

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset as of August 28, 2014

| |
|--|
| COST-1: Cost of Ambulatory Surgery PMPM |
|--|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure
Specifications based on: Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: N/A

DESCRIPTION: The cost of ambulatory surgeries PMPM (total cost / member months)

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of outpatient ambulatory surgeries during the quarter

EXCLUSIONS: If a claim is billed with an ED revenue code, all services billed on that claim (such as x-ray, lab, supplies, surgical codes, etc.) are included in the ED category for cost measurement. If a claim is billed with an Ambulatory Surgery revenue code (and no ED code), however, all services billed on that claim (such as x-ray, lab, supplies, etc.) are included in the Ambulatory Surgery category for cost measurement.

MEASURE DETAILS:

CPT Codes:

- between 10021 and 36410
- between 36420 and 55920
- between 56405 and 58301
- between 58340 and 58960
- between 59100 and 62365

between 63001 and 69020
between 69100 and 69990
between 92920 and 92944
between 92973 and 92974
between 93451 and 93462
between 93501 and 93533
between 93580 and 93581
between 99141 and 99150
between G0104 and G0105
between G0168 and G0173
between G0289 and G0291
between G0297 and G0305
between G0338 and G0343
between G0392 and G0393
between G0413 and G0419
between G0440 and G0441
between S2053 and S2118
between S2135 and S2152
between S2205 and S2900
59899, G0127, G0251, G0259, G0267, G0269, G0364, G0455, M0301, S0199, S0400, S0601,
S9034

Revenue Codes:

between 360 and 369
481
between 490 and 499
between 750 and 759
between 790 and 799

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|---|
| COST-2: Cost of Prescriptions PMPM |
|---|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure Specifications.

URL of Specifications: N/A

DESCRIPTION: The total cost of all prescriptions drugs per member per month and a separate subtotal calculating the cost of all generic prescriptions drugs per member per month

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: 1. Total allowed cost of all prescriptions (in any setting)
2. Total allowed cost of all generic prescriptions (in any setting)

EXCLUSIONS: N/A

MEASURE DETAILS: N/A

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|---|
| COST 3: Cost of Avoidable ED Visits PMPM (NYU algorithm) |
|---|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: Version 21 of the NYU ED Algorithm. Code Sets source: Milliman HCG Grouper, 2013 version 3

URL of Specifications: <http://wagner.nyu.edu/faculty/billings/nyued-download>

DESCRIPTION: With support from the Commonwealth Fund, the Robert Wood Johnson Foundation, and the United Hospital Fund of New York, the NYU Center for Health and Public Service Research has developed an algorithm to help classify ED utilization. The algorithm was developed with the advice of a panel of ED and primary care physicians, and it is based on an examination of a sample of almost 6,000 full ED records. Data abstracted from these records included the initial complaint, presenting symptoms, vital signs, medical history, age, gender, diagnoses, procedures performed, and resources used in the ED.

The NYU Center for Health and Public Service Research has developed software for applying the algorithm using three different software applications: SAS, SPSS, and ACCESS. Detailed instructions on how to use the algorithm are included in Download section of its website. All three applications produce an output data set that adds a new set of variables to your original data set.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed costs per ED category:

- Non-Emergent

- Emergent, Primary Care Treatable
- Emergent, ED Care Needed, Preventable/Avoidable
- Emergent, ED Care Needed, Not Preventable/Avoidable
- Injury
- Mental Health, Alcohol and Substance Abuse
- Unclassifiable
- Total Cost

EXCLUSIONS: N/A

MEASURE DETAILS:

Each case is classified into one of the following categories:

- Non-emergent - The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours;
- Emergent/Primary Care Treatable - Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CT scan or certain lab tests);
- Emergent - ED Care Needed - Preventable/Avoidable - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.), and
- Emergent - ED Care Needed - Not Preventable/Avoidable - Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).
- Injury
- Mental Health, Alcohol and Substance Abuse
- Unclassifiable

CPT Codes:

between 99281 and 99288
 between G0378 and G0384
 G0244

Revenue Codes:

between 450 and 459

See the NYU Center for Health and Public Service Research website for more information: <http://wagner.nyu.edu/faculty/billings/nyued-background>

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|--|
| COST-4: Cost of Ambulatory Care PMPM (ED rate only) |
|--|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure
Specifications based on: HEDIS® 2015 Technical Specifications for Health Plans (Volume 2), Report ED visit rate only. Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: n/a

DESCRIPTION: This measure summarizes utilization of ambulatory care in the following categories: ED Visits. Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of ED visits

EXCLUSIONS: The measure does not include mental health or chemical dependency services. Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency (AMB Exclusions Value Set).

