

# NATIONAL QUALITY FORUM

TO: NQF Members

FR: NQF staff

RE: Revised voting draft for *National Voluntary Consensus Standards for Ambulatory Care: Additional Eye Care and Melanoma Measures*

DA: June 23, 2009

## BACKGROUND

In the past several years NQF has addressed the great interest in information about the quality of physician performance and clinician-level measurement by endorsing more than 100 clinician-level ambulatory care performance measures in a variety of areas. During the 2007 review, candidate eye care (cataracts) and skin care (melanoma) measures were not endorsed despite the importance and impact of these conditions. In a continuation of the Ambulatory Care project, ten revised and updated measures for eye care and melanoma have been reviewed to fill the gaps in the endorsed measures. Two measures for melanoma and four eye care measures are recommended for endorsement.

## COMMENTS AND REVISED DRAFT REPORT

The public comment period for the *National Voluntary Consensus Standards for Ambulatory Care: Additional Eye Care and Melanoma Measures* draft report closed on April 7. NQF received approximately 86 comments from 18 organizations and individuals. The comments are available for review at <http://www.qualityforum.org/projects/ongoing/ambulatory/eyederm/view.asp> Measure evaluations, summaries of the Steering Committee deliberations, and a table of detailed comments submitted during the review period with responses and actions taken by the Steering Committee are also posted on the NQF voting web page.

The Steering Committee reviewed the comments including the feedback on measure *AED-08-08 20/40 Visual Acuity after Cataract Surgery* with did not have a consensus recommendation and requests for reconsideration of two measures not recommended. The report has been modified to reflect these comments and the Steering Committee's responses. The revised (redlined) report with the proposed measure set, recommendations, and research recommendations is attached. Syntheses of several of the major concerns identified during the review period are summarized below.

## Recommended Measures

### 1. **AED-003-08 Melanoma Coordination of Care (©AAD/PCPI/NCQA)**

During the comment period CMS advised that experience in the field identified difficulties in implementation of this measure. The measure developers addressed CMS's difficulties with revisions of the specifications to add ICD-9 and CPT procedure codes to better align with office work flow.

### 2. **AED-04-08 Melanoma: Appropriate Use of Imaging Studies (©AAO/PCPI/NCQA)**

During the comment period, NQF received many supportive comments, however, it was suggested that a more appropriate name for the measure would use the term "appropriate

use” rather than “overuse”. The measure developer has renamed the measure “Appropriate Use of Imaging Studies.”

**3. AED-05-08 Primary Open Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care (©AAO/PCPI/NCQA)**

During the review period, several comments supported the concern about whether the 15% reduction was the appropriate target. The measure developer responded “the glaucoma measure was developed in a similar manner as other NQF-endorsed measures including the NQF-endorsed measure, #0059, ‘Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control)’ measure. A slightly less aggressive target was selected, 15% reduction, because this is constructed as a “failure” measure: everyone can agree that a reduction of 15% is the floor or minimum reduction. If this reduction cannot be achieved, then treatment has “failed” and a new plan of care is required. It is for this reason that the threshold set for this measure differs from the figures found in the scientific evidence and in the American Academy of Ophthalmology’s Preferred Practice Pattern.

Several comments questioned how this measure is reported since it contains both a process and an outcome component. The measure developer clarified that there should be 3 rates reported:

- % of patients for whom either the intermediate outcome was achieved or the process of care was completed – % of patients whose most recent IOP was reduced by at least 15% from the pre-intervention level OR if it was not reduced by at least 15% a plan of care was documented.
- % of patients for whom the intermediate outcome was achieved – % of patients whose most recent IOP was reduced by at least 15% from the pre-intervention level.
- % of patients for whom the process of care was completed – % of patients whose most recent IOP was not reduced by at least 15% but a plan of care was documented.

