FY 2013

BHO-HCPF Annual Performance Measures Scope Document

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(Listed According to BHO Contract)

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Introduction

This document includes the details for calculations of the BHO-HCPF Annual Performance Measures for the five Colorado Behavioral Health Organizations (BHOs). Some of these measures are calculated by HCPF using eligibility data and encounter data submitted by the BHOs, other measures are calculated by the BHOs. With the exception of Penetration Rates, all measures are calculated using paid claims/encounters data.

Performance Measures Indexed by Agency Responsible for Calculation

Calculated by the BHO:

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Indicator 22: Change in recovery and resilience - Void 38

Update Process

1. For all indicators, each BHO will be responsible for updating code changes after July 1, 2013.
2. Indicator #2: Name changed to include "atypical." Barb Smith (FBHP) and Scott Marmulstein will provide list of atypical antipsychotics for addition to the scope document by August 1st, 2013 from First Data Bank (Value Options has subscription to database). Breaks in Fiscal Year were updated to reflect most current fiscal year.
3. Indicators #4, #5, #21, and #22 information was removed from scope document and can be found in earlier scope documents if needed. Indicator #4 has been replaced with the Behavioral Health Engagement Measure and will be added to the scope document after the August BQuIC meeting.
4. Indicator #12 is new and adapted from HEDIS measure. Indicator #12 was moved from calculated by BHO to calculated by HCPF.
5. Indicator #13 the last sentence of the description paragraph was deleted as it conflicted with covered diagnoses.
6. Indicator #14 in the numerator description the first bullet was deleted to add clarity to the measurement. Also updated Table 11 under "POS" to only list excluded places of service.
7. Indicator #15 updated Table 12 to reflect both adult and child codes. CPT codes added are 99381-99384, 99391-99394. HCPCS codes added are G0402, G0438, and G0439. ICD-9-CM Diagnosis code V20.2 was added.
8. Indicators #8-11: Definition of denominator was changed at the request of group. Also, added more information to Table 8 about the numerator and denominator. Table 7 was changed to reflect new eligibility types and race categories. Codes were updated by HCPF to include new codes. PEI service codes were added.
9. Indicator #3 and #20 were updated to reflect the most recent HEDIS changes. A list of changes are noted in the respective Tables.
10. Indicator #1 ratios were updated to reflect all ratios that are calculated.
11. Indicator #13 ratios were clarified to reflect the specific ratios calculated
12. Codes highlighted and in blue lettering are codes that were added to reflect the most current USCS Manual. Codes highlighted and in black lettering reflect either HEDIS changes are changes made by the Performance Measure workgroup. Codes underlined will be deleted for ***next year's*** calculations.
13. Added Behavioral Health Engagement measure
14. Added verbage to Hospital discharge criteria
15. Added allowable gap in enrollment to Indicator 13: Follow up after hospital discharge.

Definitions

24 Hour Treatment Facility – A residential facility that has 24-hr professional staffing and a program of treatment services and includes PRTF and TRCCFs. Does not include Nursing Facilities or ACFs (defined as an assisted living residence licensed by the State to provide alternative care services and protective oversight to Medicaid clients).

Age Category – Based on HEDIS age categories: 0-12 (Child), 13-17 (Adolescent), 18-64 (Adult), and 65+ (Older Adult). Age category determination will be based upon the client's age on the date of service for all performance indicators except for inpatient hospitalization and penetration rates. For inpatient hospitalization, age category determination will be based upon the client's age on the date of discharge. For penetration rates, age category determination will be based upon the age of the client on the last day of the fiscal year.

Covered Mental Health Diagnoses: The BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain mental health diagnoses are covered. These specific diagnoses can be found below or in the BHO Medicaid BHO contract Exhibit D. Only those services that cover mental health, with the exception of services related to Assessment, Prevention, and Crisis procedure coding as a diagnosis may have yet to be ascribed, will be included in the calculations of performance measures.

- **295.00-298.99**
- **300.00-301.99**
- **307.00-309.99**
- **311.00-314.99**

Fiscal Year (FY) or State Fiscal Year (SFY): Based on the state fiscal year July 1-June 30 of the measurement year

HCPF— The Department of Health Care Policy and Financing for the State of Colorado.

HEDIS—Healthcare Effectiveness Data and Information Set

Hospital Admit – An admission to a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis. There can be multiple admits during the specified fiscal year period. The admission must result in a paid claim for the hospital episode, except where the admission is from a State Hospital for ages 21-64.

Hospital Discharge – A discharge from a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis that does not result in a re-hospitalization within 24 hrs (transfer). There can be multiple discharges during the specified fiscal year period. The discharge must result in a paid claim for the hospital episode, except where the discharge is from a State Hospital for ages 21-64. Adult members on the list of discharges from the State hospital who are not eligible at the time of hospital admission should be included in the measure if eligibility is discontinued 1 day before the admission date. Adult members on the list of discharges from the State hospital who are eligible at the time of hospital admission, but who lose eligibility during the hospital stay should also remain on the hospital discharge list.

Members: Individuals eligible for Medicaid assigned to a specific BHO. Membership is calculated by the number of member months during a 12-month period divided by 12, which gives equivalent members or the average health plan enrollment during the 12-month reporting period.

Member Months: Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.

Penetration Rate is the number of members who received at least one service (paid or denied claim) divided by the number of FTE enrolled in the Medicaid mental health managed care program.

Per 1000 members – A measure based on total eligible members per 1000.

Quarter – Based on fiscal year quarters (Jul-Sep, Oct-Dec, Jan-Mar, Apr-Jun)

Indicator 1: Hospital readmissions within 7, 30, 90 days post-discharge

Description: Proportion of BHO member discharges from a hospital episode for treatment of a covered mental health diagnosis and readmitted for another hospital episode for treatment of a covered mental health diagnosis within 7, 30, 90 days by age group and overall (recidivism rates). Two indicators are provided: 1) **Non-State:** Recidivism rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Recidivism rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at first hospital discharge.

Denominator: Total number of BHO member discharges during the reporting period. The population is based on discharges (e.g., one member can have multiple discharges).

- **Non-State Hospital:** Total number of Member discharges from a non-State hospital during the specified fiscal year
- **All Hospitals:** Total number of Member discharges from all hospitals during the specified fiscal year

Numerator: Number of BHO member discharges with an admission within 7, 30, and 90 days of the discharge, reported cumulatively.

- **Non-State Hospital:** Total number of Member discharges from a non-State hospital, during the specified fiscal year, July 1 through June 30, and then admitted to any hospital (non-state or state) 7, 30, and 90 days after the discharge.
- **All Hospitals:** Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, and then admitted to all hospitals 7, 30, and 90 days after the discharge.

Data Source(s): Denominator: Number of Member discharges, from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by HCPF. Numerator: Admissions from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Admissions from the State hospital system, ages 21 through 64 years, will be provided by the HCPF.