MEASURE DETAILS:

CPT Codes:

between 99281 and 99288

between G0378 and G0384

G0244

Revenue Codes:

between 450 and 459

Place of Service Code:

23 - Emergency Room - hospital

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|---|
| COST-5: Cost of ED Use for Ambulatory Care-Sensitive Conditions PMPM |
|---|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure
Specifications based on ahrq.gov Archive Appendix B and Code Sets Source: Milliman
HCG Grouper 2013 version 3

URL of Specifications: <http://archive.ahrq.gov/data/safetynet/billappb.htm>

DESCRIPTION: The cost of ED visits for Ambulatory Care-Sensitive Conditions compared to all ED visits. Ambulatory Care Sensitive conditions such as asthma, diabetes or dehydration are hospitalization conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or conditions, controlling an acute episode of an illness or managing a chronic disease or condition.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of Ambulatory Care-Sensitive Condition ED visits

EXCLUSIONS: Please see table below for details.

MEASURE DETAILS:

CPT Codes:

between 99281 and 99288
between G0378 and G0384
G0244

Revenue Codes:

between 450 and 459

Place of Service Code:

23 - Emergency Room – hospital

The table below is taken from the AHRQ website and lays out the Ambulatory Care-Sensitive Conditions that were identified in the Billings algorithm and used in the following paper: “Using Administrative Data to Monitor Access, Identify Disparities, and Assess Performance of the Safety Net” in Billings J, Weinick R. Eds A Tool Kit for Monitoring the Local Safety Net. Agency for Health Care Research and Quality. July 2003. This algorithm is available in SAS, SPSS and MS Access formats.

Ambulatory Care-Sensitive Conditions

<http://archive.ahrq.gov/data/safetynet/billappb.htm>

Appendix B. Ambulatory Care-Sensitive Conditions

List of ACS Condition and ICD-9-CM Code(s)

Where only three digits are listed, all diagnoses at the 4th and 5th digit should be included (e.g., asthma is listed as 493, but you should include 493.00, 493.01, 493.1, 493.10, 493.11, etc.). Where only four digits are listed, all diagnoses at the 5th digit should also be included.

All diagnoses refer to principal diagnosis, unless otherwise specified (e.g., dehydration, iron deficiency, nutritional deficiency, etc.). Where exclusions of surgical patients are specified (e.g., hypertension), search all procedure fields for excluded procedures.

| List of ACS Condition and ICD-9-CM Code(s) | | |
|--|--|--|
| ACS Number | Ambulatory Care Sensitive conditions and ICD-9_CM Code(s) | Comments |
| 1 | Congenital syphilis [090] | Secondary diagnosis for newborns only |
| 2 | Immunization-related and preventable conditions [033, 037, 045, 320.0, 390, 391] | Hemophilus meningitis [320.2] age 1-5 only |
| 3 | Grand mal status and other epileptic | |

| List of ACS Condition and ICD-9-CM Code(s) | | |
|--|---|---|
| ACS Number | Ambulatory Care Sensitive conditions and ICD-9_CM Code(s) | Comments |
| | convulsions [345] | |
| 4 | Convulsions "A" [780.3] | Age 0-5 |
| 5 | Convulsions "B" [780.3] | Age >5 |
| 6 | Severe ear, nose, and throat infections [382, 462, 463, 465, 472.1] | Exclude otitis media cases [382] with myringotomy with insertion of tube [20.01] |
| 7 | Pulmonary tuberculosis [011] | |
| 8 | Other tuberculosis [012-018] | |
| 9 | Chronic obstructive pulmonary disease [491, 492, 494, 496, 466.0] | Acute bronchitis [466.0] only with secondary diagnosis of 491, 492, 494, 496 |
| 10 | Bacterial pneumonia [481, 482.2, 482.3, 482.9, 483, 485, 486] | Exclude case with secondary diagnosis of sickle cell [282.6] and patients <2 months |
| 11 | Asthma [493] | |
| 12 | Congestive heart failure [428, 402.01, 402.11, 402.91, 518.4] | Exclude cases with the following surgical procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7 |
| 13 | Hypertension [401.0, 401.9, 402.00, 402.10, 402.90] | Exclude cases with the following procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7 |
| 14 | Angina [411.1, 411.8, 413] | Exclude cases with a surgical procedure [01-86.99] |
| 15 | Cellulitis [681, 682, 683, 686] | Exclude cases with a surgical procedure [01-86.99], except incision of skin and subcutaneous tissue [86.0] where it is the only listed surgical procedure |
| 16 | Skin grafts with cellulitis [DRG 263, DRG 264] | Exclude admissions from skilled nursing facility/intermediate care facility |
| 17 | Diabetes "A" [250.1, 250.2, 250.3] | |

