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Military Healthcare System
Population Health Portal (MHSPHP)

METHODOLOGY DOCUMENT

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Background

The Military Health System Population Health Portal (MHSPHP) is a centralized, secure, web-based population health management system used by Army, Navy, and Air Force health care teams, as well as Managed Care Support Contractors. The MHSPHP transforms Department of Defense (DoD) and purchased care administrative data into actionable information. TRICARE Prime/Plus enrollees in need of potential clinical preventive services, disease management or case management are identified on health care action lists. Specific data sources are outlined in each methodology. MHSPHP methodologies are based on Healthcare Effectiveness Data Information Set (HEDIS[®]) methodologies or on DoD/VA Clinical Practice Guidelines. The National Committee for Quality Assurance (NCQA) developed and maintains HEDIS[®]. Using the MHSPHP, all MTF and MCSC health care teams can proactively manage the health status of their patients over the web.

What is the MHSPHP?

The MHSPHP is easy to navigate with three primary sections: Overview, Patient Management and Metrics/Reporting. The Overview section provides an aggregate view of the TRICARE Prime/Plus enrolled population stratified by age, gender, beneficiary category (BenCat), as well as lists counts of patients on Disease/Condition Prevalence and Action Lists. The Patient Management section displays provider-level patient action lists for screening procedures (e.g., breast cancer, cervical cancer, chlamydia, colon cancer, lipid panel; and provider-level patient action lists targeting patients with coded diagnoses for diseases/conditions (e.g., asthma, diabetes, low back pain, high utilizers). In addition to the action lists, a “Quicklook” sheet displays enrollee-centric information regarding co-morbid conditions and clinical preventive services tracked on the MHSPHP. Users can enter data, exclude patients and enter notes from the Patient Management section. The Metrics/Reporting sections provides aggregate data in table and chart formats of HEDIS scores, numerator and denominator information over time as well as the Medical Home information (Adjusted HEDIS).

The level of access is determined by the Service or TRICARE Regional Office (TRO)-Specific representative.

How did the MHSPHP originate?

In FY 03, a Tri-Service Tiger Team was chartered by the DoD Deputy Surgeon Generals to review and recommend a Population Health Information Technology (IT) Tool for the MHS. The team met for seven months and reviewed 10 Population Health IT tools. The team recommended that the Air Force Population Health Portal (AFPHP) be used as an MHS-wide solution for patient-level actionable information for all three Services. The APHP was expanded to all services in January 2004 and renamed the MHSPHP.

Who can be contacted to answer questions?

If the answer to a question is not found in the users’ manual or methodologies guide, please contact the respective service representative by e-mail. Each of the Services has an appointed

MHSPHP administrator or “super-user” to address service specific questions. The Service-Specific Representative also establishes who should have access to patient-level data within MHSPHP.

The current service-specific Points of Contact (POC) are:

Air Force

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Development of Methods

A major challenge in measuring and monitoring health care is defining measures that relate to a relevant outcome, and that can be systematically applied across the MHS and other health care plans. In order to address this challenge, the NCQA established HEDIS® a national standardized set of measures that assesses the performance of managed care organizations. HEDIS® was developed to provide reliable, comparative data about health care quality using data from health plans across the country. It is intended to monitor how well health plans are delivering preventive care (e.g., cancer screening), how well members with acute illnesses (e.g., acute myocardial infarction) or chronic diseases (e.g., asthma or diabetes) are managed to avoid or minimize complications. There are many HEDIS® measures, but those selected for use in the MHSPHP are related to outpatient processes of care.

How are the populations in the HEDIS® measure and the action lists defined?

Because continuity of care is an important consideration when measuring and comparing the appropriateness of care over time, the HEDIS® methodologies are all based on continuous enrollment criteria. The MHS is not benchmarked on individuals who are not enrolled in TRICARE Prime/Plus or who do not meet specific continuous enrollment criteria. Therefore, in order to be eligible for inclusion in the HEDIS® population, individuals must be continuously enrolled in the TRICARE Prime/Plus option for a minimum period of time (differences in continuous enrollment exist for each metric). For example, to be included in the eligible population for the diabetes care HEDIS®-based measures, an individual must be enrolled in the TRICARE Prime/Plus option for 10 or more months during the 12-month measurement period.

Note: The patient action lists have no continuous enrollment criteria. They reflect patients that meet the specific inclusion criteria and are currently enrolled in TRICARE Prime/Plus regardless of enrollment length or lapses.

How is enrollment determined?

Enrollees are those individuals registered in the Defense Eligibility Enrollment Reporting System (DEERS) who are enrolled in the TRICARE Prime / Plus care option and empanelled to an MTF or Network Provider.

The DEERS database is used to identify military sponsors, families and others worldwide who are entitled, under the law, to TRICARE benefits. An individual who is eligible for TRICARE medical benefits and is authorized treatment at an MTF or in the Network is eligible to enroll in TRICARE Prime. TRICARE Prime is a managed care option similar to a civilian health maintenance organization (HMO). However, this option requires active enrollment. All personnel should complete a TRICARE Enrollment Form to be enrolled in the TRICARE Prime. In some regions, active duty service members may be automatically enrolled; however, most active duty service members are required to actively enroll in TRICARE Prime. If active duty service members are not officially enrolled into the DEERS they will not be included as an enrollee in MHSPHP. Active duty family members, retirees and their family members are encouraged, but not required, to enroll in TRICARE Prime.

How is the health care data obtained?

The main source for measures comes from MHS administrative data from the MHS Management Analysis and Reporting Tool (M2), formerly the All Region Server (ARS) Bridge. The M2 is an informational system built by the Executive Information/Decision Support (EI/DS) Program Office in conjunction with the TRICARE Management Activity, Health Program Analysis and Evaluation (HPA&E) Directorate. The M2 is a set of MHS data files from MTFs, managed care support contractors, the Defense Manpower Data Center, and Pharmacy Data Transaction Service (PDTs) that are incorporated into a central database. The inpatient, outpatient and pharmacy data from network claims and direct care encounters stored in M2 are used to produce the products seen in the MHSPHP.

Because significant lag times exist from the date of service to the final posting of the purchased care claims records in the M2, timing of the data extraction plays a significant role in the completeness of data for the measures. The time it takes to file, pay and adjudicate the claim and then post the record to the M2 for analysis is not the same for all patient records. Although most claims are adjudicated and paid within a few months of billing, this adjudication may be months from the actual date of service.

Other administrative health care data sources include:

- ➔ Composite Health Care System (CHCS) ad hoc reports from all DoD CHCS servers
- ➔ Laboratory and Radiology ad hoc reports
- ➔ National Enrollment Database (NED) module ad hoc report for PCM by name information
- ➔ AHLTA Clinical Data Mart (CDM) Historical Procedures

What is the importance of high utilizer information?

Analysis of health care service utilization is a key component of population health management. Information indicating the number of provider visits per member per year (PMPY) establishes a comparative baseline and identifies patients with significantly “low or high” utilization. Low utilizers may represent an at-risk group who can be targeted for delivery of preventive services while high utilizers may be potential candidates for disease and case management strategies. Reducing the rate of utilization can effectively reduce demand and facilitate recapture of care from the private sector.

Why is the data in the MHSPHP different than the data in the medical record?

MHS encounter and claims data limitations center around two issues: completeness and consistency. Completeness usually depends on the provider’s willingness to accurately reflect findings and procedures during an encounter. Within a fee-for-service environment (i.e., network providers), there is great incentive to completely document an encounter because providers are paid for what they document. No equivalent benefit exists within direct care to “reward” complete documentation. However, even in the network care setting, complete diagnosis and procedure documentation for each encounter is not always required. For

example, prenatal care is often paid for on a “bundled” per-visit basis; no individual encounters are documented since no individual charges were incurred. Additionally, just because someone is TRICARE Prime/Plus enrolled does not mean they actively seek care within the MHS. Despite accessing care through other venues (e.g., Medicare or second-party payers), the assumption is made that they did not receive care.

Consistency of data is also a problem given the wide latitude in the assignment of diagnostic codes assigned and the level of detail used in reporting services rendered. Since the direct care and purchased care data collection systems are different (encounter vs. claims), consistency issues are magnified within the M2 data set. The use of varying coding structures to meet a clinic’s own administrative needs or the use of different “pick lists” among providers further complicate the issue.

MHSPHP Methodology & Measurement

The following measures are reported in MHSPHP.

Antidepressant Medication Management

This methodology measures the percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported.

Measure Definition:

- ➔ Effective Acute Phase Treatment - The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- ➔ Effective Continuation Phase Treatment - The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions:

Term	Description
Intake Period	The 12-month window starting 20 months prior to the reporting month.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression that meets the following criteria. <ul style="list-style-type: none">➔ A 120-day Negative Diagnosis History➔ A 90-day Negative Medication History➔ For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge. <i>For a direct transfer, the IESD is the discharge date from the facility to which the member was transferred.</i>
Negative Diagnosis History	A period of 120 days (4 months) prior to the IESD, during which time the member had no claims/encounters with any diagnosis of major depression or prior episodes of depression. <i>For an inpatient (acute or nonacute) claim/encounter, use the date of admission to determine Negative Diagnosis History.</i> <i>For direct transfers, use the first admission to determine Negative Diagnosis History.</i>
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.

Term	Description
Treatment days	The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Effective Acute Phase Treatment	62.6%, 66.7%, 70.8%
Effective Continuation Phase Treatment	45.9%, 50.0%, 55.7%

Numerator:**Effective Acute Phase Treatment**

Number of patients, currently enrolled to an MTF, age 18 and older, who were diagnosed with a new episode of depression, treated with antidepressant medication and who remained on an antidepressant medication for at least 84 days (12 weeks) during the 114-day period following the earliest prescription dispensing date for an antidepressant medication, during the period of 30 days prior to the Index Episode Start Date (IESD), and 14 days after IESD.

Effective Continuation Phase Treatment

Number of patients, currently enrolled to an MTF, age 18 and older, who were diagnosed with a new episode of depression, treated with antidepressant medication and who remained on an antidepressant medication for at least 180 days (6 months) during the 231-day period following the earliest prescription dispensing date for an antidepressant medication.

Denominator:

Number of patients enrolled to an MTF in the intake period, age 18 and older, diagnosed with a new episode of depression and treated with antidepressant medication. The steps below will be followed to identify the eligible population for both treatment phases:

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 in an outpatient, ED, intensive outpatient or partial hospitalization setting, or At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting on different dates of service with any diagnosis of major depression, or At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression
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	Test for Negative Diagnosis History. Exclude members who had a claim/encounter for any diagnosis of major depression or prior episodes of depression during the 120 days prior to the IESD.
Step 4	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 5	Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD.
Step 6	Calculate continuous enrollment. Members must be continuously enrolled for 120 days prior to the IESD to 245 days after the IESD.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Pharmacy Data Transcription Service (PDTs) (Includes prescriptions received from MTF, network and mail order pharmacies)

Methodology:

- ➔ Use DEERS to identify patients enrolled to specific MTFs
- ➔ Use M2 (SIDR and Network(M2)) data to identify hospital patients treated for depression
- ➔ Use SADR (M2), SIDR (M2) and NETWORK (M2) data to identify ambulatory patients treated for depression
- ➔ Use PDTs to identify members with antidepressant medication

Data Sources & Codes:
Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major Depression	296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 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 because these codes are less specific in identifying major depression.	

Codes to Identify Visit Type

Description	CPT
ED	99281-99285
Outpatient, intensive outpatient and partial hospitalization	90801, 90802; 90804-90815, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99241-99245, 99251-99255, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510

Additional Codes to Identify Depression

Description	ICD-9-CM Diagnosis
Depression	296.26, 296.36, 296.4-296.9, 309.0, 309.28

Antidepressant Medications

Description	Prescription	
Miscellaneous antidepressants	bupropion	
Monoamine oxidase inhibitors	isocarboxazid phenelzine	selegiline tranylcypromine
Phenylpiperazine antidepressants	nefazodone	trazodone
Psychotherapeutic combinations	amitriptyline- chlordiazepoxide amitriptyline- perphenazine	fluoxetine-olanzapine
SSNRI antidepressants	desvenlafaxine duloxetine	venlafaxine
SSRI antidepressants	citalopram escitalopram fluoxetine	fluvoxamine paroxetine sertraline

Description	Prescription	
Tetracyclic antidepressants	maprotiline	mirtazapine
Tricyclic antidepressants	amitriptyline	imipramine
	amoxapine	nortriptyline
	clomipramine	protriptyline
	desipramine	trimipramine
	doxepin	

HEDIS® MTF/MCSC Metrics and Report:

The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication in the 12-month window starting 20 months prior to the reporting month and who remained on antidepressant medication treatment for the acute phase or continuation phase.

