

# Comments on the Entry and Verification Criteria in general

## Draft CMS Submission for discussion with RETAP on 26 March 2009

The following areas of concern in the Entry and Verification Criteria were identified during the development of the invasive audit module and need to be addressed in the next version of the Entry and Verification Criteria:

- Age band calculation
- Beneficiary active status
- Authorisation active dates
- Diagnosis of cases that have been started with treatment before January 2006
- Registered medical practitioner
- Interpretation of the algorithms for:
  - Diabetes (DM1 and DM2)
  - Multiple Sclerosis
  - Rheumatoid Arthritis
  - Hyperlipidaemia
  - Chronic Renal Disease
  - Maternity

### Age band calculation

Current wording: Section 3.4 in version 4:

*The age band is determined by taking age last birthday on 1 January. The beneficiary is then placed in the appropriate age band. Under 1, 1-4, 5-9, 10-14, ... , 75-79, 80-84 or 85+.*

The age bands are unfortunately open for different interpretation and it is recommended that we use the open and close bracket notation, or we must define it more clearly if we want to use the old notation.

A closed bracket will include the nearest value in the interval and an open bracket will exclude the nearest value in the interval. For a beneficiary to be included in the age band [1; 5), the beneficiary should be one or older, but not five yet.

Current notation	Alternative notation
Under 1	(Under 1)
1-4	[1;5)
5-9	[5;10)
10-14	[10; 15)
15-19	[15; 20)
20-24	[20; 25)
25-29	[25; 30)
30-34	[30; 35)
35-39	[35; 40)
40-44	[40; 45)
45-49	[45; 50)
50-54	[50; 55)
55-59	[55; 60)

60-64	[60; 65)
65-69	[65; 70)
70-74	[70; 75)
75-79	[75; 80)
80-84	[80; 85)
85+	[85+ )

Below is an example of a programming code that could be used to calculate the different age bands. The first step in the age band calculation is to calculate the exact age of a beneficiary for a specific grid period. For any month in 2009 it would be:

```
AgeGrid='01JAN2009'D;
Age=(AgeGrid-Birthdate)/365.25;

IF Age LT 1 THEN AgeBand EQ 'Under 1';
IF Age GE 1 AND Age LT 5 THEN AgeBand EQ '1-4';
IF Age GE 5 AND Age LT 10 THEN AgeBand EQ '5-9';
IF Age GE 10 AND Age LT 15 THEN AgeBand EQ '10-14';
.
.
.
IF Age GE 80 AND Age LT 85 THEN AgeBand EQ '80-84';
IF Age GE 85 THEN AgeBand EQ '85+';
```

Note:    LT = Less than  
           GE = Greater equal to  
           EQ = Equal to

### Beneficiary active status

A beneficiary qualifies to be counted for the REF grid if a beneficiary is entitled to benefits in respect of that month. The Cover start date should be less than or equal to the last day of the grid month.

From section 3.3 in the Entry and Verification criteria it is not clear what is meant by that the service date is used to establish in which month a beneficiary is counted. The service date is only applicable on the CDL counting.

### Authorisation active date

A beneficiary qualifies to be counted in a grid for a specific CDL, if the authorisation active date is less or equal than the last day of the grid month. This must be defined in more detail in the Entry and Verification criteria. Multiple authorisation dates with different sets of ICD10 codes can make the extraction of data and auditing very difficult.

## **Diagnosis of cases that have been started with treatment before January 2006**

Only the testing for a valid registered medical practitioner and a valid ICD10 code(s) are necessary for cases where the diagnoses was made before 1 January 2006. In some cases the application of the rule is not clear – whether it pertains to all aspects of the criteria other than the list of ICD codes, or only the diagnosing provider type aspects of the criteria. This arrangement must be reviewed by RETAP.

## **Registered medical practitioner**

Registered medical practitioner is not properly defined in the Entry & Verification Criteria. The schemes must know against what standard or body (BHF, etc.) they must compare a practice to verify if a medical practitioner is registered, or not.

## **Diabetes (DM1 and DM2)**

Differential diagnosis for Diabetes Type 1 or 2 seems to depend on claims data. It's also not clear what is meant by "Evidence of use of oral hypoglycaemic or euglycaemic agents".

It is not clear if the evidence is dependant on the count rule (2/3) for Diabetes Type 2. With the current layout it is possible to exclude a beneficiary who has received insulin treatment in one of the preceding three months of the grid month, if he or she has also received oral treatment once.

The algorithm (table layout) should be restructured. One rule for Diabetes Type 1 and another for Diabetes Type 2 and another rule where the patient is on insulin and oral medicine treatment. Alternatively, they can be combined as only Diabetes. It will make the extraction and classification process for the scheme much easier.

This matter will also be dealt with by representatives from CDE who have agreed to attend RETAP meeting.

## **Multiple Sclerosis**

For MSS, the claims related info is for drugs in specified ATC classes, but also for the hospitalisation code G35. Together with the ICD10 code, G35, the schemes must have proof of a hospital admission (such as hospital admission date) for Multiple Sclerosis.

## **Rheumatoid Arthritis**

The table layout for Rheumatoid Arthritis can be improved. It is not clear if the diagnosis codes are applicable for the listed practice types, or for all practice types. There appears to be some confusion between treatment and diagnosis (there is duplication in the table).

The algorithm should be divided in two rules. The first rule should be for any registered medical practitioner combined with the list of ICD10 codes and a subset of the ATC codes (one or more of: A07EC01, L01AA01, L01BA01, L04A, M01C or P01BA01).

The second rule should be applicable on the specialist physicians, paediatricians or rheumatologists combined with the list of ICD10 codes and the complete list of ATC codes (one or more of: A07EC01, H02AB, L01AA01 , L01BA01 , L04A , M01AB , M01AC , M01AE , M01AF , M01AG , M01AH , M01C or P01BA01).

### **Hyperlipidaemia**

If possible, the Hyperlipidaemia algorithm should be simplified. In the current table layout it is not clear if there are specific ICD10 codes for genetic hyperlipidaemia diagnosed by an endocrinologist. A practice type for an endocrinologist on its own is not enough proof of authorisation.

### **Chronic Renal Disease**

For Chronic Renal Disease, the definition of the practice specific tariff (treatment/service) codes should allow for tariff codes led by the practice type. The term 'sessions' should be more clearly defined; i.e. can a session only occur over one day or can it be split over a couple of days?

### **Maternity**

In the current table layout it is not clear if both the procedure codes and diagnosis codes are a prerequisite, or if only one of them is necessary for authorisation. This could be easily done in a Boolean table as for the other criteria.