

Relative Resource Use for People With Diabetes (RDI)

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 stratified into HCC-RRU risk categories).

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	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).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	<p>There are two ways to identify members with diabetes: by pharmacy data and by claim/encounter data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method 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.</p> <p><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).</p> <p><i>Claim/encounter data.</i> 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 any 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.</p>

Exclusions (optional)

- Members with any diagnosis of polycystic ovaries who did not have any face-to-face encounters, in any setting, with any 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 any diagnosis of diabetes; refer to Table CDC-O for codes to identify any diagnosis of polycystic ovaries.

- Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters, in any setting, with any 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 any 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 even if they are excluded during chart review for CDC.

Exclusions (required)

Members with one or more of the following dominant conditions during the measurement year should be excluded from all RRU measures.

- Active cancer.** Members who had at least one face-to-face encounter, in any setting, with any diagnosis of cancer in conjunction with any treatment code (Table RRU-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 RRU-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 RRU-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 any diagnosis of HIV (Table RRU-D), with different dates of service during the measurement year. Refer to Table RRU-E for codes to identify visit type.

Table RRU-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, 79005-79999, 96401-96549	00.10, 00.15, 41.0, 41.91, 92.2, 99.25, 99.28, 99.85	028x, 033x, 0342, 0344, 0973

Table RRU-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, 36147, 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 RRU-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 RRU-D: Codes to Identify HIV

Description	ICD-9-CM Diagnosis
HIV	042

Table RRU-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, 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, 021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Categorization of Eligible Population

Major clinical condition Diabetes.

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 15, 2011).

Apply standard price SPTs categorize services as follows.

- Inpatient Facility
- E&M
 - Inpatient Services
 - Outpatient Services
- Laboratory Services
- Surgery and Procedure Inpatient Services
- Outpatient Services
- Imaging 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 *Guidelines for Cost of Care* 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 service category, if a member's standard cost exceeds the service category cap amount, report the total standard cost specified in the NCQA 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. For RDI the reporting cohorts are:

- 18-44
- 45-64
- 65-75

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 utilization categories.

- Total Inpatient Facility: Discharges, Days and ALOS
 - Acute Inpatient: Discharges, Days, ALOS
 - Acute Medicine: Discharges, Days, ALOS
 - Acute Surgery: Discharges, Days, ALOS
 - Nonacute: Discharges, Days, ALOS
- ED Discharges
- Pharmacy Utilization
 - Name brand only (N1)
 - Name brand—Generic exists (N2)
 - Generic only (G1)
 - Generic name—Name brand exists (G2):
- Cardiac Catheterization
- PCI
- CABG
- Carotid Endarterectomy
- Carotid Artery Stenosis Diagnostic Test
- Cardiac Computed Tomography
- CAD Diagnostic Test Using EBCT/Nuclear Imaging Stress Test

Refer to the instructions in the *Guidelines for Cost of Care*. The Pharmacy Utilization categories are included in Table SPT-Pharm.

Inpatient Facility

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

If days from the stay are counted in the cost calculation, the stay should also be counted in the inpatient frequency calculation.

Refer to the *Guidelines for Cost of Care* to identify acute inpatient (including medicine and surgery) and nonacute discharges, days and ALOS. For nonacute discharges, days and ALOS, include care from any institution that provides nonacute care in hospice, nursing homes, rehabilitation, SNFs, transitional care and respite.

ED Discharges

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 Utilization

Use Table SPT-Pharm to identify the prescription categories for each drug dispensed in the treatment period.

Sum and report the number of prescriptions in each of the four categories in the Pharmacy—Total Service Frequency by Prescription Category table.

Other condition-specific categories:

Refer to Table RDI-H for codes to selected procedures and to the instructions in the *Guidelines for Cost of Care*.

Cardiac catheterization

Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a PCI in the cardiac catheterization rate; report only the PCI.

Do not report PCI cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG.

PCI

Report all PCIs performed separately. Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG.

CABG

Coronary artery bypass graft. Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved.

Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG.

Carotid endarterectomy Report the number of carotid endarterectomies.

Carotid artery stenosis diagnostic test Report the number of carotid artery stenosis diagnostic tests.

Cardiac computed tomography Report the number of cardiac computed tomographies.

CAD diagnostic test using EBCT/nuclear imaging stress tests Report the number of coronary artery disease diagnostic tests using EBCT and nuclear imaging stress tests.

Table RDI-H: Codes to Identify Selected Procedures

Description	CPT	HCPCS	ICD-9-CM Procedure
Cardiac catheterization	93501, 93510, 93511, 93514, 93524, 93526-93529, 93539-93545		37.21-37.23, 88.55-88.57
PCI	92980, 92982, 92995	G0290	00.66, 36.06, 36.07
CABG	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209	36.1, 36.2
Carotid endarterectomy	34001, 35001, 35301, 35501, 35601		38.12
Carotid artery stenosis diagnostic test	75660, 75671, 75676, 75680, 75662, 75665		
CAD diagnostic test using EBCT or nuclear imaging stress test	78491, 78492, 78469, 78466, 78468, 78459, 78473, 78483, 78472, 78469, 78494, 78466, 78468, 75557, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 78451, 78452, 78453, 78454, 78481	S8092	
Cardiac computed tomography	75571, 75572, 75573, 75574		