Calculation of Measure: BHO, with some data provided by HCPF

Ratios: Child 7 day readmit/Non-state Child discharges; Child 30 day readmit/Non-state Child discharges; Child 90 day readmit/Non-state Child discharges; Child 7 day readmit/All Hospital Child discharges; Child 30 day readmit/All Hospital Child Discharges; Child 90 day readmit/All Hospital Child discharges; Adolescent 7 day readmit/Non-state Adolescent discharges; Adolescent 30 day readmit/Non-state Adolescent discharges; Adolescent 90 day readmit/Non-state Adolescent discharges; Adolescent 7 day readmit/All Hospital Adolescent discharges; Adolescent 30 day readmit/All Hospital Adolescent Discharges; Adolescent 90 day readmit/All Hospital Adolescent discharges; Adult 7 day readmit/Non-state Adult discharges; Adult 30 day readmit/Non-state Adult discharges; Adult 90 day readmit/Non-state Adult discharges; Adult 7 day readmit/All Hospital Adult discharges; Adult 30 day readmit/All Hospital Adult Discharges; Adult 90 day readmit/All Hospital Adult discharges; Older Adult 7 day readmit/Non-state Older Adult discharges; Older Adult 30 day readmit/Non-state Older Adult discharges; Older Adult 90 day readmit/Non-state Older Adult discharges; Older Adult 7 day readmit/All Hospital Older Adult discharges; Older Adult 30 day readmit/All Hospital Older Adult Discharges; Older Adult 90 day readmit/All Hospital Older Adult discharges; All ages 7 day readmits/All ages All hospital discharges; All 30 day readmits/All ages all hospital discharges; All 90 day readmits/All ages hospital discharges; All 7 day readmits/Non-state hospital discharges; All 30 day readmits/Non-state hospital discharges; All 90 day discharges/Non-state hospital discharges

Benchmark: Overall BHOs.

Indicator 2: Percent of members prescribed redundant or duplicated atypical antipsychotic medication

Description: The proportion of members, with one or more atypical antipsychotics prescribed, that have, for 120 days or more, two or more different atypical antipsychotic medications prescribed

Denominator: Number of unduplicated members with one or more net value paid pharmacy claims for an atypical antipsychotic medication during the first nine months of the fiscal year studied. The date used to determine whether the claim is within the first nine months is the service date.

Numerator: Number of unduplicated members in the denominator with two concurrent pharmacy claims for an atypical antipsychotic for 120 days or more during the study period. The field for determining the prescribed date is the date of the service date. A member is only counted once in the numerator even though they may have more than one 120 day period with two concurrent service dates for an atypical antipsychotic. The study period is the fiscal year.

Use 9 (120 day periods) for the Fiscal Year (see example below).

07/01/12	to	10/31/12
08/01/12	to	11/30/12
09/01/12	to	12/31/12
10/01/12	to	01/31/13
11/01/12	to	02/28/13
12/01/12	to	03/31/13
01/01/13	to	04/30/13
02/01/13	to	05/31/13
03/01/13	to	06/30/13

Break each 120-day period into four 30-day parts (assumption most are for 30 days based on VO analysis 76%). Each member had to have had a fill for 2 different atypical antipsychotics in each 30 day part to be included for the whole period.

Data Source: Pharmacy claims

Calculation of Measure: BHOs. HCPF will provide the specified pharmacy claim files to each BHO for calculation, Barb Smith (FBHP) and Scott Marmulstein (VO) will provide HCPF with a list of the most recent (as of July 23, 2013) atypical antipsychotic drug list by July 26, 2013 from First Data Bank. HCPF will then forward this list to the other BHOs.

Benchmark: Overall BHO percentage

Issues:

1. Assumption that the claims are for a 30 day supply
2. Discuss alignment with new CMS Polytherapy with Oral Antipsychotics measure: more specific methodology (p 36-39) and developed using expert panel
    a. Ages 18+ (p. 1); Continuously enrolled 1 year (ability to improve outcomes) (p.2); All oral antipsychotics (excluding clozapine), not just atypicals (p 35); Excludes clozapine (p. 9, 17);

       Uses days supply instead of spans; Denominator (p 3); "routinely" scheduled: at least 2 "consecutive" dispensings of at least 25 day supply "consecutive" dispensings: days' supply for first dispensing divided by difference in days between first and next dispensing is (MPR) >=.8 (example consecutive: 25/25=1, not consecutive 25/36=.7); Caveat as to completeness of data – Medicare Part B does not share their data; as a result any data on Medicare Dual-Eligible individuals should be considered incomplete. This issue may be revisited once changes to this process are made.

Indicator 3: Percent of members diagnosed with major depression, newly treated with antidepressant medication and maintained on antidepressants for at least 84 days (12 weeks)

Description: Percent of members diagnosed with major depression, newly treated with antidepressant medication, and maintained on antidepressants for at least 84 days (12 weeks). Refer to Table 1 for specific criteria on calculating this measure

Denominator: Members ages 18 years and older who were diagnosed with major depressive disorder and newly treated with antidepressant medication. Note: this denominator is the same as measure #20

Numerator: The number of members in the denominator who remained on antidepressant medication treatment for 84 days (12 weeks).

Data Source (s): HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: BHOs

Benchmark: Overall BHOs and HEDIS

Issues: Caveat as to completeness of data – Medicare Part D does not share their data; as a result, any data on Medicare Dual-Eligible individuals should be considered incomplete. This issue may be revisited once changes to this process are made.

TABLE 1

HEDIS Antidepressant Medication Management (AMM)-Effective Acute Phase Treatment
Summary of Changes to HEDIS 2013

- Deleted Negative Diagnosis History
- Revised Continuous enrollment criteria
- Deleted codes 300.4 and 309.1 from Table AMM-A
- Deleted Table AMM-C: Additional Codes to Identify Depression
- Previous Table AMM-D is now Table AMM-C

Description

The percentage of members 18 years of age and older with a diagnosis of major depression, newly treated with antidepressant medication, and who remained on antidepressant medication treatment during the acute phase of treatment

Effective Acute Phase Treatment: The percentage of newly treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

Definitions

Intake Period	The 12-month window starting on July 1 and ending on June 30 of the measurement year.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression (Table AMM-A) and has a 90 day (3 month) negative medication history. *For an inpatient (acute or nonacute) claim/encounter*, the IESD is the date of discharge. *For a direct transfer*, the IESD is the discharge date from the facility to which the member was transferred.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).

Negative Medication History	A period of 90 days (3 months) prior to the IPSD, during which time the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication (Table AMM-C).
Treatment days	The actual number of calendar days covered with prescriptions within the specified 84-day measurement interval.

Eligible Population

Product lines	Medicaid
Ages	18 years and older as of June 30 of the measurement year.
Continuous enrollment	90 days prior to the IESD through 128 days after the IESD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IESD.
Benefits	Medical, pharmacy (HCPF)
Event/diagnosis	The organization should follow the steps below to identify the eligible population, which should be used for rate.

