

Clinical Specifications for the 2011 UCare Pay for Performance (P4P) Program

About the UCare Pay for Performance (P4P) program:

The UCare P4P program supports and encourages quality improvement by providing financial recognition to primary care providers demonstrating superior or improved performance.

Measures are divided between the Minnesota Health Care Program (MHCP) population and the Medicare Advantage/MSHO/MSHC+ population. Many measures apply to both populations.

P4P is based upon administrative claims data and lab submission data. For the lab submission template and upload directions, please see the Pay for Performance section of the Provider page on the UCare website here: [http://www.ucare.org/providers/Pages/PayforPerformance\(P4P\).aspx](http://www.ucare.org/providers/Pages/PayforPerformance(P4P).aspx)

All measures except blood lead screening require 11-month continuous enrollment and enrollment in December of the measurement year. Some measures require additional continuous enrollment criteria.

For more information on how and where to submit claim attachments to UCare, please download the *Quick Reference Sheet: Claim Submission*, available here: <http://www.ucare.org/providers/Pages/default.aspx>

Due to possible changes to clinical guidelines and recommendations, unforeseen administrative constraints, and possible coding updates, clinical specifications are subject to change.

Child and Teen Checkups (C&TC)	
Population	Members 0-20 years of age as of December 31 of the measurement year. MHCP members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year.
What	Member who had required number of complete C&TCs during the measurement year.
Specifications Source	MDH Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Schedule, CMS 416 Specifications
Methodology	Administrative claims data

Codes used to Identify C&TC	
CPT Codes	ICD-9-CM Codes
99201-99205 99211-99215	V20.2 V70.0 V70.3 V70.5 V70.6 V70.8 V70.9
99381-99385 99391-99395	

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Chlamydia Screening	
Who	Women 16-24 years of age as of December 31 of the measurement year who are sexually active. MHCP members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year.
What	At least one Chlamydia screen during the measurement year.
Specifications Source	HEDIS 2011
Methodology	Administrative claims data

Codes used to identify sexually active women (member must have had at least one encounter during the measurement year with any of the diagnosis or procedure codes below)			
CPT Codes	ICD-9-CM Codes	UB-Revenue Codes	HCPCS
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 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	042 054.10 054.11 054.12 054.19 078.11 078.88 079.4 079.51- 079.53 079.88 079.98 091-097 098.0 098.10 098.11 098.15-098.19 098.2 098.30 098.31 098.35-098.8 099 131 339.82 614 615 622.3 623.4 626.7 628 630-679 795.0 795.1 796.7 996.32 VCodes: 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 Procedure Codes: 69.01 69.02 69.51 69.52 69.7 72-75 88.78 97.24 97.71 97.73	0112 0122 0132 0142 0152 0720- 0722 0724 0729 0923 0925	G0101 G0123 G0124 G0141 G0143-G0145 G0147 G0148 H1000 H1001 H1003-H1005 P3000 P3001 Q0091 S0199 S4981 S8055

Codes to Identify Chlamydia screening
CPT Codes
87110 87270 87320 87490-87492 87810

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Cervical Cancer Screening	
Who	Women 24-64 years of age as of December 31 of the measurement year. MHCP members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year.
What	Women who received one or more Pap tests to screen for cervical cancer during 2008, 2009 or 2010.
Specifications Source	HEDIS 2011
Methodology	Administrative claims data

Codes to Identify Cervical Cancer Screening			
CPT Codes	ICD-9-CM Codes	UB-92 Revenue Codes	HCPCS
88141-88143 88147 88148 88150 88152-88155 88164- 88167 88174 88175	V72.32 V76.2 91.46	0923	G0123 G0124 G0141 G0143-G0145 G0147 G0148 P3000 P3001 Q0091

Codes to Identify Exclusions for Cervical Cancer Screening	
CPT Codes	ICD-9-CM Codes
51925 56308 57540 57545 57550 57555 57556 58548 58150 58152 58200 58210 58240 58260 58262 58263 58267 58270 58275 58280 58285 58290-58294 58550- 58554 58570-58573 58951 58953 58954 58956 59135	618.5 V67.01 V76.47 V88.01 V88.03 68.4-68.8

