eCQM Title	**Diabetes: Glycemic Status Assessment Greater Than 9%**		
eCQM Identifier (Measure Authoring Tool)	122	**eCQM Version Number**	13.0.000
CBE Number	Not Applicable	**GUID**	f2986519-5a4e-4149-a8f2-af0a1dc7f6bc
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	National Committee for Quality Assurance		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	None		
Description	Percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) > 9.0% during the measurement period		
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Measure Scoring	Proportion		
Measure Type	Intermediate Clinical Outcome		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Diabetes is the seventh leading cause of death in the United States (Centers for Disease Control and Prevention [CDC], 2022a). In 2019, diabetes affected more than 37 million Americans (11.3% of the U.S. population) and killed more than 87,000 people (American Diabetes Association [ADA], 2022a). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (CDC, 2022a). People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney damage, amputation of feet or legs, and premature death (CDC, 2022b). In 2017, diabetes cost the U.S. an estimated $327 billion: $237 billion in direct medical costs and $90 billion in reduced productivity. This is a 34% increase from the estimated $245 billion spent on diabetes in 2012 (ADA, 2018). Controlling A1c blood levels helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) (ADA, 2022b).		
Clinical Recommendation Statement	American Diabetes Association (2023): - Assess glycemic status (A1C or other glycemic measurement such as time in range or glucose management indicator) at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control). (Level of evidence: E) - An A1C goal for many nonpregnant adults of <7% (53 mmol/mol) without significant hypoglycemia is appropriate. (Level of evidence: A) - On the basis of health care professional judgement and patient preference, achievement of lower A1C levels than the goal of 7% may be acceptable and even beneficial if it can be achieved safely without significant hypoglycemia or other adverse effects of treatment. (Level of evidence: B) - Less stringent A1C goals (such as <8% [64 mmol/mol]) may be appropriate for patients with limited life expectancy or where the harms of treatment are greater than the benefits. Health care professionals should consider deintensification of therapy if appropriate to reduce the risk of hypoglycemia in patients with inappropriate stringent A1C targets. (Level of evidence: B) - Standardized, single-page glucose reports from continuous glucose monitoring (CGM) devices with visual cues, such as the ambulatory glucose profile, should be considered as a standard summary for all CGM devices. Level of evidence: E		
Improvement Notation	Lower score indicates better quality		
Reference	Reference Type: CITATION Reference Text: 'American Diabetes Association. (2018). Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care, 41, 917-928. Retrieved from http://care.diabetesjournals.org/content/early/2018/03/20/dci18-0007'		
Reference	Reference Type: CITATION Reference Text: 'American Diabetes Association. (2022a). Statistics About Diabetes. Retrieved from https://diabetes.org/about-us/statistics/about-diabetes'		

Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2022a). What is Diabetes? Retrieved from https://www.cdc.gov/diabetes/basics/diabetes.html'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2022b). Diabetes Report Card 2021. US Dept of Health and Human Services. Retrieved from https://archive.cdc.gov/www_cdc_gov/diabetes/library/reports/reportcard.html'
Reference	Reference Type: CITATION Reference Text: 'ElSayed, N.A., Aleppo, G., Ardoda, V.R., Bannuru, R.B., Brown, F.M., Bruemmer, D.,…Staton, R.C., American Diabetes Association (ADA). (2022). 6. Glycemic Targets: Standards of Care in Diabetes—2023. Diabetes Care 2023,46(Supplement_1):S97–S110. https://doi.org/10.2337/dc23-S006'
Definition	None
Guidance	If the glycemic status assessment (HbA1c or GMI) is in the medical record, the test can be used to determine numerator compliance. Glycemic status assessment (HbA1c or GMI) must be reported as a percentage (%). If multiple glycemic status assessments were recorded for a single date, use the lowest result. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period. Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period. Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: - Advanced illness diagnosis during the measurement period or the year prior - OR taking dementia medications during the measurement period or the year prior Exclude patients receiving palliative care for any part of the measurement period.
Numerator	Patients whose most recent glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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Population Criteria

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
) in Interval[18, 75]
  and exists ( "Qualifying Encounters" )
  and exists ( ["Diagnosis": "Diabetes"] Diabetes
      where Diabetes.prevalencePeriod overlaps day of "Measurement Period"
  )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or AIFrailLTCF."Is Age 66 or Older with Advanced Illness and Frailty"
  or PalliativeCare."Has Palliative Care in the Measurement Period"
```

Numerator

```
"Has Most Recent Glycemic Status Assessment Without Result"
  or "Has Most Recent Elevated Glycemic Status Assessment"
  or "Has No Record Of Glycemic Status Assessment"
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

AIFrailLTCF.Has Advanced Illness in Year Before or During Measurement Period

```
exists ( ["Diagnosis": "Advanced Illness"] AdvancedIllnessDiagnosis
    where AdvancedIllnessDiagnosis.prevalencePeriod starts during day of Interval[start of "Measurement Period" - 1 year, end of "Measurement Period"]
)
```