**4. AED-07-08 Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures (©AAO/PCPI/NCQA)**

During the comment period, one reviewer asked how the number of exclusions affects the reliability and validity of the measure. The measure developer responded “as the measure was developed, a large insurance company ran its claims to gather information for this measure. Only about one- third of the claims were dropped because of these exclusions. Thus, by defining an uncomplicated cataract, it provides a “clean” indicator that captures care for the large majority of patients undergoing cataract surgery. This preservation of over 2/3 of cataract surgery cases for analysis was also seen in the results of the Cataract Appropriateness Project at RAND. As this measure will be endorsed as time-limited, we will continue to explore the reliability and validity of the measure including the exclusions, which serve as a proxy for risk adjustment.”

**Measure without Consensus Recommendation**

**AED-08-08 Cataracts: 20/40 or Better Visual Acuity within 90 days following Cataract Surgery (©AAO/PCPI/NCQA)**

During the comment period, numerous comments were submitted in support of the measure, citing the importance of outcome measures, the high volume of cataract surgery and the lack of data on current performance for non-academic or community practitioners. The Steering

Committee considered the review comments and a majority recommended the measure for time-limited endorsement.

### **Measures Not Recommended**

#### **1. AED-06-08 Primary Open Angle Glaucoma: Counseling on Glaucoma (©AAO/PCPI/NCQA)**

The Steering Committee reviewed several comments requesting reconsideration of this measure because it addresses a National Priorities Partnership area of patient engagement and that treatment adherence is concern that impacts outcomes. The Steering Committee reconsidered this measure but again did not recommend it for endorsement due to continuing concerns about the meaning and likely variability in the quality of “counseling” and the ultimate relationship to outcomes.

#### **2. AED-09-08 Comprehensive Pre-Operative Assessment for Cataract Surgery with Intraocular Lens (IOC) Placement (©AAO/PCPI/NCQA)**

The Steering Committee reviewed several comments requesting reconsideration of this measure because it is a measure of “appropriateness” for a frequently performed surgical procedure. The Steering Committee reconsidered the measure; however, again the majority did not recommend the measure for endorsement because the concern that the compliance gap could represent a documentation issue rather than true poor performance has not been addressed.

### **NQF Member Voting**

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted by e-mail and identify the submitter, organization and the specific ballot item that the comments accompany.

**Please note that voting concludes on Wednesday, July 22, 2009 at 6:00 PM Eastern Time – no exceptions.**

# NATIONAL QUALITY FORUM

## NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR AMBULATORY CARE: ADDITIONAL EYE CARE AND MELANOMA PERFORMANCE MEASURES

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# NATIONAL QUALITY FORUM

## NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR AMBULATORY CARE: ADDITIONAL EYE CARE AND MELANOMA MEASURES

### EXECUTIVE SUMMARY

In the past several years NQF has addressed the great interest in information about the quality of physician performance and clinician-level measurement by endorsing more than 100 clinician-level ambulatory care performance measures in a variety of areas. During the 2007 review, candidate eye care (cataracts) and skin care (melanoma) measures were not endorsed despite the importance and impact of these conditions. Ten revised and updated measures in these topic areas have been reviewed to fill the gaps in the endorsed measures for ambulatory care.

The Steering Committee used NQF's standardized measure evaluation criteria, revised August 2008, to evaluate the measures. This report recommends 56 performance measures for eye care and melanoma for time-limited endorsement as voluntary consensus standards:

- ◆ Melanoma Coordination of Care
  - ◆ Melanoma: ~~Over-utilization of Imaging Studies in Stage 0-1A Melanoma~~ Appropriate Use of Imaging Studies
  - ◆ Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care
  - ◆ Cataracts: Complications within 30 days following cataract surgery requiring additional surgical procedures
  - ◆ Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- ~~The Steering Committee could not reach a consensus recommendation for one measure:~~
- ◆ Cataracts: 20/20 or better visual acuity within 90 days following cataract surgery

The purpose of these consensus standards is to improve the quality of healthcare – via accountability and public reporting – by standardizing quality measurement in all relevant care settings. All NQF-endorsed measures are fully disclosed and available for use by any interested parties. The eye care and melanoma consensus standards are intended for use at clinician and group level assessment.