Prevalence Report:

Listing of all TRICARE Prime/Plus enrolled members 18 years of age and older with a new episode of major depression and treated with antidepressant medications during the 20 months prior to the end of the reporting month. In addition to criteria specified by HEDIS, the report lists patients who were identified in the current DEERS enrollment file as well as those newly diagnosed and treated after the HEDIS defined 12 month window.

Prevalence Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number (SSN)
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ Primary Care Manager (PCM)
- ➔ Provider Group
- ➔ Earliest Diagnosis Date
- ➔ Total Visits
- ➔ Hospitalizations
- ➔ Prescription date

- ➔ Remained on antidepressant medications for at least 84 days (Yes or No) - Patients starting treatment less than 84 days ago will be NA
- ➔ Remained on antidepressant medications for at least 180 days (Yes or NO) - Patients starting treatment less than 180 days ago will be NA
- ➔ Source
- ➔ Contact Information
- ➔ Defense Medical Information System (DMIS)
- ➔ Service

Recommended Action:

- ➔ Primary care teams can use the information as a starting point to assist them in identifying individuals who may benefit from more optimal depression management.
- ➔ Consider condition management program
- ➔ Consider implementation of Department of Defense/Veterans Affairs (DoD/VA) or other clinical practice guidelines <https://www.qmo.amedd.army.mil/pguide.htm>
- ➔ Notes:

Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Asthma - Use of Appropriate Medications

This process measure evaluates if enrollees with persistent asthma are prescribed medications for long-term asthma control. In order to obtain information based on administrative sources, the term “persistent” asthma is based on two years of services and/or medication use rather than the clinical measurement of severity. The “action list” provided to medical treatment facilities (MTF) and Managed Care Support Contractors (MCSC) on the MHSPHP includes all TRICARE Prime/Plus asthmatics regardless of age or continuous enrollment.

Measure Definition:

Percentage of enrollees continuously enrolled in TRICARE Prime/Plus, age 5–50, with persistent asthma, who are prescribed medications considered acceptable as a primary therapy for the long-term control of asthma.

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
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Benchmark	HEDIS Percentiles (50-75-90)
Appropriate Meds for Asthmatics	92.6% - 93.8% - 95.1%

Numerator:

Patients dispensed at least one prescription for a preferred asthma therapy medication during the measurement year. Short and long acting inhaled beta-2 agonists do not meet the numerator criteria.

Denominator:

Number of enrollees, ages 5-50, continuously enrolled for the last two years, who were identified as having persistent asthma. Persistent asthma is defined by meeting at least one of the criteria listed below, during BOTH the last 12 months (measurement year) and the year prior to the measurement year. The criteria met do not need to be the same across years. A patient whose coverage lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled.

1. At least four outpatient asthma visits with asthma as one of the listed diagnoses and at least two asthma medications dispensing events.
2. At least one acute inpatient discharge with asthma as the principle diagnosis.
3. At least one Emergency Department (ED) visit with asthma as the principal diagnosis.
4. At least four medication dispensing events of medications listed in the table below.
5. Patients identified as having persistent asthma because of at least four medication dispensing events, where leukotriene modifiers were the sole medication dispensed in that year, must also have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (measurement year or year prior to the measurement year).

Note: Patients with diagnosis codes for emphysema, Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, or acute respiratory failure are *excluded*.

Dispensing Events:

Oral medication dispensing event: One prescription for an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, the days supply is divided by 30 and rounded down.

Multiple prescriptions dispensed on the same day: Multiple prescriptions for different medications dispensed on the same day are assessed separately. If multiple prescriptions for the same medication are dispensed on the same day, the days supply is summed and divided by 30. The Drug ID is used to determine if prescriptions are the same or different. For example:

- ➔ *Two prescriptions for different* medications dispensed on the same day, each with a 60 day supply, will be counted as four dispensing events (two prescriptions with 2 dispensing events each)
- ➔ *Two prescriptions for different* medications dispensed on the same day, each with a 15 day supply, is counted as 2 dispensing events (two prescriptions with one dispensing event each)
- ➔ *Two prescriptions for the same* medication dispensed on the same day, each with a 15 day supply is considered one dispensing event (sum the days supply for a total of 30 days).
- ➔ *Two prescriptions for the same* medication dispensed on the same day, each with a 60 day supply, equals four dispensing events (sum the days supply for a total of 120 days)

Inhaler/Injection dispensing events: Inhalers and injections count as one dispensing event. An inhaler with a 90 day supply is considered one dispensing event. Multiple inhalers or injections of the same medication (identified by Drug ID in the NDC list) filled on the same date of service count as one dispensing event. The dispensing events are attributed to the year in which the prescription is filled.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Purchased Care Claims Data: (NETWORK) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Pharmacy Data Transcription Service (PDTS) (Includes prescriptions received from MTF, network and mail order pharmacies)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

Methodology:

- ➔ Use DEERS to identify patients continuously enrolled in TRICARE Prime/Plus
- ➔ Use M2 (SADR, SIDR, PDTS and Network) claims data to identify patients with persistent asthma
- ➔ Use PDTS to identify members with appropriate medication
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM) in direct care

Data Sources & Codes:

Codes to Identify Asthma and Outpatient, ED, and Inpatient Asthma Encounters

Description	Current Procedural Technology (CPT) Codes	ICD-9-CM Diagnosis
Acute Inpatient	M2 does not use five digit CPT Codes	493
ED Services	99281-99285	493
Outpatient Visits	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429	493

Codes to Exclude Members with COPD and Emphysema

Description	ICD-9-CM Codes
Emphysema	492, 506.4, 518.1, 518.2
COPD	491.2, 493.2, 496, 506.4
Cystic Fibrosis	277.0
Acute Respiratory Failure	518.81

Asthma Medications

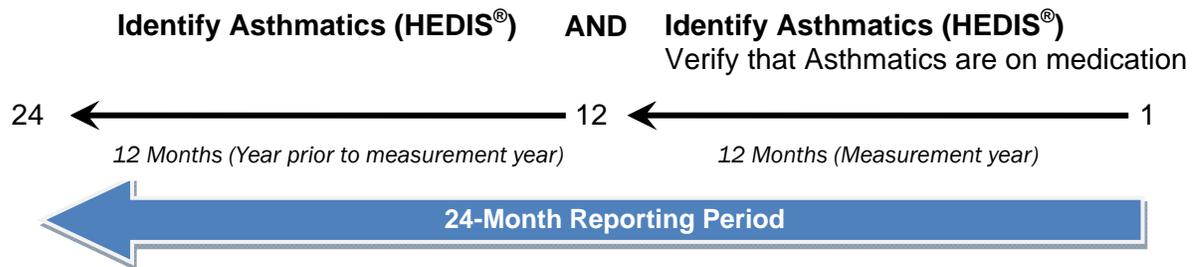
Description	Prescriptions	
Preferred Asthma Therapy		
Antiasthmatic combinations	dyphylline-guaifenesin guaifenesin-theophylline potassium iodide-theophylline	
Antibody inhibitor	omalizumab	
Inhaled steroid combinations	budesonide-formoterol fluticasone-salmeterol formoterol-mometasone	
Inhaled corticosteroids	beclomethasone budesonide ciclesonide flunisolide	fluticasone CFC free mometasone triamcinolone
Leukotriene modifiers	montelukast zafirlukast zileuton	
Mast cell stabilizers	cromolyn	

Description	Prescriptions
	nedocromil
Methylxanthines	aminophylline dyphylline oxtriphylline theophylline
Additional Asthma Medications *Do not meet numerator criteria	
Long-acting, inhaled beta-2 agonists	aformoterol formoterol salmeterol formoterol-mometasone
Short-acting, inhaled beta-2 agonists	albuterol levalbuterol pirbuterol metaproterenol

HEDIS® MTF/MCSC Metrics and Report:

The numerator and denominator that meet the HEDIS® criteria. This report will use a more restrictive methodology than the action report in order to fully comply with HEDIS®. The following additional criteria are used:

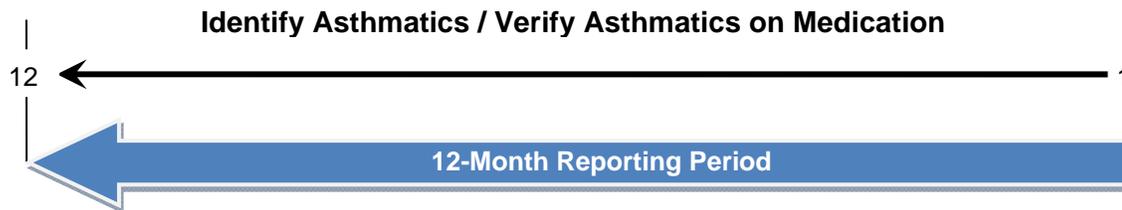
- ➔ The HEDIS® report will include only persistent asthmatics. Those identified as having asthma in BOTH the year prior to measurement year and the measurement year.
- ➔ The HEDIS® report will contain all MTF enrollees with coded asthma, age 5-50. Asthmatics must be continuously enrolled for the last 24 months.



Action Report:

The action report contains patient information for enrollees regardless of age or continuous enrollment. It also includes all enrollees who met the asthma criteria during the measurement year (the last 12 months) without regard to persistence—it does NOT require they also meet criteria in the year prior to the measurement year. It displays the date and name of the last asthma numerator medication received within the past 12 months and

information on how the asthmatic was identified by displaying counts for asthma coded hospitalizations, ED visits, outpatient visits, and dispensing events.



A member may be listed more than once if more than one medication with the same quantity was dispensed on the same day. The Persistence column identifies Persistent Asthmatics.

Action Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number (SSN)
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ Primary Care Manager (PCM)
- ➔ Provider Group**
- ➔ PCM ID*
- ➔ PCMID Type*
- ➔ Hospitalizations
- ➔ ER Visits
- ➔ Outpatient Visits
- ➔ Dispensing Events
- ➔ Rx Date
- ➔ Drug Name
- ➔ Steroid
- ➔ Steroid Rx Date
- ➔ Spirometry Date

- ➔ Controller
- ➔ Ratio
- ➔ Persistence
- ➔ Source
- ➔ Contact Information**
- ➔ Defense Medical Information System (DMIS)
- ➔ TRO*
- ➔ Service
- ➔ *TRO Action Lists only
- ➔ **Direct Care Action Lists only
- ➔ Recommended Action:
 - ➔ Primary care teams can use the information as a starting point to assist them in identifying individuals who may benefit from more optimal asthma management.
 - ➔ Consider condition management program
 - ➔ Consider implementation of Department of Defense/Veterans Affairs (DoD/VA) or other clinical practice guidelines <https://www.qmo.amedd.army.mil/pguide.htm>
 - ➔ Notes:

Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Breast Cancer Screening

Women age 42-69 were selected for benchmarking measurement, because evidence supporting screening is strongest among this age group. The “action report” provided to Medical Treatment Facilities (MTF) and Managed Care Support Contractors (MCSC) on the MHSPHP includes all enrolled women age 40-69, regardless of continuous enrollment.

Measure Definition:

Percentage of women continuously enrolled in TRICARE Prime/Plus, age 42-69, who had a mammogram in the previous 24 months.

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Breast Cancer Screening -women age 42-69*	70.0%---74.2%---78.7%

*HEDIS no longer stratifies by age group

Numerator:

Number of women continuously enrolled in TRICARE Prime/Plus, age 42-69, who had one or more mammograms in the previous 24 months in MTF or Network care.

Denominator:

Number of women enrollees as of the last day of the measurement month, age 42-69, continuously enrolled during the preceding 24-month period. A woman whose coverage lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled.

Women with bilateral surgical mastectomy codes were excluded (see exclusion codes below under “Data Sources & Codes”).

Performance measures require a retrospective approach; women are not included in the denominator for this measure until age 42 (2-year look back). Reports will be stratified into the following age groups:

- ➔ 42-51 years of age
- ➔ 52-69 years of age
- ➔ Total

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Ambulatory Data Record (SADR) (M2)*
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ CHCS Radiology
- ➔ M2 Radiology
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ AHLTA Clinical Data Mart (CDM) Historical Procedures

Methodology:

- ➔ Use DEERS to identify women continuously enrolled in TRICARE Prime/Plus, age 42-69

- ➔ Use SADR (M2), SIDR (M2) and NETWORK (M2) data to identify women who have had a mammogram
- ➔ Use SADR (M2), SIDR (M2) and NETWORK (M2) data to exclude women with bilateral mastectomy surgical codes
- ➔ Use CHCS Radiology ad hoc to identify women who had a mammogram at a military facility
- ➔ Use M2 Radiology to identify women who had a mammogram at a military facility
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM) in direct care
- ➔ Use CDM Historical Procedures to identify women who had mammograms in the past 2 years according to historical diagnoses and procedures as documented in Historical Procedures

Data Sources & Codes:

Codes to identify women with mammography screening:

CPT Codes	ICD-9-CM Diagnosis	ICD-9-CM Procedure
77055-77057	V76.11 (Screening mammogram for high-risk patient)*, V76.12 (Other screening mammogram)*	87.36 (Xerography of breast), 87.37 (Other mammography)

* V76.11 and V76.12 will be removed from the 2012 HEDIS specifications and will no longer identify a completed mammogram beginning with the Jan 2012 data release.