AIFrailLTCF.Has Criteria Indicating Frailty

```
exists ( ["Device, Order": "Frailty Device"] FrailtyDeviceOrder
    where FrailtyDeviceOrder.authorDatetime during day of "Measurement Period"
)
  or exists ( ["Assessment, Performed": "Medical equipment used"] EquipmentUsed
      where EquipmentUsed.result in "Frailty Device"
        and Global."NormalizeInterval" ( EquipmentUsed.relevantDatetime, EquipmentUsed.relevantPeriod ) ends during day of "Measurement Period"
  )
  or exists ( ["Diagnosis": "Frailty Diagnosis"] FrailtyDiagnosis
      where FrailtyDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
  )
  or exists ( ["Encounter, Performed": "Frailty Encounter"] FrailtyEncounter
      where FrailtyEncounter.relevantPeriod overlaps day of "Measurement Period"
  )
  or exists ( ["Symptom": "Frailty Symptom"] FrailtySymptom
      where FrailtySymptom.prevalencePeriod overlaps day of "Measurement Period"
  )
```

AIFrailLTCF.Has Dementia Medications in Year Before or During Measurement Period

```
exists (["Medication, Active": "Dementia Medications"] DementiaMedication
  where Global."NormalizeInterval" ( DementiaMedication.relevantDatetime, DementiaMedication.relevantPeriod ) overlaps day of Interval[start of "Measurement Period" -
1 year,
  end of "Measurement Period"])
```

AIFrailLTCF.Is Age 66 or Older Living Long Term in a Nursing Home

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  )>= 66
)
  and ( ( Last(["Assessment, Performed": "Housing status"] HousingStatus
        where Global."NormalizeInterval"(HousingStatus.relevantDatetime, HousingStatus.relevantPeriod) ends on or before day of
        end of "Measurement Period"
        sort by
        end of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)asc
    )) LastHousingStatus
      where LastHousingStatus.result ~ "Lives in nursing home (finding)"
  ) is not null
```

AIFrailLTCF.Is Age 66 or Older with Advanced Illness and Frailty

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  ) >= 66
    and "Has Criteria Indicating Frailty"
    and ( "Has Advanced Illness in Year Before or During Measurement Period"
        or "Has Dementia Medications in Year Before or During Measurement Period"
    )
)
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or AIFrailLTCF."Is Age 66 or Older with Advanced Illness and Frailty"
  or PalliativeCare."Has Palliative Care in the Measurement Period"
```

Glycemic Status Assessment

```
( ["Laboratory Test, Performed": "HbA1c Laboratory Test"]
  union ["Laboratory Test, Performed": "Glucose management indicator"] ) GlycemicStatus
  where Global."LatestOf" ( GlycemicStatus.relevantDatetime, GlycemicStatus.relevantPeriod ) during day of "Measurement Period"
```

Has Most Recent Elevated Glycemic Status Assessment

```
"Lowest Glycemic Status Assessment Reading on Most Recent Day".result > 9 '%'
```

Has Most Recent Glycemic Status Assessment Without Result

```
"Lowest Glycemic Status Assessment Reading on Most Recent Day" is not null
  and "Lowest Glycemic Status Assessment Reading on Most Recent Day".result is null
```

Has No Record Of Glycemic Status Assessment

```
not exists "Glycemic Status Assessment"
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
        or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps day of "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps day of "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps day of "Measurement Period"
  )
or exists ( ["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
      where HospiceCareDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
  )
```

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
) in Interval[18, 75]
  and exists ( "Qualifying Encounters" )
  and exists ( ["Diagnosis": "Diabetes"] Diabetes
      where Diabetes.prevalencePeriod overlaps day of "Measurement Period"
  )
```

Lowest Glycemic Status Assessment Reading on Most Recent Day

```
First("Glycemic Status Assessment" QualifyingGlycemicStatus
    where Global."LatestOf"(QualifyingGlycemicStatus.relevantDatetime, QualifyingGlycemicStatus.relevantPeriod) same day as "Most Recent Glycemic Status Date"
    sort by(result as Quantity)
)
```

Most Recent Glycemic Status Date

```
Last(("Glycemic Status Assessment" QualifyingGlycemicStatus
    return date from start of Global."NormalizeInterval"(QualifyingGlycemicStatus.relevantDatetime, QualifyingGlycemicStatus.relevantPeriod))
QualifyingGlycemicStatusDays
    sort asc
)
```

Numerator

```
"Has Most Recent Glycemic Status Assessment Without Result"
  or "Has Most Recent Elevated Glycemic Status Assessment"
  or "Has No Record Of Glycemic Status Assessment"
```

PalliativeCare.Has Palliative Care in the Measurement Period