Step 1 Identify all members who met at least one of the following criteria during the Intake Period.

- At least one principal diagnosis of major depression (Table AMM-A) in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B), ***or***
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B) on different dates of service with any diagnosis of major depression (Table AMM-A), ***or***
- At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table AMM-A)

Table AMM-A: Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, , , 311

*****Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of that code). Additionally, other possible codes that could indicate a depression diagnosis (296.4–296.9, 309.0, 309.28) are not included in this list because these codes are less specific in identifying members with major depression.

Table AMM-B: Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510, 90839?	G0155, G0176, G0177, G0409-G0411,H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
	CPT		**POS**
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 90791, 90792, 90832, 90834, 90837	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

Step 2 Determine the IESD. For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter.

Step 3 Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period.

Step 4 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD.

***Step* 5** Calculate continuous enrollment. Members must be continuously enrolled for 90 days prior to the IESD to 128 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator

Effective Acute Phase Treatment At least 84 days (12-weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period.

Allowable medication changes or gaps include:

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

Regardless of the number of gaps, there may be no more than 30 gap days. The organization may count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Please use the 2013(posted November 2012) list to calculate this measure. The list of medications can be found at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013FinalNDCLists.aspx

Note: *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame specified (e.g., during the Intake Period).*

Indicator 4: Behavioral Health Engagement (BHE)

Description

The percentage of new members diagnosed with a covered mental health diagnosis who were engaged by the behavioral health organization, as defined below:

- *Engagement:* New members who received at least four engagement services (on different dates of service) within 45 days of the initial visit or episode. The initial visit may be counted as the first engagement service.

Definitions

Intake Period	July 1, 2012 to May 16, 2013. The Intake Period is used to capture new episodes.
Index Episode Start Date (IESD)	The earliest visit during the Intake Period with one of the selected covered diagnoses from Table A. *For an outpatient, or ED visit (not resulting in an inpatient stay) claim/encounter,* the IESD is the date of service. *For an inpatient (acute or non-acute) claim/encounter,* the IESD is the date of discharge. *For an ED visit that results in an inpatient stay,* the IESD is the date of the inpatient discharge. *For direct transfers*, the IESD is the discharge date from the second admission.
Negative Diagnosis History	A period of 90 days before the IESD, during which the member had no claims or encounters with a diagnosis from Table A. *For an inpatient claim/encounter,* use the admission date to determine the Negative Diagnosis History. *For ED visits that result in an inpatient stay,* use the ED date of service to determine the Negative Diagnosis History. *For direct transfers,* use the first admission date to determine the Negative Diagnosis History.

Eligible Population

Age	All members are included in this measure. Report age stratifications and a total rate. Report the age as of the IESD as defined below: • 0 -12 years • 13 - 17 years • 18 - 64 years • 65+ years • Total The total is the sum of the age stratifications
Continuous enrollment	The IESD through 45 days after the IESD, with no gaps of enrollment during the 45 day period. Note: the member does not need to be continuously enrolled for the negative diagnosis history period since any new member for the BHO with a covered mental health diagnosis should receive engagement services following the visit or episode.
Event/ diagnosis	New episode during the Intake Period. Follow the steps below to identify the eligible population, which is the denominator.

Step 1 Identify the Index Episode Start Date (IESD). Identify all members during the Intake Period that had at least one of the following:

Any mental health claim or encounter with a diagnosis from Table-A.

Notes:

For members with more than one episode, use the first episode.

For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.

Step 2 Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis in Table-A, or a service from Table-C during the 90 days before the IESD.

Notes:

Using a 90 day negative diagnosis history is meant to help define new members, and exclude medication only members that are seen infrequently.

For an inpatient IESD, use the admission date to determine the Negative Diagnosis History.

For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled without any enrollment gaps from the IESD through 45 days after the IESD.

Table-A: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
295.00-298.99, 300.00-301.99, 307.10-309.99, 311.00-314.99

Table B: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

Numerator

Engagement Four or more engagements (Table C below) on different dates of service within 45 days after the date of the initial visits (IESD encounter). The initial visit may count as one engagement service.

The intent of this measure is to ensure members receive ongoing engagement within the first 45 days of an initial visit. Therefore, with the exception of the monthly supported housing (H0044), multiple engagement services provided on the same day count as only one engagement.

Engagement services for the monthly supported housing (H0044) may only count as one service during the 45-day period. The "per day" supported housing (H0043) can be counted multiple times within the 45 day period.

Examples:

- A member receiving two monthly supported housing services (H0044) in the 45-day period should count as one service.
- A member receiving two supported housing services (H0043) in the 45 day period may count as two services.

Rates Rates are reported by age group and total. Report the percentage who received one, two, three, and four or more services within the 45 days from the IESD.

Table C: Numerator Codes to Identify Engagement Services

CPT	HCPCS
90791, 90792, 90801, 90802, 90804-90815, 90832-90834, 90836-90839, 90846, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 90887, 96101, 96102, 96116, 96118, 96372, 97535, 97537, 99202-99205, 99212-99215, 99334, 99347, 99441-99443	G1055, G0176, G1077, G0409, H0002, H0004, H0031, H0032, H0034, H0036, H0037, H0038, H0039, H0043, H1011, H2000, H2001, H2011, H2014, H2015, H2016, H2017, H2018, H2021, H2023 – H2025, H2027, H2030, H2031, H2032, H2033, H2036, M0064, S5150, S5151 S9453, S9454, S9480, S9485, T1016, T1017
Only one monthly supported housing service (H0044) may be counted towards the numerator.	

Indicator 5: Improvement in symptom severity: Adult – Void

Indicator 6: Maintaining independent living status for members with severe mental illness (SMI)

Description: The percent of clients, age 18 years and older, living independently, that maintain this status during the measurement period.

Denominator: Total number of unduplicated clients with SMI **(see Table 2 for how to determine with SMI status for adults)** with an update or discharge CCAR in the study period and a previous CCAR (admit or update) completed no later than within the previous fiscal year, where the Place of Residence is rated as 15 (independent living). The client must be a member of the same BHO on both CCARs.

Numerator: Total number of clients in the denominator whose place of residence is 15 (independent living) on the most recent CCAR

Data Source(s): The most recent CCAR for the fiscal year and the previous CCAR.

Calculation of Measure: HCPF

Benchmark: Overall BHOs

Issues: None

TABLE 2

Severe Mental Illness Definition of all Adults

Severe Mental Illness includes Adults with SPMI and SMI; all steps 1-3 must be completed in order to calculate the full list of Adults with SMI.

