Measure Information Form

Measure Name

Specifications Tab

Descriptive Information

Measure Name (Measure Title De.2.)

NQF 2468: Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus

Measure Type De.1.

Process

Brief Description of Measure De.3.

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with diabetes mellitus who had at least two prescription drug claims for oral diabetes agents (ODAs) and had a Proportion of Days Covered (PDC) of at least 0.8 for ODAs during the measurement period (12 consecutive months).

If Paired or Grouped De.4.

This measure is paired with

- NQF 0545: Adherence to Statins for Individuals with Diabetes Mellitus
- NQF 2467: Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus

Diabetic patients often require chronic treatment with oral diabetes agents, statins, and/or ACEIs/ARBs to lower their risk of diabetic complications, adverse cardiovascular disease outcomes, and mortality. Adherence to chronic medication regimens has been documented in the literature to be less than optimal. Poor adherence can reduce the effectiveness of treatment, and interventions to improve adherence can provide opportunities for quality improvement.

Subject/Topic Areas De.5.

Endocrine: Endocrine
Endocrine: Diabetes
Cross-Cutting Areas: Disparities, Safety: Medication Safety

Measure Specifications

Measure-Specific Web Page S.1.

Not applicable

If This is an eMeasure S.2a.

Not applicable

Data Dictionary Code Table S.2b.

ICD-9 to ICD-10 Crosswalk and National Drug Code (NDC) Table are available in the attached file.

For Endorsement Maintenance S.3.

Date Endorsed: September 23, 2011

Previously endorsed as a submeasure of NQF 545: Adherence to Chronic Medications for Individuals with Diabetes Mellitus.

The age requirement for the target population was changed from 18 years of age or older as of the end of the measurement period to 18 years of age or older as of the beginning of the measurement period to harmonize with other measures in the portfolio. ICD-9-CM, ICD-10-CM, and National Drug Codes have been updated annually. Optional criteria to stratify the measure between new and continuous users were removed to harmonize with other NQF-endorsed measures. The new drugs on the market that are applicable to the measure have been added to the medication list, and agents that have been discontinued for more than three years have been removed.

Numerator Statement S.4.

Individuals with diabetes mellitus who had at least two prescription drug claims for ODAs and have a PDC of at least 0.8 for ODAs

Time Period for Data S.5.

The time period for data is defined as any time during the measurement period (12 consecutive months).

Numerator Details S.6.

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:
PDC NUMERATOR
The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all oral diabetes agents. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR*
The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

*Individuals switching to insulin or incretin mimetics are identified by having at least one prescription drug claim for any type of insulin or incretin mimetics (Table 3) after the end of the days' supply of the last ODA prescription drug claim. For these individuals, the ODA therapy period is set to the end date of the days' supply of the last ODA claim during the measurement period, and adherence is only calculated while the patient is taking ODAs.

Denominator Statement S.7.

Individuals at least 18 years of age as of the beginning of the measurement period with diabetes mellitus and at least two prescription drug claims for ODAs during the measurement period (12 consecutive months)

Target Population Category S.8.

Populations at Risk: Populations at Risk
Populations at Risk: Dual Eligible Beneficiaries
Senior Care

Denominator Details S.9.

Target population meets the following conditions:
1. Continuously enrolled in Part D with no more than a one-month gap in enrollment during the measurement period;
2. Continuously enrolled in Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and,

3. No more than one-month of HMO (Health Maintenance Organization) enrollment during the measurement period.

IDENTIFICATION OF DIABETES MELLITUS

Individuals with diabetes mellitus are identified using diagnosis codes and/or drug proxy to identify diabetes mellitus within the inpatient or outpatient claims data.*

Individuals must have:
At least two encounters with a principal or secondary diagnosis of diabetes with different dates of service in an outpatient setting or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a principal or secondary diagnosis of diabetes in an acute inpatient or emergency department setting during the measurement period;

OR

At least one prescription drug claim for any diabetes medication (except metformin) dispensed during the measurement period.

*Adapted from NCQA HEDIS 2012 (2012). Note: HEDIS uses a look-back period of one year for both the prescription data and diagnosis.