# THE NATIONAL QUALITY FORUM

## NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR AMBULATORY CARE: ADDITIONAL EYE CARE AND MELANOMA MEASURES

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## NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR AMBULATORY CARE: ADDITIONAL EYE CARE AND MELANOMA MEASURES

### BACKGROUND

In the past several years NQF has addressed the great interest in information about the quality of physician performance and clinician-level measurement by endorsing more than 80 clinician-level ambulatory care performance measures in a variety of areas: asthma/respiratory illness; bone and joint conditions; diabetes; heart disease; hypertension; medication management; mental health and substance abuse; obesity; prenatal care; and prevention/ immunization/ screening<sup>1</sup>. Twenty additional measures for clinician-level specialty care in the ambulatory setting were endorsed in 2007<sup>2</sup> for the areas of bone and joint conditions (osteoporosis); emergency care; eye care; geriatrics; and gastrointestinal conditions. During the 2007 review, candidate eye care (cataracts) and skin care (melanoma) measures were not endorsed despite the importance and impact of these conditions. Ten revised and updated measures in these topic areas have been reviewed to fill the gaps in the endorsed measures for ambulatory care.

### STRATEGIC DIRECTIONS FOR NQF

As NQF nears completion of its first decade, consideration of strategic issues to guide current and future activities has resulted in an expansion of NQF's mission to include three parts: 1) establishing priorities and goals for performance improvement; 2) endorsing performance measures; and 3) education and outreach. As greater numbers quality measures are developed and brought to NQF for consideration of endorsement, it is incumbent on NQF to assist stakeholders to "measure what makes a difference" and address what is important to achieve the best outcomes for patients and populations. An updated Measurement Framework, reviewed by NQF Members in December 2007, promotes shared accountability and measurement across episodes of care with a focus on outcomes, appropriateness, and

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<sup>1</sup> National Quality Forum. *National Voluntary Consensus Standards for Ambulatory Care: Parts 1 and 2*. Washington, DC: National Quality Forum; 2006. [http://www.qualityforum.org/publications/reports/ambulatory\\_parts12.asp](http://www.qualityforum.org/publications/reports/ambulatory_parts12.asp)

<sup>2</sup> National Quality Forum. *National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures*. Washington, DC: National Quality Forum; 2007. [http://www.qualityforum.org/publications/reports/ambulatory\\_clinician.asp](http://www.qualityforum.org/publications/reports/ambulatory_clinician.asp)

cost/resource use measures, coupled with quality measures.

Several strategic issues have been identified to guide consideration of candidate consensus standards:

Driving toward high performance. Over time, the bar of performance expectations should be raised to encourage achievement of higher levels of system performance.

Emphasis on composite measures. Composite measures provide much needed summary information pertaining to multiple dimensions of performance, and are more comprehensible to patients and consumers.

Moving toward outcomes measurement. Outcomes measures provide information of intense interest to consumers and purchasers, and, when coupled with healthcare process measures, provide useful and actionable information to providers. Outcome measures also focus attention on much-needed system-level improvements, because achieving the best patient outcomes often requires carefully designed care process, teamwork, and coordinated action on the part of many providers.

Consider disparities in all that we do. All Americans should receive quality health care, regardless of their race, ethnicity, language, and socioeconomic status. Unfortunately, significant healthcare disparities persist. Particular attention should be focused on identifying disparity-sensitive measures and strategies that move toward routine data collection of race, ethnicity, and language data and stratification of disparities-sensitive performance measures for reporting purposes.