Step 1 **Diagnosis**
Exclusions -Adults and Older Adults with the following **AXIS I Primary Diagnoses** on the CCAR form automatically **DO NOT MEET ANY OF THE SEVERITY LEVEL CATEGORIES.**

Description	Primary Diagnosis Code (217)
Mental Retardation	317, 318.X, 319
Alcohol	291.X, 303.XX, 305.00
Substance	292.XX, 304.XX, 305.10-90
Dementias & other diagnoses due to medical conditions	290.XX, 293.XX, 294.X, 310.X
Other	799.9, V71.09

Step 2 **Serious and Persistent Mental Illness (SPMI)**
For an Adult or Older Adult to meet the criteria for SPMI, s/he must first pass the Exclusion criteria in Step 1 and then meet the criteria in the History and/or Self Care categories below: Any three (3) of the following six (6) of the following History items on the CCAR form must be met:

History Criteria	Value
SSI (265)	"1"
SSDI (266)	"1"
Presenting Problem has Existed (283) for longer than 1 year	"1"
Inpatient Care (360)	"1"

Other 24-Hour Care (361)	"1"
Partial Care (362)	"1"

Or any four (4) of the following five (5) Self Care Items must be met:

Self-Care Criteria	Value
Place of Residence (270)	All codes except "12" and "15"
Self-Care Problems (294)	"1"
Food Attainment (295)	"1"
Housing Access (296)	"1"
Self-Care/Basic Needs (384)	"7-9"

Step 3 **SMI**

For those cases remaining (not excluded by diagnosis and not SPMI): Severity level is determined by the presence of a **Serious Mental Illness (SMI)** as defined by these diagnosis codes:

Description	Primary Diagnosis Code (217)
Schizophrenia & other Psychosis	295.1X, .2X, .3X, .6X, .9X
Paranoid	297.1, 297.3
Other Psychosis	295.4X, .7X, 298.8, .9
Major Affective	296.X, 296.XX, 300.4, 311
Personality Disorder	301.0, .20, .22
Dissociative Identify Disorder	300.14
Post-Traumatic Stress	309.81, plus the score for the Overall Symptom Severity must be a 4 or higher.

Any adult not meeting the SPMI or SMI not SPMI criteria is not counted towards this measure.

NOTE: A client meeting both SPMI and SMI not SPMI is recorded in the Management Information System as SPMI.

Serious Mental Illness (SMI) – The national definition for SMI is much broader than the one used in Colorado. To update the Colorado severity level categories, the Division of Mental Health will combine SPMI and SMI not SPMI into a single SMI category.

Indicator 7: Progress toward independent living for members with severe mental illness (SMI)

Description: The percent of clients, age 18 years and older, who move to a less restricted place of residence, including independent living, during the measurement period.

Denominator: Total number of unduplicated clients with a severe mental illness (SMI) **(see Table 3 to determine SMI status for adults)** with an update or discharge CCAR in the study period with a previous CCAR (admit or update) completed no later than within the previous fiscal year, where the Place of Residence is not rated as 15 (independent living) on the previous CCAR. The client must be a member of the same BHO on both CCARs.

Numerator: Total number of clients in the denominator with a gain in a place of residence that is less restrictive. Criteria for gain: Movement from a lower numbered category to a higher numbered category (**see Table 6 for categories and numbers**)

Data Source(s): The last CCAR for the study period and the previous CCAR

Calculation of Measure: HCPF

Benchmark: Overall BHOs

Issues: Need to be sure categories are organized accurately re: restriction in living arrangement.

TABLE 3

Severe Mental Illness Definition For All Adults

Severe Mental Illness includes Adults with SPMI and SMI; all steps 1-3 must be completed in order to calculate the full list of Adults with SMI.

Step 1 **Diagnosis**
Exclusions -Adults and Older Adults with the following **AXIS I Primary Diagnoses** on the CCAR form automatically **DO NOT MEET ANY OF THE SEVERITY LEVEL CATEGORIES.**

Description	Primary Diagnosis Code (217)
Mental Retardation	317, 318.X, 319
Alcohol	291.X, 303.XX, 305.00
Substance	292.XX, 304.XX, 305.10-90
Dementias & other diagnoses due to medical conditions	290.XX, 293.XX, 294.X, 310.X
Other	799.9, V71.09

Step 2 **SPMI – Serious and Persistent Mental Illness**
For an Adult or Older Adult to meet the criteria for SPMI, s/he must first pass the Exclusion criteria in Step 1 and then meet the criteria in the History and/or Self Care categories below: Any three (3) of the following six (6) History items on the CCAR form must be met:

History Criteria	Value
SSI (265)	"1"
SSDI (266)	"1"
Presenting Problem has Existed (283)	"1"
Inpatient Care (360)	"1"
Other 24-Hour Care (361)	"1"
Partial Care (362)	"1"

Or any four (4) of the following five (5) Self Care Items must be met:

Self Care Criteria	Value
Place of Residence (270)	All codes except "12" and "15"
Self Care Problems (294)	"1"
Food Attainment (295)	"1"
Housing Access (296)	"1"
Self-Care/Basic Needs (384)	"7-9"

Step 3 **SMI**
For those cases remaining (not excluded by diagnosis and not SPMI): Severity level is determined by the presence of a **Serious Mental Illness** as defined by these diagnosis codes:

Description	Primary Diagnosis Code (217)
Schizophrenia & other Psychosis	295.1X, .2X, .3X, .6X, .9X
Paranoid	297.1, 297.3
Other Psychosis	295.4X, .7X, 298.8, .9
Major Affective	296.X, 296.XX, 300.4, 311
Personality Disorder	301.0, .20, .22
Dissociative Identify Disorder	300.14
Post-Traumatic Stress	309.81, plus the score for the Overall Symptom Severity must be a 4 or higher.

Any adult not meeting the SPMI or SMI criteria is not counted towards this measure.
NOTE: A client meeting both SPMI and SMI not SPMI is recorded in the Management Information System as SPMI.
Serious Mental Illness (SMI) – The national definition for SMI is much broader than the one used in Colorado. To update the Colorado severity level categories, the Division of Mental Health will combine SPMI and SMI not SPMI into a single SMI category.

Categories of CCAR Place of Residence with increasing restrictive living with lower number assigned to category:

7 = independent Living (rating of "15" on CCAR)
6 = supported housing (13)
5 = boarding home (6) & group home (7), assisted living (14)
4 = residential (9,10)
3 = nursing home (8)
2 = ATU
1 = inpatient (2), correctional facility (01)
0 = homeless

Indicators 8-11: Penetration rates (including breakouts by HEDIS age groups, Medicaid eligibility category, race, and service category)

Description: Percent BHO Members with one contact (paid or denied) in a specified fiscal year (12-month period) by HEDIS age group, Medicaid eligibility category **(refer to Table 4),** race **(refer to Table 4),** and service category **(refer to Table 5 for HEDIS specs and additional place of service (POS) and service codes.)**

- Medicaid eligibility category is the eligibility category on the member's most recent Medicaid eligibility span during the fiscal year.
- Race/ethnic group is the race category on the member's most recent Medicaid eligibility span during the fiscal year.
- Service category is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category.
- Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are analyzed.
- All enrollment spans identified as: enrollment begin date <= the last date of the fiscal year (6/30) AND enrollment end date >= the first date of the fiscal year (7/1).
- Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.
- NOTE: The Data Analysis Section tailors data to specific internal and external customer needs that are not met through existing reporting. Thus, calculations may differ from existing published figures due to several factors that may include, but are not limited to: the specificity of the request, retroactivity in eligibility determination, claims processing and dollar allocation differences between MMIS and COFRS.

