

APPENDIX F  
TECHNICAL SPECIFICATION MANUAL

**TECHNICAL MANUAL  
OF  
ADMINISTRATIVE QUALITY MEASURES**

**FOR**

**Care Provided to People with Disabilities  
Enrolled in:  
HMOs, Medicaid programs, Special Needs Plans, Organized Health  
Systems, and  
Care Coordination Organizations**

**NATIONAL INSTITUTE FOR DISABILITY AND REHABILITATION  
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## Types of Living Arrangements (TLA)

### Description

Percentage of working age beneficiaries with disabilities who live in different types of living structures:

- Institutions
- Structured Residences in the Community
- Independent Living

The health plans and programs that coordinate and/or provide care for working aged people with disabilities generally have as one of their major goals to provide benefits so that the beneficiary can live in the community rather than in an institutional setting. Members living in the community, either independently or in a structured community environment, is the plan's goal for every member as long as it is the best environment for the member.

### Definition of Living Arrangements

- Institutions
  - Long term - resides in a hospital, nursing home, Long Term Acute Care (LTAC) Setting, etc. 6 months or longer during the measurement year
  - Short stay - resides in an LTAC or nursing home for less than 6 continuous months during the measurement year.
- Structured Community Residences resides in group/foster homes, assisted living, congregate living, homeless shelters for 6 continuous months or longer during the measurement year.
- Independent Living - resides alone or with significant other/s in apt. or house for 6 continuous months or longer during the measurement year.

### Eligible Population

<b>Product Lines</b>	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
<b>Ages</b>	Eligible beneficiaries with disabilities between the ages of 18 – through 64 years.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose

coverage lapses for 2 months (60 days) is not considered continuously enrolled.

**Anchor Date**                      Enrolled as of December 31 of the measurement year

**Administrative Specification**

**Denominator**                      Eligible population of Medicaid and dual-eligible (Medicaid and Medicare) beneficiaries who have been continuously enrolled in the plan during the measurement year.

**Numerator 1**                      Numbers of eligible beneficiaries who resided in an institution (hospital, or long term acute care setting (LTAC) or nursing homes) for *6 months or more* continuously in the measurement year.

- Review the facility claims (UBs) for bill types below, for the continuous service date range of six months or more.

Type of Bills UBs

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed
041X Religious Nonmedical Health Care Institutions

AND/OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided in the institutional settings below for the six month or more.

**Place of Service**

31 Skilled Nursing
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
54 Intermediate care facility/mentally retarded

OR

The Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is institutional in facilities such as nursing home, skilled or non-skilled for six months or more.

**Numerator 2**                      Number of eligible beneficiaries who resided in an institution (hospital, or long term acute care setting (LTAC) or nursing homes) for *less than 6 continuous months* of the measurement year.  
Looking across claims spans for from/through dates = 6 months

Review the facility claims (UBs) for bill types below, for any occurrence and any duration less than six months AND a status code in the Status Code listing below.

**Type of Bills UBs**

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed

**Status Code UBs**

01 Discharged to home or self care (routine discharge)
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05)
50 Discharged/transferred to Hospice – home

OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided in the institutional settings below for less than six months.

**Place of Service**

31 Skilled Nursing
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
54 Intermediate care facility/mentally retarded

OR

The Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is institutional in facilities such as nursing home, skilled or non-skilled facility for less than six months.

**Numerator 3**                      Number of beneficiaries who resided in structured community residences (e.g. group home, assisted living, congregate living or homeless shelters for a minimum of six months during the measurement year.

Review of facility claims (UBs) where any claims should the identified type of bill over a six month or more period.

**Type of Bill**

- 013X Hospital Outpatient
- 032X Home Health
- 033X Home Health
- 034X Home Health (Part B Only)
- 071X Clinical Rural Health
- 072X Clinic ESRD
- 074X Clinic OPT
- 075X Clinic CORF
- 076X Community Mental Health Centers
- 081X Nonhospital based hospice
- 083X Hospital Outpatient (ASC)

OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided while in one of the settings below.

**Place of Service (HCFAs)**

13 Assisted living facility
14 Group Home

OR the Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is residing in a structured environment such as group home, assisted living or being cared for in someone else home on a full time basis.

**Numerator 4**                      Number of beneficiaries in the program during the measurement year who resided in the independent setting (apartment or house) for a minimum of 6 continuous months alone or with significant other/s

Review of facility claims (UBs) where any claims should the identified type of bill over a six month or more period.