Description	HCPCS
Digital Mammography Images	G0202 , G0204, G0206

Codes to **exclude** women with bilateral mastectomy: ¹

Description	CPT Codes	ICD-9-CM
Bilateral mastectomy surgical codes	19180, 19200, 19220, 19240, 19303-19307 WITH Modifier .50 or modifier code 09950	85.42, 85.44, 85.46, 85.48, *V45.71 3 (Acquired absence of bilateral breasts) *DOD Extender code – military specific
Unilateral mastectomy codes (need 2 separate occurrences on 2 different dates of service)	19180, 19200, 19220, 19240, 19303-19307	85.41, 85.43, 85.45, 85.47

*.50 and 09950 modifier codes indicate the procedure was bilateral and performed during the same operative session.

Military specific codes to **exclude** women with documented absence of left and right breast:

Description	ICD-9-CM
Bilateral mastectomy surgical codes	*V45.71 1 (Acquired absence of left breast) *V45.71 2 (Acquired absence of right breast) *DOD Extender codes – military specific

Note: Enrollees with a documented history of bilateral mastectomy will appear in the QuickLook sheet with a date for the clinical preventive service set to “MASTECT.”

HEDIS® MTF/MCSC Metrics and Report:

Percentage of continuously enrolled women, age 42-69 years, identified as having a mammogram in the past two years. In addition to the HEDIS® metric, age stratifications are available for the 42-51 and 52-69 populations.

Action Report:

List of all enrolled women, age 40 and older, by PCM. Identifies women with the date of their most recently documented mammogram and those who could not be identified as having a mammogram in the past two years.² The action report is based on current DEERS enrollment, in contrast to the HEDIS® aggregate report which specifies continuous enrollment and age constraints.

Note: Women with a documented history of bilateral mastectomies will not be included in the Action Report, but will appear in the QuickLook prevalence report with mammography date of “MASTECT.”

Action Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group**

- ➔ PCM ID*
- ➔ PCM IDTYPE*
- ➔ Last Exam Date
- ➔ System
- ➔ Source
- ➔ Contact Info**
- ➔ Defense Medical Information System (DMIS)
- ➔ TRO*
- ➔ Service

*TRO Action Lists only

**Direct Care Action Lists only

Recommended Action:

Review medical records of the patients identified as NOT having a mammogram in the past two years.

- ➔ Schedule the mammogram if patient is overdue
- ➔ Anticipate those women who will need mammograms in the near future for demand forecasting and the initiation of population health initiatives.

Notes:

¹ In addition to the codes listed, individuals with a DoD ICD-9-CM extender code for a previously performed bilateral mastectomy will be excluded from the denominator.

² Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Cardiovascular Disease Risk

Measure Definition:

The proportion of MTF enrollees with all three of following conditions:

- ➔ Diabetes
- ➔ Hypertension (by ICD-9-CM Code 401.X, 405.X)
- ➔ Dyslipidemia as defined by Total Cholesterol/HDL Ratio > 5 and/or LDL > 130

Benchmark:

N/A

Numerator:

Number of MTF enrollees identified on all three of the following patient lists in the current release of MHSPHP data: diabetes, hypertension and dyslipidemia.

Denominator:

All MTF enrollees at the time of the reporting period.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ MHS CHCS laboratory ad hoc

Methodology:

- ➔ Use DEERS to identify patients enrolled to MTFs.
- ➔ Use SADR (M2) and NETWORK (M2) data to identify patients who have had an outpatient or Emergency Department (ED) visits for diabetes, hypertension and dyslipidemia (refer to individual methodologies).
- ➔ Use SIDR (M2) and NETWORK (M2) data to identify patients with hospitalizations for diabetes, hypertension and dyslipidemia (refer to individual methodologies).
- ➔ Use CHCS Lab ad hoc for total cholesterol, LDL, and HDL cholesterol1
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM)

Data Sources & Codes:

Refer to methodologies for diabetes, hypertension and dyslipidemia.

Prevalence Report:

MTF list of all enrolled patients with ALL of the following cardiovascular risk conditions as identified by the methodologies of their corresponding MHSPHP action list or prevalence report.²

- ➔ Diabetes

- ➔ Hypertension
- ➔ Dyslipidemia as defined by Total Cholesterol/HDL Ratio > 5 and/or LDL > 130

Prevalence Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number (Sponsor SSN)
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Source
- ➔ Contact Information
- ➔ Defense Medical Information System (DMIS)
- ➔ Service

Recommended Action

- ➔ Review chronic disease burden data to project health needs associated with chronic diseases/conditions
- ➔ Consider using or implementing cardiovascular risk clinical guidelines
- ➔ Consider targeting this population for secondary and tertiary prevention strategies
- ➔ Consider possible case management

Notes:

¹ The last known certified results are utilized for calculations of cholesterol ratios. Lab values currently cannot be obtained from network data.

² Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Cervical Cancer Screening

Women, age 21-64, were selected for benchmarking measurement, because evidence supporting screening is strongest among this age group. The “action report” provided to MTFs and MCSCs on the MHSPHP includes all TRICARE Prime/Plus enrolled women, age 21-64, regardless of continuous enrollment.

Measure Definition:

Percentage of women continuously enrolled in TRICARE Prime/Plus, age 24-64 years, who had cervical cancer screening in the past three years.

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Cervical Cancer Screening	81.4%---84.2%---86.7%

Numerator:

Number of women continuously enrolled in TRICARE Prime/Plus, age 24-64, with coded cervical cancer screening at least once in the past three years in direct or purchased care.

Denominator:

Number of women enrollees as of the last day of the measurement month, age 24-64, continuously enrolled during the preceding 36-month period without a documented hysterectomy. A woman whose coverage lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled. Performance measures require a retrospective approach. Women are not included in the denominator for this measure until age 24 (3-year look back).

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ MHS CHCS lab and pathology ad hocs
- ➔ AHLTA Clinical Data Mart (CDM) Historical Procedures

Methodology:

- ➔ Use DEERS to identify women continuously enrolled in TRICARE Prime/Plus, age 24-64
- ➔ Use SADR (M2), SIDR (M2) and NETWORK (M2) data to identify women who have had an outpatient or inpatient visit with cervical cancer screening
- ➔ Use SADR (M2), SIDR (M2) and NETWORK (M2) data to exclude women with a history of hysterectomy and no residual cervix¹
- ➔ Use CHCS laboratory and pathology “pap” ad hocs to identify women who have had a pap smear completed in direct care
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM) in direct care
- ➔ Use CDM Historical procedures to identify women who have a documented history of cervical pap smear in the past 3 years or history of a total hysterectomy in Historical Procedures

Data Sources & Codes:

Codes to identify an outpatient or inpatient visit in direct care or purchased care:

CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V72.32, V76.2*	91.46

* V72.32 and V76.2 will be removed from the 2012 HEDIS specifications and will no longer identify a completed pap smear beginning with Jan 2012 data release.

Codes to exclude women with a hysterectomy and no residual cervix:¹

CPT Codes	ICD-9-CM Codes*	ICD-9-CM Procedure
51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5 V Codes: V67.01, V76.47, V88.01, V88.03 *Exclusion codes must be documented in one of the first 4 diagnosis codes. The M2 professional outpatient encounter data, provided for the MHSPHP, currently includes only Diagnosis Codes 1-4. V45.77 1 ** **(Military specific code – Acquired absence of Uterus and Cervix. This V45.77 1 code has been replaced with V88.01. Patients previously coded with V45.77 1 will continue to be excluded; therefore, it is not necessary to	68.4-68.8

CPT Codes	ICD-9-CM Codes*	ICD-9-CM Procedure
	recode these patients with the V88.01 code.)	

Note: Enrollees with a documented history of hysterectomy and no residual cervix appear in the QuickLook sheet with a date for the clinical preventive service set to "HYSTER."

HEDIS® Metrics and Report:

Percentage of TRICARE Prime/Plus continuously enrolled women, age 24-64, who were identified as having cervical cancer screening in the past 36 months.

Action Report:

Listing of all TRICARE Prime/Plus enrolled women, age 18-64, by PCM. Identifies women with the date of their most recently documented Pap smear and those who have not had a coded exam during the past 36 months.² The action report is based on current DEERS enrollment, in contrast to the HEDIS® aggregate report which specifies continuous enrollment and age constraints.

Note: Women with a documented history of hysterectomy and no residual cervix, will not be included in the Action Report, but will appear in the QuickLook prevalence report with a Pap Date of "HYSTER."

Action Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group**
- ➔ PCM ID*
- ➔ PCM IDTYPE*
- ➔ Last Exam Date
- ➔ System
- ➔ Source

- ➔ Contact Info**
- ➔ Defense Medical Information System (DMIS)
- ➔ TRO
- ➔ Service

*TRO Action Lists only

**Direct Care Action Lists only

Recommended Action:

Review patient medical records identified as NOT having a cervical cancer screening in the past 36 months. Schedule overdue patients for an exam.

Notes:

¹ In addition to the codes listed, individuals with a DoD ICD-9-CM extender code for a previously performed total hysterectomy will be excluded from the denominator.

² Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Chlamydia Screening

Women age 16-24 were selected for the benchmarking measurement, because evidence supporting screening is strongest among this age group. The Chlamydia screening "action report" provided to medical treatment facilities on the MHSPHP includes all currently enrolled, sexually-active¹ Active Duty women only, age 16-24, regardless of continuous enrollment.

Measure Definition:

Percentage of women continuously enrolled in TRICARE Prime/Plus age 16-24 that are sexually active and have had Chlamydia screening in the past 12 months.

Benchmark:

HEDIS[®] 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Chlamydia Screening – Total	41.0%---48.1%---53.9%
Chlamydia Screening – 16 – 20 years	39.3% - 45.7% - 51.1%
Chlamydia Screening – 21 – 24 years	43.1% - 50.9% - 56.8%

Numerator:

Number of sexually-active women continuously enrolled in TRICARE Prime/Plus, age 16-24, with at least one screening test for Chlamydia in the past 12 months in direct care or purchased care.

Denominator:

Number of sexually-active, female enrollees, as of the last day of the measurement month, age 16-24, continuously enrolled during the preceding 12-month period. Women are identified as sexually active by using encounter/claims data and pharmacy data. Although two methods are used to identify the eligible population, a woman only needs to be identified in one method. Pharmacy data is used to identify women who were dispensed prescription contraceptives (e.g., oral contraceptive, IUD, diaphragm or other prescribed contraceptive) during the past year. Encounter/claims data (including laboratory tests) include numerous diagnosis and procedure codes used to determine sexual activity for the purposes of this measure. A woman whose coverage lapses for more than two months (60 days) during the previous 12-month period of enrollment is not considered continuously enrolled and not eligible for inclusion.

Exclusions:

Pregnancy tests are frequently ordered for the purposes of ensuring patient safety prior to prescribing radiologic procedures and high-risk medications (e.g., isotretinoin) and do not reflect sexual activity. Thus, women with pregnancy tests ordered within a seven day window (inclusive) of these procedures or prescriptions will be excluded from the denominator. This exclusion applies only if a pregnancy test was the sole criteria for determining sexual activity status.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ MHS CHCS lab module
- ➔ Pharmacy Data Transcription Service (PDTs) (Includes prescriptions received from MTF, network and mail order pharmacies)
- ➔ AHLTA Clinical Data Mart (CDM) Historical Procedures

Methodology:

- ➔ Use DEERS to identify women continuously enrolled in TRICARE Prime/Plus, age 16-24
- ➔ Use SADR (M2) and NETWORK (M2) data to identify women who were sexually active and had an outpatient visit with Chlamydia screening
- ➔ Use SIDR (M2) and NETWORK (M2) data to identify women who were sexually active according to inpatient diagnoses and procedures
- ➔ Use CHCS laboratory ad hocs to identify women who had a Chlamydia test, pap smear, or a pregnancy screen completed at an MTF
- ➔ Use NETWORK (M2) to identify women who had a Chlamydia test completed in the NETWORK
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM) in direct care
- ➔ Use PDTS to identify members with appropriate medications and contraceptive devices
- ➔ Use CDM Historical Procedures to identify members who were sexually active according to historical diagnoses and procedures and women who had a Chlamydia test documented in Historical Procedures

Data Sources & Codes:

Claims/encounter data:

Women who had at least one coded visit indicating “sexual activity” in the past 12 months.

