Quality Measures Specifications for PY 2013 and PY 2014 ESRD QIP Final Rule

November 1, 2011

Anemia Management – Hemoglobin > 12 g/dl

Measure Description

This measure reports the percentage of eligible Medicare dialysis patients with a mean hemoglobin value greater than 12.0 g/dL.

Data Source

Medicare claims

Care Setting

Dialysis provider/facility

Measurement Duration

The measurement duration is 12 months. Patients with at least 4 months of eligible claims at the facility are included.

Improvement Notation

Better quality=Lower Proportion

Denominator

The number of eligible Medicare dialysis patients at the facility during the measurement (baseline or performance) period.

The denominator will include all dialysis patients 18 years and older with ESRD for 90 days or longer, who are treated with erythropoiesis stimulating agents (ESAs), and have valid hemoglobin values.

A hemoglobin value is considered valid if it is greater than or equal to 5 g/dl and less than or equal to 20 g/dl. When hematocrit is reported on the claim it is changed to hemoglobin by dividing by 3 and rounding to the first decimal place. After the criteria above are met we restrict to the last claim of the month for a patient at a facility. A patient must have at least 4 months of eligible claims at the facility to be included in the denominator.

Denominator Exclusions

Claims are excluded if any of the following criteria are met:

- Patient is less than 18 years old as of the start of the claim, or
- Patient is in the first 89 days of ESRD as of the start of the claim, or
- Patient's reported hemoglobin value (or hematocrit value divided by 3) is less than 5 g/dl or greater than 20 g/dl, or
- Patient is not treated with ESAs according to the claim, specifically epoetin alfa or darbepoetin alfa, or
- Patient has fewer than 4 months of eligible claims at the facility in the measurement period.

Numerator

Number of eligible Medicare dialysis patients at the facility during the measurement period with a mean hemoglobin value greater than 12.0 g/dl.

Patients from the denominator are included in the numerator if the mean of their monthly hemoglobin values (rounded to a single decimal place) is greater than 12.0 g/dl.

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Hemodialysis Adequacy – Urea Reduction Ratio (URR)

Measure Description

This measure reports the percentage of eligible Medicare in-center hemodialysis (HD) patients with a median urea reduction ratio (URR) of at least 65%.

Data Source

Medicare claims

Care Setting

Dialysis provider/facility

Measurement Duration

The measurement duration is 12 months. Patients with at least 4 months of eligible claims at the facility are included.

Improvement Notation

Better quality=Higher Proportion

Denominator

Number of eligible Medicare in-center hemodialysis patients at the facility during the measurement period (baseline or performance).

The denominator will include all in-center hemodialysis patients 18 years and older with ESRD for 183 days or longer, and whose last claim of the month for the patient at the facility indicates thrice-weekly in-center hemodialysis with a valid URR reading.

Denominator Exclusions

Claims are excluded if any of the following criteria are met:

- Patient is less than 18 years old as of the start of the claim, or
- Patient has fewer than 7 dialysis sessions per month (HCPCS modifier=G6), or
- Patient is in the first 182 days of ESRD as of the start of the claim, or
- Patient is on home hemodialysis or peritoneal dialysis (PD) according to the claim, or
- Patient is on frequent hemodialysis (see below), or
- Patient has fewer than 4 months of eligible claims at a facility in the measurement period.

Frequent hemodialysis claims are indentified for exclusions in three ways:

- If the claim covers 7 or fewer days, the claim must have had fewer than 4 sessions documented.
- If the claim covers more than 7 days, the claim must have had a rate of fewer than 4 sessions per week.
- The beginning date of the claim must not have occurred in a month during which the SIMS database recorded the patient's modality as frequent in-center hemodialysis (defined as 5 or more dialysis sessions per week).

Numerator

The number of eligible Medicare in-center hemodialysis patients with a median urea reduction ratio (URR) category greater than or equal to 65%.

Patients from the denominator are included in the numerator if the median of their monthly URR category indicates a value of at least 65%.

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Vascular Access Type – Catheter ≥ 90 Days

Measure Description

This measure reports the percentage of months where an intravenous catheter was in use for 90 days or more, among adult hemodialysis patients at the facility.

Data Source

Medicare claims

Care Setting

Dialysis provider/facility

Measurement Duration

The measurement duration is 12 months. Patients with at least 4 months of eligible claims at the facility are included.