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Breast Cancer Screening	
Who	Women 52 to 69 years of age as of December 31 of the measurement year. <i>Note: Age range is consistent with MN Community Measures specifications.</i> MHCP, Medicare Advantage, MSHO, and MSC+ members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year and the year prior.
What	One or more mammograms in the measurement year or two years prior.
Specifications Source	MMA, MCHP P4P Alignment Committee and consistent with MN Community Measures specifications.
Methodology	Administrative claims data

Codes to Identify Breast Cancer Screening			
CPT Codes	ICD-9-CM Codes	UB-92 Revenue Codes	HCPCS
76090-76092 77055-77057	V76.11 V76.12 87.36 87.37	0401 0403	G0202 G0204 G0206

Codes to Identify Exclusions for Breast Cancer Screening		
Breast Cancer Screening	CPT Codes	ICD-9 Procedure Codes
Bilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307. each needs a modifier .50 or modifier code 09950	85.42, 85.44, 85.46, 85.48
Unilateral mastectomy (must have 2 separate occurrences and 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.

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Colorectal Cancer Screening	
Who	Members 51-75 years of age as of December 31 of the measurement year who had screening for colorectal cancer. MHCP, Medicare Advantage, MSHO, and MSC+ members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year and the year prior.
What	One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: <ul style="list-style-type: none"> • Fecal occult blood test (FOBT) guaiac or immunochemical during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years prior to the measurement year.
Specifications Source	HEDIS 2011
Methodology	Administrative claims data

Codes to Identify Colorectal Cancer Screening				
Description	CPT Codes	ICD-9-CM Codes	HCPCS	
FOBT	82270 82274	V76.51	G0328 G0394	
Flexible sigmoidoscopy	45330-45335 45337-45342 45345	45.24	G0104	
Colonoscopy	44388-44394 44397 45355 45378-45387 45391 45392	45.22 45.23 45.25 45.42 45.43	G0105 G0121	
Codes to Identify Exclusions for Colorectal Cancer Screening				
Colon Cancer Screening	CPT Codes	ICD-9 Procedure Codes	ICD-9 Diagnosis Codes	HCPCS Codes
Colorectal Cancer			153,154.0, 154.1, 197.5, V10.05	G0213-G0215, G0231
Total Colectomy	44150-44153, 44155- 44158, 44210-44212	45.8		

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Diabetes Care	
Who	Members 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 or 2) as identified through pharmacy and claims data. MHCP, Medicare Advantage, MSHO, and MSC+ members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year.
What	<p>Payment is based upon claims data for the following diabetic measure:</p> <ul style="list-style-type: none"> • Eye exam (retinal) performed. <p>Payment is based upon lab submissions for the following diabetic measures. Clinics/systems are asked to submit the following five measures for diabetic members. If the member is “In control” (LDL-C<100 mg/dL, HbA1c <8%, and BP<140/90 mm Hg) with smoking cessation and aspirin therapy discussion documented, the system/clinic will receive the “In control” payment. If the clinic/system submits the following five measures but one or more values are not in the specified range, the clinic/system will receive the “Submission of results” payment. In other words, the clinic/system is only eligible for one payment, either “In control” or “Submission of results.” The measures are:</p> <ul style="list-style-type: none"> • LDL Cholesterol Test (<100mg/dL to be “In control”) • HbA1c (<8% to be “In control”) • Blood Pressure (<140/90 mm Hg to be “In control”) • Documentation of current non-tobacco user status • Documentation of daily aspirin or accepted contraindication (for members with co-morbidity of Ischemic Vascular Disease (see p.7) <p>Based upon lab submissions but measured separately from the measures above:</p> <ul style="list-style-type: none"> • Reduction in Percentage of HbA1c in Poor Control (HbA1c level >9% is “poor control”) • To receive payment for this measure, the clinic/system must have submitted lab data for the member for P4P in the previous year. If the HbA1c value for the member in the previous year was >9% and the value is ≤9% in the current measurement year, the clinic/system will receive payment for that member.
Specifications Source	MNCM Optimal Diabetes Care & HEDIS 2011
Methodology	Administrative claims data used to identify eye exams. Direct data submission from clinics and/or care systems used for LDL-C, HbA1c, blood pressure, aspirin therapy discussion, and smoking cessation discussion measures.

