# IT-1.5: Annual monitoring for patients on persistent medications - Anticonvulsant

| **Measure Title** | **Annual monitoring for patients on persistent medications - Anticonvulsant** | | |
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| **Description** | Percentage of patients 18 years of age and older who received at least 180 treatment days of an anticonvulsant in the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. | | |
| **NQF Number** | Not applicable | | |
| **Measure Steward** | National Committee for Quality Assurance | | |
| **Link to measure citation** | <http://www.qualitymeasures.ahrq.gov/content.aspx?id=38912>  HEDIS 2014 NDC Lists: <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014FinalNDCLists.aspx> | | |
| **Measure type** | Non Stand-Alone (NSA) | | |
| **Measure status** | P4P | | |
| **DSRIP-specific modifications to Measure Steward’s specification** | The Measure Steward’s specification has been modified as follows:   * Replaced term "member" with "patient" * Replaced continuous enrollment language with a requirement that the patient must have at least one outpatient encounter in the measurement year * Replaced inclusion criteria with reference to refer to the measure specifications * Removed references to Medicare specifications * Removed references to specific dates | | |
| **Denominator Description** | Patients\* 18 years of age and older as of the last day of the measurement year on persistent anticonvulsants\*\* -- defined as patients who received at least 180 treatment days\*\*\* of ambulatory medication during the measurement year.  **Note**: Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.  \*Patients must have had at least one encounter during the measurement year.  \*\*Refer to Table MPM-D in the original measure documentation to identify anticonvulsants. Patients who are on multiple anticonvulsant drugs count toward the denominator multiple times if they meet the persistent medications criteria for each drug taken during the measurement year (i.e., a patient who received at least 180 days of phenytoin and 180 days of valproic acid is counted twice in the denominator, once for each drug).  \*\*\*Treatment Days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on the first day of month 12 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond the last day of the measurement year. | | |
| **Denominator Inclusions** | The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description. | | |
| **Denominator Exclusions** | Exclude members who had an inpatient (acute or nonacute) encounter during the measurement year. (Optional) | | |
| **Denominator Size** | Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)   * For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. * For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. * For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases. | | |
| **Numerator Description** | Patients from the denominator with at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year (refer the original measure documentation for codes to identify drug serum concentration monitoring tests)  If a member received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication (i.e., a member on phenytoin received a drug serum test for phenytoin).  If a member persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a member on both phenytoin and valproic acid with at least 180 treatment days for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug [Table MPM-E] to be considered numerator-compliant for each drug). | | |
| **Numerator Inclusions** | The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description. | | |
| **Numerator Exclusions** | The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. | | |
| **Setting** | Ambulatory | | |
| **Data Source** | Administrative clinical data; Laboratory data; Pharmacy data | | |
| **Denominator Sub-set Definition (Optional)** | Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process.  **Payer:** Providers may define the denominator population such that it is limited to one of the following options:   1. Medicaid 2. Uninsured/Indigent 3. Both: Medicaid and Uninsured/Indigent   **Gender:** Providers may define the denominator population such that it is limited to one of the following options:   1. Male 2. Female   **Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options:   1. White/Caucasian 2. Black/African American 3. Latino/Hispanic 4. Asian 5. American Indian/Alaskan Native 6. Native Hawaiian/Other Pacific Islander   **Age:** Providers may define the denominator population such that it is limited to an age range:  Lower Bound: \_\_\_\_ (Provider defined)  Upper Bound: \_\_\_\_ (Provider defined)  **Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions:  Comorbid condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined)  **Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s).  Service Setting/Delivery Location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined) | | |
| **Demonstration Years** | **DY3**  **10/01/13 – 09/30/14** | **DY4**  **10/01/14 – 09/30/15** | **DY5**  **10/01/15 – 09/30/16** |
| **Measurement Periods**  *(Note: For P4P measures, DY3 Measurement Period is equivalent to the Baseline Period for purposes of measuring improvement.)* | **Providers must report data for one of the following DY, SFY, or CY time periods:**  12 Month Period:   1. 10/01/13 – 09/30/14, or 2. 09/01/13 – 08/31/14, or 3. 01/01/13 – 12/31/13, or 4. 10/01/12 – 09/30/13, or 5. 09/01/12 – 08/31/13   6 Month Period:   1. 04/01/14 – 09/30/14, or 2. 03/01/13 – 08/31/14, or 3. 01/01/13 – 06/30/13, or 4. 07/01/13 – 12/31/13   Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC. | **Providers must report data across a 12-month time period that meets the following parameters:**  1. Start date: The start date for the reporting period must occur after the provider’s DY3 Measurement Period.  2. End date: The end date for the reporting period must occur on or before 09/30/15. | **Providers must report data across a 12-month time period that meets the following parameters:**  1. Start date: The start date for the reporting period must occur after the provider’s DY4 Measurement Period.  2. End date: The end date for the reporting period must occur on or before 09/30/16. |
| **Reporting Opportunities to HHSC** | 10/31/2014 | 4/30/2015  10/31/2015 | 4/30/2016  10/31/2016 |
| **Pay for Performance Target Methodology** | Not Applicable | QISMC | QISMC |
| **Pay for Performance QISMC Benchmark Definition** | Not Applicable | National/ 90th- Medicaid | National/ 90th- Medicaid |
| **Pay for Performance QISMC Benchmark Source** | Not Applicable | HEDIS Quality Compass | HEDIS Quality Compass |
| **Pay for Performance QISMC High Performance Level Definition** | Not Applicable | 90th percentile | 90th percentile |
| **Pay for Performance QISMC High Performance Level Value** | Not Applicable | 76.64% | 76.64% |
| **Pay for Performance QISMC Minimum Performance Level Definition** | Not Applicable | 25th percentile | 25th percentile |
| **Pay for Performance QISMC Minimum Performance Level Value** | Not Applicable | 61.7% | 61.7% |