

## **Proposed Measure Refinement for HEDIS® 2011: Applicable to All Relative Resource Use Measures**

NCQA seeks comments on the new pharmacy utilization reporting categories for the Relative Resource Use (RRU) measures. The RRU cost measures do not report generic and name-brand drug resource use separately. To provide increased detail for the Pharmacy Service category, NCQA has developed measure specifications that collect and report generic and name brand utilization separately. These additional categories will refine the measure by providing information about the proportion of generic and name brand drugs used for each RRU clinical area, as follows:

- Diabetes (RDI)
- Asthma (RAS)
- Cardiovascular Conditions(RCA)
- Hypertension (RHY)
- COPD (RCO)
- Acute Low Back Pain (RLB)

Generic and name brand prescription utilization will be accounted for separately in the pharmacy service category specifications. Health plans will summarize and report the frequency of the following four prescription categories:

1. Name brand, no generic available (N1)
2. Multisource\*—Name brand (N2)
3. Multisource\*—Generic (G1)
4. Generic, no name brand available (G2)

*\*Multi-source drugs are available as both name brand and generic.*

Based on these data elements, NCQA will report:

1. Generic Utilization, given existence of generic option  $(G1 + G2) / (N2 + G1 + G2)$
2. Generic Substitution Rate  $(G1) / (N2 + G1)$
3. Overall Generic Utilization  $(G1 + G2) / (N1 + N2 + G1 + G2)$

To provide consistency and accuracy for pharmacy utilization, NCQA will categorize each drug NDC code as name-brand, multisource or generic, based on the patent protection status of the corresponding drug. This field will be provided to plans, and instructions on how to use and apply the categories will be included in the HEDIS RRU technical specifications.

A draft measure specification showing the proposed changes is provided.

**Note:** *The posted draft specification is for one RRU measure, as an example; the proposed changes would be incorporated into all six RRU measures.*

**NCQA thanks and acknowledges the contributions of the Efficiency Measurement Advisory Panel.**

**Note:** Changes, with additional steps and data elements, would be applied to all six RRU measures. This RRU measure specification is an example, and includes the pharmacy frequency service category update in track changes (i.e., revisions showing).

## Relative Resource Use for People With Diabetes (RDI)

### SUMMARY OF CHANGES TO HEDIS **2011**

- [Summarize and report pharmacy services use within the following prescription categories:](#)
  - [Name brand, no generic available \(N1\)](#)
  - [Multisource—Name brand \(N2\)](#)
  - [Multisource—Generic \(G1\)](#)
  - [Generic, no name brand available \(G2\)](#)

#### Description

The relative resource use by members with diabetes during the measurement year.

#### Eligible Population

**Note:** The eligible population is based on the CDC measure. It contains additional exclusion criteria and is further stratified into clinical categories (e.g., diabetes type 1 or type 2).

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	18–75 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	There are two ways to identify members with diabetes: by pharmacy data and by claim/encounter data. The organization must use both to identify the eligible population, but a member only needs to be identified in one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.  <i>Pharmacy data.</i> Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year, on an ambulatory basis (Table CDC-A).

*Claim/encounter data.* Members who had two face-to-face encounters in an outpatient setting or nonacute inpatient setting, or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes (Table CDC-B), on different dates of service during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table CDC-C for codes to identify visit type.

**Exclusions (optional)**

- Members with a diagnosis of polycystic ovaries who did not have any face-to-face encounters in any setting (CDC-C) with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member’s history, but must have occurred by December 31 of the measurement year. Refer to Table CDC-B for codes to identify a diagnosis of diabetes; refer to Table CDC-O for codes to identify a diagnosis of polycystic ovaries.
- Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters in any setting (CDC-C) with a diagnosis of diabetes during the measurement year or year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year. Refer to Table CDC-B for codes to identify a diagnosis of diabetes; refer to Table CDC-O for codes to identify gestational and steroid-induced diabetes.