Prescriptions to Identify Members with Diabetes	
Description	Prescription
Alpha-glucosidase inhibitors	acarbose miglitol
Amylin analogs	pramlinitide
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 pork insulin isophane-insulin regular

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	insulin lispro insulin lispro-insulin lispro protamine insulin regular beef-pork insulin regular human insulin regular pork insulin zinc beef-pork insulin zinc extended human insulin zinc human insulin zinc pork
Meglitinides	nateglinide repaglinide
Miscellaneous antidiabetic agents	exenatide sitagliptin
Sulfonylureas	acentohexamide chlorpropamide glimepiride glipizide glyburide tolazamide tolbutamide
Thiazolidinediones	pioglitazone rosiglitazone

Codes to Identify Diabetics Using Claims/Encounter Data

Description	ICD-9-CM Codes
Diabetes	250 357.2 362.0 366.41 648.0

Codes to Identify Visit Type for Diabetics

Description	CPT Codes	UB-92 Revenue 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	051x 0520-0523 0526-0529 057x-059x 082x-085x 088x 0982 0983
Nonacute inpatient	99304-99310 99315 99316 99318 99324- 99328 99334-99337	0118 0128 0138 0148 0158 019x 0524 0525 055x 066x
Acute inpatient	99221-99223 99231-99233 99238 99239 99251-99255 99291	010x 0110-0114 0119 0120-0124 0129 0130-0134 0139 0140-0144 0149 0150- 0154 0159 016x 020x 021x 072x 080x 0987
ED	99281-99285	045x 0981

Codes to Identify Co-Morbidity of Ischemic Vascular Disease

ICD-9 Codes
410-410.92 411-411.89 412 413-413.9 414.0- 414.07 414.2 414.3 414.8 414.9 429.2 433-433.91 434-434.91 440.1 440.2-440.29 440.4 444-444.9 445-445.8

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Codes to Identify Eye Exams for Diabetics			
CPT Codes	CPT Category II Codes	ICD-9-CM Codes	HCPCS
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	2022F 2024F 2026F 3072F***	V72.0 14.1-14.5 14.9 95.02-95.04 95.11 95.12 95.16	S0620 S0621 S0625** S3000

* Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.

** The organization does not need to limit CPT Category II codes or HCPCS S0625 to an optometrist or an ophthalmologist. These codes indicate an eye exam was performed by an eye care professional.

***CPT Category II code 3072F can only be used if the claim/encounter was during the measurement year because it indicates the member had “no evidence of retinopathy in the prior year.” Additionally, because the code definition itself indicates results were negative, an automated result is not required.

Diabetes Lab Submission Specifications		
Lab (must be most recent result of each)	Numerator Compliant	Not Numerator Compliant
LDL-C level “In control”	LDL-C < 100 mg/dL	LDL-C ≥ 100 mg/dL
HbA1c level “In control”	HbA1c < 8%	HbA1c ≥ 8%
HbA1c level in “Poor control” (for the reduction in HbA1c level in poor control measure—if the reading is “numerator compliant,” the patient is “out of control.”)	HbA1c > 9%	HbA1c ≤ 9%
Systolic and Diastolic BP levels	BP < 140/90 mm Hg	BP ≥ 140/90 mm Hg
Current non-tobacco user	Must be documented	
Daily Aspirin/Contraindication for members with IVD co-morbidity	Must be documented	