## EVALUATING POTENTIAL CONSENSUS STANDARDS

During the initial review of eye and skin care measures, the Steering Committee and Technical Advisory Panels made numerous suggestions on revising and improving candidate measures in these topic areas. Four updated skin care (melanoma) measures and six eye care measures were submitted to NQF to fill important gaps in the ambulatory care measure set. The Ambulatory Care Steering Committee evaluated the candidate standards using the standardized criteria revised in August 2008<sup>3</sup>. The revisions to the criteria were made to achieve:

- a stronger link to national priorities and higher-level performance measures;

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<sup>3</sup> [http://www.qualityforum.org/about/leadership/measure\\_evaluation.asp](http://www.qualityforum.org/about/leadership/measure_evaluation.asp)

- greater measure harmonization;
- greater emphasis on outcome measures; and
- for process measures, a tighter outcomes-process linkage.

The revised standardized criteria are:

*Important to Measure and Report* - The specific measure focus (i.e., what is measured) should be important enough to expend resources for measurement and reporting, not merely that it is related to an important broad topic area. Important to Measure and Report is a “must pass” criterion, which emphasizes that finite resources for collecting and reporting quality measures should be used only for the most important measures that will drive improvement in healthcare quality.

*Scientifically acceptability of Measure Properties* – This criterion applies to measure properties (e.g., reliability and validity) and all the sub-criteria reflect that focus. This criterion still includes: precise specifications, reliability, validity, discrimination, and risk-adjustment. The modifications clearly indicate that testing is expected to demonstrate reliability and validity.

*Usable* - Demonstrates that the measure results are meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement. This is consistent with NQF policy of not endorsing measures solely for quality improvement.

*Feasible* – Feasibility is important to adoption and ultimate impact of the measure and needs to be assessed through testing or actual operational use of the measures.

## RELATIONSHIP TO OTHER NQF-ENDORSED CONSENSUS STANDARDS

NQF has endorsed four eye care measures at the clinician-level:

- ◆ Primary Open Angle Glaucoma: Optic Nerve Evaluation © AAO/AMA PCPI/NCQA
- ◆ Age-Related Macular Degeneration: Dilated Macular Examination © AAO/AMA PCPI/NCQA
- ◆ Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy © AAO/AMA PCPI/NCQA
- ◆ Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care © AAO/AMA PCPI/NCQA

No measures for melanoma were endorsed during the 2007 review, however, it was noted that measures assessing dermatologic care are urgently needed. Recommendations were made for measure development measures of coordination and continuity of care as well as measures in other dermatologic areas besides melanoma.

**NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR EYE CARE AND MELANOMA**

This report recommends 56 performance measures for eye care and melanoma (Table 1) for time-limited endorsement as voluntary consensus standards. ~~The Steering Committee could not reach a consensus recommendation for one measure—the issues and discussion are described below.~~—The purpose of these consensus standards is to improve the quality of healthcare—via accountability and public reporting—by standardizing quality measurement in all relevant care settings. All NQF-endorsed measures are fully disclosed and available for use by any interested parties. The eye care and melanoma consensus standards are intended for use at clinician and group level assessment.

The Steering Committee determined that one of the melanoma measures, AED-02-08 Melanoma Continuity of Care- Recall System, would be better considered by the Care Coordination project that has recently begun. The Committee noted that recall systems may be important aspects of care coordination but questioned whether multiple condition-specific recall system measures would be the best approach. The Committee recommended that the Care Coordination Steering Committee consider this measure within a global consideration of care coordination.