**Note:** Organizations that apply the optional exclusions for the CDC measure must apply them for the RDI measure. Organizations that do not apply the optional exclusions for the CDC measure should not apply the optional exclusion for the RDI measure. Because RDI is administrative-only, do not exclude members from this measure based on exclusions found during chart review for the CDC measure. Members must be included in RDI whether or not they are excluded during chart review for CDC.

**Exclusions (required)**

- Members with one or more of the following dominant conditions during the measurement year.
  - *Active cancer.* Members who had at least one face-to-face encounter, in any setting, with a diagnosis of cancer in conjunction with any treatment code (Table RDI-A), during the measurement year.
  - *ESRD.* Members who had at least one face-to-face encounter, in any setting, with any code to identify ESRD (Table RDI-B), during the measurement year.
  - *Organ transplant.* Members who had at least one face-to-face encounter, in any setting, with any code to identify organ transplant (Table RDI-C), during the measurement year.
  - *HIV/AIDS.* Members who had at least two face-to-face encounters in an outpatient or nonacute inpatient setting, or at least one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of HIV (Table RDI-D), with different dates of service during the measurement year. Refer to Table RDI-E for codes to identify visit type.

**Table RDI-A: Codes to Identify Active Cancer Treatment**

Description	ICD-9-CM Diagnosis
Cancer	140-209, 230-239

WITH

Description	CPT	ICD-9-CM Procedure	UB Revenue
Treatment	38230, 38240-38242, 77261-77799, 79000-79999, 96401-96549	41.0, 41.91, 92.2	028x, 033x, 0342, 0344, 0973

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**Table RDI-B: Codes to Identify ESRD**

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS
ESRD (including renal dialysis)	36145, 36800-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0311-G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339	585.5, 585.6, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98	080x, 082x-085x, 088x	72x	65

**Table RDI-C: Codes to Identify Organ Transplant**

Description	CPT	HCPCS	ICD-9-CM Procedure	UB Revenue
Organ transplant	32850-32856, 33930-33945, 44132-44137, 44715-44721, 47133-47147, 48160, 48550-48556, 50300-50380	S2152, S2053-S2055, S2060, S2061, S2065	33.5, 33.6, 37.5, 41.94, 46.97, 50.5, 52.8, 55.6	0362, 0367, 0810-0813, 0819

**Table RDI-D: Codes to Identify HIV**

Description	ICD-9-CM Diagnosis
HIV	042

**Table RDI-E: Codes to Identify Visit Type**

Description	CPT	UB Revenue
Outpatient	92002, 92004, 92012, 92014, 98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 077x, 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-022x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

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**Categorization of Eligible Population**

**Major clinical condition** Diabetes.

**Clinical category** 1. Diabetes type 1                      2. Diabetes type 2

Count members in only one clinical category. All members are counted as diabetes type 2 unless they are identified as having diabetes type 1. Members are identified as having diabetes type 1 if they have at least two face-to-face encounters in any setting (RDI-E), with any diagnosis of type 1 diabetes, on different dates of service during the measurement year or the year prior to the measurement year.

Members who have only pharmacy data and do not have any claim data with a diagnosis of diabetes during the measurement year or the year prior to the measurement year should be included in the diabetes type 2 clinical category. The organization may count services that occur over both years. Refer to Table RDI-F for codes to identify diabetes type 1.

**Table RDI-F: Codes to Identify Clinical Category**

Description	ICD-9-CM Diagnosis
Diabetes type 1	250.x1, 250.x3

**Comorbid categorization** Members in the eligible population with evidence of asthma, cardiovascular conditions, COPD, depression, hypertension or chronic kidney disease are identified to be “with comorbidity” for the measure. The organization must use all methods to identify comorbid status, but once a member meets the criteria for one comorbid condition, the organization does not need to verify whether the member has another listed condition. Follow the instructions for each comorbid condition.

**Asthma**

**Step 1** Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A), **or**
- At least one acute inpatient discharge (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A), **or**
- At least four outpatient asthma visits (Table ASM-B) with asthma as one of the listed diagnoses (Table ASM-A) and at least two asthma medication dispensing events (Table ASM-C), **or**
- At least four asthma medication dispensing events (Table ASM-C)

**Step 2** A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier (i.e., the measurement year or the year prior to the measurement year).