Note that for a claim to be considered eligible, it must be the fourth claim in 4 consecutive months of dialysis claims at the facility (see below). During the baseline period, only months in the baseline period are used to determine a patient's treatment history, because these data were not collected prior to the baseline period. However, for the performance period, the prior 3 months of dialysis claims may be before the performance period in order to determine the treatment history of the patient when evaluating whether a claim in the first month of the performance period is eligible.

Improvement Notation

Better quality=Lower Proportion

Denominator

Number of eligible Medicare in-center or home hemodialysis months summed across patients at the facility during the measurement period (baseline or performance).

The denominator includes all in-center and home hemodialysis patients aged at least 18 years and 90 days. We restrict the claims to the last claim of the month for a patient at a facility. A patient must have at least 4 consecutive months of dialysis claims at the facility to be included in the denominator. During the baseline period, only months in the baseline period are used to determine a patient's treatment history. However, for the performance period, only the fourth month must be in the performance period; the prior three months may be from before the performance period and are used only to determine a patient's treatment history. After the criteria above are met, claims are further restricted to in-center and home hemodialysis patients.

Due to a change in data submission instructions, claims during the baseline period with multiple V modifiers reported will not be included in the denominator; however, claims during the performance period with AV fistula *or* graft reported along with catheter will be included in the denominator. During the performance period when these claims are included in the denominator, they will be considered as using an AV fistula or graft and thus not be counted in the numerator. Claims with both AV fistula *and* graft reported will not be included in the denominator (regardless of time period).

Denominator Exclusions

Claims are excluded if any of the following criteria are met:

- Patient is less than 18 years and 90 days old as of the start of the claim, or
- Patient is on PD according to the claim, or
- Patient does not have four consecutive months of eligible claims at the facility among the appropriate months for the baseline and performance periods as described above.

Numerator Statement

The number of eligible Medicare in-center or home hemodialysis months in which an intravenous catheter was in use for 90 days or longer summed across such patients at the facility during the measurement period.

Numerator Details

Patients from the denominator are included in the numerator if:

- The last claim of the month for the patient at the facility reports HCPCS modifier code V5: Catheter, and
- Each of the last dialysis claims of the previous 3 calendar months for the patient at the facility indicates HCPCS modifier code V5: Catheter. (See above for treatment of claims with multiple V modifiers reported.)

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Vascular Access Type – Arterial Venous (AV) Fistula

Measure Description

This measure reports the percentage of months where an arterial venous (AV) fistula was in use, among adult hemodialysis patients at the facility.

Data Source

Medicare claims

Care Setting

Dialysis provider/facility

Measurement Duration

The measurement duration is 12 months. Patients with at least 4 months of eligible claims at the facility are included.

Improvement Notation

Better quality=Higher Proportion

Denominator

Number of eligible Medicare in-center or home hemodialysis months summed across patients at the facility during the measurement period (baseline or performance).

The denominator includes all in-center and home hemodialysis patients 18 years and older
We restrict to the last claim of the month for a patient at a facility. A patient must have at least 4 months of eligible claims at the facility to be included in the denominator.

Due to a change in data submission instructions, claims during the baseline period with HCPCS modifiers for different vascular access on the same claim will not be included in the denominator; however, claims during the performance period with AV fistula *or* graft reported along with catheter will be included in the denominator. During the performance period when these claims are included in the denominator, they will be considered as using an AV fistula or graft and thus, will be eligible for counting in the numerator. Claims with both AV fistula *and* graft reported will not be included in the denominator (regardless of time period).

Denominator Exclusions

Claims are excluded if any of the following criteria are met:

- Patient is less than 18 years old as of the start of the claim, or
- Patient is on peritoneal dialysis (PD) according to the claim, or
- Patient has fewer than 4 months of eligible claims at the facility in the measurement period.

Numerator

The number of eligible adult Medicare in-center or home hemodialysis months in which an AV fistula with two needles was in use during the last HD treatment of the month summed across such patients at the facility during the measurement period. Patients from the denominator are included in the

numerator if the last claim of the month for the patient at the facility reports the HCPCS modifier code V7: AV Fistula. (See above for treatment of claims with multiple V modifiers reported.)