**TABLE 1: NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR AMBULATORY CARE: ADDITIONAL EYE CARE AND MELANOMA MEASURES, 2009**  
**All measures are recommended for time-limited endorsement<sup>4</sup>**

Title	Description	IP Owner <sup>5</sup>
<b>MELANOMA</b>		
<b>AED-03-08</b>	Percentage of patients seen with a new occurrence of melanoma	©AAD/PCPI/

<sup>4</sup> NQF Board allows “time-limited endorsement” for up to 2-years for measures meeting ALL criteria except field testing. [http://www.qualityforum.org/pdf/txtime%20limited%20endorsement\\_CSAC\\_edits11-12-07.pdf](http://www.qualityforum.org/pdf/txtime%20limited%20endorsement_CSAC_edits11-12-07.pdf)

<sup>5</sup> Intellectual Property and copyright owners ALL RIGHTS RESERVED:  
 PCPI – American Medical Association sponsored Physician Consortium for Performance Improvement  
 AAD – American Academy of Dermatology  
 AAO – American Academy of Ophthalmology  
 NCQA- National Committee for Quality Assurance

Melanoma Coordination of Care	who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis	NCQA
<b>AED-04-08</b> Melanoma: <del>Over Utilization of Imaging Studies in Stage 0-IA Melanoma</del> <u>Appropriate Use of Imaging Studies</u>	Percentage of patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies were ordered	©AAD/PCPI/NCQA
<b>EYE CARE</b>		
<b>AED-05-08</b> Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months	©AAO/PCPI/NCQA
<b>AED-07-08</b> Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	©AAO/PCPI/NCQA
<b>AED-10-08</b> Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD  Definition of counseling: Documentation in the medical record should include a discussion of the risks and/or benefits of the AREDS formulation. This can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk of cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given some of the purported risks associated with antioxidant use, patients should be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate about overuse as well as appropriate use	©AAO/PCPI/NCQA

<u><a href="#">AED-08-08 Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</a></u>	<u><a href="#">Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery</a></u>	<u><a href="#">©AAO/PCPI/ NCQA</a></u>

## MELANOMA

The American Cancer Society estimates that about 62,480 new melanomas will be diagnosed in the United States during 2008. Incidence rates for melanoma increased sharply at about 6% per year in the 1970s. During the 1980s and 1990s, the rate of increase slowed to a little less than 3% per year. Since 2000, the rate has been fairly stable. About 8,420 people in the United States are expected to die of melanoma during 2008. The death rate has been stable since the 1990s for those older than 50, and has been dropping in those younger than 50.

Melanoma is more than 10 times more common in whites than in African Americans. It is slightly more common in males than in females. Overall, the lifetime risk of getting melanoma is about 2% (1 in 50) for whites, 0.1% (1 in 1,000) for blacks, and 0.5% (1 in 200) for Hispanics. Unlike many other common cancers, melanoma has a wide age distribution. It occurs in younger as well as older people. Rates continue to increase with age and are highest among those in their 80s, but melanoma is not uncommon even among those younger than 30. In fact, it is one of the more common cancers in adolescents and young adults.

## MEASURES RECOMMENDED

### **AED-003-08 Melanoma Coordination of Care (©AAD/PCPI/NCQA)**

Guidelines from National Institute for Health and Clinical Excellence (UK) (NICE) state that there should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the specialist to the primary care provider.

The Steering Committee noted that this measure supports the NPP priority of care coordination, though information on current performance is lacking. Patients who self-refer to specialists are of particular concern as the PCP may not receive any information. The measure developer responded to the Committee's request for clarification on the meaning of "communication: *"Communication may include: documentation in the medical record indicating that the physician treating the melanoma communicated (eg, verbally, by letter, copy of treatment plan sent) with the physician(s) providing continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma."* The measure developer also clarified a question about the timing, specifically "around 1 month", which was defined as "from the time the biopsy result is reported by the pathologist". The Committee agreed that this measure is intended to measure the clinician managing the melanoma regardless of specialty.

During the comment period CMS advised that experience in the field identified difficulties in implementation of this measure. The measure developers addressed CMS's difficulties with revisions of the specifications to add ICD-9 and CPT procedure codes to better align with office work flow.

