

Appropriate Treatment for Children with Upper Respiratory Infections

Question 1: *What is the clinical importance of the measure?*

The common cold (or URI) is a frequent reason for children visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Pediatric clinical practice guidelines do not recommend antibiotics for a majority of upper respiratory tract infections because of the viral etiology of these infections, including the common cold. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.

Question 2: *What is the intent of the measure as part of the larger measure set?*

Through the development of the Medicaid Quality Strategy, the Office of Medical Assistance (OMA) designated upper respiratory infections as a clinical focus area. All claims data were reviewed to identify the most costly and prevalent conditions for children and adults. Concerns with URIs for children include both treatment and appropriateness of care setting. OMA is focusing quality improvement efforts on inappropriate antibiotic prescribing and inappropriate use of the emergency department. As Health Homes take on the responsibility of whole-person care management and care coordination, it is expected that all quality improvement efforts align with Medicaid's Quality Strategy. The inclusion of the URI measure and the emergency department measure in the measurement set for Health Homes will assure quality improvement efforts are aligned with Medicaid's Quality Strategy.

Medication Reconciliation Post-Discharge

Question 3: *What constitutes medication reconciliation for purposes of this measure?*

After discharge from the hospital, a patient may continue taking some medications at home, but not perhaps all of them. Therefore, it is extremely important to compare the discharge medication orders with the nursing medication administration record (MAR) to check for any discrepancies. If a medication the patient has been receiving in the hospital is not in the discharge orders, and there is no adequate documentation indicating why that medication has been omitted, then a nurse or pharmacist should contact the patient's physician to verify whether or not the patient should discontinue use of the medication.

- ◆ Create a standardized form that lists all the medications the patient has been receiving in the hospital, and include space on the form for physicians to document the reasons for omitting certain medications upon discharge from the hospital. Physicians can also use this form for ordering medications.

- ◆ Attach the pre-admission medication list to the discharge orders form — the patient may need to discontinue some medications that were being taken at home.
- ◆ Provide the patient with a comprehensive list of all medications — those being taken before admission plus the new medications from the discharge orders. Clearly indicate the name of each drug, its purpose, and the instructions.

Adolescent Well-Care Visits

Question 4: Can you provide clarification on the clinical rationale for the age band including members up to age 21 rather than 18?

The rationale is supported by the American Medical Association (AMA) Guidelines for Adolescent Preventive Services (GAPS) recommendation that all adolescents receive annual preventive services visits between the ages of 12 and 21 that address both the biomedical and psychosocial aspects of health.¹

Follow-up After Hospitalization for Mental Illness

Question 5: Please provide an updated list of codes due to the MITS change that occurred on January 1, 2013.

Updates have been made to the following table to reflect changes made to the CPT codes used to identify follow-up visits. CPT codes 90801 and 90862 were changed to 90792 and 90863, respectively, beginning January 1, 2013. Therefore, the table has been updated to reflect which codes will be used based on the discharge date. This list of CPT codes may be updated further after further review of CPT code changes. Code changes are highlighted in the table below. The methods will be updated to reflect these changes.

CPT Codes		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner (Table FUH-F).		
90801*, 90792**, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862*, 90863**, 90870, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53
*This code is to be used on all discharges prior to January 1, 2013.		
** This code is to be used on all discharges on or after January 1, 2013.		

¹ American Medical Association Web site. *Guidelines for Adolescent Preventive Services (GAPS)*. Available at: <http://www.ama-assn.org/resources/doc/ad-hlth/gapsmono.pdf>. Accessed on: March 7, 2013.

Question 6: Who can provide the follow-up visit?

A mental health provider is defined as a practitioner who provides mental health services and meets any of the following criteria:²

- ◆ An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- ◆ An individual who is licensed as a psychologist in his/her state of practice.
- ◆ An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- ◆ A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- ◆ An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is license. or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- ◆ An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

The Ohio Counselor, Social Worker, and Marriage and Family Therapist Board clarified that if the intent of the post-discharge follow-up relates to diagnosing and/or treating mental and emotional disorders, that person would have to be licensed as a professional counselor, professional clinical counselor, social worker, independent social worker, marriage and family therapist or independent marriage and family therapist. Given this clarification, non-licensed individuals would not be recognized as providers that meet the intent of the measure.

² National Committee for Quality Assurance. *HEDIS® 2013 Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2012.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Question 7: *What is considered counseling and who can conduct the counseling?*

Counseling for nutrition is identified by any one of the following:

- ◆ Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- ◆ Checklist indicating nutrition was addressed.
- ◆ Counseling or referral for nutrition education.
- ◆ Member received educational materials on nutrition.
- ◆ Anticipatory guidance for nutrition.

Counseling for physical activity is identified by any one of the following:

- ◆ Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- ◆ Checklist indicating physical activity was addressed.
- ◆ Counseling or referral for physical activity.
- ◆ Member received educational materials on physical activity.
- ◆ Anticipatory guidance for physical activity.

Counseling can be conducted by a PCP or OB/GYN, or by a non-physician provider including registered dietitians, nutrition professionals, RNs, nurse practitioners, and physician assistants. The specifications indicate that the member must have an outpatient visit with a PCP or OB/GYN to be included in the denominator. To be included in the numerator, members must have documentation of weight assessment and counseling for nutrition and physical activity.

Annual Dental Visits

Question 8: *Will an adult rate be made available for this measure as well?*

OMA recognizes that adults with special needs or mental health disorders are much more susceptible to adverse dental events and poor dental care than the overall population as their limitations may adversely impact the ability to perform routine self-care. In addition, many of the medications prescribed to members of these populations tend to have adverse side effects on oral hygiene.

While there currently are no established measures that assess the occurrence of an annual dental visit for adults at the national level; OMA is altering the eligible population of the Annual Dental Visits measure to include adults 22 years of age and older.

A separate rate will be calculated for adults and children/adolescents.