Codes to identify sexually-active women in direct care or the purchased care sector:

(includes various diagnoses and procedures related to women’s reproductive health, including, but not limited to, pregnancy and sexually transmitted diseases)

CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812,	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1003-H1005, P3000, P3001, Q0091, S0199, S4981, S8055	042, 054.10, 054.11, 054.12, 054.19, 078.11, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 339.82, 614-6, 622.3, 623.4, 626.7, 628, 630-	69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 88.78, 97.24, 97.71, 97.73

CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84704, 86592-86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87660, 87808, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269		679, 795.0, 795.1, 796.7, 996.32, V01.6, V02.7, V02.8, V08, V15.7, V22-V28, V45.5, V61.5-V61.7, V69.2, V72.3, V72.4, V73.81, V73.88, V73.98, V74.5, V76.2	

Codes to identify Chlamydia screening:

CPT Codes:

- ➔ 87110
- ➔ 87270
- ➔ 87320
- ➔ 87490
- ➔ 87491
- ➔ 87492
- ➔ 87810

Pharmacy data:

Women dispensed prescribed contraceptives in the past year.

Codes to exclude patients with pregnancy testing followed by x-ray or Accutane:

Description	CPT Codes
Pregnancy test	81025, 84702, 84703
WITH	
Diagnostic radiology	70010-76499

Medications to identify exclusions:

Retinoid - isotretinoin

Prescriptions to identify contraceptives:

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

HEDIS® Metrics and Report:

Percentage, by MTF, of continuously enrolled sexually-active women, age 16-24, who were identified as having Chlamydia screening in the past 12 months.

Reports will be stratified by age:

- ➔ 16-20 years of age
- ➔ 21-24 years of age
- ➔ Total

Action Report:

Listing of all sexually-active Active Duty enrolled women, age 16-24, by PCM2. The list includes the date of women's most recently documented Chlamydia screening, and also identifies women who have not had a coded test during the past 12 months³. The Action Report is based on current DEERS enrollment, in contrast to the HEDIS® aggregate report which specifies continuous enrollment and age constraints.

Action Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth

- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Last Exam Date
- ➔ System
- ➔ Source
- ➔ Contact Info
- ➔ Defense Medical Information System (DMIS)

Recommended Action:

Review patient medical records of Active Duty women identified as sexually active and NOT having a Chlamydia screening in the past 12 months.

Notes:

¹ Women are identified as sexually active based on either encounter/claims data or pharmacy data.

² Currently, Air Force MTFs do not receive an Action Report for Chlamydia testing. Only Metrics and Reports will be shown for Air Force MTFs.

³ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Cholesterol Management for Patients with Cardiovascular Conditions

This methodology measures the follow-up care regarding LDL-C screenings and control for patients age 18 to 75 who were discharged alive for acute myocardial infarction (AMI), coronary bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PCI) between 13 and 24 months prior to the measurement month, or who had a diagnosis of ischemic vascular disease (IVD) during the 12 months prior to the measurement month and the 12 months prior to that.

Measure Definition:

Percent of cardiac patients enrolled to MTFs who received LDL-C screening

Percent of cardiac patients enrolled to MTFs whose LDL-C is controlled (<100 mg/dL)

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
LDL-C screening	89.5%, 91.4%, 93.2%
LDL-C is controlled (<100 mg/dL)	60.8%, 65.5%, 70.6%

Numerator:

- ➔ Number of patients, continuously enrolled for the last two years, age 18-75, who were discharged alive for AMI, CABG, or PCI between 13 and 24 months prior to the measurement month, or who had a diagnosis of IVD during the 12 months prior to the measurement month and the 12 months prior to that, and had an LDL-C screening during the measurement year.
- ➔ Number of patients, continuously enrolled for the last two years, age 18-75, who were discharged alive for AMI, CABG, or PCI between 13 and 24 months prior to the measurement month, or who had a diagnosis of IVD during the 12 months prior to the measurement month and the 12 months prior to that, and had an LDL-C level below 100 mg/dL the last time it was checked during the measurement year.

Denominator:

Number of patients, continuously enrolled for the last two years, age 18-75, who were discharged alive for AMI, CABG, or PCI between 13 and 24 months prior to the measurement month, or who had a diagnosis of IVD during the 12 months prior to the measurement month and the 12 months prior to that.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Laboratory ad-hoc

Methodology:

- ➔ Use DEERS to identify patients enrolled to specific MTFs.
- ➔ Use M2 (SIDR and Network) data to identify hospital patients treated for selected cardiovascular conditions/events.
- ➔ Use SADR (M2), SIDR (M2) and NETWORK (M2) data to identify ambulatory patients treated for selected cardiovascular conditions/events.

Data Sources & Codes:

Codes to Identify AMI, PCI and CABG

Description	CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
AMI (include only inpatient claims)			410.x1	
CABG (include only inpatient claims)	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209		36.1, 36.2
PCI	92980, 92982, 92995	G0290		00.66, 36.06, 36.07

Codes to Identify IVD

Description	ICD-9-CM Diagnosis
IVD	411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445

Codes to Identify Visit Type

Description	CPT Codes
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

Codes to Identify LDL-C Screening

CPT Codes	CPT Category
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F

HEDIS® Metrics and Report:

- ➔ The percentage of enrolled cardiac patients who had an LDL-C screen in the measurement period.
- ➔ The percentage of enrolled cardiac patients who have an LDL-C <100mg/dL on the most recent screen in the measurement period.

Prevalence Report

List of all patients age 18-75, who were discharged alive for AMI, CABG, or PCI in the last 24 months prior to the measurement month, or who had a diagnosis of IVD during the 12 months prior to the measurement month and the 12 months prior to that.

Prevalence Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group**
- ➔ PCM ID*
- ➔ PCMID Type*
- ➔ AMI (Acute Myocardial Infarction: Yes or No)
- ➔ AMI Date
- ➔ AMI System
- ➔ AMI Source
- ➔ CABG (Coronary Artery Bypass Graft: Yes or No)
- ➔ CABG Date
- ➔ CABG System
- ➔ CABG Source
- ➔ PCI (Percutaneous Coronary Interventions: Yes or No)
- ➔ PCI Date
- ➔ PCI System
- ➔ PCI Source
- ➔ IVD (Ischemic Vascular Disease: Yes or No)
- ➔ IVD Date
- ➔ IVD System
- ➔ IVD Source
- ➔ LDL Result1

- ➔ LDL Date
- ➔ LDL System
- ➔ LDL Source
- ➔ Contact Information**
- ➔ Defense Medical Information System (DMIS)
- ➔ TRO*
- ➔ Service*

*TRO Action List only

**Direct Care Action Lists only

Recommended Action:

- ➔ Review chronic disease burden data to project provision of health care services and exams.
- ➔ Review medical records of the patients that have not had an LDL annually after the cardiovascular diagnosis/event then schedule the test with the patient if needed.
- ➔ Consider case management for patients with LDL >100.

Notes:

¹ Lab values cannot be obtained from purchased care data. Only the exam date will be displayed.

² Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Chronic Obstructive Pulmonary Disease (COPD) Prevalence

Measure Definition:

The proportion of MTF enrollees, 18 years and older, with COPD subject to DoD/VA guidelines clinical management.

Benchmark:

N/A

Numerator:

MTF enrollees, 18 years and older, identified (see Data Sources & Codes) as having COPD during the 12 months prior to the end of the reporting period.

Denominator:

All MTF enrollees, 18 years and older, at the time of the reporting period.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

Methodology:

- ➔ Use DEERS to identify patients enrolled to MTFs.
- ➔ Use SADR(M2) and NETWORK (M2) data to identify patients who have had an outpatient or Emergency Department (ED) visit for chronic obstructive pulmonary disease.
- ➔ Use SIDR (M2) and NETWORK (M2) data to identify patients with hospitalizations for chronic obstructive pulmonary disease.
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM).

Data Sources & Codes:**Codes to identify patients with COPD:**

ICD-9-Codes:

- ➔ 491.20
- ➔ 491.21
- ➔ 492.x
- ➔ 493.2x
- ➔ 496

Aggregate Report:

A table displaying the proportion of COPD as part of the total enrolled population, 18 years and older.

Prevalence Report:

MTF list of all enrolled patients by PCM with at least one outpatient visit for chronic obstructive lung disease.¹

Prevalence Report Data Elements:

- ➔ Patient's name
- ➔ Sponsor's Social Security Number (Sponsor SSN)
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Number of Visits
- ➔ Contact Information
- ➔ Defense Medical Information System (DMIS)
- ➔ Service

Recommended Action

- ➔ Review chronic disease burden data to project health needs associated with chronic diseases/conditions
- ➔ Consider utilizing condition management programs
- ➔ Consider implementation of DOD/VA (or other) clinical practice guidelines²

Notes:

¹ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

² DoD/VA guidelines can be located at <https://www.qmo.amedd.army.mil/pguide.htm>

Colorectal Cancer Screening

Adults, age 51-75, were selected for benchmarking measurement, because evidence supporting screening is strongest among this age group. The "action report" provided to medical treatment facilities (MTF) and Managed Care Support Contractors (MCSC) on the MHSPHP includes all

TRICARE Prime/Plus adults age 50-75, regardless of continuous enrollment, accounting for at least a one year look back.

Measure Definition:

Percentage of adults enrolled in TRICARE Prime/Plus, age 51-75, who had appropriate colorectal cancer screening. Screening intervals vary according to the method of screening.

Benchmark:

HEDIS[®] 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Colorectal Cancer Screening	59.4%---65.0%---69.6%

Numerator:

Number of adults continuously enrolled in TRICARE Prime/Plus, age 51-75, who had appropriate colorectal cancer screening in direct care or purchased care. Screening intervals vary according to the method of screening.

One or more screenings for Colorectal Cancer. Appropriate screening must meet one of three criteria:

- Fecal Occult Blood Test (FOBT) within the last 12 months
- Flexible Sigmoidoscopy within the last 60 months
- Colonoscopy within the last 120 months

Denominator:

Number of adult enrollees as of the last day of the measurement month, age 51-75, who were continuously enrolled during the preceding 24-month period. An adult whose coverage lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled.

Patients with a diagnosis of colorectal cancer or with a previous total colectomy are excluded (see exclusion codes below under “Data Sources & Codes”). Performance measures require a retrospective approach; adults are not included in the denominator for this measure until age 51 (1-year look back).

Data Sources:

- Defense Eligibility Enrollment Registration System (DEERS)
- Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Standard Ambulatory Data System (SADR) (M2)
- ➔ Standard Inpatient Data System (SIDR) (M2)
- ➔ M2_RAD
- ➔ CHCS Lab
- ➔ AHLTA Clinical Data Mart (CDM) Historical Procedures

Methodology:

- ➔ Use DEERS to identify adults continuously enrolled in TRICARE Prime/Plus, age 51-75
- ➔ Use SADR/SIDR/NETWORK (M2) data to identify adults, age 51-75, with at least one code to identify colorectal cancer screening
- ➔ Use SADR/SIDR/NETWORK (M2) data to exclude adults with a history of colorectal cancer or total colectomy
- ➔ Use CHCS Lab ad hoc to identify additional Fecal Occult Blood Tests in direct care
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM) in direct care
- ➔ Use CDM Historical procedures to identify adults who have a documented history of colon cancer screening (FOBT, DCBE, sigmoidoscopy, colonoscopy) or total colectomy in Historical procedures

Data Sources & Codes:

Codes to Identify Colorectal Cancer Screening

Description	CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
FOBT	82270, 82274	G0328, G0394	V76.51	
Flexible Sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104		45.24
Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121		45.22, 45.23, 45.25, 45.42, 45.43

Codes to **exclude** members for Colorectal Cancer Screening

Description	CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Colorectal Cancer		G0213-G0215, G0231	153, 154.0, 154.1, 197.5, V10.05	

Description	CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Total Colectomy	44150-44153, 44155-44158, 44210-44212			45.8

Note: Enrollees with a documented history of total colectomy appear in the QuickLook sheet with a date for the clinical preventive service set to 09 Sep 9999.

HEDIS® MTF/MCSC Aggregate Report:

Percentage of adults enrolled in TRICARE Prime/Plus, age 51-75, identified as having appropriate colorectal cancer screening. Screening intervals vary according to the method of screening.

Action Report:

List of all adults enrolled in TRICARE Prime/Plus age 50 and older, by Primary Care Manager (PCM) or TRICARE Region. Identifies adults with the date of their most recently documented colorectal cancer screening and those who could not be identified as having a colorectal cancer screening. The action list is based on current DEERS enrollment, in contrast to the HEDIS® aggregate report which specifies continuous enrollment.

Note: Adults with a documented history of total colectomy will not be included in the Action Report, but will appear in the QuickLook sheet with a Colon Ca Scr Date of 09 Sep 9999.