**AED-04-08 Melanoma: ~~Over-utilization of Imaging Studies in Stage 0-1A Melanoma~~ Appropriate Use of Imaging Studies (©AAD/PCPI/NCQA)**

Ninety per cent of new melanomas are Stage 0-1A and there are 700,000 people with the diagnosis. The measure developer noted that melanoma care costs \$240 million/year and as much as 50% is related to routine imaging ordered by a host of providers, including dermatologist and primary care physicians. The benefit of the routine use of imaging studies in early stage melanoma has not been demonstrated to impact outcomes. Several studies support the overall perception that imaging studies are performed much too frequently and are not only clinically unnecessary, but also costly. <sup>i,ii,iii,iv,v</sup> This measure addresses the NPP goal of overuse. The technical advisor noted that the NCCN guideline for not imaging in Stage 0-1A melanoma is in response to general perception of widespread overuse

In response to the Committee's request for clarification on the intent of the measure, the developer responded that "any imaging studies ordered during the one year measurement time frame would be considered as a failure of the measure, unless an exception is documented." The measure is intended to measure any clinician who manages melanoma and applies to "all patients, regardless of age, with Stage 0 or IA melanoma, seen for an office visit during the one-year measurement period."

During the comment period, NQF received many supportive comments, however, it was suggested that a more appropriate name for the measure would use the term "appropriate use" rather than "overuse". The measure developer has renamed the measure "Appropriate Use of Imaging Studies."

## EYE CARE

Glaucoma, cataracts and macular degeneration are common eye conditions that threaten the eye sight of many patients annually:

Glaucoma - According to the Glaucoma Research Foundation over 4 million Americans have glaucoma but only half of those know they have it, accounting for 9% to 12% of all cases of blindness in the U.S. Glaucoma is the leading cause of blindness among African-Americans. Glaucoma is 6 to 8 times more common in African-Americans than Caucasians and African-Americans ages 45-65 are 14 to 17 times more likely to go blind from glaucoma than Caucasians with glaucoma in the same age group. Glaucoma accounts for over 7 million visits to physicians each year. In terms of Social Security benefits, lost income tax revenues, and health care expenditures, the cost to the U.S. government is estimated to be over \$1.5 billion annually. (NEI, Report of Glaucoma Panel, Fall 1998)

Cataracts - According to the National Eye Institute and Prevent Blindness America, (2002) cataracts affect nearly 20.5 million Americans age 40 and older. By age 80, more than half of all Americans have cataracts. It is estimated that the federal government spends more than \$3.4 billion each year treating cataracts through the Medicare program<sup>vi</sup>.

Age-related Macular Degeneration (AMD) - Age-related macular degeneration affects more than 1.75 million individuals in the United States. Owing to the rapid aging of the US population, this number will increase to almost 3 million by 2020<sup>vii</sup>.

## MEASURES RECOMMENDED

### **AED-05-08 Primary Open Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care (©AAO/PCPI/NCQA)**

This is a combined process and outcome measure designed by the developers as a “failure” measure” rather than an assessment of optimal management. The technical advisors noted that this level of treatment may not prevent blindness and questioned why 15% reduction in IOP was chosen as opposed to aligning with studies that indicate 18% as presented by the measure developer. The measure developer noted that 15% is more easily calculated – particularly for clinicians in the office. During the review period, several comments supported the concern about whether the 15% reduction was the appropriate target. The measure developer responded “the glaucoma measure was developed in a similar manner as other NQF-endorsed measures including the NQF-endorsed measure, #0059, ‘Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control)’ measure. A slightly less aggressive target was selected, 15% reduction, because this is constructed as a “failure” measure: everyone can agree that a reduction of 15% is the floor or minimum reduction. If this reduction cannot be achieved, then treatment has “failed” and a new plan of care is required. It is for this reason that the threshold set for this measure differs from the figures found in the scientific evidence and in the American Academy of Ophthalmology’s Preferred Practice Pattern.