| List of ACS Condition and ICD-9-CM Code(s) | | |
|--|---|--|
| ACS Number | Ambulatory Care Sensitive conditions and ICD-9_CM Code(s) | Comments |
| 18 | Diabetes "B" [250.8, 250.9] | |
| 19 | Diabetes "C" [250.0] | |
| 20 | Hypoglycemia [251.2] | |
| 21 | Gastroenteritis [558.9] | |
| 22 | Kidney/ urinary infection [590, 599.0, 599.9] | |
| 23 | Dehydration - volume depletion [276.5] | Examine principal and secondary diagnoses separately |
| 24 | Iron deficiency anemia [280.1, 280.8, 280.9] | Age 0-5 only, and examine principal and secondary diagnoses separately |
| 25 | Failure to thrive [783.4] | Age <1 only |
| 26 | Pelvic inflammatory disease [614] | Women only denominator - exclude cases with a surgical procedure of hysterectomy [68.3-68.8] |
| 27 | Dental Conditions [521, 522, 523, 525, 528] | |

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|--|
| COST-6: Cost of Imaging Procedures PMPM |
|--|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure
Specifications based on Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: n/a

DESCRIPTION: Two rates, the cost of all imaging procedures and the cost of high tech imaging procedures (cost of imaging procedures / member months).

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: 1. Total allowed cost of all imaging procedures
2. Total allowed cost of high tech imaging procedures

EXCLUSIONS: N/A

MEASURE DETAILS:

CPT Codes:

Outpatient Radiology - High-end Imaging:

CT

0066T

between 70450 and 70498

between 71250 and 71275

between 72125 and 72133

between 72191 and 72194

72292

between 73200 and 73206

between 73700 and 73706

between 74150 and 74178

between 74261 and 74263

between 75571 and 75574

75635

between 76070 and 76071

between 76355 and 76370

76380

73497

between 77011 and 77014

between 77078 and 77079

G0288

between S8092 and S8093

MRI

70336

between 70540 and 70559

between 71550 and 71555

between 72141 and 72159

between 72195 and 72198

between 73218 and 73225

between 73718 and 73725

between 74181 and 74185

between 75552 and 75565

between 76093 and 76094

between 76390 and 76400

76498

between 77021 and 77022

between 77058 and 77059

77084

between S8035 and S8037

S8042

PET

78459

between 78491 and 78492

between 78608 and 78609

between 78810 and 78816

between G0030 and G0047

G0125

between G0210 and G0235

between G0252 and G0254

G0296

between G0330 and G0331

G0336

S8085

CPT Codes (cont'd):

Outpatient Radiology - Non-high-end Imaging:

Complete (4 views): 70260

Ortho: 70350, 70355

Duodenography: 74260

Cholecystography: 74290, 74291

Urography: 74400, 74410, 74415, 74710, 76506

Echography: 76536, 76604, 76645, 76700, 76705, 76770, 76775, 76800, 76805,
76810, 76815, 76816, 76830, 76856, 76857, 76870, 76873, 76885, 76886

Ultrasound: 76776, 76801, 76802, 76811, 76812 - 76814, 76817, 76970, 76975, 76872, 76881, 76882

Radiologic Examination: 77074 - 77077, 70030, 70100, 70110, 70120, 70130, 70134, 70140, 70150,
70160, 70170, 70190, 70200, 70210, 70220, 70240, 70250, 70300, 70310, 70320, 70328, 70330, 70332,
70360, 70370, 70380, 70390, 71010, 71015, 71020 - 71023, 71030, 71034, 71035, 71100, 71101, 71110,
71111, 71120, 71130, 72010, 72020, 72040, 72050, 72052, 72069, 72070, 72072, 72074, 72080, 72090,
72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220, 73000, 73010, 73020, 73030, 73040,
73050, 73060, 73070, 73080, 73085, 73090, 73092, 73100, 73110, 73115, 73120, 73130, 73140, 73500,
73510, 73520, 73525, 73530, 73540, 73550, 73560, 73562, 73564, 73565, 73580, 73590, 73592, 73600,
73610, 73615, 73620, 73630, 73650, 73660, 74000, 74010, 74020, 74022, 74190, 74210, 74220, 74240,
74241, 74245 - 74247, 74249 - 74251, 74270, 74280, 76010, 76080, 76098