Action Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number (SSN)
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM Name
- ➔ Provider Group**
- ➔ PCM ID*
- ➔ PCMID Type*
- ➔ Colonoscopy Date
- ➔ Colonoscopy System

- ➔ Colonoscopy Source
- ➔ Flex Sigmoid Date
- ➔ Flex Sigmoid System
- ➔ Flex Sigmoid Source
- ➔ FOBT Date
- ➔ FOBT System
- ➔ FOBT Source
- ➔ CT Colonoscopy Date ²
- ➔ CT Colonoscopy System
- ➔ CT Colonoscopy Source
- ➔ Contact Info**
- ➔ Defense Medical Information System (DMIS)
- ➔ TRO
- ➔ Service**

*TRO Action Lists only

**Direct Care Action Lists only

Recommended Action:

Review medical records of the patients identified as NOT having a colorectal cancer screening.

- ➔ Schedule/initiate colorectal cancer screening if patient is overdue
- ➔ Anticipate those adults who will need colorectal cancer screening in the near future for demand forecasting and the initiation of population health initiatives

Notes:

1. Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.
2. The US Preventive Services Task Force has concluded that the evidence is insufficient to assess the benefits and harms of computer tomographic (CT) colonoscopy as a screening test for colorectal cancer. The CT colonoscopy date is included in the action list for informative purposes only; CT colonoscopy screens do not qualify for the HEDIS® numerator and therefore do not impact the HEDIS® MTF/MCSC Aggregate Report. CT Colonoscopy dates are for informational purposes only. CPT Codes 0066T (no longer

active January 2010) and 74263 (replaced previous code) are used to identify CT colonoscopy procedures.

Congestive Heart Failure (CHF) Prevalence

Measure Definition:

The proportion of MTF enrollees, 18 years and older, with CHF subject to DoD/VA guidelines clinical management.

Benchmark:

N/A

Numerator:

MTF enrollees age 18 years and older identified (see Data Sources & Codes) as having CHF during the 12 months prior to the end of the reporting period.

Denominator:

All MTF enrollees, 18 years and older, at the time of the reporting period.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

Methodology:

- ➔ Use DEERS to identify patients enrolled to MTFs.
- ➔ Use SADR (M2) and NETWORK (M2) data to identify patients who had 2 or more outpatient visits for CHF (non- Emergency Department (ED) visits).
- ➔ Use SADR (M2) and NETWORK (M2) outpatient data to identify patients with 2 or more ED visits with CHF as the primary diagnosis.
- ➔ Use SIDR (M2) and NETWORK (M2) data to identify patients with hospitalizations for CHF.
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify PCM.

Data Sources & Codes:

Criteria to identify patients with CHF:

- ➔ At least one encounter from SIDR (M2) and/or Network (M2) inpatient with one of the listed diagnoses below as primary diagnosis
- ➔ At least two encounters (non-ED) from SADR (M2) or Network (M2) outpatient with one of the listed diagnoses below as primary diagnosis
- ➔ At least two encounters from Emergency Departments with one of the listed diagnoses below as primary diagnosis

Description	ICD-9-CM Codes
CHF	398.91, 402.0, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.9

Prevalence Report:

MTF list of all enrolled patients by PCM with at least one inpatient, two outpatient encounters (primary diagnosis), or two ED encounters (primary diagnosis) for CHF.¹

Prevalence Report Data Elements:

- ➔ Patient's name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Outpatient Visits
- ➔ Inpatient Visits
- ➔ ER Visits
- ➔ Source
- ➔ Contact Information
- ➔ Defense Medical Information System (DMIS)

Recommended Action

- ➔ Review chronic disease burden data to project health needs associated with chronic diseases/conditions
- ➔ Consider utilizing condition management programs
- ➔ Consider implementation of DOD/VA (or other) clinical practice guidelines²

Notes:

¹ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

² DoD/VA guidelines can be located at <https://www.qmo.amedd.army.mil/pguide.htm>

Depression Prevalence

Measure Definition:

The proportion of MTF enrollees with depression subject to DoD/VA guidelines clinical management.

Benchmark:

N/A

Numerator:

MTF enrollees identified (see Data Sources & Codes) as having depression during the 12 months prior to the end of the reporting period.

Denominator:

All MTF enrollees at the time of the reporting period.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

Methodology:

- ➔ Use DEERS to identify patients enrolled to MTFs

- ➔ Use SADR (M2) and NETWORK (M2) claims data to identify patients who have had an outpatient or Emergency Department (ED) visit for depression
- ➔ Use SIDR (M2) and NETWORK (M2) claims data to identify patients with hospitalizations for depression
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM)

Data Sources & Codes:

Criteria to identify patients with depression:

- ➔ At least one principal diagnosis with the below ICD- 9 codes (outpatient, ED, inpatient) **OR**
- ➔ At least two secondary diagnoses with the below ICD-9 codes on separate encounter dates in any outpatient setting (ED included) **OR**
- ➔ At least one secondary diagnosis of major depression associated with any inpatient discharge

Codes to identify patients with Depression:

ICD-9-Codes:

- ➔ 296.2
- ➔ 296.3
- ➔ 298.0
- ➔ 300.4
- ➔ 309.1
- ➔ 311

Prevalence Report:

MTF list of all enrolled patients by PCM with at least one outpatient visit for depression.¹

Prevalence Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender

- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Outpatient Visits PR
- ➔ Outpatient Visits SEC
- ➔ Hospitalizations
- ➔ ED Visits PR
- ➔ ED Visits SEC
- ➔ Source
- ➔ Contact Info
- ➔ Defense Medical Information System (DMIS)
- ➔ Service

Recommended Action

- ➔ Review chronic disease burden data to project health needs associated with chronic diseases/conditions.
- ➔ Consider utilizing condition management programs.
- ➔ Consider implementation of DOD/VA (or other) clinical practice guidelines.²

Notes:

¹ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

²DOD/VA guidelines can be located at <https://www.qmo.amedd.army.mil/pguide.htm>

Diabetes Care

A set of comprehensive diabetes benchmarking measurements were selected for diabetic patients age 18-75. As a set they provide a comprehensive view of the clinical management of patients diagnosed with diabetes. The "action report" provided to MTFs and MCSCs on the MHSPHP includes information regarding annual A1c testing, A1c control, LDL screening and control, retinal eye exams, and monitoring of kidney disease for MTF enrollees, at least age 1, identified with diabetes, regardless of continuous enrollment.

Measure Definition:

- ➔ Percent of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with at least one A1c test during the past year.

- ➔ Percent of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with most recent A1c value > 9.0% or no A1c test during the past year.
- ➔ Percent of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with most recent A1c value <7.0%. (Selected population. See exclusions below)
- ➔ Percent of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with most recent A1c value <8.0%.
- ➔ Percent of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, who had their most recent LDL-C lab performed during the past year.
- ➔ Percent of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with most recent LDL-C value < 100 mg/dl. Enrollees with no test on record will be assumed to be above 100 mg/dl.

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Annual A1c	89.0%---91.7%---93.7%
Annual LDL-C	85.1%---87.4%---89.8%
LDL-C < 100mg/dl	45.3%---50.6%---53.9%
A1c < 7.0	43.7%-48.8%-54.3%
A1c < 8.0	63.3%--67.5%--71.5%
A1c > 9.0 or No Annual Exam <i>A lower rate indicates better performance (i.e., low rates of poor control indicate better care). Therefore, the 10th percentile is a better performing level than the 90th percentile for this measure. This runs in the opposite direction of all other measures, therefore the percentiles are inverted on the MHSPHP to make higher score better.</i>	HEDIS® Percentiles (10-25-50) 18.7%---22.6%---27.8%

Numerators (A1c):

- ➔ Number of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, who had at least one A1c test during the past year
- ➔ Number of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with their most recent A1c value > 9.0% or no A1c test in the past year
- ➔ Number of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-64, with their most recent A1c value < 7.0%, performed sometime during the past year. (Note: Denominator is different from the other control measures. Patients

must “not” meet certain criteria to be included in this measure. See A1c<7% exclusion criteria below.)

- ➔ Number of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with their most recent A1c value <8.0%, performed sometime during the past year

Numerators (LDL-C)

- ➔ Number of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with at least one LDL-C test during the past year
- ➔ Number of patients enrolled to TRICARE Prime/Plus with Type 1 or Type 2 diabetes, age 18-75, with their most recent LDL-C lab value < 100 mg/dl (performed sometime during the past year)

Denominator:

Number of patients, age 18-75, who were continuously enrolled in TRICARE Prime/Plus during the past 12 months with Type 1 or Type 2 diabetes. Two types of data are used to identify members with diabetes, pharmacy data and claims/encounter data. A patient only needs to be identified by one source, pharmacy data or encounter/claims data, to be included in the measure. A patient whose enrollment lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled.

Notes:

- ➔ Lab values are not used to identify diabetics, because of the high false positive rate associated with this method.
- ➔ The A1c <7.0 measure has a separate denominator. Diabetics in this denominator will not meet any of the following exclusion criteria:

A1c<7% exclusion criteria:

To be evaluated against the A1c values <7.0% control indicator, patients must NOT fall into one or more of the following categories:

- ➔ 65years of age and older as of the last day of the measurement period.
- ➔ Discharged following coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) in the measurement year or the year prior to the measurement year. Inpatient CABG cases only. Includes all cases of PCI regardless of setting.
- ➔ Ischemic vascular disease (IVD). Enrollees who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
 - At least one outpatient visit with an IVD diagnosis or
 - At least one acute inpatient visit with an IVD diagnosis

- ➔ For the following conditions patients must have had at least one encounter, in any setting with any code, to identify the condition. The diagnosis can occur at any time during the patient’s history, through the last day of the measurement period.
 - Chronic Heart Failure (CHF)
 - Prior myocardial infarction (MI)
 - Chronic Renal Failure/End Stage Renal Disease (CRF/ESRD)
 - Dementia
 - Blindness
 - Amputation – lower extremity

Criteria to identify patients with diabetes via encounter data (within the past 24 months):

- ➔ Two or more face to face encounters with different dates of service in an outpatient setting
- ➔ Two or more face to face encounters in a non-acute inpatient setting
- ➔ One acute inpatient visit
- ➔ One Emergency Department (ED) visit

Pharmacy Data Criteria:

Prescription medications will also be used to identify diabetics. These include ambulatory prescriptions dispensed during the past 24 month period for any of the following:

Description	Prescription	
Alpha-glucosidase inhibitors	acarbose	miglitol
Amylin analogs	pramlintide	
Antidiabetic combinations	glimepiride-pioglitazone glimepiride-rosiglitazone glipizide-metformin glyburide-metformin	metformin-pioglitazone metformin-rosiglitazone metformin-sitagliptin
Insulin	insulin aspart insulin aspart-insulin aspart protamine insulin detemir insulin glargine insulin glulisine insulin inhalation insulin isophane beef-pork insulin isophane human	insulin isophane-insulin regular insulin lispro insulin lispro-insulin lispro protamine insulin regular beef-pork insulin regular human insulin regular pork insulin zinc beef-pork

Description	Prescription	
	insulin isophane pork	insulin zinc extended human insulin zinc human insulin zinc pork
Meglitinides	nateglinide	repaglinide
Miscellaneous antidiabetic agents	exenatide liraglutide sitagliptin	
Sulfonylureas	acetohexamide chlorpropamide glimepiride glipizide	glyburid tolazamide tolbutamide
Thiazolidinediones	pioglitazone	rosiglitazone

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis coding only.

Exclusions

- ➔ Exclude patients with a diagnosis of polycystic ovaries if they did not have any face-to-face encounters that were coded for diabetes, in any setting, in the past 2 years. A diagnosis of polycystic ovaries can occur at any time in the patient’s history, but must have occurred by the last day of the measurement period.
- ➔ Exclude patients with steroid induced diabetes, gestational diabetes, prediabetes, or metabolic syndrome if they did not have any face-to-face encounters that were coded for diabetes, in any setting, in the past 2 years. A diagnosis of steroid induced diabetes gestational diabetes, prediabetes, or metabolic syndrome can occur any time during the past 2 years, but must have occurred by the last day of the measurement period.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ MHS CHCS laboratory module

- ➔ Pharmacy Data Transcription Service (PDTS) (M2) (Includes prescriptions received from MTF, network and mail order pharmacies)

Methodology:

- ➔ Use DEERS to identify patients enrolled to specific MTFs and MCSCs
- ➔ Use M2 (SADR, SIDR, PDTS and Network) data to identify patients with diabetes via diabetes-related visits and medications
- ➔ Use M2 (SADR, SIDR, PDTS and Network) data to identify diabetes-related visits, retinal eye exams, and number of prescriptions
- ➔ Use CHCS Lab ad hocs to identify diabetes-related labs in direct care
- ➔ Use M2 Network data to identify diabetes-related labs in network
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM) in direct care

Numerator Data Sources & Codes:

Identifying A1c Tests:

CHCS Laboratory extract to identify patients with the above diabetes codes who had at least one A1c test completed in the past 12 months, in direct care, and value of the test documented. CPT codes and lab test names are used to find individuals with A1c tests performed. Purchased care claims are used to identify A1c test performed in purchased care.