Current performance data was not provided though many perceive the gap in performance to be as much as 50%. According to the measure developer, “plan of care” includes documentation of allergies to medications and surgical alternatives. ~~The measure developer recommends reporting two rates: (1) % reduction >15% and (2) plan of care.~~

Several comments questioned how this measure is reported since it contains both a process and an outcome component. The measure developer clarified that there should be 3 rates reported:

1. % of patients for whom either the intermediate outcome was achieved or the process of care was completed – % of patients whose most recent IOP was reduced by at least 15% from the pre-intervention level OR if it was not reduced by at least 15% a plan of care was documented.

2. % of patients for whom the intermediate outcome was achieved – % of patients whose most recent IOP was reduced by at least 15% from the pre-intervention level.
3. % of patients for whom the process of care was completed – % of patients whose most recent IOP was not reduced by at least 15% but a plan of care was documented.

**AED-07-08 Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures (©AAO/PCPI/NCQA)**

This measure of adverse outcomes for patients undergoing cataract surgery is important to patients and providers alike. The developer noted that use of this measure based on administrative data in a “major payer” group identified a complication rate of 1-2%. Steering Committee members were concerned with the large number of exclusions allowed – the measure developer reported that in the same “major payer” analysis, only 25% of patients were excluded. The developer also noted that due to the large number of exclusions, for the remaining patients complications are “never event” and the target should be 0%. The measure applies to all sites of care including hospitals and ambulatory surgery centers. A Steering Committee member asked why not develop a more traditional method of outcomes measurement, such as a registry with a risk model. The AAO measure developer noted that attempts to establish a registry have not been successful to date.

During the comment period, one reviewer asked how the number of exclusions affects the reliability and validity of the measure. The measure developer responded “as the measure was developed, a large insurance company ran its claims to gather information for this measure. Only about one- third of the claims were dropped because of these exclusions. Thus, by defining an uncomplicated cataract, it provides a “clean” indicator that captures care for the large majority of patients undergoing cataract surgery. This preservation of over 2/3 of cataract surgery cases for analysis was also seen in the results of the Cataract Appropriateness Project at RAND. As this measure will be endorsed as time-limited, we will continue to explore the reliability and validity of the measure including the exclusions, which serve as a proxy for risk adjustment.”

**AED-10-08 Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement**

The AREDS Research Group reported that if all patient at risk would receive supplements, more than 300,000 (95% confidence interval, 158,000 – 487,000) would avoid advanced AMD and any associated vision loss during the next 5 years<sup>viii</sup>. The measure developer noted that this measure is revised from a measure considered two year ago in which the supplements were “prescribed”. As a result of concerns revealed in a JAMA article in February 2007<sup>ix</sup>, the measure was changed from definitive therapy to counseling of all patients. The developer noted that the American Academy of Ophthalmology has clear guidelines on who is appropriate for treatment. It is expected that the record will indicate a discussion all patients, including those in which the supplements are not indicated. The Steering Committee requested clarification on how counseling is defined, particularly the frequency and the level of documentation. The measure developer clarified the definition in the measure specifications.

**TABLE 2: MEASURE WITHOUT A CONSENSUS RECOMMENDATION**

Title	Description	IP-Owner <sup>6</sup>
<p><del>AED-08-08 Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</del></p>	<p><del>Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery</del></p>	<p>©AAO/PCPI/NCQA</p>

**AED-08-08 Cataracts: 20/40 or Better Visual Acuity within 90 days following Cataract Surgery (©AAO/PCPI/NCQA)**

Even though the measure assesses a readily understandable and important outcome, the Steering Committee questioned the value of a measure for which data on current performance is already very high. Committee members noted that the reference submitted by the measure developer of the NEON<sup>x</sup> study of reports a 96% performance for uncomplicated cataract surgery (complicated cases are excluded from this measure). Technical advisors noted that detecting differences among providers at such a high performance level would require large numbers of patients. It was also noted that CMS doesn’t use visual acuity for determining the

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 AAD – American Academy of Dermatology  
 AAO – American Academy of Ophthalmology  
 NCQA- National Committee for Quality Assurance

need for cataract surgery, but uses ADLs instead. Initially, the Committee felt the measure did not meet the ‘Importance to measure and report’ criteria, specifically on the “demonstrated quality problem and opportunity for improvement”.

