

Effectiveness of Care

Appropriate Treatment for Children With Upper Respiratory Infection

SUMMARY OF CHANGES TO HEDIS 2004

- First-year measure.
- Additional data elements are included for first-year measure analysis. The MCO should submit these data elements if they are readily available, but is not obligated to collect these additional elements.

Note: NCQA will provide a comprehensive list of NDC codes for antibiotic medications on its Web site at www.ncqa.org by December 15, 2003.

Description

The percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or 3 days after the Episode Date. This process measure assesses if antibiotics were inappropriately prescribed for children with URI.

The measure is reported as an inverted rate [1 minus (numerator/denominator)]. A higher score indicates appropriate treatment of children with upper respiratory infection (i.e., proportion for whom antibiotics *were not* prescribed).

This is the first measure in HEDIS evaluating antibiotic prescribing and utilization. NCQA is first measuring these issues in children and may later adopt measures for adults.

Definitions

Episode Date	The date of service for any outpatient claim/encounter during the Intake Period with only a diagnosis of URI (refer to Table E3-A). Exclude claims/encounters with more than one diagnosis. Use Tables E3-B and E3-C to identify outpatient visits.
First Eligible Episode	The <i>first</i> episode during the Intake Period that meets all criteria. To qualify, the episode must meet all of the following criteria: <ul style="list-style-type: none">• the outpatient claim/encounter during the Intake Period (refer to Table E3-B and E3-C) has only a diagnosis of URI (refer to Table E3-A), excluding encounters with more than one diagnosis• there was a 30-day Negative Medication History prior to the Episode Date• the member was continuously enrolled 30 days prior to the Episode Date through 3 days after the Episode Date .
Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture eligible episodes of treatment.
Negative Medication History	A period of 30 days prior to the Episode Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug or a prescription that was active on the Episode Date.

A prescription is **active** if the “days supply” indicated on the date the member filled the prescription is the number of days or more between the date the prescription was filled and the relevant service date.

The 30-day look back period for pharmacy data includes the 30 days prior to the Intake Period (see definition of Intake Period).

Outpatient Visit Claim/Encounter

Claim/encounter data for outpatient visits, including visits to the emergency room that did not result in hospitalization, urgent care and doctor’s office (refer to Tables E3-B and E3-C).

Prescription Date

The earliest prescription for antibiotics (Table E3-D) filled on or during the 3-day period after the Episode Date.

Eligible Population

Product lines	Medicaid, commercial (report each product line separately).
Ages	Children age 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
Continuous enrollment	30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Outpatient visit with only a diagnosis of nonspecific upper respiratory infection during the Intake Period.

Follow the steps below to identify the eligible population:

- Step 1 Identify all members in the specified age range**, who during the 12-month Intake Period had a claim/encounter with only a diagnosis of URI (Table E3-A) and an outpatient visit code (Tables E3-B and E3-C).

Table E3-A: Codes to Identify URI

Description	ICD-9-CM Codes
Acute nasopharyngitis (common cold)	460
URI unspecified site	465

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Table E3-B: Codes to Identify Outpatient Visits

Description	CPT Codes	UB-92 Revenue Codes
Evaluation and management codes—office or other outpatient services	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275, 99381-99385, 99391-99395	
Other evaluation and management services	99499	
After hours nonemergency urgent care		462
Clinic		51X
Freestanding clinic		52X
Professional fees, outpatient services		982
Professional fees, clinic		983

Table E3-C: Codes to Identify Emergency Department Visits*

UB-92 Type of Bill Codes		UB-92 Revenue Codes
13x, 43X	AND	45X, 981

CPT Codes
99281-99288

*Exclude from the denominator patients admitted to the hospital from the ED.

Step 2 Determine all URI Episode Dates. For each member identified in Step 1, determine all outpatient Episode Dates.

Step 3 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or which was active on the Episode Date Refer to the comprehensive list of NDC codes for antibiotic medications found on the NCQA Web site.

Note: If the episode occurred on July 1 of the year prior to the measurement year, the MCO should look 30 days prior to the start of the Intake Period (June 1–June 30) to check for the member’s negative medication history.