**Type of Bill**

013X Hospital Outpatient
032X Home Health
033X Home Health
034X Home Health (Part B Only)
071X ClinicalRural Health
072X Clinic ESRD
074X Clinic OPT
075X Clinic CORF
076X Community Mental Health Centers
081X Nonhospital based hospice
083X Hospital Outpatient (ASC)

OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided while in one of the settings below.

**Place of Service (HCFAs)**

12 home
---------

OR

The Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is residing independently in a home or in someone else's home but independent on a full time basis.

Note:

Type of Bill Code on UB: FL7 Type of Bill

Status Codes on UB: FL22 Patient Discharge Status/UB92 or FL17 Patient Discharge Status/UB04.

Place of Service Code on HCFA: FL24b for any service listed.

## Migration from Institution to Community Setting (MTLAD)

### Description

Percentage of eligible beneficiaries with disabilities who moved their residence from an institution (hospitals, LTACs, nursing homes) to a community type setting (structured community or independent) during the measurement year

### Eligible Population

<b>Product Lines</b>	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
<b>Ages</b>	Eligible beneficiaries with disabilities between the ages of 18 – through 64 years.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor Date</b>	Enrolled as of December 31 of the measurement year.

### Administrative Specification

<b>Denominator</b>	Eligible population of Medicaid and dual-eligible (Medicaid and Medicare) beneficiaries who have been continuously enrolled in the plan during the measurement year.
<b>Numerator</b>	Number of eligible beneficiaries who resided in an institutional setting (hospital, long term acute care (LTAC) or nursing home) and moved to an independent or structured community setting (e.g. group home, assisted living, congregate living or homeless shelters) during the measurement year.  Looking across claims spans for from/through dates = 6 months

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- Review the facility claims (UBs) for type of bill below with a continuous service date range of six months or more AND a status code below at the end of the final service date (discharge date).

**Type of Bills UBs**

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed
041X Religious Nonmedical Health Care Institutions

**Status Code UBs**

<i>01 Discharged to home or self care (routine discharge)</i>
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05)
50 Discharged/transferred to Hospice – home

OR the Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is institutional in facilities such as nursing home, skilled or non-skilled for six months or more then notes the change in residence to structured community (group home, assisted living facility) or independent living for a period of six months or more.

## Migration from Community Setting to an Institution (MTLAI)

### Description

Percentage of eligible beneficiaries with disabilities who moved their residence for four or more months continuously from a community or independent setting to an institution (hospitals, LTACs, nursing homes) setting during the measurement year.

### Eligible Population

<b>Product Lines</b>	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
<b>Ages</b>	Eligible beneficiaries with disabilities between the ages of 18 – through 64 years.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor Date</b>	Enrolled as of December 31 of the measurement year.

### Administrative Specification

<b>Denominator</b>	Eligible population of Medicaid and dual-eligible (Medicaid and Medicare) beneficiaries who have been continuously enrolled in the plan during the measurement year.
<b>Numerator</b>	Number of eligible beneficiaries who resided in an independent or structured community setting and moved for four or more months to an institutional setting (hospital, long term acute care (LTAC) or nursing home) during the measurement year.

Review the facility claims (UBs) for bill types below, for any occurrence and any duration less than four months AND a status code in the Status Code listing below.

**Type of Bills UBs**

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed

**Status Code UBs**

<i>01 Discharged to home or self care (routine discharge)</i>
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05)
50 Discharged/transferred to Hospice – home

OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided in the institutional settings below for four months or less.

Place of Service

21 Inpatient Hospital
31 Skilled Nursing
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
51 Inpatient Psychiatric Hospital
54 Intermediate care facility/mentally retarded
61 Comprehensive inpatient rehabilitation facility

OR the Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary starts out with a residence of structured community (group home, assisted living) or independent living and move to an institutional facilities such as hospital, long-term acute center, nursing home, skilled or non-skilled facility for four months or less during that period.

## Termination of Participation (TP)

### Description

The percentage of beneficiaries with disabilities whose membership in the health plan is terminated in the measurement year, voluntarily or involuntarily.

**Definition of Involuntary** Member is terminated by the state involuntarily for multiple reasons:

- Income that exceeds eligibility standards;
- Incarceration;
- Change in geographic location outside plan parameters;
- Health plan request.

