# URI algorithm summary (1/2)

| **Triggers** | An episode is triggered by a claim for office, clinic or ED visits with a primary diagnosis of an Acute Ambulatory URI that do not fall within the time window of a previous URI. For specific ICD-9-CM codes and CPT procedure codes, please see dataset. |
| **PAP assignment** | The Principal Accountable Provider (PAP) for an episode is the first Arkansas Medicaid enrolled and qualified provider to diagnose a beneficiary with an Acute Ambulatory URI during an in-person visit within the time window for the episode. |
| **Exclusions** | Episodes meeting one or more of the following criteria will be excluded:  
A. Children younger than 1 year of age  
B. Beneficiaries with inpatient stays or hospital monitoring during the episode duration  
C. Beneficiaries with surgical procedures related to the URI (tonsillectomy, adenoidectomy).  
D. Beneficiaries with the following comorbidities diagnosed at least twice in the one year period before the episode end date: 1) asthma; 2) cancer; 3) chronic URI; 4) end-stage renal disease; 5) HIV and other immuno-compromised conditions; 6) post-procedural state for transplants, pulmonary disorders, rare genetic diseases, and sickle cell anemia  
E. Beneficiaries with the following comorbid diagnoses during the episode: 1) croup, 2) epiglottitis, 3) URI with obstruction, 4) pneumonia, 5) influenza, 6) otitis media  
F. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode |
| **Episode time window** | Episodes begin on the day of the triggering visit and conclude after 21 days. Comorbidities are assessed starting 365 days prior to first triggering visit through the end of the episode |
| **Claims included** | All services relating to the treatment of a URI within the duration of the episode are included. The following services are excluded:  
1. Surgical procedures  
2. Transport  
3. Immunizations commonly administered for preventative care  
4. Non-prescription medications |
| **Quality measures** |  
**Quality measures “to pass”:**  
1. Frequency of strep testing for beneficiaries who receive antibiotics (for Acute Pharyngitis episode only) – must meet minimum threshold of 47%  
**Quality measures “to track”:**  
1. Frequency of antibiotic usage  
2. Frequency of multiple courses of antibiotics during one episode  
3. Average number of visits per episode |
| **Adjustments** | The reimbursement for the initial visit that is attributable to the PAP is normalized across different places of service (e.g., “Level 2” visits will count equally toward average reimbursement regardless of place of service). Reimbursements for the facility claim associated with the initial visit are not counted in the total reimbursements attributed to a PAP for calculation of performance. Reimbursement attributed to the calculation of a PAP’s performance was adjusted by age stratification. |
| Trigger codes | The following CPT codes and ICD-9 codes are considered for this episode:  
**ICD-9-CM codes**: 034.0x, 461.0x-461.3x, 461.8x, 461.9x, 462.xx, 463.xx, 464.0x, 464.00, 464.10, 464.20, 465.0x, 465.8x, 465.9x  
**Procedure codes**: 99201-99205, 99211-99215, 99241-99245, 99281-99285, T1015, T1015 U1-U3  
Episodes are assigned a sub-type based upon the final diagnosis code within the episode. The classification of diagnosis code is as follows:  
**Non-specific URI**: 460.xx, 464.0x, 464.00, 464.10, 464.20, 465.0x, 465.8x or 465.9x  
**Pharyngitis**: 462.xx, 463.xx, 034.0x  
**Sinusitis**: 461.0x, 461.1x, 461.2x, 461.3x, 461.8x, 461.9x |
| Exclusion codes | Beneficiaries are excluded if they have co-morbid condition matching the following ICD-9 codes will be excluded:  
Any episode including a claim with any of the following ICD-9 or procedure code is excluded:  
**ICD-9-CM codes**: 381.xx-382.xx, 464.3x, 464.4x., 464.01, 464.11, 464.21, 464.51, 478.xx, 480.xx-487.xx, 480.xx-488.xx  
**Procedure codes**: 42140,42700, 42820, 42821, 42825, 42826, 42830, 42860, 99217-99223, 99231-99236, 99238, 99251-99255, 99291, 99307, 99354-99356, 99367, 99381-99384, 99391-99395  
Claims with the following procedure codes are excluded:  
**Procedure codes**: 99307, 99354-99256, 99367, 99381-99384, 99391-99395  
These codes represent the set of business and clinical exclusions described previously |
| Included claim codes | Medical claims with the certain ICD-9 diagnosis codes and pharmacy claims with certain AHFS classifications as follows:  
**ICD-9-CM code**: 034.0x, 460.xx, 461.0x, 461.1x, 461.2x, 461.3x, 461.8x, 461.9x, 462.xx, 463.xx, 464.00, 464.0x, 464.10, 464.20, 465.0x, 465.8x, 465.9x, 786.2x  
**AHFS**: 081206, 081212, 081216, 081218, 081220, 081224, 081228, 081828, 082400, 084000, 680400, 812120, 812240 |