Step 4 Calculate Continuous Enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 5 Calculate Measure Denominator. This measure examines one eligible episode per member. Select the First Eligible Episode for each member during the measurement Intake Period that meets all criteria for inclusion in the denominator.

Administrative Specification

Denominator The eligible population.

Numerator

Antibiotic prescription Dispensed prescription for antibiotic medication (Table E3-D) on or 3 days after the Episode Date.

This measure examines one eligible episode per member.

Table E3-D: Antibiotic Medications

Prescriptions			
<ul style="list-style-type: none"> • Amoxicillin • Amox/Clavulanate • Ampicillin • Azithromycin • Cefaclor • Cefadroxil hydrate • Cefdinir • Cefixime • Cefditoren 	<ul style="list-style-type: none"> • Ceftibuten • Cefpodoxime proxetil • Cefprozil • Ceftriaxone • Cefuroxime • Cephalexin • Ciprofloxacin • Clindamycin • Dicloxacillin 	<ul style="list-style-type: none"> • Dirithromycin • Doxycycline • Erythromycin • Ery E-Succ/Sulfisoxazole • Flomefloxacin • Gatifloxacin • Levofloxacin • Loracarbef • Minocycline 	<ul style="list-style-type: none"> • Ofloxacin • Penicillin VK • Penicillin G • Sparfloxacin • Sulfisoxazole • Tetracycline • Trimethoprim • Trimethoprim-sulfamethoxazol

Note:

- *NCQA will provide a comprehensive list of NDC codes for antibiotic medications on its Web site at www.ncqa.org by December 15, 2003.*
- *Refer to the Enrollment by Product Line measure for instructions on calculating member months.*
- *Complete Tables E3-1 and E3-2 to facilitate tracking the population based rate of URI diagnosis. This data will be used by NCQA to calculate the rate of eligible URI episodes per 1,000 member months for Medicaid and 1,000 member years for commercial. The MCO's diagnosis rate will not be publicly reported. For more details on calculating member months of enrollment, refer to Specific Instructions for Use of Services Tables.*

Table E3-1: Member Months of Enrollment—Total Medicaid

Age	Member Months
<1	_____
1-4	_____
5-9	_____
10-14	_____
15-17	_____
<i>Total:</i>	_____

Table E3-2: Member Months of Enrollment—Total Commercial

Age	Member Months
<1	_____
1-4	_____
5-9	_____
10-14	_____
15-17	_____
<i>Total:</i>	_____

Data Elements for Reporting

MCOs that submit HEDIS data to NCQA must provide the following data elements:

Table E3-1/2: Data Elements for Appropriate Treatment for Children With Upper Respiratory Infection

	Administrative
Measurement year	X
Data collection methodology (administrative only)	X
Member months of enrollment	X
Eligible member population (i.e., members who meet all criteria)	X
Denominator by non-ER/urgent care visits*	X
Denominator by ER/urgent care visits*	X
Total Denominator	X
Numerator by non-ER/urgent care visits*	X
Numerator by ER/urgent care visits*	X
Total Numerator events by administrative data	X
Reported rate	X
Lower 95% confidence interval	X
Upper 95% confidence interval	X

*Reporting these additional data elements will be optional in the data submission tool (DST).

Appropriate Testing for Children With Pharyngitis

SUMMARY OF CHANGES TO HEDIS 2004

- First-year measure.
- Additional data elements are included for first-year measure analysis. The MCO should submit these data elements if they are readily available, but is not obligated to collect these additional elements.

Note: NCQA will provide a comprehensive list of NDC codes for antibiotic medications on its Web site at www.ncqa.org by December 15, 2003.

Description

The percentage of children 2–18 years of age who were diagnosed with pharyngitis, prescribed an antibiotic and who received a group A streptococcus test for the episode.

This measure assesses the adequacy of clinical management of pharyngitis episodes for members who received an antibiotic prescription.