➔ CPT Codes:

- 83036
- 83037

Identifying LDL-C Lab Tests:

CHCS Laboratory extract to identify diabetic patients with the specified diabetes codes who had at least one LDL-C screening test completed in the past 12 months and value of test documented. CPT and lab test names were used to find individuals with LDL-C labs performed.

➔ CPT Codes:

- 80061
- 83700
- 83701
- 83704
- 83721

Codes to identify eye exams using Network (M2) and SADR (M2) claims data:

CPT Codes	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213- 99215, 99242-99245	S0620, S0621, S0625**, S3000	V72.0	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16

** HCPCS S0625 does not need to be limited to an optometrist or ophthalmologist. These codes indicate an eye exam was performed by an eye care professional.

Codes to identify Microalbuminuria Tests:

CHCS Laboratory extract to identify patients who had at least one microalbuminuria lab test completed in the past 12 months and value of test documented. CPT and lab test names were used to find individuals with microalbuminuria labs performed.

➔ Microalbuminuria CPT Codes

- 82042
- 82043
- 82044
- 84156

Denominator Data Sources & Codes:

Codes to identify diabetics:

➔ Diabetes Mellitus ICD-9-CM Codes:

- 250
- 357.2
- 362.0
- 366.41
- 648.0

Codes to identify Diabetic Visits:

Description	CPT Codes
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

Description	CPT Codes
Nonacute Inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
Acute Inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
Emergency Dept	99281-99285

Codes to exclude patients for secondary diabetes and other conditions requiring diabetic medications:

Description	ICD-9-CM Codes	Notes
Polycystic Ovarian Syndrome	256.4	Occurring anytime during the member's history with no face to face encounters for diabetes, in any setting, during the past 24 months.
Steroid-Induced Diabetes	249, 251.8, 962.0	Occurring during the past 24 months with no face to face encounters for diabetes, in any setting, during the past 24 months.
Gestational Diabetes	648.8	Occurring during the past 24 months with no face to face encounters for diabetes, in any setting, during the past 24 months.
Prediabetes	790.29	Occurring during the past 24 months with no face to face encounters for diabetes, in any setting, during the past 24 months.
Metabolic Syndrome	277.7	Occurring during the past 24 months with no face to face encounters for diabetes, in any setting, during the past 24 months.

Codes to identify required exclusions for A1c < 7.0 measure:

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	POS
IVD			411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445		
CABG (inpatient only)	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209		36.1, 36.2	
PCI	92980, 92982, 92995	G0290		00.66, 36.06, 36.07	
Dementia			290, 291.2, 292.82, 294.0, 294.1, 294.8, 331.0, 331.1, 331.82		

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	POS
MI			410, 412		
CRF/ESRD	36145, 36800-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512, 36147	G0257, G0311-G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339	585.4, 585.5, 585.6, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98	65
Blindness			369.0, 369.1, 369.2, 369.4, 369.6, 369.7		
Amputation (lower extremity)	27290, 27295, 27590-27592, 27594, 27596, 27598, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28800, 28805, 28810, 28820, 28825			84.1	

Action Report:

List of TRICARE Prime/Plus enrolled diabetics, at least age 1, by PCM.² The action list is based on current DEERS enrollment, in contrast to the HEDIS[®] aggregate report which specifies continuous enrollment and age constraints.

Action Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)

- ➔ PCM
- ➔ Provider Group**
- ➔ PCM ID*
- ➔ PCMID Type*
- ➔ Number of Diabetic Outpatient Visits
- ➔ Number of Diabetic Hospitalizations
- ➔ Number of Diabetic ED Visits
- ➔ Rx Count
- ➔ Insulin
- ➔ A1C Date
- ➔ A1C Result3
- ➔ A1C Source
- ➔ A1C System
- ➔ Retinal Exam Date4
- ➔ Retinal Source
- ➔ Retinal System
- ➔ LDL Date
- ➔ LDL Result1
- ➔ LDL Source
- ➔ LDL System
- ➔ Cholesterol Date
- ➔ Cholesterol Result
- ➔ Cholesterol Source
- ➔ Cholesterol System
- ➔ HDL Date
- ➔ HDL Result
- ➔ HDL Source
- ➔ HDL System
- ➔ CHOL/HDL Ratio

- ➔ Comorbid
- ➔ Comorbid Date
- ➔ Contact Information**
- ➔ Defense Medical Information System (DMIS)
- ➔ TRO*
- ➔ Service*

*TRO Action List only

**Direct Care Action Lists only

For known diabetics, if microalbumin results can be found in CHCS lab data, those results are displayed in a separate file.

Recommended Action:

- ➔ Review chronic disease burden data to project provision of health care services and exams.
- ➔ Consider implementation of DoD/VA (or other) clinical practice guidelines.⁵
- ➔ Review medical records of the patients that need to have an HbA1c, LDL or retinal exam and arrange to have a member of the health care team schedule the test.
- ➔ Consider case management for patients with HbA1c >9.0, or LDL >100.

Notes:

¹ Lab values cannot be obtained from purchased care data. Only the exam date will be displayed.

² Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

³ A1c values are not available for tests accomplished in purchased care.

⁴ Only retinal exams with provider specialty codes of (120, 121, 510, 708) (Direct Care) or (18, 98) (Purchased Care Claims) will be counted.

⁵ DoD/VA guidelines can be located at: <https://www.qmo.amedd.army.mil/pguide.htm>

Dyslipidemia Prevalence (Lipid Panel)

Measure Definition:

The proportion of MTF enrollees age 1 or older, with dyslipidemia defined as a Total Cholesterol/HDL Ratio > 5 or an LDL result > 130 mg/dl in the last 24 months, or diabetic patients with an LDL > 100 mg/dl.

Benchmark:

N/A

Numerator:

Number of MTF enrollees age 1 or older, identified as having dyslipidemia during the 24 months prior to the end of the reporting period (see Data Sources & Codes).

Denominator:

Number of all MTF enrollees at the time of the reporting period

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ CHCS Laboratory ad hoc

Methodology:

- ➔ Use DEERS to identify patients enrolled to MTFs
- ➔ Use CHCS Laboratory ad hoc for total cholesterol, LDL, and HDL cholesterol1
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM)
- ➔ CHCS Laboratory ad hoc to identify patients with dyslipidemia

Data Sources & Codes:**Criteria to determine dyslipidemia:**

- ➔ Total Cholesterol/HDL Ratio > 5 **OR**
- ➔ LDL result > 130 mg/dl **OR**
- ➔ Diabetic patients with an LDL > 100 mg/dl (see Diabetes methodology)

Prevalence Report:

MTF list of all enrolled patients by PCM age 1 or older, with dyslipidemia defined as a Total Cholesterol/HDL Ratio > 5 or an LDL result > 130 mg/dl in the last 24 months, or diabetic patients with an LDL >100 mg/dl.²

Prevalence Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number

- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Cholesterol Date3
- ➔ Cholesterol Result
- ➔ Cholesterol Source
- ➔ Cholesterol Result
- ➔ Cholesterol System
- ➔ HDL Date3
- ➔ HDL Source
- ➔ HDL Result1
- ➔ HDL System
- ➔ LDL Date3
- ➔ LDL Source
- ➔ LDL Result1
- ➔ LDL System
- ➔ CHOL/HDL Ratio1
- ➔ Contact Information
- ➔ Defense Medical Information System (DMIS)

Recommended Action

- ➔ Review chronic disease burden data to project health needs associated with chronic diseases/conditions
- ➔ For adult patients with high CHOL/HDL ratios or elevated LDL results, review the medical treatment record for other risk factors such as diabetes, hypertension, and smoking. Intervention may be required to help lower the patient's risk for future cardiovascular disease events

- ➔ Consider using or implementing dyslipidemia clinical guidelines

LIST Limitations:

- ➔ This list does not include patients who met dyslipidemia criteria prior to the last 24 months and have not had a subsequent test.
- ➔ Patients who have normal tests and are taking lipid lowering medications are not included on this list.

Notes:

¹ Lab values currently cannot be obtained from network data.

² Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

³ The cholesterol, HDL, and LDL tests must have the same certification date to be included in this file. The last known certified results are shown and utilized for calculations of cholesterol ratios.

High Utilizers

Analysis of health care service utilization is a key component of population health management. Information indicating the number of physician visits per member per year (PMPY) establishes a comparative baseline and identifies patients with significantly low or high utilization. Low utilizers may represent an at-risk group who can be targeted for delivery of preventive services while high utilizers may be potential candidates for disease and case management strategies. Reducing the rate of utilization can effectively reduce demand and facilitate recapture of care from the private sector.

Measure Definition:

Military Treatment Facility (MTF) enrollees with more than 10 outpatient visits for primary, urgent or emergent care services.

Benchmark:

N/A

Numerator (Direct Care):

MTF enrollees identified with more than 10 outpatient visits to the following clinics (at any MTF), during the previous 12 months: Family Practice (BGA), Primary Care (BHA), Flight Medicine (BJA), Pediatric (BDA), Adolescent (BDB), Internal Medicine (BAA), Intermediate Care (BHI), and Emergency Department (BIA). Includes only face-to-face encounters with to a physician, physician assistant, nurse practitioner or independent duty technician/corpsman. Excludes visits for conditions that do not impact the use of primary care services (see Data Sources & Codes).

Numerator (Network Care [HCSR-NI]):

Visits by MTF enrollees to the network for primary care meeting the following criteria:

- ➔ Provider specialty: (General Practice, Family Practice, Internal Medicine, Pediatrics, Geriatrics) **AND**
- ➔ Service nature: (Medical Care, Consultation, Other Medical Service, Mental Health Care) **AND**
- ➔ Place of service: (Office, Urgent Care, Outpatient Hospital, Emergency Room - Hospital)
- ➔ Procedure code: All non-urgent care encounters must have a face-to-face evaluation and management code. (see Data Sources & codes)

Denominator:

All MTF enrollees at the end of the reporting period.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

Methodology:

- ➔ Use DEERS to identify patients enrolled to MTFs.
- ➔ Use M2 (SADR and Network) to identify outpatient and emergency department visits (excluding telephone consults).
- ➔ Use M2 (SADR and Network) to exclude conditions requiring frequent visits.
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify PCM

Data Sources & Codes:

Primary diagnosis codes for exclusion that do not impact the use of primary care services:

Description	ICD-9-CM Codes
Allergic Rhinitis	477
Vaccinations	V03.0-V06.9
Desensitization to allergens	V07.1
Prophylactic immunotherapy	V07.2
Routine infant or child health check	V20.2

Description	ICD-9-CM Codes
Pregnancy focused care	V22.0 - V24.9
Delivery/Birth focused care	V27.0 - V 39.9
Dialysis	V56.0 - V56.9
Therapy (Occupational, Speech, Physical, Rehab)	V57.0 - V57.9
Long-term use of anticoagulants	V58.61
Therapeutic drug monitoring	V58.83*
Administrative	V68.0 - V68.9
Health Survey	V70.5 & V70.6

*Encounters with primary diagnosis="V58.83" (Encounter for therapeutic drug monitoring) are dropped only if "V58.61" (Long-term (current) use of anticoagulants) is also listed as the second diagnosis.

Evaluation and Management (E&M) codes for inclusion as a face-to-face encounter:

99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99281, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99455, 99456

Prevalence Report: High Utilizer and High Utilizer Summary

MTF list of all enrolled patients by PCM with > 10 outpatient visits that meet numerator criteria¹. The Prevalence Report includes information from visits captured in the network meeting the numerator definition². Same exclusions as those listed in numerator.

Prevalence Report Data Elements:

- ➔ Patient's name
- ➔ Sponsor's Social Security Number (Sponsor SSN)
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Encounter Date

- ➔ Clinic
- ➔ Treatment Location
- ➔ System
- ➔ ICD-9 CM Code
- ➔ ICD-9 Description
- ➔ Appointment Type³
- ➔ Source
- ➔ Contact Info
- ➔ Defense Medical Information System (DMIS)

Difference between High Utilizer and High Utilizer Summary Prevalence Reports:

High Utilizer Report displays every encounter for each high utilizer as a separate line on the list. The Summary report displays each patient as a separate line on the list with the ability (+) to expand a sub-table for each patient that displays all the patient's encounters.