Table 1. Codes Used to Identify Diabetes Mellitus Diagnosis

ICD-9-CM: 250.xx, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

ICD-10-CM: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.40, E08.42, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.40, E09.42, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.311, O24.312, O24.313, O24.319, O24.32, O24.33, O24.811, O24.812, O24.813, O24.819, O24.82, O24.83, O24.911, O24.912, O24.913, O24.919, O24.92, O24.93
DRG: 637,638

CODES USED TO IDENTIFY ENCOUNTER TYPE

Table 2.1. Outpatient Setting

CPT: 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
UB-92 revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983

Table 2.2. Non-Acute Inpatient

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x

Table 2.3 Acute Inpatient
CPT: 99221-99223, 99224-99226, 99231-99233, 99238, 99239, 99251-99255, 99291
UB-92 revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987

Table 2.4 Emergency Department
CPT: 99281-99285
UB-92 revenue: 045x, 0981

The following are the diabetic medications by class for the denominator. The route of administration includes all oral and injectable formulations of the medications listed below.

Table 3. Medications Used to Identify Diabetic Individuals

Alpha-Glucosidase Inhibitors:
acarbose
miglitol

Anti-Diabetic Amylin Analogs:
pramlintide

Anti-Diabetic Combinations:
alogliptin-metformin
alogliptin-pioglitazone
glipizide-metformin
glyburide-metformin
pioglitazone-glimepiride
pioglitazone-metformin
rosiglitazone-glimepiride
rosiglitazone-metformin
saxagliptin-metformin
sitagliptin-metformin
repaglinide-metformin
sitagliptin-simvastatin
linagliptin- metformin

Dipeptidyl Peptidase-4 (dpp-4) Inhibitors:
alogliptin
sitagliptin,
saxagliptin,
linagliptin

Incretin Mimetics:
exenatide
liraglutide

Insulin:
insulin aspart
insulin aspart
protamine & aspart (human)
insulin detemir
insulin glargine
insulin glulisine
insulin isophane & reg (human)
insulin isophane (human)

insulin lispro (human)
insulin lispro protamine & lispro (human)
insulin regular (human)

Meglitinides:
nateglinide
repaglinide

Sodium-Glucose Co-Transporter 2 Inhibitors:
canagliflozin

Sulfonylureas:
chlorpropamide
glimepiride
glipizide
glyburide
tolazamide
tolbutamide
glyburide micronized

Thiazolidinediones:
pioglitazone
rosiglitazone

The following are the oral diabetes agents by class for the denominator. The route of administration includes all oral formulations of the medications listed below.

Table 4. Oral Diabetes Agents
Alpha-Glucosidase Inhibitors:
acarbose
miglitol

Anti-Diabetic Combinations:
alogliptin-metformin
alogliptin-pioglitazone
glipizide-metformin
glyburide-metformin
metformin-dietary management product
pioglitazone-glimepiride
pioglitazone-metformin
rosiglitazone-glimepiride
rosiglitazone-metformin
sitagliptin-metformin
repaglinide-metformin
saxagliptin-metformin
sitagliptin-simvastatin
linagliptin-metformin

Biguanides:
metformin

Dipeptidyl Peptidase-4 (dpp-4) Inhibitors:
alogliptin
sitagliptin

saxagliptin
linagliptin

Meglitinides:
nateglinide
repaglinide

Sodium-Glucose Co-Transporter 2 Inhibitors:
canagliflozin

Sulfonylureas:
chlorpropamide
glimepiride
glipizide
glyburide
tolazamide
tolbutamide
glyburide micronized

Thiazolidinediones:
pioglitazone
rosiglitazone

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.

1. Individuals with a diagnosis of polycystic ovaries who do not have a visit with a diagnosis of diabetes in any setting during the measurement period*
2. Individuals with a diagnosis of gestational diabetes or steroid-induced diabetes who do not have a visit with a diagnosis of diabetes mellitus in any setting during the measurement period

*Adapted from NCQA HEDIS 2013 (2013). Note: HEDIS uses a look-back period of one year prior to the measurement period for both the prescription data and diagnosis.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.