Definitions

Episode Date	The date of service for any outpatient claim/encounter during the Intake Period with only a diagnosis of pharyngitis (refer to Table E4-A). Exclude claims/encounters with more than one diagnosis. Use Tables E4-B and E4-C to identify outpatient visits.
First Eligible Episode	The <i>first</i> episode during the Intake Period that meets all criteria qualifies as the First Eligible Episode. To qualify as the First Eligible Episode during the Intake Period, all of the following criteria must be met: <ul style="list-style-type: none"> • the outpatient claim/encounter with only a diagnosis of pharyngitis must be linked to an antibiotic prescription on or during the 3 days after the Episode Date • there must be a 30-day Negative Medication History prior to the Episode Date • the member was continuously enrolled during the 30 days prior to and 3 days after the Episode Date.
Group A streptococcus test	A group A streptococcus (strep) test (Table E4-E) administered in the 7-day period from 3 days prior to the First Eligible Episode Date through 3 days after the First Eligible Episode Date.
Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture eligible episodes of treatment.
Negative Medication History	A period of 30 days prior to the Episode Date during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug or a prescription that was active on the Episode Date (refer to Table E4-D).

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A prescription is considered active if the “days supply” indicated on the date the member filled the prescription is the number of days or more between the date the prescription was filled and the relevant service date.

The 30-day look back period for pharmacy data includes the 30 days prior to the Intake Period (see definition of **Intake Period**).

Outpatient Visit Claim/Encounter

Claims or encounter data for outpatient visits, including visits to the emergency room that did not result in hospitalization, urgent care and doctor’s office (see Tables E4-B and E4-C).

Prescription Date

The earliest prescription for antibiotics (Table E4-D) filled on or during the 3-day period after the Episode Date.

Eligible Population

Product lines

Medicaid, commercial (report each product line separately).

Ages

Children age 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.

Continuous enrollment

30 days prior to the Episode Date to 3 days after the Episode Date (inclusive)

Allowable gap

No gaps in enrollment during the continuous enrollment period.

Anchor dates

None.

Benefits

Medical and pharmacy.

Event/diagnosis

Outpatient visit with only a diagnosis of pharyngitis during the Intake Period and prescribed an antibiotic for that episode of care.

Follow the steps below to identify the eligible population:

- Step 1 Identify all members in the specified age range** who during the 12-month Intake Period had an outpatient visit (Tables E4-B and E4-C) with only a diagnosis of pharyngitis (Table E4-A). Exclude claims/encounters with more than one diagnosis.

Table E4-A: Codes to Identify Pharyngitis

Description	ICD-9-CM Codes
Acute or unspecified pharyngitis	462
Acute tonsillitis	463
Streptococcal tonsillitis	034.0

Table E4-B: Codes to Identify Outpatient Visits

Description	CPT Codes	UB-92 Revenue Codes
Evaluation and management codes—office or other outpatient services	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99220, 99381-99385, 99391-99395	
Other evaluation and management services	99499	
Emergency department services	99281-99288	
After-hours nonemergency urgent care		462
Clinic		51X
Freestanding clinic		52X
Professional fees, outpatient services		982
Professional fees, clinic		983

Table E4-C Codes to Identify Emergency Department Visits

UB-92 Type of Bill Codes	AND	UB-92 Revenue Codes
13x, 43X		45X, 981

CPT Codes
99281-99288

*Patients admitted to the hospital from the ED should not be included in the denominator.

Step 2 Determine all Pharyngitis Episode Dates. For each member identified in Step 1, determine all Episode Dates with only a diagnosis of pharyngitis in the 12-month Intake Period (refer to Tables E4-A and E4-B).

Exclude claims/encounters with more than one diagnosis.

Step 3 Determine if antibiotics (Table E4-D) were prescribed for any of the Episode Dates. For each Episode Date with a qualifying diagnosis, determine if antibiotics were prescribed on or 3 days after the Episode Date. Exclude Episode Dates if the member did not receive antibiotics on or 3 days after the Episode Date.