Denominator: Number of FTE Enrollees

Numerator: Members with any MH service in the specified fiscal year (12-month period) in each age group, Medicaid eligibility category, race/ethnic group, and by service category grouped as inpatient, intensive outpatient/partial hospitalization, and ambulatory care.

Data Source(s): BHO claims/encounter file (both paid and denied claims/encounters will be used).

Calculation of Measure: HCPF (by Overall, HEDIS age, eligibility category, cultural/ethnic [% total missing])

Benchmark: Overall BHO

TABLE 4

Medicaid Eligibility and Race/Ethnicity Categories

Medicaid Eligibility Category is determine by the member's most recent Medicaid eligibility span during the fiscal year

Eligibility Type Code	Description
001	OAP-A
002	OAP-B-SSI
003	AND/AB-SSI
004	AFDC/CWP Adults
005	AFDC/CWP CHILDREN
006	FOSTER CARE
007	BC WOMEN
008	BC CHILDREN
020	BCCP-WOMEN BREAST&CERVICAL CAN
030	ADULTS WITHOUT DEPEND CHILDREN
031	BUYIN: WORKING ADULT DISABLED
032	BUYIN: CHILDREN W/ DISABILITIES

Medicaid Race Category is determined by the member's most recent Medicaid eligibility span during the fiscal year.

Race Code	Description
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ASIAN
6	OTHER
7	UNKNOWN
8	NATV HAWAIIAN OTH PACIFIC ISL

TABLE 5

Penetration Rates by Service Category

Description: The number and percentage of members receiving the following mental health services during July 1 and June 30 of the fiscal year.

- *Any service*
- *Inpatient*
- *Intensive outpatient or partial hospitalization*
- *Outpatient or ED*

Calculations

Counts

- Members who received inpatient, intensive outpatient, partial hospitalization, and outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits.
- Count members in the *Any Services* column for any service during the measurement year. is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category.

Age

- Members should be reported in the respective age category as of the last date of the fiscal year

Denominator

1. Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are pulled from the DSS. The data are pulled after the end of the prior fiscal year thus allowing for retroactive enrollment to be captured.
2. The enrollment spans are converted to a number of days enrolled by taking the enrollment end date minus the enrollment begin date plus one. The days are then summed and divided by 365 (366 in leap years). This creates a member year or FTE calculation.
3. Each client's age group, race, and eligibility type are determined using the most recent data stored in MMIS client demographic and eligibility records.

Numerator

1. Encounter data submitted by the BHOs are analyzed in the Colorado Medicaid decision support system (DSS).
2. The encounters are grouped by Medicaid managed care mental health provider (BHO) number, and the number of unique client IDs are summed to obtain the number of clients served.
3. For unique client IDs by age, race, and eligibility type the client's demographic information is pulled and then joined to the encounter information, by Medicaid client ID, so that each BHO encounter is associated with an age group, race code and eligibility type

Member months

Report all member months during the measurement year for members with the benefit. Refer to *Specific Instructions for Use of Services Tables.* Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the *Any* column should include all members with any mental health benefit. Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.

Inpatient

- Include inpatient care at either a hospital or treatment facility with a covered mental health diagnosis as the principal diagnosis:
- **295.00-298.99**
- **300.00-301.99**
- **307.00-309.99**
- **311.00-314.99**

One of the following criteria should be used to identify inpatient services.

- An Inpatient Facility code in conjunction with a covered mental health diagnosis. o***r***
- DRGs (Table MPT-B)

Include discharges associated with residential care and rehabilitation

Codes to Identify Inpatient Service

Inpatient Facility codes : 100, 101, 110, 114, 124, 134, 144, 154, 204
Sub-acute codes : 0919
ATU codes : 190, H2013, H0018AT, H0017
RTC codes : H2013, 0191, 0192, 0193, H0018, H0019, S5135

Table MPT-B Codes to Identify Inpatient Services

MS—DRG
876, 880-887

Codes to Identify Intensive Outpatient and Partial Hospitalization Services:

HCPCS	UB Revenue		
Visits identified by the following HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).			
G0410, G0411, H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913,		
CPT			**POS**
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876; 90791, 90792, 90832, 90834, 90837		***WITH***	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.			
99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99201-99205, 99211-99219, 99241-99245, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350, 99366-99368, 99441-99443		***WITH***	52

Codes to Identify Outpatient and ED Services: Additional BHO codes & POS

CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
90804-90815, 96101-96103, 96105, 96110, 96111, 96116, 96118-20, 96125, 90832, 90834, 90837, 90839	G0155, G0176, G0177, G0409, H0002, H0004, H0023, H0025, H0031,H0032 H0034, H0036, H0037, H0039, H0040, H0044, H1011, H2000, H2010, H2011, H2013-H2020, H2027, H2033, M0064, S9484, S9485, T1005, T1016, T1017, H0033, H0038, H0043, H0046, H2012, H2021, H2022, H2023, H2024, H2025, H2026, H2030, H2031, H2032, S5150, S5151, S0220, S0221, S9449, S9451, S9452, S9453, S9454, S9470	0513, 0900-0904, 0911, 0914-0919, 0762, 0769, 045x

CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 90791, 90792, 90785, 90846	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 23, 33, 49, 50, 53*, 71, 72, 19, 26, 32, 34, 41, 99
CPT		**UB Revenue**
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.		
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510, 90772, 97535, 97537		045x, 0510, 0515-0517, 0519,-0523, 0526-0529, 0762, 0981-0983

* POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization elects to use POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

- Note: The specifications presented here for the Penetration Rates by Service Category performance indicator are closely based upon HEDIS 2013 specifications.

Indicator 12: Adherence to antipsychotics for individuals with schizophrenia

Description: The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Denominator: The eligible population

Numerator: The number of members who achieved a PDC of at least 80% for their antipsychotic medications (Table SAA-A) during the measurement year.

Data Source (s): HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: HCPF

Benchmark: Overall BHOs and HEDIS

TABLE 6

Description

The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
Oral medication dispensing event	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 Multiple prescriptions for different medications dispensed on the same day are counted as separate dispending events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescription are the same or different.
Long-acting injections dispensing event	Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.