```
exists ( ["Assessment, Performed": "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)"] PalliativeAssessment
    where Global."NormalizeInterval" ( PalliativeAssessment.relevantDatetime, PalliativeAssessment.relevantPeriod ) overlaps day of "Measurement Period"
)
  or exists ( ["Diagnosis": "Palliative Care Diagnosis"] PalliativeDiagnosis
      where PalliativeDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
  )
  or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
      where PalliativeEncounter.relevantPeriod overlaps day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
      where Global."NormalizeInterval" ( PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod ) overlaps day of "Measurement Period"
  )
```

Qualifying Encounters

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Home Healthcare Services"]
  union ["Encounter, Performed": "Nutrition Services"]
  union ["Encounter, Performed": "Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes"]
  union ["Encounter, Performed": "Telephone Visits"] ) ValidEncounters
  where ValidEncounters.relevantPeriod during day of "Measurement Period"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer Type"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.HasEnd(period Interval<DateTime>)

```
not (
  end of period is null
    or
    end of period = maximum DateTime
)
```

Global.Latest(period Interval<DateTime>)

```
if ( HasEnd(period)) then
end of period
  else start of period
```

Global.LatestOf(pointInTime DateTime, period Interval<DateTime>)

```
Latest(NormalizeInterval(pointInTime, period))
```

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Glucose management indicator" ("LOINC Code (97506-0)")

- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Housing status" ("LOINC Code (71802-3)")
- code "Lives in nursing home (finding)" ("SNOMEDCT Code (160734000)")
- code "Medical equipment used" ("LOINC Code (98181-1)")
- code "Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes" ("HCPCS Code (G0271)")
- code "Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes" ("CPT Code (97804)")
- code "Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes" ("CPT Code (97802)")
- code "Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes" ("CPT Code (97803)")
- code "Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes" ("HCPCS Code (G0270)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Dementia Medications" (2.16.840.1.113883.3.464.1003.196.12.1510)
- valueset "Diabetes" (2.16.840.1.113883.3.464.1003.103.12.1001)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Frailty Device" (2.16.840.1.113883.3.464.1003.118.12.1300)
- valueset "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)
- valueset "Frailty Encounter" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Frailty Symptom" (2.16.840.1.113883.3.464.1003.113.12.1075)
- valueset "HbA1c Laboratory Test" (2.16.840.1.113883.3.464.1003.198.12.1013)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Nutrition Services" (2.16.840.1.113883.3.464.1003.1006)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Payer Type" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal) (LOINC Code 71007-9)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Assessment, Performed: Housing status" using "Housing status (LOINC Code 71802-3)"
- "Assessment, Performed: Medical equipment used" using "Medical equipment used (LOINC Code 98181-1)"
- "Device, Order: Frailty Device" using "Frailty Device (2.16.840.1.113883.3.464.1003.118.12.1300)"
- "Diagnosis: Advanced Illness" using "Advanced Illness (2.16.840.1.113883.3.464.1003.110.12.1082)"
- "Diagnosis: Diabetes" using "Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)"
- "Diagnosis: Frailty Diagnosis" using "Frailty Diagnosis (2.16.840.1.113883.3.464.1003.113.12.1074)"
- "Diagnosis: Hospice Diagnosis" using "Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165)"
- "Diagnosis: Palliative Care Diagnosis" using "Palliative Care Diagnosis (2.16.840.1.113883.3.464.1003.1167)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Frailty Encounter" using "Frailty Encounter (2.16.840.1.113883.3.464.1003.101.12.1088)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes" using "Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes (HCPCS Code G0271)"
- "Encounter, Performed: Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes" using "Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes (CPT Code 97804)"
- "Encounter, Performed: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes" using "Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes (CPT Code 97802)"
- "Encounter, Performed: Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes" using "Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes (CPT Code 97803)"
- "Encounter, Performed: Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes" using "Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes (HCPCS Code G0270)"
- "Encounter, Performed: Nutrition Services" using "Nutrition Services (2.16.840.1.113883.3.464.1003.1006)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Palliative Care Encounter" using "Palliative Care Encounter (2.16.840.1.113883.3.464.1003.101.12.1090)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services Initial Office Visit, 18 and Up" using "Preventive Care Services Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Palliative Care Intervention" using "Palliative Care Intervention (2.16.840.1.113883.3.464.1003.198.12.1135)"
- "Laboratory Test, Performed: Glucose management indicator" using "Glucose management indicator (LOINC Code 97506-0)"
- "Laboratory Test, Performed: HbA1c Laboratory Test" using "HbA1c Laboratory Test (2.16.840.1.113883.3.464.1003.198.12.1013)"
- "Medication, Active: Dementia Medications" using "Dementia Medications (2.16.840.1.113883.3.464.1003.196.12.1510)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer Type" using "Payer Type (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Symptom: Frailty Symptom" using "Frailty Symptom (2.16.840.1.113883.3.464.1003.113.12.1075)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer Type"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None