Table E4-D: Antibiotic Medications

Prescriptions			
<ul style="list-style-type: none"> • Amoxicillin • Amox/Clavulanate • Ampicillin • Azithromycin • Cefaclor • Cefadroxil hydrate • Cefdinir • Cefixime • Cefditoren 	<ul style="list-style-type: none"> • Cefibuten • Cefpodoxime proxetil • Cefprozil • Ceftriaxone • Cefuroxime • Cephalexin • Ciprofloxacin • Clindamycin • Dicloxacillin 	<ul style="list-style-type: none"> • Dirithromycin • Doxycycline • Erythromycin • Ery E-Succ/Sulfisoxazole • Flomefloxacin • Gatifloxacin • Levofloxacin • Loracarbef • Minocycline 	<ul style="list-style-type: none"> • Ofloxacin • Penicillin VK • Penicillin G • Sparfloxacin • Sulfisoxazole • Tetracycline • Trimethoprim • Trimethoprim-sulfamethoxazole

Note: NCQA will provide a comprehensive list of NDC codes for antibiotic medications on its Web site at www.ncqa.org by December 15, 2003.

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Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or which was active on the Episode Date. Refer to the comprehensive list of NDC codes for antibiotic medications found on the NCQA Web site.

Note: If the episode occurred on July 1 of the year prior to the measurement year, the MCO should look back 30 days prior to the start of the Intake Period (i.e., June 1–June 30) to check for the member’s medication history.

Step 5 Calculate Continuous Enrollment. The member must be continuously enrolled without any gaps in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6 Calculate Measure Denominator. This measure examines one eligible episode per member. When calculating the final measure denominator, select the First Eligible Episode for each member during the measurement Intake Period that meets all criteria for inclusion in the denominator.

Administrative Specification

Denominator The eligible population.

Numerator

Group A strep test A Group A strep test (Table E4-E) administered in the 7-day period from 3 days prior to the First Eligible Episode Date through 3 days after the First Eligible Episode Date.

Table E4-E: Codes to Identify Group A. Streptococcus Tests

Description	CPT Codes
<i>Antigen detection...</i>	
• by enzyme immunoassay	87430, 86317, 86403, 86588, 87449
• by nucleic acid	87650-87652
• by direct optical observation	87880
• by throat culture	87060, 87081-87083, 87070-87071

Data Elements for Reporting

MCOs that submit HEDIS data to NCQA must provide the following data elements:

Table E4-1/2: Data Elements for Appropriate Testing for Children With Pharyngitis

	Administrative
Measurement year	X
Data collection methodology (administrative only)	X
Member months of enrollment	X
Eligible member population (i.e., members who meet all criteria)	X
Denominator by non-ER/urgent care visits*	X
Denominator by ER/urgent care visits*	X
Total Denominator	X
Numerator by non-ER/urgent care visits*	X
Numerator by ER/urgent care visits*	X
Total Numerator events by administrative data	X
Reported rate	X
Lower 95% confidence interval	X
Upper 95% confidence interval	X

* Reporting these additional data elements will be optional in the Data submission tool (DST).

Colorectal Cancer Screening

SUMMARY OF CHANGES TO HEDIS 2004

- First-year measure.
- Additional data elements are included for first-year measure analysis. The MCO should submit these data elements if they are readily available, but is not obligated to collect these additional elements.

Description

The percentage of adults 50–80 years of age who had appropriate screening for colorectal cancer (CRC). The hybrid method is recommended to calculate this measure.

Eligible Population

Product line	Commercial, Medicare (report each product line separately).
Ages	52–80 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	Enrolled as of December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	<p>One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:</p> <ul style="list-style-type: none"> • fecal occult blood test (FOBT) during the measurement year • flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year • double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year • colonoscopy during the measurement year or the nine years prior to the measurement year.

A member had an appropriate screening if a submitted claim/encounter contains any one of the following codes:

Table E5-A: Codes to Identify Colorectal Cancer Screening

Description	CPT Codes	ICD-9-CM Codes
Fecal occult blood test (FOBT)	82270,82274	
Flexible sigmoidoscopy	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340	45.22, 45.23, 45.24, 45.25, 45.42
Double contrast barium enema (DCBE)	74270, 74280	
Colonoscopy	44388, 44389, 44390, 44391, 44392, 44393, 44394, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45387	

Exclusion (optional):

Members with a diagnosis of colorectal cancer. The MCO should look for evidence of colorectal cancer as far back as possible in the member's history, through either administrative data or medical record review. The following codes in Table E5-B identify allowable exclusions:

Table E5-B: Codes to Identify Exclusions for Colorectal Cancer Screening

Description	ICD-9-CM Codes
Malignant neoplasm of colon and other specified sites of colon and large intestine	153.X, 154.0, 154.1, 197.5

Hybrid Specification**Denominator**

A systematic sample drawn from the eligible population for each product line. The MCO may reduce the sample size using the current year's administrative rate. For information on reducing the sample size, refer to the *Guidelines for Calculations and Sampling*.