**Definition of Voluntary** Beneficiaries who choose to terminate their membership in the plan of their own volition.

### Eligible Population

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities.
<b>Ages</b>	18-through 64 years as of December 31 of the measurement year
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year

### Administrative Specification

<b>Denominator</b>	Number of beneficiaries with disabilities in the plan between 18-64 years who were continuously enrolled in the measurement year.
<b>Numerator 1</b>	Number of beneficiaries with disabilities between 18-through 64 years whose membership in the program was <i>involuntarily</i> terminated.

**Numerator 2**

Number of beneficiaries with disabilities between 18-through 64 years whose membership in the program was *voluntarily* terminated.

**Termination Codes**

Many plans receive codes from the state that indicate members who are terminating their membership in the program. Other plans report members who are terminating to the state.. Regardless of notification methods, codes usually indicate the reason – either involuntary or voluntary termination.

## Member Complaints and Grievances (MCG)

### Description

The percentage of beneficiaries, continuously enrolled in the measurement year, who reported verbal and/or written complaints and/or grievances to the plan or to the state Medicaid agency. (States have different definitions and requirements for the reporting and handling complaints and/or grievances).

### Definition of Complaint

Complaint refers to a criticism or statement of dissatisfaction that addresses one or more of the following categories:

- Access to care;
- Billing;
- Doctor/patient communication and rapport;
- Lack of cleanliness and/or unsafe conditions within the treating facility.

### Eligible Population

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities
<b>Ages</b>	18-through 64 years as of December 31 of the measurement year
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### Administrative Specification

<b>Denominator</b>	Number of beneficiaries with disabilities in the plan between 18-through 64 years who were continuously enrolled in the measurement year.
<b>Numerator</b>	Number of beneficiaries with disabilities between 18-through 64 years who had submitted complaints or

grievances, written or verbal, in the measurement year.

### **Data Collection**

Due to the diverse nature of the way states and individual plans define complaints and grievances, there are no standardized codes.

Programs would have to specify:

- ◆ how they define “complaints” and “grievances,”
- ◆ identify their collection methods and
- ◆ report their outcomes..

## Timeliness of New Beneficiary Assessment Screens (NBEAS)

### Description

The percent of new beneficiaries (18 yrs – through 64 years) enrolled during the measurement year that had their initial assessment screens completed within 30 days, 60 days or 120 days of enrollment in the health plan.

### Definition of new beneficiary

New beneficiary is defined in two ways:

- Person with a disability new to the plan
- Person with a disability who was in the plan previously, terminated from the plan, and is now being readmitted.

### Eligible Population

<b>Product Lines</b>	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
<b>Ages</b>	Beneficiaries with disabilities between the ages of 18 – through 64 years.
<b>Anchor Date</b>	Enrolled as of September 30 of the measurement year

### Administrative Specification

<b>Denominator</b>	Eligible population of Medicaid and dual-eligible beneficiaries admitted in the measurement year.
<b>Numerator 1</b>	Beneficiaries who receive the admission screen within 30 days of admission
<b>Numerator 2</b>	Beneficiaries who receive the admission screen within 60 days of admission
<b>Numerator 3</b>	Beneficiaries who receive the admission screen within 120 days of admission

Review the out patient/professional claims (HCFA 1500s) for the evidence of admission screening within the period.

#### **Admission Screening**

1003F – Level of Activity Assessment
99450 – 99456 Assessment of Disability

OR

The Plan maintains an in house system of noting the date of enrollment to the Plan and the date of completion of the beneficiary assessment screening.

## **Timeliness Individual Service Plans Initiated (ISPI)**

### **Description**

The percent of new beneficiaries (18 yrs – 64 years) enrolled during the measurement year that had their initial Individual Service Plan (ISP) initiated within 30 days or 60 days of enrollment in the health plan.

### **Definition of new beneficiary**

New beneficiary is defined in two ways:

- Person with a disability new to the plan
- Person with a disability who was in the plan previously, terminated from the plan, and is now being readmitted.