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Cardiovascular Disease (CVD) Care	
Who	Members 18-75 years of age as of December 31 of the measurement year who were discharged from the hospital between January 1-November 1 of the year prior to the measurement year for AMI, CABG, PCI, or had a diagnosis of IVD during the measurement year or the year prior. Medicare Advantage, MSHO, and MSC+ members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year and the year prior.
What	Payment is based upon lab submissions for the following CVD measures. To receive payment, the clinic or care system must submit all four lab values/measures, and they must be "In control" for LDL-C and BP and have aspirin therapy and smoking cessation discussion documented. There is no payment for incomplete submission or if any of the values are out of control. <ul style="list-style-type: none"> • LDL Cholesterol Test (<100mg/dL to be "In control") • Blood Pressure (<140/90 mm Hg to be "In control") • Documentation of current non-tobacco user status • Documentation of daily aspirin or accepted contraindication
Specifications Source	MNCM Optimal Vascular Care & HEDIS 2011
Methodology	Administrative claims data used to identify eligible members. Direct data submission from clinics and/or care systems used for measures.

Codes to Identify AMI, PTCA, and CABG			
Descriptions	CPT Codes	HCPCS	ICD-9-CM Codes
AMI (inpatient only)			410.x1
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

Codes to Identify IVD	
Description	ICD-9-CM Codes
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	UB-92 Revenue 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	051x 0520-0523 0526-0529 057x-059x 0982 0983
Acute Inpatient	99221-99223 99231-99233 99238 99239 99251- 99255 99291	010x 0110-0114 0119 0120-0124 0129 0130- 0134 0139 0140-0144 0149 0150-0154 0159 016x 020x 021x 072x 0987

CVD Lab Submission Specifications		
Lab (must be most recent result of both)	Numerator Compliant	Not Numerator Compliant
LDL-C level "In control"	LDL-C <100 mg/dL	LDL-C ≥100 mg/dL
Systolic and Diastolic BP levels	BP < 140/90 mm Hg	BP ≥ 140/90 mm Hg
Current non-tobacco user	Must be documented	
Daily Aspirin/Contraindication	Must be documented	

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Controlling High Blood Pressure (CBP)	
Who	Members 18-85 years of age as of December 31 of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year. Medicare Advantage, MSHO, and MSC+ members
Continuous Enrollment	Eleven-month continuous enrollment and enrolled in December of the measurement year and the year prior.
What	Payment is based upon lab submission. To receive payment, the clinic or care system must submit the most recent blood pressure reading for the member, which must occur after the date on which the diagnosis of hypertension was made or confirmed, and the member must be "In control." <ul style="list-style-type: none"> • Blood Pressure (<140/90 mm Hg to be "In control")
Specifications Source	HEDIS 2011
Methodology	Administrative claims data used to identify eligible members. Direct data submission from clinics and/or care systems used for measures.

Codes to Identify Hypertension	
Description	ICD-9-CM Codes
Hypertension	401

Codes to Identify Outpatient Visits	
Description	CPT
Outpatient visits	99201-99205 99211-99215 99241-99245 99384-99387 99394-99397

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Blood Lead Screen Testing	
Who	Children ages 9-30 months during the measurement year. MHCP members
Continuous Enrollment	None
What	Children who received one or more capillary or venous blood lead tests during the measurement year while age 9 - 30 months.
Specifications Source	UCare and MN DHS Contract Specifications, MDH recommendations
Methodology	Administrative data, including UCare claim data and MDH Lead Registry Data.
Requirement for Payment	Payment is contingent upon UCare achieving the 2010 DHS lead withhold goal.

Codes to Identify Blood Lead Screenings
CPT Code[†]
83655

[†]The appropriate CPT code is 83655 without a UC modifier, and includes claims when UCare is the secondary payee or if the lead test was sent to an outside laboratory for processing. If the blood test was sent to an outside laboratory, it is important to identify this circumstance by appending a modifier –90 with \$0.00 in order to accurately reflect that a blood lead test was performed.