERIOS
3584	TOT COR TRANSPOS GRT VES
3591	INTERAT VEN RETRN TRANSP
3592	CONDUIT RT VENT-PUL ART
3593	CONDUIT LEFT VENTR-AORTA
3594	CONDUIT ARTIUM-PULM ART
3595	HEART REPAIR REVISION
3596	PERC BALLOON VALVUPLASTY
3597	PERC MTRL VLV REPR W IMP
3598	OTHER HEART SEPTA OPS
3599	OTHER HEART VALVE OPS
3601	PTCA-1 VESSEL W/O AGENT
3602	PTCA-1 VESSEL WITH AGNT
3603	OPEN CORONRY ANGIOPLASTY
3604	INTRCORONRY THROMB INFUS
3605	PTCA-MULTIPLE VESSEL
3606	INS NONDRUG ELUT COR ST
3607	INS DRUG-ELUT CORONRY ST
3609	REM OF COR ART OBSTR NEC
3610	AORTOCORONARY BYPASS NOS
3611	AORTOCOR BYPAS-1 COR ART
3612	AORTOCOR BYPAS-2 COR ART
3613	AORTOCOR BYPAS-3 COR ART
3614	AORTCOR BYPAS-4+ COR ART
3615	1 INT MAM-COR ART BYPASS
3616	2 INT MAM-COR ART BYPASS
3617	ABD-CORON ARTERY BYPASS HRT
3619	REVAS BYPS ANAS NEC ARTERIAL
362	IMPLANT REVASC OTH HEART
363	REVASCULAR OPEN CHEST TRANS
3631	REVASC OTH TRANSMYO
3632	REVASCULAR
3633	ENDO TRANSMYO REVASCULAR
3634	PERC TRANSMYO REVASCULAR
3639	OTH HEART REVASULAR
3691	CORON VESS ANEURYSM REP
3699	HEART VESSEL OP NEC
3731	PERICARDIECTOMY
3732	HEART ANEURYSM EXCISION
3733	EXC/DEST HRT LESION OPEN
3734	EXC/DEST HRT LES OTHER
3735	PARTIAL VENTRICULECTOMY
3736	EXC,DESTRCT,EXCLUS LAA
3737	EXC/DEST HRT LES, THRSPC IMPL
3741	CARDIAC SUPPORT DEV
375	HEART TRANSPLANTATION
3751	HEART TRANPLANTATION
3752	IMP TOT INT BI HT RP SYS

3560	GRFT REPAIR HRT SEPT NOS
3561	GRAFT REPAIR ATRIAL DEF
3562	GRAFT REPAIR VENTRIC DEF
3563	GRFT REP ENDOCAR CUSHION
3570	HEART SEPTA REPAIR NOS
3571	ATRIA SEPTA DEF REP NEC
3572	VENTR SEPTA DEF REP NEC
3573	ENDOCAR CUSHION REP NEC
3581	TOT REPAIR TETRAL FALLOT
3766	IMPLANTABLE HRT ASSIST INT
3770	INSERT PACEMAK LEAD
3771	INT INSERT LEAD IN VENT
3772	INT INSER LEAD ATRI-VENT
3773	INT INSER LEAD IN ATRIUM
3774	INT OR REPL LEAD EPICAR
3775	REVISION OF LEAD
3776	REPL TV ATRI-VENT LEAD
3777	REMOVAL OF LEAD W/O REPL
3778	INSER TEAM PACEMAKER SYS
3779	REV/RELOC CARD DEV POCKT
3780	INT OR REPL PERM PACEMKR
3781	INT INSERT 1-CHAM, NON
3753	REPL/REP THR UNT TOT HRT
3754	REPL/REP OTH TOT HRT SYS
3755	REM INT BIVENT HRT SYS
3760	IMP BIVN EXT HRT AST SYS
3761	PULSATION BALLOON IMPLAN
3762	INSRT NON-IMPL CIRC DEV
3763	REPAIR HEART ASSIST SYS
3764	REMVE EXT HRT ASSIST SYS
3765	IMP VENT EXT HRT AST SYS
3782	INT INSERT 1-CHAM, RATE INT
3783	INSERT DUAL-CHAM DEV
3785	REPL PACEM W 1-CHAM, NON
3786	REPL PACEM 1-CHAM, RATE REPL
3787	PACEM W DUAL-CHAM
3789	REVISE OR REMOVE PACEMAK
3794	IMPLT/REPL CARDDEFIB TOT
3795	IMPLT CARDIODEFIB LEADS
3796	IMPLT CARDIODEFIB GENRATR
3797	REPL CARDIODEFIB LEADS
3798	REPL CARDIODEFIB GENRATR
3826	INSRT PRSR SNSR W/O LEAD

Appendix D – Immunocompromised State Diagnosis and Procedure Codes

This appendix is posted at *http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%20Appendices.pdf.*

Note: This appendix is named Appendix C instead of Appendix D on the AHRQ website.