### **Eligible Population**

<b>Product Lines</b>	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
<b>Ages</b>	Beneficiaries with disabilities between the ages of 18 – through 64 years.
<b>Anchor Date</b>	Enrolled as of October 31 of the measurement year

### **Administrative Specification**

<b>Denominator</b>	Eligible population of Medicaid and dual-eligible beneficiaries (Medicaid and Medicare) admitted in the measurement year.
<b>Numerator 1</b>	Beneficiaries with ISPs completed within 30 days of admission to the plan.
<b>Numerator 2</b>	Beneficiaries with ISPs completed within 60 days of admission to the plan.

Review the out patient/professional claims (HCFA 1500s) for the evidence of the creation of the individuals' service plan within the period.

Individual Service Plan

S0315-S0320 Disease Management Planning Elements

OR

The Plan maintains an in house system of noting the date of enrollment to the Plan and the date of completion of the individuals' service plan.

## **Beneficiaries with Dental Encounters (BWDE)**

### **Description**

The percentage of beneficiaries with disabilities, continuously enrolled in the measurement year, who had at least one dental encounter for routine dental care.

### **Definition of Routine**

One or more visits with a dental practitioner during the measurement year.

### **Dental Care**

Diagnostic, preventive, and restorative interventions related to the teeth and gums.

### **Eligible Population**

#### **Product lines**

Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities

#### **Ages**

18-through 64 years as of December 31 of the measurement year

#### **Continuous enrollment**

The measurement year.

#### **Allowable gap**

No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

#### **Anchor date**

Enrolled as of December 31 of the measurement year.

### **Administrative Specification**

#### **Denominator**

Number of beneficiaries with disabilities in the plan between 18-64 years who were continuously enrolled in the measurement year.

#### **Numerator**

Number of beneficiaries with disabilities between 18-64 years who had at least one dental visit during the measurement year.

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Review the out patient/professional claims (HCFA 1500s) for the evidence of the following dental encounter codes within the period.

**Dental Encounters**

70300-70320 Radiological Examinations
70350-70355 Radiological Examinations
D0120-D9999 Oral Evaluations & Treatments

## **Timely Access to Durable Medical Equipment: Wheelchair (TADMEW)**

### **Description**

The average time in days it takes an eligible beneficiary to receive a wheelchair during the measurement year from the date of request to the date of authorization and the time from the date of authorization until the date of delivery (assumed to be the date the claim was submitted).

### **Eligible Population**

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities who received a wheelchair during the measurement year..
<b>Ages</b>	18-through 64 years as of December 31 of the measurement year
<b>Continuous enrollment</b>	The measurement year, continuous enrollment not necessary. New members who have not been in the plan may require a wheelchair as one of the initial benefits.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### **Administrative Specification**

<b>Denominator</b>	Number of beneficiaries in the plan between 18-through 64 years who received wheelchairs in the measurement year.
<b>Numerator1</b>	The average number of days between the initial request and the authorization of the wheelchair request.
<b>Numerator 2</b>	The average number of days between the authorization date of the wheelchair and the date the beneficiary receives the wheelchair (i.e. date on the claim).

#### **Numerator 1**

Review the prior authorization system to identify both the request date of a wheelchair and the final decision of approval of that request.

#### **Numerator 2**

Review the prior authorization system and the out-patient/professional claims (HCFA 1500s) for the evidence of the wheelchair rental or purchase within the period. Capturing

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both the date of approved authorization and the date of delivery of the wheelchair  
(include both rental and purchased methods).

**Wheelchair**

E1031-E1298 Wheelchairs (reclining, standard, amputee, special size, & varies weights
K0001-K1009 Wheelchairs and accessories for wheelchairs
K0800-K0898 Power operated vehicles & motorized wheelchairs

Note: Modifiers may include NR, NU, or RR

## **Timely Access to Durable Medical Equipment: Wheelchair Repair (TADMWR)**

### **Description**

The average time in days it takes an eligible beneficiary to get a wheelchair repaired and/or obtain additional parts..

### **Eligible Population**

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities who had a wheelchair repaired or had additional parts added during the measurement year.
<b>Ages</b>	18-64 years of the measurement year.
<b>Continuous enrollment</b>	The measurement year, continuous enrollment not necessary. New or continuing beneficiaries may require a wheelchair repair.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### **Administrative Specification**

<b>Denominator</b>	Number of beneficiaries in the plan between 18-64 years who received wheelchair repairs or additional parts in the measurement year.
<b>Numerator</b>	The average number of days between the authorization and the wheelchair repair completed.
<b>Numerator 2</b>	The average number of days between the authorization date of the wheelchair and the date the beneficiary receives the wheelchair (i.e. date on the claim).