Calculating number of days covered for oral medications	If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the drug ID provided on the NDC list to determine if the prescription are the same or different
Calculating the number of days covered for long-acting injections	Calculate number of days covered (for the numerator) for long-acting injections using the days-supply specified for the medication in Table SAA-A. For multiple J codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply. For multiple J codes or NDCs for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

Eligible Population

Product lines	Medicaid
Ages	19-64 years of age as of December 30 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 30 of the measurement year
Benefits	Medical, pharmacy (HCPF) and mental health (inpatient and outpatient).
Event/diagnosis	The organization should follow the steps below to identify the eligible population, which should be used for rate.

Step 1 Identify all members who met at least one of the following criteria during the measurement year

- At least one acute inpatient claim/encounter (Table SSD-A) with any diagnosis of schizophrenia (ICD-9-CM-Diagnosis: 295) ***or***
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting, or non-acute inpatient setting (Table SSD-A) on different dates of service with any diagnosis of schizophrenia (ICD-9-CM Diagnosis: 295).

Required Exclusions

- Members with a diagnosis of dementia during the measurement year (DSM-IV Diagnosis: 290, 291.2, 292.82, 294.0-294.2, 331.0, 331.1, 331.82)
- Members who did not have at least two antipsychotic medication (Table SAA-A) dispensing events during the measurement year.

Step 2 Identify the IPSD. The IPSD is the earliest dispensing events for any antipsychotic medication (Table SAA-A) during the measurement year.

***Step* 3** To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.

***Step* 4** Count the days covered by at least one antipsychotic medications (Table SAA-A) during the treatment period. To ensure that the days supply does not exceed the treatment period, subtract any day's supply that extends beyond December 30 of the measurement year.

Step 5 Calculate the member's PDC using the following equation

$$\frac{Total\ days\ covered\ by\ an\ antipsychotic\ medication\ in\ the\ treatment\ period\ (Step\ 4)}{Total\ days\ in\ treatment\ period\ (Step\ 3)}$$

Step 6 Sum the number of members whose PDC is ≥80% for their treatment period

Table SSD-A Codes to Identify Visit Type

Description	UB Revenue		
Acute inpatient	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987		
	CPT		**POS**
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	***WITH***	21, 51
	CPT	**HCPCS**	**UB Revenue**
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0516, 0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
Outpatient, intensive outpatient, and partial hospitalization continued	**CPT**		**POS**
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT		**UB Revenue**
ED	99281-99285		045x, 0981
	CPT		**POS**
	90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	***WITH***	23

	CPT	HCPCS	UB Revenue
Non-acute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	H0017-H0019, T2048	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1000, 1001, 1003-1005
	CPT		**POS**
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	***WITH***	31, 32, 56

Table SAA-A: Antipsychotic Medications

Description	Prescription		J codes	Covered Days
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurisadone • Molindone	• Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone		
Phenothiazine antipsychotics	• Clorpromazine • Fluphenazine • Perphenazine • Perphenazine-amitriptyline	• Prochlorperazine • Thioridazine • Trifluoperazine		
Psychotherapeutic combinations	• Fluoxetine-olanzapione			
Thioxanthenes	• Thiothixene			
Long-acting injections	• Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate	J1631, J2358 J2426, J2680	28 day supply
	• Risperidone		J2794	14 day supply
Please use the 2013(posted November 2012) list to calculate this measure. The list of medications can be found at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013FinalNDCLists.aspx				

Indicator 13: Follow-up appointments within seven (7) and thirty (30) days after hospital discharge

Description: The percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider by age group and overall within 7 or 30 days (follow-up rates). Two indicators are provided: 1) **Non-State:** Follow-up rates for member discharges from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Follow-up rates for member discharges from all hospital episodes for a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.

Numerators: Total number of discharges with an outpatient service (**see Table 7)** within 7 and 30 days (the 30 days includes the 7 day number also). For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure. See codes in **Table 7** for follow-up visit codes allowed.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year with an outpatient service within 7 and 30 days.
All Hospitals: All discharges from any inpatient facility for a specified fiscal year with an outpatient service within 7 and 30 days.

Denominators: The population based on discharges during the specified fiscal year July 1 through June 30 (can have multiple discharges for the same individual). Discharges for the whole fiscal year are calculated because the use of 90 day run out data provides the time to collect 30 day follow-up information.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year.
All Hospitals: All discharges from any inpatient facility for the specified fiscal year.

Data Source(s): Denominator: Number of Member discharges, from non-State hospitals, ages 6+, and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the State. Numerator: An outpatient visit, intensive outpatient encounter or partial hospitalization provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO; Calculation: Includes 4 ratios: Numerator (7 days, non-state hospital)/Denominator (non-State hospital); Numerator (30 days, non-state hospital)/Denominator (non state hospital), Numerator (7 days, all hospital)/Denominator (all hospital), Numerator (30 days, all hospital)/Denominator (all hospital

Benchmark: HEDIS and all BHOS

TABLE 7

Description

The percentage of discharges for members 6-20 years of age and 21 and older who were hospitalized for treatment of a covered mental health diagnosis and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

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

Eligible Population

Ages	Two age categories are identified, ages 6-20 and 21+.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gap in enrollment except for State hospital stays (age 22-64) which allow gaps at 1 day prior to admission through 1 day after discharge.
Event/diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a covered mental health diagnosis during July1 and June 30 of the fiscal year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge during July1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If readmission or direct transfer to an acute facility follows the discharge for any covered mental health diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health diagnosis, it is probably for a related condition. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after June 30 of the fiscal year. Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for any covered mental health diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to the following table for codes to identify non-acute care.
Exclusion	Because residential treatment for Foster Care members is paid under fee-for-service, the BHOs cannot easily determine if a Foster Care member was discharged to residential treatment. Therefore, prior to official rate reporting, the HCPF Business Analysis Section will forward each BHO a list of foster care members who were discharged from an inpatient setting to a residential treatment facility, in order to assist the BHOs in removing these members from this measure.

Codes to Identify Non-acute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB Revenue or Type of Bill codes for billing (e.g., ICF, SNF)				

Administrative Specification	
Denominator	The eligible population.
Numerators	
30-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.
7-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.

Codes to Identify Visits

CPT	HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, 90839	G0155, G0176, G0177, G0409, G0410, G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 90791, 90792, 90832, 90834, 90837	***WITH***	03, 04, 05, 07, 11, 12, 13, 14, 15, 16, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	***WITH***	52, 53

UB Revenue
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.
0513, 0900-0905, 0907, 0911-0917, 0919
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with covered any diagnosis code.
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

- Note: The specification presented here for the Follow up Post Discharge performance indicator are closely based upon HEDIS 2013 specifications.

Indicator 14: Percent of members with SMI with a focal point of behavioral health care

Description: The percent of members with SMI who have a focal point of care identified and established. For the purpose of this indicator, SMI includes the following: Schizophrenia, Schizoaffective, and Bipolar diagnoses. See Table 8.