Numerator

One or more screenings for colorectal cancer. Appropriate screenings must meet one of four criteria:

- FOBT during the measurement year
- flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- DCBE during the measurement year or the four years prior to the measurement year
- colonoscopy during the measurement year or the nine years prior to the measurement year.

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

Medical record Documentation in the medical record must include both of the following:

- a note indicating the date the colorectal cancer screening was performed, *and*
- the result or finding.

Exclusion (optional):

Refer to the *Administrative Specification* above for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer. The diagnosis of colorectal cancer must have occurred by December 31 of the measurement year. The MCO may use the description of the codes listed in Table E5-B as synonyms for a diagnosis of colorectal cancer.

Data Elements for Reporting

MCOs that submit HEDIS data to NCQA must provide the following data elements:

Table E5-2/3: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	X	X
Data collection methodology (administrative or hybrid)	X	X
Sampling method used		X
Eligible member population (i.e., members who meet all criteria)	X	X
Number of numerator events by administrative data in eligible population (before exclusions)		X
Current year's administrative rate (before exclusions)	X	X
Minimum required sample size (MRSS) or other sample size		X
Oversampling rate		X
Final sample size (FSS)		X
Number of numerator events by administrative data in FSS		X
Administrative rate on FSS		X
Number of original sample records excluded because of valid data errors		X
Number of records excluded because of contraindications identified through administrative data	X	X
Number of records excluded because of contraindications identified through medical record review		X
Number of employee/dependent medical records excluded		X
Additional records added from the auxiliary list		X
Denominator	X	X
• fecal occult blood test (FOBT) by administrative data*	X	X
• flexible sigmoidoscopy by administrative data*	X	X
• double contrast barium enema (DCBE) by administrative data*	X	X
• colonoscopy by administrative data*	X	X
Numerator events by administrative data	X	X
• fecal occult blood test (FOBT) by medical records*		X
• flexible sigmoidoscopy by medical records*		X
• double contrast barium enema (DCBE) by medical records*		X
• colonoscopy by medical records*		X
Numerator events by medical records		X
Reported rate	X	X
Lower 95% confidence interval	X	X
Upper 95% confidence interval	X	X

*Reporting these additional data elements will be optional in the Data Submission Tool (DST).

Osteoporosis Management in Women Who Had a Fracture

SUMMARY OF CHANGES TO HEDIS 2004

- First-year measure.
- Additional data elements are included for first-year measure analysis. The MCO should submit these data elements if they are readily available, but is not obligated to collect these additional elements.

Description

The percentage of women 67 years of age and older who suffered a fracture, and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the 6 months after date of the fracture. Because women who suffer a fracture are at an increased risk of additional fractures and are more likely to have osteoporosis, this measure assesses how well plans manage women at high risk for a second fracture.

Eligible Population

Product line	Medicare.
Age	Women 67 years and older as of December 31 of the measurement year.
Continuous enrollment	12 months prior to the initial eligible fracture through 6 months post-fracture.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Fracture between July 1 of the year prior to the measurement year through June 30 of the measurement year. If a member has more than one fracture during the specified period, the MCO should include only the first fracture (refer to the codes listed in Table E9-A to identify fractures).