Recommended Action

- ➔ Review high utilizers and prioritize analysis, i.e., type of appointments, location of care
- ➔ Consider condition management programs
- ➔ Consider case management or disease management
- ➔ Consider implementing appropriate DOD/VA (or other) clinical practice guidelines⁴

Notes:

¹ The MTF Prevalence Report is centered on patient utilization of "Primary Care Services". MEPRS data is used to identify the type of visit, "Primary Care", not the physical location of the visit. Clinic utilization, if needed, should be conducted separately.

² Due to the record reporting lag time, not all of the previous month's records may be included in this reporting period.

³ Appt Types: Scheduled Appt; Walk-in; Sick Call; N=Network

⁴ DoD/VA guidelines can be located at <https://www.qmo.amedd.army.mil/pguide.htm>

Hypertension Prevalence

Measure Definition:

The proportion of MTF enrollees with hypertension subject to DoD/VA guidelines clinical management.

Benchmark:

N/A

Numerator:

MTF enrollees identified as having hypertension during the 12 months prior to the end of the reporting period (see Data Sources & Codes).

Denominator:

All MTF enrollees at the end of the reporting period.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

Methodology:

- ➔ Use DEERS to identify patients enrolled to MTFs
- ➔ Use SADR (M2) and NETWORK (M2) claims data to identify patients who have had an outpatient or Emergency Department (ED) visit for hypertension
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM)

Data Sources & Codes:

ICD-9-CM Codes

- ➔ 401.x
- ➔ 405.x

DoD SADR (M2) and NETWORK (M2) data to identify patients with at least two outpatient visits on separate encounter dates in the previous 12 months.

Note: Excludes hypertension associated with pregnancy, childbirth, or the puerperium and hypertension involving coronary vessels.

Prevalence Report:

MTF list of all enrolled patients by PCM with at least one outpatient visit for hypertension.¹

Prevalence Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ Number of Visits
- ➔ Contact Information
- ➔ Defense Medical Information System (DMIS)

Recommended Action

- ➔ Review chronic disease burden data to project health needs associated with chronic diseases/conditions
- ➔ Consider utilizing condition management programs
- ➔ Consider implementation of DOD/VA (or other) clinical practice guidelines²

Notes:

¹ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

² DoD/VA guidelines can be located at <https://www.qmo.amedd.army.mil/pguide.htm>

Use of Imaging Studies for Low Back Pain

Measure Definition:

Percentage of adults age 18-50 enrolled in TRICARE Prime/Plus with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Percentage with no Imaging Study for newly diagnosed Low Back Pain	73.7, 77.8, 81.1

Numerator:

Number of continuously enrolled adults in TRICARE Prime/Plus, age 18-50, who did NOT have an imaging study conducted on the first encounter with a principal diagnosis of low back pain or within 28 days following the first diagnosis during the measurement period. Members were required to be continuously enrolled 180 days (6 months) prior to the first diagnosis and 28 days after the first diagnosis with no gaps in enrollment during the measurement period.

Imaging studies include:

- ➔ X-ray
- ➔ Magnetic Resonance Imaging(MRI)
- ➔ X-Ray Computed Tomography(CT Scan)

Denominator:

Number of adults enrolled in TRICARE Prime/Plus, ages 18-50, who were continuously enrolled 180 days (6 months) prior to the first diagnosis of low back pain through 28 days after the first diagnosis during the measurement period and no gaps in enrollment during the continuous enrollment period.

Exclusions

Patients with previous history of cancer or evidence of recent trauma, IV drug abuse, or neurologic impairment in the 12 months prior to the first encounter with a principal diagnosis of low back pain are (see exclusion codes below under “Data Sources & Codes).

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)

- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Standard Ambulatory Data System (SADR) (M2)
- ➔ M2_RAD
- ➔ AHLTA Clinical Data Mart (CDM) Historical Procedures

Methodology:

- ➔ Use DEERS to identify enrolled in TRICARE Prime/Plus, age 18-50
- ➔ Use SADR/NETWORK (M2) data to identify adults with the first encounter with a principal diagnosis of low back pain during the measurement period
- ➔ Use SADR/NETWORK (M2) data to exclude adults with a history of cancer, or a diagnoses of recent trauma, IV drug abuse, or neurologic impairment diagnoses in the 12 months prior to the first encounter with a principal diagnosis of low back pain
- ➔ Use SADR/NETWORK/RAD (M2) data to identify adults who had a documented imaging study conducted on the first encounter with a principal diagnosis of low back or in the 28 days following the first encounter during the measurement period
- ➔ Use CDM Historical Procedures to identify adults who had a documented imaging study conducted on the first diagnosis of low back pain or in the 28 days following the first diagnosis

Data Sources & Codes:

ICD-9-CM (Diagnosis) Codes to Identify Low Back Pain Diagnosis

- ➔ 721.3 ➔ 724.03 ➔ 738.5
- ➔ 722.10 ➔ 724.2 ➔ 739.3
- ➔ 722.32 ➔ 724.3 ➔ 739.4
- ➔ 722.52 ➔ 724.5 ➔ 846,
- ➔ 722.93 ➔ 724.6 ➔ 847.2
- ➔ 724.02 ➔ 724.7

ICD-9-CM (Diagnosis) to exclude members for Low Back Pain Screening

Description	ICD-9-CM Diagnosis
Cancer	140-209, 230-239, V10
Trauma	800-839, 850-854, 860-869, 905-909, 926.11, 926.12, 929, 952, 958-959
IV Drug Abuse	304.0-304.2, 304.4, 305.4-305.7
Neurologic Impairment	344.60, 729.2

HEDIS® Metrics and Report:

Percentage of adults enrolled in TRICARE Prime/Plus, age 18-50, with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Prevalence Report:

List of all adults enrolled in TRICARE Prime/Plus age 18-50, by Primary Care Manager (PCM) or TRICARE Region with the date of the first encounter with a principal diagnosis of low back pain along with the imaging study date, system and source conducted on the first encounter or in the 28 days following the first encounter. The action list is based on current DEERS enrollment, in contrast to the HEDIS® aggregate report which specifies continuous enrollment.

Prevalence Report Data Elements:

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number (SSN)
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM Name
- ➔ Provider Group**
- ➔ PCM ID*
- ➔ PCMID Type*
- ➔ X-ray Date***
- ➔ X-ray System***
- ➔ X-ray Source***
- ➔ MRI Date***
- ➔ MRI System***
- ➔ MRI Source***
- ➔ CT Scan Date***
- ➔ CT Scan System***

- ➔ CT Scan Source***
- ➔ Contact Info**
- ➔ X-ray Count****
- ➔ MRI Count****
- ➔ CT scan Count****
- ➔ Defense Medical Information System (DMIS)
- ➔ TRO
- ➔ Service**

*TRO/MCSC Action lists only

**Direct Care Action Lists only

***Indicates which imaging study was conducted on the first encounter or in the 28 days following the first encounter. Note: one or more studies may have been conducted

****Indicates the number of X-ray, MRI, or CT scans conducted AFTER the imaging study was conducted on the first encounter date or in the 28 days following the first encounter

Notes:

¹ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

Low Back Pain (LBP) (Acute) Prevalence

Back injuries account for nearly 20% of all injuries and illness in the workplace and cost the nation 20 to 50 billion dollars per year. LBP adversely influences fitness for duty and long-term productivity throughout the Military Health System (MHS).

LBP tends to be a self-limiting problem of relatively short duration, the majority of patients can be expected to improve within six weeks of treatment with a combination of activity motivation, oral medication, self-applied thermal therapies, physical therapy, and manual therapy according to symptoms. DOD/VA guidelines address "mandatory" provisions that call for referral of chronic sciatica patients to a surgical specialist if 1) LBP has continued more than six weeks and 2) results of imaging studies are positive.

The intent of this data set is to assist the Military Treatment Facility (MTF) in the epidemiological assessment of acute LBP. This file provides a list of patients in all beneficiary categories who had at least two outpatient visits for LBP during the measurement period. The duty Air Force Specialty Code (AFSC) and Unit are provided for Air Force active duty personnel. The purpose of this information is to assist the MTFs in identifying opportunities to target preventive interventions. The file can also assist in identifying patients with a high volume of outpatient

visits to determine if care is consistent with established guidelines (e.g., DoD/VA guideline for LBP).

Measure Definition:

The proportion of MTF enrollees, 18 years or older, with a minimum of two outpatient visits for LBP/sciatica, in a MTF during the past year.

Benchmark:

N/A

Numerator:

Number of enrolled beneficiaries, 18 years or older, with a minimum of two outpatient visits for LBP/sciatica, in a MTF during the past year.

Denominator:

Number of MTF enrolled beneficiaries, 18 years or older.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- ➔ Air Force Personnel System (AFPERS)

Methodology:

- ➔ Use DEERS to identify beneficiaries at least 18 years old enrolled to MTFs.
- ➔ Use Standard Ambulatory Data Record (SADR) (M2) to identify patients seen for LBP at primary care clinics.
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify the Primary Care Manager.
- ➔ Use Air Force Personnel System (AFPERS) to identify the AFSC and rank of active duty personnel.

Data Sources & Codes:

ICD-9-CM Codes to identify patients with LBP:

- ➔ 724.2 – 724.5
- ➔ 724.8
- ➔ 846.X

➔ 847.2

➔ 847.3

➔ 847.4

Codes for LBP exclude: cauda equina syndrome, progressive neurological deficit, fracture, neoplasm, infection, chronic pain syndrome, persistent pain from previous spinal surgery and extra-spinal condition.

Codes to identify patients seen at primary care clinics:

MEPRS Code	Description
BGA	Family Practice
BHA	Primary Care
BJA	Flight Medicine
BDA	Pediatric
BAA	Internal Medicine
BHI	Intermediate Care
BIA	Emergency Department

Prevalence Report:

MTF list of all enrolled patients, by PCM, with at least two coded outpatient visits for LBP/sciatica.¹

Prevalence Report Data Elements:

- ➔ Patient's name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ DAFSC – Duty Air Force Specialty Code
- ➔ Encounter Date

- ➔ ICD-9 Code
- ➔ Total number of Visits
- ➔ Source
- ➔ Contact Info
- ➔ Defense Medical Information System (DMIS)

Recommended Action

- ➔ Review medical records for patients listed
- ➔ Identify trends within active duty units and consider possible interventions
- ➔ Consider DoD/VA Guidelines for LBP2

Notes:

¹ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

² DoD/VA guidelines can be located at <https://www.qmo.amedd.army.mil/pguide.htm>

Low Back Pain (LBP) (Recurrent) Prevalence

Back injuries account for nearly 20% of all injuries and illness in the workplace and cost the nation 20 to 50 billion dollars per year. LBP adversely influences fitness for duty and long-term productivity throughout the Military Health System (MHS).

LBP tends to be a self-limiting problem of relatively short duration, the majority of patients can be expected to improve within six weeks of treatment with a combination of activity motivation, oral medication, self-applied thermal therapies, physical therapy, and manual therapy according to symptoms. DOD/VA guidelines address "mandatory" provisions that call for referral of chronic sciatica patients to a surgical specialist if 1) LBP has continued more than six weeks and 2) results of imaging studies are positive.

The intent of this data set is to assist the Military Treatment Facility (MTF) in the epidemiological assessment of acute LBP. This file provides a list of patients in all beneficiary categories who had at least two outpatient visits for LBP during the measurement period. The duty Air Force Specialty Code (AFSC) and Unit are provided for Air Force active duty personnel. The purpose of this information is to assist the MTFs in identifying opportunities to target preventive interventions. The file can also assist in identifying patients with a high volume of outpatient visits to determine if care is consistent with established guidelines (e.g., DoD/VA guideline for LBP).

Measure Definition:

The proportion of Military Treatment Facility (MTF) enrollees 18 years or older, identified with acute LBP or sciatica who progress to a chronic condition, as defined by a minimum of two outpatient visits at any MTF greater than 42 days apart in the past year as per the DoD/VA Recommendations for Monitoring Low Back Pain (23 Apr 99).

Benchmark:

N/A

Numerator:

Number of enrolled patients 18 years or older with acute LBP or sciatica who progress to a chronic condition as defined by at least a minimum of 2 outpatient visits at any MTF greater than 42 days apart in the past year.¹

Denominator:

Number of MTF enrolled beneficiaries 18 years or older with acute LBP.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ CHCS Managed Care Platform National Enrollment Database (NED) module ad hoc report

Methodology:

- ➔ Use DEERS to identify beneficiaries at least 18 years old enrolled to MTFs
- ➔ Use Standard Ambulatory Data Record (SADR) (M2) to identify patients seen for LBP at primary care clinics

Data Sources & Codes:

ICD-9-CM Codes to identify patients with LBP:

- ➔ 724.2 – 724.5
- ➔ 724.8
- ➔ 846.X
- ➔ 847.2
- ➔ 847.3
- ➔ 847.4

Codes for LBP exclude: cauda equina syndrome, progressive neurological deficit, fracture, neoplasm, infection, chronic pain syndrome, persistent pain from previous spinal surgery and extra-spinal condition.

