

## Measure Information Form

### Measure Name

### Specifications Tab

### Descriptive Information

**Measure Name (Measure Title De.2.)**

NQF 0545: Adherence to Statins 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 statins and had a Proportion of Days Covered (PDC) of at least 0.8 for statins during the measurement period (12 consecutive months)

**If Paired or Grouped De.4.**

This measure is paired with

- NQF 2467 – Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus; and
- NQF 2468 – Adherence to Oral Diabetes Agents 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 statins and have a PDC of at least 0.8 for statins

**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 statin medications. 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.

**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 statins 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 insulin or other oral diabetes medication 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. Codes 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 statin medications by class for the denominator. The route of administration includes all oral formulations of the medications listed below.

Table 4. Statin Medications

**HMG-CoA Reductase Inhibitors (statins):**

atorvastatin  
fluvastatin  
lovastatin  
pitavastatin  
pravastatin  
rosuvastatin  
simvastatin

**HMG-CoA Reductase Inhibitors (statins) Combinations:**

amlodipine-atorvastatin  
ezetimibe-atorvastatin  
ezetimibe-simvastatin  
niacin-lovastatin  
niacin-simvastatin  
sitagliptin-simvastatin

**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.**

No 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 Part 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 statins 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 insulin or other oral diabetes medication 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 any statin medication. 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 statin medication on different dates of service during the measurement period.

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

**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 a statin medication in the measurement period.
2. Within the medication therapy period, count the days the individual was covered by at least one drug in the statin class based on the prescription drug claim service date and days of supply.
  - a. Sort and de-duplicate Part D statin claims 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 statin therapy 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.
3. 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>.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the statins. This is the numerator.

**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\_prfrmng) 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\_prfrmng, 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 occur 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 np\_i\_prfrmng.
- 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 physician, 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 4.0

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

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This performance measure does not establish a standard of medical care and has not been tested for all potential applications.