Table 5. Diagnostic Exclusions for Diabetes Denominator
Polycystic Ovaries:
ICD-9-CM: 256.4
ICD-10-CM: E28.2

Steroid-Induced Diabetes:
ICD-9-CM: 249.xx, 251.8, 962.0

ICD-10-CM: E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.41, E08.42, E08.43, E08.44, E08.49, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E16.8, T38.0X1A, T38.0X2A, T38.0X3A, T38.0X4A, T50.0X1A, T50.0X2A, T50.0X3A, T50.0X4A

Gestational Diabetes:
ICD-9-CM: 648.80, 648.81, 648.82, 648.83, 648.84

ICD-10-CM: O24.410, O24.414, O24.419, O24.420, O24.424, O24.429, O24.430, O24.434, O24.439, O99.810, O99.814, O99.815

Stratification Details/Variables S.12.

Depending on the operational use of the measure, measure results may be stratified by:

- State
- Accountable Care Organizations (ACOs)*
- Plan
- Physician Group**
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers.
** See **Calculation Algorithm/Measure Logic S.18** below for physician group attribution methodology used for this measure.

Risk Adjustment Type S.13.

No risk adjustment or risk stratification

Statistical Risk Model and Variables S.14.

Not applicable

Detailed Risk Model Specifications S.15.

Not applicable

Type of Score S.16.

Rate/proportion

Interpretation of Score S.17.

Better quality= higher score

Calculation Algorithm/Measure Logic S.18.

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Parts A, B, and D

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with diabetes mellitus and at least two prescription drug claims for ODAs during the measurement period (12 consecutive months)

Create Denominator:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.
2. Include individuals who were continuously enrolled in Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.
3. Include individuals who had no more than a one-month gap in Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).
4. Of those individuals identified in Step 3, keep those who had:
   At least two encounters with a principal or secondary diagnosis of diabetes with different dates of service in an outpatient setting or non-acute inpatient setting during the measurement period;
   OR
   At least one encounter with a principal or secondary diagnosis of diabetes in an acute inpatient setting or emergency department setting during the measurement period;
   OR

At least one prescription drug claim for any diabetes medication (except metformin) dispensed during the measurement period.

5. Of the individuals identified in Step 4, exclude those with a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes who do not have at least one visit with a diagnosis of diabetes in any setting during the measurement period.
6. For the remaining individuals, extract Part D claims for oral diabetes agents. Attach generic name and drug ID to the dataset.
7. Of the individuals identified in Step 6, exclude those who did not have at least two Part D claims for any oral diabetes agent on different dates of service during the measurement period.

Numerator: Individuals with diabetes mellitus who had at least two prescription drug claims for ODAs and have a PDC of at least 0.8 for ODAs

Create Numerator:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an ODA in the measurement period.
2. Adjust the medication therapy period for individuals who switched from ODAs to an insulin- or incretin mimetics-only therapy according to the following methods:

   Identify Individuals with therapy switch

   2a. Extract all Part D claims for insulin and incretin mimetics during the measurement period. Sort the dataset by beneficiary ID and service date. Merge with denominator file (denominator step 7) to create a new dataset with individuals in the denominator with claims for insulin or incretin mimetics.

   2b. Keep beneficiary ID, generic names, days' supply, and service dates for all ODA, insulin, and incretin mimetics claims.

   2c. Identify the last ODA claim for each individual in step 2a and calculate the end date of the ODA supply, which is the service date of the last ODA claim plus the days' supply of the same claim.

   2d. Identify and keep individuals who had at least one claim for insulin or incretin mimetics after the last ODA by comparing the service date of the insulin or incretin mimetics claim to the end date of ODA supply. These are the individuals who made the therapy switch.

   Adjust the medication therapy period for individuals with therapy switch

   2e. Merge the dataset from Step 2d with the dataset from Step 1 to add the end date of ODA supply in the dataset.

   2f. For the individual who made the therapy switch, the medication therapy period is defined as the index date to the end date of the ODA supply (i.e., the service date of the last ODA claim plus the days' supply), or death, whichever comes first.