Codes to identify patients seen at primary care clinics:

MEPRS Code	Description
BGA	Family Practice
BHA	Primary Care
BJA	Flight Medicine
BDA	Pediatric
BAA	Internal Medicine
BHI	Intermediate Care
BIA	Emergency Department

Prevalence Report:

List of enrolled patients with two or more outpatient visits for LBP, and have at least 2 visits that are a minimum of six weeks apart.²

Prevalence Report Data Elements:

- ➔ Patient's name
- ➔ Sponsor's Social Security Number
- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM
- ➔ Provider Group
- ➔ DAFSC – Duty Air Force Specialty Code
- ➔ Encounter Date
- ➔ ICD-9 Code
- ➔ Source
- ➔ Contact Info

➔ DMIS

Recommended Action

- ➔ Review medical records of patients listed.
- ➔ Determine if treatment is consistent with DoD/VA guidelines.³
- ➔ Determine if patient has had positive imaging studies and requires referral to musculoskeletal specialist.

Notes:

¹ Given the construct of the query, it is difficult to discern whether an individual has chronic LBP or recurrent episodes of injuries and acute LBP.

² Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

³ DoD/VA guidelines can be located at <https://www.qmo.amedd.army.mil/pguide.htm>

Follow-Up After Hospitalization for Mental Illness

This methodology measures the follow-up care for patients 6 years of age and older hospitalized for selected mental health disorders. This measure is strictly an aggregate measure and does not include an Action List.

Measure Definition:

- ➔ Percent of patients enrolled to MTFs who received follow-up within 30 days of discharge.*
- ➔ Percent of patients enrolled to MTFs who received follow-up within 7 days of discharge.*

* Measure is based on discharges. Patient may have more than one discharge in 11 month period. All discharges will be included provided they are not followed by a readmission within 30 days.

Benchmark:

HEDIS[®] 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Follow-up within 30 days of discharge	77.7%, 82.9%, 87.1%
Follow-up within 7 days of discharge	57.1%, 66.1%, 73.3%

Numerator:

Number of patients, currently enrolled to an MTF, age 6 years and older, who were hospitalized for a mental health disorder in the first 11 months of the past 12 month period, and received a follow-up visit within 30 days of discharge. Follow-up includes an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health provider.

Number of patients, currently enrolled to an MTF, age 6 years and older, who were hospitalized for a mental health disorder in the first 11 months of the past 12 month period, and received a follow-up visit within 7 days of discharge. Follow-up includes an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health provider, to include visits and encounters that occur on the date of discharge.

Denominator:

Number of patients currently enrolled to an MTF, age 6 years and older, who were discharged for selected mental health disorders during the first 11 months of the past 12 month period. Patients must have been continuously enrolled for 30 days after discharge. Direct care and network inpatient data are used to identify these patients. Patients may be included in the denominator more than once.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Inpatient Data Record (SIDR) (M2)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)

Methodology:

- ➔ Use DEERS to identify patients enrolled to specific MTFs.
- ➔ Use M2 (SIDR and Network) data to identify patients hospitalized for selected mental health disorders.
- ➔ Use SADR (M2), SIDR (M2) and NETWORK (M2) data to identify mental health follow-up visits.

Numerator Data Sources & Codes:**Codes to identify visits:**

Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health provider.

CPT	HCPCS
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039,

CPT	HCPCS
99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

Follow-up visits identified by the following CPT/POS codes must be with a mental health provider.

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

Denominator Data Sources & Codes:

Codes to identify mental health diagnoses:

➔ ICD-9-CM Mental Health Diagnoses Codes

- 295 – 299
- 300.3
- 300.4
- 301
- 308
- 309
- 311-314

Hospitalizations to exclude:

Type of Hospitalization	Mental Health ICD-9-CM Codes	Notes
Mental Health readmission or direct transfer	290, 293-302, 306-316	If the patient’s discharge is followed by a readmission or direct transfer to an acute facility, for any mental health diagnosis within the 30-day follow-up period, only the admission discharge or the discharge from the transfer facility will be used. Discharges followed by a readmission or direct transfer to a non-acute facility for any mental health principal diagnosis within the 30 day follow-up period will also be excluded. These discharges are excluded because the readmission or transfer may

Type of Hospitalization	Mental Health ICD-9-CM Codes	Notes
		prevent an outpatient follow-up.
Non-mental health readmission or direct transfer		Discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis are excluded. This includes any ICD-9-CM diagnosis code other than a mental health diagnosis. These discharges are excluded from the measure because re-hospitalization or transfer may prevent outpatient follow-up.

Codes to identify Non-acute care

Description	HCPCS	POS
Hospice		34
SNF		31, 32
Intermediate Care facility		54
Residential substance abuse treatment facility		55
Psychiatric residential treatment center	T2048,H0017-H0019	56
Comprehensive inpatient rehabilitation facility		61

Quicklook

The Military Health System Population Health Portal (MHSPHP) Quicklook Sheet was developed to provide users a quick and efficient way to view portal data “by patient”. The Quicklook Sheet is stratified by provider, and lists patients enrolled to those providers alphabetically. The Quicklook Sheet references the clinical preventive service “action lists” and disease management/condition “action lists/prevalence reports” of the MHSPHP. It displays each enrollee’s common clinical preventive service needs and co-morbid conditions on one line. The Quicklook Sheet saves time, because it is not necessary to search each individual “action list” to see if a patient is listed on it.

The MHSPHP now provides nightly updates of various lab results, procedures, radiological exams, and asthma medication dispensing events. See the Quicklook Field Descriptions table below for information on the update frequency of various Quicklook components.

Flu Risk

The following chart describes the hierarchical coding system implemented by the MHSPHP for each flu risk category for seasonal flu within the Quicklook. If an individual falls under

multiple categories (e.g. AD, Asthmatic, Pregnant Female), the MHSPHP will code the higher risk category (e.g. pregnant).

High Risk Flu categories	Code
Pregnant	PRG
*Comorbidity	COM
Asthmatic	AST
Diabetic	DIA
Household Contacts	HOU
Child (6-59 mos)	CHD
Over 50 Yr	>50
AD Designation	AD

*Comorbid conditions include:

- ➔ Tuberculosis
- ➔ HIV
- ➔ Sarcoidosis
- ➔ Malignant Neoplasms
- ➔ Cystic Fibrosis
- ➔ Immune Deficiencies
- ➔ Thalessemia
- ➔ Sickle Cell
- ➔ Hemoglobinopathies
- ➔ Aplastic anemias
- ➔ Leukemias
- ➔ Chronic Rheumatic Heart Disease
- ➔ Other chronic ischemic heart disease Heart Disease
- ➔ Chronic Bronchitis
- ➔ Emphysema
- ➔ COPD
- ➔ Pneumoconioses and other lung disease due to external agents

- ➔ Chronic respiratory disease due to vapors
- ➔ Renal Diseases
- ➔ Other congenital anomalies of the heart
- ➔ Radiotherapy
- ➔ Chemotherapy
- ➔ Multiple Sclerosis
- ➔ Other demyelinating diseases
- ➔ Infantile cerebral palsy
- ➔ Other paralytic syndromes
- ➔ Epilepsy
- ➔ Other degenerative diseases of the basal ganglia
- ➔ Motor neuron disease (includes ALS)
- ➔ Parkinson Disease
- ➔ Muscular Dystrophy

The co-morbid category is not all inclusive as there may be patients with conditions other than those listed that should also be considered high risk for flu. Please follow provider recommendations.

Quicklook Field Descriptions:

Freq	Field	Description
M	Name	Patient Name
M	Sponsor SSN	
M	FMP	Family Member Prefix
M	DOB	
M	Age	Age as of beginning of the measurement month
M	Gender	
M	BenCat	Beneficiary Category
M	PCM Name	
M	Provider Group	
M	Street1	
M	Street2	
M	City	

Freq	Field	Description
M	State	
M	Zip	
M	Country	
M	Home Phone	
M	Work Phone	
M	DMIS	Enrolled DMIS ID
D	Pap	From MHSPHP Cervical Cancer Screening Action List. Patients with a history of total hysterectomy are noted with 'HYSTER'
D	Mammo	From MHSPHP Breast Cancer Screening Action List. Patients with a history of bilateral mastectomy will be noted with 'MASTECT'
D	Colonoscopy	From Colorectal Cancer Screening Action List. Patients with a history of total colectomy are noted with 'TOTCOLEC'
D	FlexSig	Date of last Flexible Sigmoidoscopy
D	FOBT	Date of last Fecal Occult Blood Test
D	CT Colon	Date of last Virtual Colonoscopy
M	Diab	"Yes" if patient is listed on MHSPHP Diabetes Action List
D	A1C Date	Date of last A1C
D	A1C Result	Result of last A1C
D	LDL Date	Date of last LDL
D	LDL Result	Result of last LDL
D	Chol Date	Date of last Cholesterol
D	Chol Result	Result of last Cholesterol
D	HDL Date	Date of last HDL
D	HDL Result	Result of last HDL
D	Chol/HDL	Cholesterol / HDL Ratio (calculated only if drawn on same day)
M	Dyslip	"Yes" if patient is listed on MHSPHP Dyslipidemia Prevalence List
M	HTN	"Yes" if patient is listed on MHSPHP Hypertension Prevalence List
M	Asthma	"Yes" if patient is listed on MHSPHP Asthma Action List
M	Asthma Rx Date	Date of last asthma medication dispensing

Freq	Field	Description
		event
M	Depr	“Yes” if patient is listed on MHSPHP Depression Prevalence List
M	Visits	Numeric count listed for those enrollees with >10 Primary Care visits in the direct/network care system. A null value doesn’t mean an enrollee hasn’t had a primary care visit in the last 12 months. It only means they haven’t exceeded the 10 visit threshold that defines a high utilizer.
M	Flu Risk	See Above
M	Flu Category	See Above

Well-Child Visits in the First 15 Months of Life

This measure monitors the frequency of Well-Child visits during the first 15 months of life. The Prevalence Report includes children currently age 18 months or younger.

Measure Definition:

Percentage of children continuously enrolled to a Military Treatment Facility (MTF) or Network Prime PCM who reached the age of 15 months during the measurement period, and had the following number of Well-Child visits during the first 15 months of life.

Benchmark:

HEDIS® 50th-75th-90th percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2009.

Benchmark	HEDIS Percentiles (50-75-90)
Six or more well-child visits	76.8% - 84.7% - 90.4%

Numerator:

Numerators are calculated to include the number of children continuously enrolled to a MTF who received 6 or more well-child visits during the first 15 months of life. To be included a visit must have been with a Primary Care Provider. Services provided in the Emergency Department or inpatient setting are not included.

Denominator:

Number of children who reached the age of 15 months during the 12 month measurement period and were continuously enrolled from 31 days-15 months of age. A child, whose

coverage lapses for two months (60 days), from age 31 days through 15 months, is not considered continuously enrolled.

Data Sources:

- ➔ Defense Eligibility Enrollment Registration System (DEERS)
- ➔ Standard Ambulatory Data Record (SADR) (M2)
- ➔ Purchased Care Claims Data (NETWORK) (M2)
- ➔ Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module

Methodology:

- ➔ Use DEERS to identify children and DMIS location at age 15 months during the measurement period, who were continuously enrolled to TRICARE Prime/Plus
- ➔ Use SADR (M2) and NETWORK (M2) data to identify children who had outpatient well-child visits with a primary care provider
- ➔ Use CHCS Managed Care Platform NED module ad hoc report to identify Primary Care Manager (PCM)

Data Sources & Codes:

Codes to identify a Well-Child Visit:

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

HEDIS[®] Metrics and Report:

Percentage of enrolled children who had 6 or more well-child visits from birth to 15 months.

Prevalence Report:

The Prevalence Report list includes all children birth to 18 months and places well child encounters in the best date window (2 weeks before column title date until 2 weeks before the next column title date). HEDIS does not have any criteria for when the encounters occur, HEDIS only counts the total number of well child encounters that occurred by the 15th month birthday.

Prevalence Report Data Elements:

(for currently enrolled children birth to 18 months of age)

- ➔ Patient's Name
- ➔ Sponsor's Social Security Number

- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age in Months (to nearest tenth of a month)
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM Name
- ➔ Provider Group
- ➔ First month date*
- ➔ 2 month visit date*
- ➔ 4 month visit date*
- ➔ 6 month visit date*
- ➔ 9 month visit date*
- ➔ 12 month visit date*
- ➔ 15 month visit date*
- ➔ Total Well Child Visits to Date
- ➔ Total Primary Care visits to Date
- ➔ Contact Info
- ➔ Defense Medical Information System (DMIS)
- ➔ Service

*As appropriate for age