Table E9-A: Codes to Identify Fractures*

CPT Codes	ICD-9-CM Codes	DRGs
21800, 21805, 21810, 21820, 21825, 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22328, 23500, 23505, 23515, 23570, 23575, 23585, 23600, 23605, 23615, 23616, 23620, 23625, 23630, 23665, 23670, 23675, 23680, 24500, 24505, 24515, 24516, 24530, 24535, 24538, 24545, 24546, 24560, 24565, 24566, 24575, 24576, 24577, 24579, 24582, 24586, 24587, 24620, 24635, 24650, 24655, 24665, 24666, 24670, 24675, 24685, 25500, 25505, 25515, 25520, 25525, 25526, 25530, 25535, 25545, 25560, 25565, 25574, 25575, 25600, 25605, 25611, 25620, 25622, 25624, 25628, 25630, 25635, 25645, 25650, 25651, 25652, 25680, 25685, 26600, 26605, 26607, 26608, 26615, 27193, 27194, 27200, 27202, 27215, 27216, 27217, 27218, 27220, 27222, 27226, 27227, 27228, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248, 27254, 27500, 27501, 27502, 27503, 27506, 27507, 27508, 27509, 27510, 27511, 27513, 27514, 27520, 27524, 27530, 27532, 27535, 27536, 27538, 27540, 27750, 27752, 27756, 27758, 27759, 27760, 27762, 27766, 27780, 27781, 27784, 27786, 27788, 27792, 27808, 27810, 27814, 27816, 27818, 27822, 27823, 27824, 27825, 27826, 27827, 27828, 28400, 28405, 28406, 28415, 28420, 28430, 28435, 28436, 28445, 28450, 28455, 28456, 28465, 28470, 28475, 28476, 28485	79.0, 79.1, 79.2, 79.3, 79.6, 733.1, 805-806, 807.0-807.3, 808-815, 818-825, 827, 828	235, 236

*Fractures of finger, toe, face and skull are not included in this measure.

Administrative Specification

Denominator	<p>The eligible population.</p> <p>Exclude members who had a BMD test (Table E9-B) during the 365 days prior to the date of the fracture.</p> <p>Exclude members who received any medication listed in Table E9-C during the 365 days prior to the date of the fracture.</p>
Numerator	<p>Members who were dispensed a prescription to treat osteoporosis or had a BMD test in the 184-day period after the <i>date of service</i> for a fracture.</p> <p><i>For fractures requiring hospitalization (inpatient), the date of service is the date of discharge from the acute care setting.</i></p> <p><i>For fractures not requiring hospitalization (outpatient), the date of service is the first date of care for the fracture.</i></p> <p>Table E9-B lists codes for bone mineral density tests. Table E9-C lists treatments for the prevention of osteoporosis.</p>

Note: NCQA will provide a comprehensive list of NDC codes for medications to treat osteoporosis on its Web site at www.ncqa.org by December 15, 2003.

Table E9-B: CPT Codes to Identify Bone Mineral Density Test

Description	CPT Codes	ICD-9-CM Codes
Computerized axial tomography bone density study, one or more sites	76070, 76071	
Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)	76075	
Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	76076	
Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites	76078	
Unlisted diagnostic radiologic procedure	76499	
Ultrasound bone density measurement and interpretation, peripheral site (any method)	76977	
Unlisted ultrasound procedure	76999	
Bone density (bone mineral content) study, one or more sites; single photon absorptiometry	78350	88.98
Bone density (bone mineral content) study, one or more sites; dual photon absorptiometry, 1 or more sites	78351	88.98

Table E9-C: Allowable FDA-Approved Osteoporosis Therapies

Prescriptions	
• Alendronate	• Raloxifene
• Risedronate	• Estrogen
• Calcitonin	• Teriparatide

Hybrid Specification

None.

Data Elements for Reporting

MCOs that submit HEDIS data to NCQA must provide the following data elements:

Table E9-3: Data Elements for Osteoporosis Management in Women Who Had a Fracture

Description	Administrative
Measurement year	X
Data collection methodology (administrative only)	X
Eligible member population (i.e., members who meet all criteria)	X
Current year's administrative rate (before exclusions)	X
Nonduplicated prior to bone mineral density exclusions*	X
Nonduplicated prior to prescription exclusions*	X
Nonduplicated other exclusions*	X
Total nonduplicated exclusions	X
Denominator	X
Numerator events for bone mineral density by administrative data*	X
Numerator events for prescription by administrative data*	X
Numerator events for both bone mineral density and prescription by administrative data*	X
Total Numerator events by administrative data	X
Reported rate	X
Lower 95% confidence interval	X
Upper 95% confidence interval	X

*Reporting these additional Data Elements will be optional in the Data Submission Tool (DST).