3. Within the medication therapy period, count the days the individual was covered by at least one drug in the ODA class based on the prescription drug claim service date and days of supply.
   a. Sort and de-duplicate Part D claims for oral diabetes agents by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.
   b. Calculate the number of days covered by ODAs per individual.
      i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.
      ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.
      iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.
4. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

Physician Group Attribution:
Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters).
2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.
3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.
4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).
5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)
    a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.
    b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.
    c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.
    d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.
6. Identify TINs that are not solo practices.
    a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.
    b. Count unique NPIs per TIN.
    c. Keep only those TINs having two or more providers.
    d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.
7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).
8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.
9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.
    a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.
    b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.
    a. Pull individuals with 11+ months of Parts A, B, & D during the measurement year.
    b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:
        - A = working-age individual/spouse with an employer group health plan (EGHP)
        - B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP
        - G = working disabled for any month of the year
    c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.
    d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.
    a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.
    b. Exclude claims with no npi_prfrmg.
12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Part B office claims from Step 12 with specialties indicating primary care, cardiology, cardiac surgery, endocrinology or nephrology (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.
    a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.
    b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.
14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.
15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.
16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*
02—General surgery
03—Allergy/immunology
04—Otolaryngology
05—Anesthesiology
06—Cardiology*
07—Dermatology
08—Family practice*
09—Interventional pain management
10—Gastroenterology
11—Internal medicine*
12—Osteopathic manipulative therapy
13—Neurology
14—Neurosurgery
16—Obstetrics/gynecology*
18—Ophthalmology
20—Orthopedic surgery
22—Pathology
24—Plastic and reconstructive surgery
25—Physical medicine and rehabilitation
26—Psychiatry
28—Colorectal surgery
29—Pulmonary disease
30—Diagnostic radiology
33—Thoracic surgery
34—Urology
36—Nuclear medicine
37—Pediatric medicine
38—Geriatric medicine*
39—Nephrology*

40—Hand surgery
44—Infectious disease
46—Endocrinology*
50—Nurse practitioner*
66—Rheumatology
70—Multi-specialty clinic or group practice*
72—Pain management
76—Peripheral vascular disease
77—Vascular surgery
78—Cardiac surgery*
79—Addiction medicine
81—Critical care (intensivists)
82—Hematology
83—Hematology/oncology
84—Preventive medicine*
85—Maxillofacial surgery
86—Neuropsychiatry
90—Medical oncology
91—Surgical oncology
92—Radiation oncology
93—Emergency medicine
94—Interventional radiology
97—Physician assistant*
98—Gynecologist/oncologist
99—Unknown physician specialty
Other—NA
*Provider specialty codes specific to this measure

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.

Not applicable

Sampling S.20.

Not applicable; this measure does not use a sample or survey.

Survey/Patient-Reported Data S.21.

Not applicable; this measure does not use a sample or survey.

Missing Data S.22.

To reduce the potential for measure result bias, patients who have prescription drug claims with missing days' supply are excluded from the analysis.

Data Source S.23.

Administrative Claims
Electronic Clinical Data: Pharmacy
Other: Please see next section for further details.

Data Source or Collection Instrument S.24.

For measure calculation, the following Medicare files are required:

- Denominator tables
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For ACO attribution, the following are required:
- Denominator tables for Parts A and B enrollment
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For physician group attribution, the following are required:
- Non-institutional claims (Part B)—physician carrier/non-DME
- Denominator tables to determine individual enrollment
- Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payer status
- CMS physician and physician specialty tables

Payer Source
- Medicare fee-for-service
- Prescription Drug Plans (PDPs)

Data Source or Collection Instrument (Reference) S.25.

Not applicable

Level of Analysis S.26.

Clinician: Group/Practice
Health Plan
Integrated Delivery System
Population: State

Care Setting S.27.

Ambulatory Care: Clinician Office/Clinic

Composite Performance Measure S.28.

Not applicable

Version Number and Effective Date

Version 1.0
January 1, 2013 – December 31, 2013

Measure Steward

Centers for Medicare & Medicaid Services (CMS)
Point of Contact: CMS Measures Management System, CMS.Measures.Inventory@hsag.com
Measure Developer: FMQAI, 5201 W. Kennedy Blvd., Suite 900, Tampa, Florida, 33609

Copyright/Disclaimer