Denominator: Total number of unduplicated members meeting the following criteria:

- 21 years of age or older on first day of the measurement period (July 1-June 30)
- Continuously enrolled 12 out of 12 months in the same BHO during the measurement period (SFY)
- Identifying outpatient service with an SMI diagnosis- at least one paid BHO outpatient service (refer to **Table 8**) in the first 9 months of the measurement period (SFY) for diagnoses in any position (refer to **Table 8**).
- The type of service identified does not lock the patient into a treatment track for the numerator

Numerator: Total number of members in the denominator that meet at least one of the following track criteria (using **Table 8**) with the same billing provider during the measurement period (SFY).

- Treatment/Recovery Track- At least 3 Treatment/Recovery or Case Management or Med Management visits
- Med Management Track- At least 2 Med Management visits

Data Source(s): BHO transaction system.

Calculation of Measure: BHO

TABLE 8

Codes to Identify BHO Outpatient Services

Service Domain and/or Category	CPT/HCPCS Procedure Code		POS
Assessment	90791, 90792, 90801, 90802, H0031	**WITH**	**Exclude POS 21, 51 and 23**
Treatment/Recovery (Psychotherapy, Svc planning, Vocational, Peer support)	90804-19, 90821-90824, 90826-90829 90846-7, 90849, 90853, 90857, H0032, H0004, H0036-40, H2014-8, H2023–7, H2030-2, 90832, 90834, 90837		
Case Management	T1016-7		
Med Management	90862, 96372, 99441-3, H0033-4, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510		

Diagnosis Codes

Diagnosis	ICD-9-CM
Schizophrenia	295.10, 295.1, 295.20, 295.2, 295.30, 295.3, 295.60, 295.6, 295.90, 295.9
Schizoaffective disorder	295.70, 295.7
Bipolar disorder	296.0x, 296.40, 296.4, 296.4x, 296.5x, 296.6x, 296.70, 296.7, 296.80, 296.89

Indicator 15: Improving physical healthcare access

Description: The total number of Members who received outpatient mental health treatment during the measurement period and also had a qualifying physical healthcare visit during the measurement period

Denominator: Total number of unduplicated members who had at least one BHO outpatient service claim/encounter during the measurement period. Members must be Medicaid eligible and enrolled at least 10 months with the same BHO during the 12-month measurement period. (This is the numerator from the Service Category Penetration Rates measures excluding ED services.)

Numerator: Total number of members in the denominator with at least one preventive or ambulatory medical visit as defined using the service codes in **Table 9** during the measurement period, excluding those services provided by rendering provider type codes identified in **Table 9**.

Data Source(s): The encounter/claims files (BHO, MCO, Fee for Service) for the fiscal year, including paid claims, provided by HCPF

Calculation of Measure: HCPF

Benchmark: Overall BHO

TABLE 9

Preventive or Ambulatory Medical Visits Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services (HEDIS 2013)

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337,			
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
General medical examination			V20.2,V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Rendering Provider Type Code Exclusions

Rendering Provider Type Code	Rendering Provider Type Description
06	Podiatrist
11	Case Manager
27	Speech Therapist
12	Independent Laboratory

Indicator 16: Inpatient utilization (per 1000 members)

Description: The total number of BHO member discharges from a hospital episode for treatment of a covered mental health diagnosis per 1000 members, by age group (see above for age categories) and total population. The discharge must occur in the period of measurement. Two indicators are provided: 1) Number of member discharges from a non-State hospital and 2) Number of member discharges from all hospitals (non-State and State hospitals). Age for this indicator is determined at hospital discharge. Please note: For members transferred from one hospital to another within 24 hours, only one discharge should be counted and it should be attributed to the hospital with the final discharge.

Denominator: Total number of members during the specified fiscal year (12-month period) per HEDIS age group.

Numerator: All discharges from a hospital episode for treatment of a covered mental health diagnosis per HEDIS age group
Non-State Hospitals: All discharges from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.
All Hospitals: All discharges from a hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.

Data Source(s): Denominator: Members by BHO provided by HCPF. Numerator: Discharge dates from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-state hospital)/Denominator x 1000; Numerator (all hospital)/Denominator x 1000

Benchmark: HEDIS for all hospital and Overall BHOs for all hospital and non-State hospital

Indicator 17: Hospital length of stay (LOS)

Description: The average length of stay (in days) for BHO members discharged from a hospital episode for treatment of a covered mental health diagnosis, by age group and total population. Two indicators are provided: 1) Average length of stay for members discharged from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30 and 2) Average length of stay for members discharged from all hospital episodes for a covered mental health diagnosis during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at hospital discharge.
Please note: For members transferred from one hospital to another within 24 hours, total length of stay for both hospitals should be attributed to the hospital with the final discharge. For final discharges from a State hospital, all days in the hospital episode will be included if the member was Medicaid eligible at the time of admission.

Denominators: Number of Members discharged from a hospital episode per HEDIS age group. The discharge day must occur within the specified fiscal year, July 1 through June 30.
Non-State Hospital: Total number of Members discharged from a non-State hospital during the specified fiscal year
All Hospitals: Total number of Members discharged from all hospitals during the specified fiscal year.

Numerators: Total days for all hospital episodes resulting in a discharge. Discharge day is not counted. The discharge day must occur within the specified fiscal year, July 1 through June 30. If the admit date and the discharge date are the same then the number of days for the episode is one.
Non-State Hospitals: Total days= Discharge date from the non-State hospital-Admit date
All Hospitals: Total days=Discharge date from all hospitals-Admit date

Data Source(s): Denominator: Number of Members discharged, from non-State hospitals and State hospitals, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the state hospital data file. Numerator: Hospital days (discharge date – admit date) from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Hospital days (discharge date – admit date) from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-State hospital)/Denominator (non-State hospital); Numerator (all hospital)/Denominator (all hospital)

Benchmark: BHO for all hospital and non-State hospital

Indicator 18: Emergency department utilization (per 1000 members

Description: Number of BHO Member emergency room visits for a covered mental health diagnosis per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this measure include only paid encounters. Age for this indicator is determined on date of service.

Denominator: Total number of Members during the specified fiscal year (12-month period).

Numerator: ED visits that don't result in an inpatient admission within 24 hrs of the day of the ED visit. ED visit codes include CPT 99281-99285 and 99291-99292 and revenue code 45x.

Data Source(s): Denominator: HCPF; Numerator: BHO encounter claim file.