Mammography: 77055 - 77057

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|--|
| COST-7: Cost of Inpatient Admissions - General Hospital/Acute Care PMPM |
|--|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The cost of General Hospital/Acute Care inpatient discharges (cost of discharges/ member months).

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of inpatient discharges during the measurement period

EXCLUSIONS: Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set), a principal diagnosis of live-born infant (Deliveries Infant Record Value Set) or an MS-DRG for mental health, chemical dependency or rehabilitation (IPU Exclusions MS-DRG Value Set).

MEASURE DETAILS: N/A

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|---|
| COST-8: Cost of primary care visits PMPM |
|---|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure Specifications

URL of Specifications: n/a

DESCRIPTION: The cost of primary care visits PMPM (unique visits/ member months)

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of visits with primary care providers

EXCLUSIONS: N/A

MEASURE DETAILS:

CPT Codes:

- between 99201 and 99205
- between 99211 and 99215
- between 99241 and 99245
- between 99304 and 99310
- between 99315 and 99316
- 99318
- between 99324 and 99328
- between 99334 and 99337

between 99339 and 99345
between 99347 and 99350
between 99354 and 99355
between 99358 and 99359
between 99381 and 99387
between 99391 and 99397
between 99401 and 99404
between 99406 and 99409
between 99411 and 99412
99420
99429
between 99460 and 99465
G0402
G0404
G0438
G0439

Revenue Codes:

521
522
523
524
525

Place of Service Codes:

11 - Office
50 - Federally Qualified Health Center
72 - Rural Health Clinic

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|--|
| COST-9: Skilled Nursing Facility (SNF) Costs PMPM |
|--|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The cost skilled nursing facilities stays PMPM (cost / member months).

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of skilled nursing facility stays

EXCLUSIONS: N/A

MEASURE DETAILS:

Place of Service Codes:

- 31 - Skilled Nursing Facility
- Medicare or Medicaid Claim Type Code = 20 or 30

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|---|
| COST-10: Cost of Specialty Visits PMPM |
|---|

Programs Requiring Use of the Measure for 2014:

Commercial: Medicaid: Medicare:

Measure Type:

Claims: Clinical data: Survey: Other (specify):

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: State Level:

Name and date of specifications used: OneCare Vermont Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The cost of specialty visits PMPM (unique specialty visits/ member months). Include all providers not included in PCP provider type.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of specialty provider visits

EXCLUSIONS: N/A

MEASURE DETAILS:

CPT Codes:

- between 99201 and 99205
- between 99211 and 99215
- between 99241 and 99245
- between 99304 and 99310
- between 99315 and 99316
- 99318
- between 99324 and 99328

between 99334 and 99337
between 99339 and 99345
between 99347 and 99350
between 99354 and 99355
between 99358 and 99359
between 99381 and 99387
between 99391 and 99397
between 99401 and 99404
between 99406 and 99409
between 99411 and 99412
99420
99429
between 99460 and 99465
G0402
G0404
G0438
G0439

Revenue Codes:

521
522
523
524
525

Place of Service Codes:

11 - Office
50 - Federally Qualified Health Center
72 - Rural Health Clinic

MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Cost Measure Subset

| |
|--|
| COST-11: Cost of Dental Visits PMPM |
|--|

Programs Requiring Use of the Measure for 2014:

Commercial: _____ Medicaid: Medicare: _____

Measure Type:

Claims: Clinical data: _____ Survey: _____ Other (specify): _____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: _____ Evaluation:

Level of Measurement for 2014:

ACO Level: Plan Level: _____ State Level: _____

Name and date of specifications used: N/A

URL of Specifications: N/A

DESCRIPTION: The cost of dental visits PMPM (cost of dental visits/ member months).

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Cumulative member months as of the last day of the quarter

NUMERATOR: Total allowed cost of dental visits

EXCLUSIONS: N/A

MEASURE DETAILS:

CPT Codes:

70300
70310
70320
70350
70355

HCPCS Codes:

Between D0120 and D9999