#### **Numerator 1**

Review the prior authorization system to identify both the request date of a wheelchair and the final decision of approval of that request.

#### **Numerator 2**

Review the prior authorization system and the out-patient/professional claims (HCFA 1500s) for the evidence of the wheelchair rental or purchase within the period. Capturing both the date of approved authorization and the date of delivery of the wheelchair (include both rental and purchased methods).

**Wheelchair**

E1340 Repair, Durable medical equipment
K0098, K0601-K0605 Replacement part essential to wheelchair basic functioning

Note: Modifier of RP is most desired

## Pressure Ulcer Management (PUM)

### Description

The percentage of members hospitalized in the measurement year that had pressure ulcer listed as one of the top 5 discharge diagnoses.

### Eligible Population

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
<b>Ages</b>	18-through 64 years as of December 31 of the measurement year
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### Administrative Specification

<b>Denominator</b>	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year.
<b>Numerator</b>	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year and had pressure ulcer listed as one of the top 5 discharge diagnoses.

Review the facility claims (UBs) for diagnoses code specified to indicate pressure ulcers below within the reporting period.

#### **Pressure Ulcers**

707.0X Pressure ulcers
707.8-707.9 Chronic ulcers of skin

## Urinary Tract Disorders Management (UTIM)

### Description

The percentage of members hospitalized in the measurement year that had urosepsis listed as one of the top 5 hospital discharge diagnoses.

### Eligible Population

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
<b>Ages</b>	18-64 years as of December 31 of the measurement year
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### Administrative Specification

<b>Denominator</b>	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year.
<b>Numerator</b>	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year and had urosepsis listed as one of the top 5 discharge diagnoses.

Review the facility claims (UBs) for diagnoses code specified to indicate presence of urinary tract below within the reporting period.

### **Urinary Tract Infection**

098.0-098.3X Acute & Chronic Genitourinary Tract Infection
112.2 Candidiasis of Urinary Tract
131.0X Urogenital Trichomoniasis
599.0 Urinary Tract Infection

## Bowel Disorder Management (BDM)

### Description

The percentage of members with disabilities hospitalized in the measurement year that had bowel disorders such as severe constipation, fecal impaction or paralytic ileus listed as one of the top 5 discharge diagnoses.

### Eligible Population

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
<b>Ages</b>	18-through 64 years as of December 31 of the measurement year
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### Administrative Specification

<b>Denominator</b>	Number of beneficiaries between 18-through 64 years who were hospitalized in the measurement year.
<b>Numerator</b>	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year and had bowel disorder listed as one of the top 5 discharge diagnoses.

Review the facility claims (UBs) for diagnoses code specified to indicate presence of fecal Impaction or severe constipation below within the reporting period.

### **Bowel Disorders**

560.30 Impaction of the intestine
560.39 Fecal impaction
564.0X Constipation

## Spasticity Management (SM)

### Description

The percentage of members with contractures and/or spasticity in the measurement year that had Baclofen to manage the spasticity.

### Eligible Population

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
<b>Ages</b>	18-through 64 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### Administrative Specification

<b>Denominator</b>	Number of beneficiaries between 18-through 64 years who had contractures and/or spasticity in the measurement year.
<b>Numerator</b>	Number of beneficiaries between 18-through 64 years with spasticity and contractures who had Baclofen injections in the measurement year.

Review the out-patient/professional claims (HCFAs) for the diagnosis indicating spasticity and the treatment code indicating baclofen administration.

#### **Spasticity (diagnoses)**

333.6 Torsion
443.9 NEC spasm
343.X Infantile Cerebral Palsy
344.XX Other paralytic syndromes
718.4X Derangement of lateral meniscus
724.8 Contractures, back
727.81 Contracture, tendon
728.85 Contracture, muscle
756.89 Congenital Contracture, muscle

**Baclofen (treatment)**

J0585 Botulinum Toxin
64612-64614 Chemodenervation of muscle(s)
67345 Chemodenervation of extraocular muscle

## **Screening of High-Risk Beneficiaries for Osteoporosis**

### **Description**

The percentage of members with have limited mobility, requiring the person to spend large amounts of time in a wheelchair or in bed that received bone density screenings in the measurement year.

