

Quality Measures Using New Medicare Claims Data

July 1, 2011

The Centers for Medicare & Medicaid Services required the reporting of the Kt/V reading and date of the reading, vascular access type, and access-related infection data on dialysis facility Medicare claims with dates of service on or after July 1, 2010. More information about this data collection is available through [Med Learn Matters Article 6782](#). This document describes the quality measures that will be calculated using these new data.

Vascular Access Infection

The measure reports the rate of hemodialysis access-related bacteremia. It uses the V8 HCPCS modifier on monthly Medicare dialysis facility claims. The measure is calculated by dividing the number of hemodialysis patients with an access-related bacteremia documented and treated by the number of eligible hemodialysis patients, resulting in a monthly rate of bacteremia reports per patient. The number is then converted to a rate per 1000 hemodialysis days (a common reporting convention).

Pediatric patients (patients <18 years of age) and peritoneal dialysis patients are excluded from the calculation of the measure.

Measure Calculation Details

As sufficient data are collected over time, quality measures will be summarized to annual periods. Annual measures will be similar to those currently reported on Dialysis Facility Compare and used in the 2012 ESRD QIP for anemia management and hemodialysis adequacy which calculate a patient's average (e.g., mean or median) value at the facility during the year.

A patient can be included in a facility's calculation regardless of whether the patient was also treated at another facility. Hence, a patient who is treated at more than one facility during the measure period may be included at multiple facilities as long as the patient meets the inclusion criteria at each facility. Currently the anemia management and hemodialysis adequacy measures on Dialysis Facility Compare and used in the 2012 ESRD QIP require a patient to have four months of claims at a facility to be included.

National measures are calculated using the patient's last claim of the month regardless of facility (to avoid double-counting patients who transfer facilities during a month).