- Cardiovascular conditions** Members are identified for cardiovascular condition comorbidity by event or by diagnosis. The organization must use *both* to identify comorbidity status, but a member need only be identified through one to be included in the Comorbidity category.
- *Event.* Discharged alive for AMI, CABG or PTCA in the measurement year or in the year prior to the measurement year. Refer to Table CMC-A for codes to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. Include all cases of PTCA, regardless of setting (e.g., inpatient, outpatient, ED).
  - *Diagnosis.* Identify members as having IVD who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
    - At least one outpatient visit (Table CMC-C) with an IVD diagnosis (Table CMC-B), **or**
    - At least one acute inpatient visit (Table CMC-C) with an IVD diagnosis (Table CMC-B)
- COPD** Identify all eligible members who had at least two claims/encounters in any setting, with any diagnosis of COPD (Table SPR-A), on different dates of service during the measurement year or the year prior to the measurement year.
- Major depression** Identify all eligible members who met at least one of the following criteria during the measurement year or the year prior to the measurement year.
- At least one principal diagnosis of major depression (Table AMM-A) in any setting (Table AMM-B), **or**
  - At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B), on different dates of service with any diagnosis of major depression (Table AMM-A), **or**
  - At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table AMM-A)
- Hypertension** Identify eligible members who had at least two outpatient encounters with a diagnosis of hypertension (Table CBP-A), on different dates of service during the measurement year or the year prior to the measurement year. The diagnosis must occur in conjunction with the visit codes in Table CBP-B.
- Chronic kidney disease** Identify eligible members who had at least two face-to-face encounters in an outpatient or nonacute inpatient setting, or at least one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of chronic kidney disease, on different dates of service during the measurement year or the year prior to the measurement year. Refer to Table RDI-G for codes to identify chronic kidney disease; refer to Table RDI-E for codes to identify visit type.

**Table RDI-G: Codes to Identify Chronic Kidney Disease**

Description	ICD-9-CM Diagnosis
Chronic kidney disease	585.1-585.4, 585.9

**Reporting categories**

Assign each member to only one of the following clinical reporting categories.

1. Diabetes Type 1, With Comorbidity
2. Diabetes Type 1, Without Comorbidity
3. Diabetes Type 2, With Comorbidity
4. Diabetes Type 2, Without Comorbidity

**Standard Cost Calculations**

The measure reports total standard costs for all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Total standard costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA’s Web site by November 16, 2009).

**Apply standard price**

SPTs categorize services as follows.

- Inpatient Facility
- E&M
  - Inpatient Services
  - Outpatient Services
- Surgery and Procedure
  - Inpatient Services
  - Outpatient Services
  - Pharmacy

Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Cost of Care Guidelines* for steps on categorizing services and linking service data to NCQA’s SPTs.

**Calculate total cost**

Sum the total standard cost for each eligible member. Within each, if a member’s standard cost exceeds the service category cap amount, report the total standard cost specified in NCQA’s Cost Cap Amounts table (released with the SPTs).

Sum and report the total standard cost for the eligible population in each service category by member cohort in Tables RDI-1/2/3.

**Service Frequency Calculations**

**Total frequency of service**

Service frequency counts are reported for all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Organizations capture each eligible member’s services rendered during the treatment period for the following service categories.

- Inpatient Facility Discharges\*
- ED Visits
- Pharmacy\*\*
  - [Name brand, no generic available \(N1\)](#)
  - [Multisource—brand \(N2\)](#)
  - [Multisource—Generic \(G1\)](#)
  - [Generic, no name brand available \(G2\)](#)

\* [These categories and codes are similar to those in the \*Inpatient Utilization—General Hospital/Acute Care, Inpatient Utilization—Nonacute Care and Ambulatory Care measures.\*](#)

[Refer to the \*Calculating Standard Services Frequency\* instructions in the \*Cost of Care Guidelines.\* Sum and report all services in each service category by member cohort in Table RDI-1/2/3.](#)

\*\*[These categories are included in Table SPT-Pharm.](#)

[Refer to the \*Calculating Standard Services Frequency\* instructions in the \*Cost of Care Guidelines.\* Sum and report totals for each prescription category in Table RDI-4.](#)

**Inpatient facility discharges**

This category measures the number of acute and nonacute inpatient facility discharges, regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.