### **Eligible Population**

<b>Product lines</b>	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
<b>Ages</b>	18-through 64 years as in the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

### **Administrative Specification**

<b>Denominator</b>	Number of beneficiaries between 18-through 64 years who are have physical impairments requiring the use of a wheelchair or are largely bedbound.
<b>Numerator</b>	Number of beneficiaries between 18-through 64 years with spend large amounts of time in a wheelchair or in bed who had bone density testing in the measurement year.

#### **Denominator**

Review outpatient/professional claims (HCFAs) for the presence of a diagnosis below during the period.

Inmobility (diagnoses)

333.6 Torsion
334.1 Hereditary spastic paraplegia
335.X Anterior Horn cell disease
336.X Other Diseases of spinal Cord
337.22 Reflex dystrophy of lower limbs
337.3 Autonomic dysreflexia

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341.X Multiple sclerosis
342.X Hemiplegia & Hemiparesis
343.X Infantile Cerebral Palsy
344.00-344.1 Quadriplegia, Paraplegia lower limbs
344.3X-344.81 Other paralytic syndromes
343.X Infantile Cerebral Palsy
344.XX Other paralytic syndromes
438.4X Late effect of CVA, Monoplegia, lower limb
438.53 Late effect of CVA, other paralytic syndrome, bilateral
443.9 NEC spasm
718.4X Derangement of lateral meniscus
724.8 Contractures, back
727.81 Contracture, tendon
728.85 Contracture, muscle
756.89 Congenital Contracture, muscle
806.00-806.5 Fracture of vertebral column with spinal cord injury

Or

Have a claim for a wheelchair by

Review the prior authorization system and the out-patient/professional claims (HCFA 1500s) for the evidence of the wheelchair rental or purchase within the period. Capturing both the date of approved authorization and the date of delivery of the wheelchair (include both rental and purchased methods).

**Wheelchair**

E1031-E1298 Wheelchairs (reclining, standard, amputee, special size, & varies weights
E1340 Repair, Durable medical equipment
K0001-K1009 Wheelchairs and accessories for wheelchairs
K0098, K0601-K0605 Replacement part essential to wheelchair basic functioning
K0800-K0898 Power operated vehicles & motorized wheelchairs

Note: Modifiers may include NR, NU, RP or RR

**Codes for the screening bone density (numerator)**

77078-77079 CT Scanning
78350-78351 Nuclear Medicine, density, bone
78300-78320 Nuclear Medicine, imaging, bone
0028T DEXA Scan CPT: 76070, 76071, 76075-76077, 76078, 76977, 77078-77083 HCPCS: G0130 ICD-9-CM Diagnosis: V82.81 ICD-9-CM Procedure: 88.98

### Glossary of Terms

TERMS	MEANING
Measurement year	Year the data is collected. The measurement year for 2008 is data from 2007
Data collection methodology	The manner in which data will be collected. Data will only be collected from electronic databases.
Eligible population	<ul style="list-style-type: none"> <li>◆ Beneficiaries who meet the criteria for inclusion, i.e. working age adults with disabilities between the ages of 18 through 64 years</li> <li>◆ For administration data, the eligible population is selected. This is the universe for each measure.</li> </ul>
Minimum required sample size	The minimum required sample size is 30
Final sample size	Number of members who meet the measures criteria
Denominator	The number of members used to report the measure
Number of numerator events by administrative data	Number of members in the denominator who met the numerator criteria using system or transactional data.

### **HEDIS Measures for Data Collection**

In addition to the measures contained in this manual, the Measurement Advisory Panel also included the following HEDIS measures as part of the quality performance system for DCCOs.

1. Enrollment by product line (Medicaid, Medicaid/Medicare, etc)
2. Race/Ethnicity Diversity of Membership
3. Language Diversity of Membership
4. Beneficiaries with Primary Care Physician encounters
5. Beneficiaries with Medical Specialist encounters
6. Beneficiaries with Surgical Specialty encounters
7. Beneficiaries with Dental Encounters
8. Hospital admissions
9. Hospital readmissions within 7 days and 14 days
10. Ambulatory visits to emergency rooms, ambulatory surgery facilities and total outpatient visits.
11. Identification of Alcohol and other Drug Services
12. Colorectal Cancer Screening
13. Breast Cancer Screening
14. Cervical Cancer Screening
15. Comprehensive Diabetes Care
16. Asthma Management
17. Management of Mental Illness after Hospital Discharge