ICD-9-CM Immunocompromised state diagnosis codes

042 HUMAN IMMUNO VIRUS DIS
1363 PNEUMOCYSTOSIS
1992 MALIG NEOPL-TRANSP ORGAN
23873 HI GRDE MYELODYS SYN LES
23876 MYELOFI W MYELO METAPLAS
23877 POST TP LYMPHPROLIF DIS
23879 LYMPH/HEMATPOITC TIS NEC
260 KWASHIORKOR
261 NUTRITIONAL MARASMUS
262 OTH SEVERE MALNUTRITION
27900 HYPOGAMMAGLOBULINEM NOS
27901 SELECTIVE IGA IMMUNODEF
27902 SELECTIVE IGM IMMUNODEF
27903 SELECTIVE IG DEFIC NEC
27904 CONG HYPOGAMMAGLOBULINEM
27905 IMMUNODEFIC W HYPER-IGM
27906 COMMON VARIABL IMMUNODEF
27909 HUMORAL IMMUNITY DEF NEC
27910 IMMUNDEF T-CELL DEF NOS
27911 DIGEORGE'S SYNDROME
27912 WISKOTT-ALDRICH SYNDROME
27913 NEZELOF'S SYNDROME
27919 DEFIC CELL IMMUNITY NOS
2792 COMBINED IMMUNITY DEFIC
2793 IMMUNITY DEFICIENCY NOS
2794 AUTOIMMUNE DISEASE, NOT ELSEWHERE CLASSIFIED
27941 AUTOIMMUN LYMPHPROF SYND
27949 AUTOIMMUNE DISEASE NEC
27950 GRAFT-VERSUS-HOST NOS
27951 AC GRAFT-VERSUS-HOST DIS
27952 CHRONC GRAFT-VS-HOST DIS
27953 AC ON CHRN GRFT-VS-HOST
2798 IMMUNE MECHANISM DIS NEC
2799 IMMUNE MECHANISM DIS NOS
28409 CONST APLASTC ANEMIA NEC
2841 PANCYTOPENIA
28411 ANTIN CHEMO INDCD PANCYT
28412 OTH DRG INDCD PANCYTOPNA
28419 OTHER PANCYTOPENIA
2880 AGRANULOCYTOSIS
28800 NEUTROPENIA NOS
28801 CONGENITAL NEUTROPENIA
28802 CYCLIC NEUTROPENIA
28803 DRUG INDUCED NEUTROPENIA
28809 NEUTROPENIA NEC
2881 FUNCTION DIS NEUTROPHILS
2882 GENETIC ANOMALY LEUKOCYT
2884 HEMOPHAGOCYTIC SYNDROMES
28850 LEUKOCYTOPENIA NOS
28851 LYMPHOCYTOPENIA
28859 DECREASED WBC COUNT NEC
28953 NEUTROPENIC SPLENOMEGALY
28983 MYELOFIBROSIS
40301 MAL HYP KID W CR KID V
40311 BEN HYP KID W CR KID V
40391 HYP KID NOS W CR KID V
40402 MAL HY HT/KD ST V W/O HF
40403 MAL HYP HT/KD STG V W HF
40412 BEN HY HT/KD ST V W/O HF
40413 BEN HYP HT/KD STG V W HF
40492 HY HT/KD NOS ST V W/O HF
40493 HYP HT/KD NOS ST V W HF
5793 INTEST POSTOP NONABSORB
585 CHRONIC KIDNEY DISEASE
5855 CHRON KIDNEY DIS STAGE V
5856 END STAGE RENAL DISEASE
9968 COMPLICATIONS OF TRANSPLANTED ORGAN
99680 COMP ORGAN TRANSPLNT NOS
99681 COMPL KIDNEY TRANSPLANT
99682 COMPL LIVER TRANSPLANT
99683 COMPL HEART TRANSPLANT
99684 COMPL LUNG TRANSPLANT
99685 COMPL MARROW TRANSPLANT
99686 COMPL PANCREAS TRANSPLNT
99687 COMP INTESTINE TRANSPLNT
99688 COMP TP ORGAN-STEM CELL
99689 COMP OTH ORGAN TRANSPLNT
V420 KIDNEY TRANSPLANT STATUS
V421 HEART TRANSPLANT STATUS
V426 LUNG TRANSPLANT STATUS
V427 LIVER TRANSPLANT STATUS
V428 OTHER SPECIFIED ORGAN OR TISSUE
V4281 TRNSPL STATUS-BNE MARROW
V4282 TRSPL STS-PERIP STM CELL
V4283 TRNSPL STATUS-PANCREAS
V4284 TRNSPL STATUS-INTESTINES
V4289 TRNSPL STATUS ORGAN NEC
V451 RENAL DIALYSIS STATUS
V4511 RENAL DIALYSIS STATUS
V560 RENAL DIALYSIS ENCOUNTER
V561 FT/ADJ XTRCORP DIAL CATH
V562 FIT/ADJ PERIT DIAL CATH

ICD-9-CM Immunocompromised state procedure codes

0018 INFUS IMMUNOSUP ANTIBODY
335 LUNG TRANSPLANTATION
3350 LUNG TRANSPLANT NOS
3351 UNILAT LUNG TRANSPLANT
3352 BILAT LUNG TRANSPLANT
336 COMB HEART/LUNG TRANSPLA
375 HEART TRANSPLANTAION
3751 HEART TRANSPLANTAION
410 OPERATIONS ON BONE MARROW AND SPLEEN
4100 BONE MARROW TRNSPLNT NOS
4101 AUTO BONE MT W/O PURG
4102 ALO BONE MARROW TRNSPLNT
4103 ALLOGRFT BONE MARROW NOS
4104 AUTO HEM STEM CT W/O PUR
4105 ALLO HEM STEM CT W/O PUR
4106 CORD BLD STEM CELL TRANS
4107 AUTO HEM STEM CT W PURG
4108 ALLO HEM STEM CT W PURG
4109 AUTO BONE MT W PURGING
5051 AUXILIARY LIVER TRANSPL
5059 LIVER TRANSPLANT NEC
5280 PANCREAT TRANSPLANT NOS
5281 REIMPLANT PANCREATIC TIS
5282 PANCREATIC HOMOTRANSPLAN
5283 PANCREATIC HETEROTRANSPL
5285 ALLOTRNSPLNT ISLETS LANG
5286 TRNSPLNT ISLETS LANG NOS
5569 KIDNEY TRNSPLANT NE