Calculation of Measure: BHO; Calculation: Numerator/Denominator x 1,000

Benchmark: Overall BHO

Indicator 19: MHSIP, YSS & YSS-F Satisfaction Surveys

Description: The Colorado Division of Behavioral Health conducts annual adult, adolescent and youth surveys to assess satisfaction with mental health services at each of the Colorado community mental health centers. The surveys address six topics of interest: Access, Appropriateness and Quality, Outcomes, Participation in Treatment, Doctor Contact outside of the Emergency Room, and Satisfaction (MHSIP only) or Cultural Sensitivity (YSS and YSS-F only). For each question in every topic other than Doctor Contact Outside of the Emergency Room, survey respondents rate their satisfaction on a scale from 1 – Most Satisfied to 5 – Least Satisfied. Survey respondents answer the Doctor Contact Outside of the Emergency Room question with yes, no, or do not remember. Refer to the current state fiscal year MHSIP, YSS and YSS-F technical reports for complete methodology. This report can be found on the State of Colorado Division of Behavioral Health website.

Denominator: Number of MHSIP (adults), YSS (adolescents) or YSS-F (youth) surveys with valid domains for each domain topic. Surveys have valid domains if at least two thirds of survey questions in that domain have been answered. For domains with a small number of questions, often all questions must be answered to meet this criterion. For example, the 2011 survey included only two questions related to Participation. In this case, both questions had to be answered for a survey to be included in the measure.

Numerator:

- For all topics other than Doctor Contact Outside of the Emergency Room, the numerator is the number of surveys with valid domains that have a positive rating of the topic. A positive rating is defined as an average of 2.49 or less across all questions in the domain.

- For the question regarding Doctor Contact Outside of the Emergency Room, the numerator is the number of survey respondents that answered yes.

Data is also presented regarding the total number of surveys returned at the mental health center and BHO levels. Finally, raw data of responses to each question and statewide means for each question are also included.

Data Source (s): OBH administered surveys; OBH will send to the Department (HCPF) for calculation the items that were answered "yes" for Medicaid (MHSIP Question #54; YSS Question #30; YSS-F Question #30).

Calculation of Measure: HCPF for the BHOs

Benchmark: Overall BHOs

Indicator 20: Antidepressant medication management-optimal practitioner contacts

Description: Percent of members diagnosed with major depression, newly treated with antidepressant medication, and who had at least three (3) follow-up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks). Refer to **Table 10 for specific criteria on calculating this measure**.

Denominator: Members ages 18 years and older who were diagnosed with major depressive disorder and newly treated with antidepressant medication. Note: this denominator is the same as Indicator #3

Numerator: The number of members in the denominator who had at least 3 follow-up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks)

Data Source (s): HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: BHOs

Benchmark: Overall BHOs

TABLE 10

Antidepressant Medication Management (AMM) Optimal Practitioner Contacts

Summary of Changes to HEDIS 2013

- Deleted Negative Diagnosis History
- Revised Continuous enrollment criteria
- Deleted codes 300.4 and 309.1 from Table AMM-A
- Deleted Table AMM-C: Additional Codes to Identify Depression

Description

The percentage of members 18 years of age and older with a diagnosis major depression and newly treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase.

Definitions

Intake Period	The 12-month window starting on July 1 and ending on June 30 of the measurement year.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression (Table AMM-A) and a 90-day (3 month) Negative Medication History *For an inpatient (acute or nonacute) claim/encounter*, the IESD is the date of discharge. *For a direct transfer*, the IESD is the discharge date from the facility to which the member was transferred.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).
Negative Medication History	A period of 90 days (3 months) prior to the IPSD, during which time the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication (Table AMM-C).
Treatment days	The actual number of calendar days covered with prescriptions within the specified 84-day measurement interval.

Eligible Population

Product lines Medicaid

Ages 18 years and older as of June 30 of the measurement year.

Continuous enrollment 90 days prior to the IESD through 128 days after the IESD.

Allowable gap One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date IESD.

Benefits Medical, pharmacy (HCPF) and mental health (inpatient and outpatient).

Event/diagnosis The organization should follow the steps below to identify the eligible population, which should be used for rate.

Step 1 Identify all members who met at least one of the following criteria during the Intake Period.

- At least one principal diagnosis of major depression (Table AMM-A) in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B), ***or***
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B) on different dates of service with any diagnosis of major depression (Table AMM-A), ***or***
- At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table AMM-A)

Table AMM-A: Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, , 311

*****Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of that code). Additionally, other possible codes that could indicate a depression diagnosis (296.4–296.9, 309.0, 309.28) are not included in this list because these codes are less specific in identifying members with major depression.

Table AMM-B: Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 G0409–G0411	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 077x, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

CPT		POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

Step 2 Determine the IESD. For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter.

Step 3 Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period.

Step 4 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD.

***Step* 5** Calculate continuous enrollment. Members must be continuously enrolled for 90 days prior to the IESD to 128 days after the IESD.

Administrative Specification

Denominator The eligible population. The denominator is the same as Indicator #3.

Numerators

Optimal practitioner contacts for medication management Three or more outpatient, intensive outpatient, or partial hospitalization follow-up visits with a practitioner within the 84-day Acute Treatment Phase. All three follow-up visits should be for mental health. Two of the three follow-up visits must be face-to-face. Case management services should not be counted toward this measure.

Identify all members in the denominator population who met one of the following criteria.

Three face-to-face visits (Table AMM-E) with a practitioner within 84 days (12 weeks) after the IESD, ***or***

Two face-to-face visits and one telephone visit (Table AMM-E) with a practitioner within 84 (12 weeks) days after the IESD

Do not count the IESD visit in cases where the member had two visits with a secondary diagnosis of major depression. The organization may include the second visit with a secondary diagnosis toward the optimal contacts rate.

Table AMM-E: Codes to Identify Visits

Description	CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS and UB Revenue codes may be with a mental health or non-mental health practitioner (i.e., the organization does not need to determine practitioner type).			
Face-to-face visits	90804-90815; 90839	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0513, 0900-0905, 0907, 0911-0917, 0919

Description	CPT	UB Revenue
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner *or* in conjunction with any mental health diagnosis code		
Face-to-face visits	98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983
Telephone visits	99371-99373	

Description	CPT		POS
Visits identified by the following CPT/POS codes may be with a mental health or non-mental health practitioner (i.e., the organization does not need to determine practitioner type).			
Face-to-face visits	90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 90791, 90792, 90832, 90834, 90837,	***WITH***	05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72
Face-to-face visits	90816-90819, 90821-90824, 90826-90829	***WITH***	52, 53
Visits identified by the following CPT/POS codes must be with a mental health practitioner *or* in conjunction with any mental health diagnosis code			
Face-to-face visits	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263	***WITH***	52, 53

Please use the 2013(posted November 2012) list to calculate this measure. The list of medications can be found at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013FinalNDCLists.aspx

Note: The intent of the telephone visit is that the exchange occurred between the patient and one of the practitioner types (mental health and non-mental health practitioners) that count for face-to-face visits. Do not count contacts from other types of services (e.g., disease management, case management) toward the Optimal Practitioner Contacts measure.

Indicator 21: Increasing post-partum depression (PPD) screening in primary care - Void

Indicator 22: Change in recovery and resilience - Void