If the discharge is counted in the cost calculation, it should also be counted in the inpatient frequency calculation. Additionally, only count the inpatient admission if the discharge date falls within the treatment period.

**ED visits**

This category measures use of ED services.

Count each visit to an ED during the treatment period that does not result in an inpatient stay, regardless of the intensity of care required during the stay or the length of stay. Count only one ED visit per date of service. Do not count visits to urgent care centers.

Refer to Table AMB-B for codes to identify ED visits. Services for members admitted to the hospital from an ED visit are included in the Inpatient Facility category only.

**Pharmacy**

[Use Table SPT-Pharm to identify the prescription categories](#) for each drug dispensed in the treatment [period](#):

- [1. Name brand, no generic available \(N1\)](#)
- [2. Multisource—Name brand \(N2\)](#)
- [3. Multisource—Generic \(G1\)](#)
- [4. Generic, no name brand available \(G2\)](#)

[Sum and report the number of prescriptions within each of the four categories in Table RDI-4.](#)

**Table RDI-1/2/3: Relative Resource Use for People With Diabetes—Commercial, Medicaid, Medicare**

Eligible Population _____	
Exclusions (required) _____	
Type 1, With Comorbidity _____	Type 2, With Comorbidity _____
Type 1, Without Comorbidity _____	Type 2, Without Comorbidity _____

**Table RDI-4 Pharmacy—Total Service Frequency by Prescription Category**

Prescription Category	Count
Name brand, no generic available (N1)	_____
Multisource—Name brand (N2)	_____
Multisource—Generic (G1)	_____
Generic, no name brand available (G2)	_____
<i>Total:</i>	_____

## Guidelines for Cost of Care Measures

### SUMMARY OF CHANGES TO HEDIS 2011

- Match the eligible populations' pharmacy services to the codes provided in the SPT table. The categories reported are as follows.
  - Pharmacy :
    - Name brand, no generic available (N1)
    - Multisource—Name brand (N2)
    - Multisource—Generic (G1)
    - Generic, no name brand available (G2)

### Description

The complete Cost of Care Guidelines are available in the HEDIS 2011 Technical Specifications. Below are updates to the guidelines that are specific to this recommendation (i.e., the addition of data elements that capture the type and frequency of prescription utilization). All unchanged sections are deleted from this document. Included below are the highlighted proposed changes to the guideline section to support the reporting of prescription generic and name brand utilization.

**Services for frequency** For inpatient discharges and ED visits, count discharges, not the frequency of procedure codes billed. For example, if for one inpatient stay with a discharge, a surgeon submits a bill for professional charges and a hospital submits a separate bill pertaining to the same surgical episode with the same date of service, count only one inpatient discharge.

Multiple prescriptions dispensed on the same date of service should count as multiple dispensing events and be counted separately when counting the frequency of name brand and generic prescriptions.

### Calculating Service Frequency

**Step 2** Match the eligible populations' services to the codes provided in the specifications. The categories reported are as follows.

- Pharmacy:
  - Name brand, no generic available (N1)
  - Multisource—Name brand (N2)
  - Multisource—Generic (G1)
  - Generic, no name brand available (G2)

**Step 4** Download Table SPT-Pharm from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)). The table contains:

- The NDC code
- Prescription category
  - Name brand, no generic available (N1)
  - Multisource—Name brand (N2)
  - Multisource—Generic (G1)
  - Generic, no name brand available (G2)

Match each NDC code to the appropriate row in Table SPT-Pharm.

**Step 5** [Aggregate and report service frequencies within each prescription category at the total level by organization for pharmacy prescription utilization..](#)