In response, the measure developer submitted additional information which explained that AAO’s NEON database report “was not a representative sample, but rather a small (249 out of 15,000 practicing ophthalmologists), self-selected sample of ophthalmologists who chose to participate on a voluntary basis, and may not have reported on all of their cases. There was never any audit to verify the accuracy or completeness of data reporting.” The Committee looked at other sources for current performance. A review of the literature regarding cataract surgery outcome also report high levels of performance on populations that sometimes included more pre-existing ocular disease to range from 91-95%<sup>xi, xii, xiii, xiv</sup>. Some Committee members concluded that current performance across the nation may be variable and some opportunity for quality improvement may be possible; others were not convinced that this measure will provide meaningful and actionable information, particularly in determining differences among providers, compared to the cost of data collection and measurement. ~~The Committee did not reach consensus on whether or not to recommend this measure for endorsement.~~

During the comment period, numerous comments were submitted in support of the measure, citing the importance of outcome measures, the high volume of cataract surgery and the lack of data on current performance for non-academic or community practitioners. The Steering Committee considered the review comments and a majority recommended the measure for time-limited endorsement.

## MEASURES NOT RECOMMENDED

### AED-01-08 Melanoma Follow Up Measure

This measure assesses the percentage of patients with a new diagnosis of melanoma or a history of melanoma who received all of the following aspects of care within the 12 month reporting period: (1) patient was asked about new and changing moles AND (2) patient received a complete physical skin examination AND (3) Patient was counseled to perform a monthly self skin examination. The Steering Committee noted this process has little documented

relationship to patient outcomes even though it should be a routine part of care. Committee members were concerned that it is too easy to simply document an exam regardless of how thoroughly performed – the developer believe that it takes only a few minutes to conduct a proper exam.

**AED-06-08 Primary Open Angle Glaucoma: Counseling on Glaucoma (©AAO/PCPI/NCQA) Importance Discussion:**

This measure addresses the percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma or their caregiver who were counseled within 12 months about 1) the potential impact of glaucoma on their visual functioning and quality of life, and 2) the importance of treatment adherence. Studies suggest that patient education and informed participation in treatment decisions may improve adherence<sup>xv</sup>. The Steering Committee felt this measure did not meet the criteria for opportunity for improvement since current performance is unclear; low on relationship to outcomes because the effectiveness of counseling is unclear.

The Steering Committee reviewed several comments requesting reconsideration of this measure because it addresses a National Priorities Partnership area of patient engagement and that treatment adherence is concern that impacts outcomes. The Steering Committee reconsidered this measure but again did not recommend it for endorsement due to continuing concerns about the meaning and likely variability in the quality of “counseling” and the ultimate relationship to outcomes.

**AED-09-08 Comprehensive Pre-Operative Assessment for Cataract Surgery with Intraocular Lens (IOC) Placement (©AAO/PCPI/NCQA)**

This measure evaluates the pPercentage of patients aged 18 years and older with a procedure of cataract surgery with IOL placement who received a comprehensive preoperative assessment of 1) dilated fundus exam, 2) axial length, corneal keratometry measurement, and method of IOL power calculation; and 3) functional or medical indication(s) for surgery prior to the cataract surgery with IOL placement within 12 months prior to cataract surgery. The Steering Committee agreed that appropriate pre-operative assessment is important for good quality care, but felt that the reported 10-30% compliance gap represents a documentation issue rather than true poor performance.

The Steering Committee reviewed several comments requesting reconsideration of this measure because it is a measure of “appropriateness” for a frequently performed surgical procedure. The Steering Committee reconsidered the measure; however, again the majority did not recommend the measure for endorsement because of the concern that the compliance gap could represent a documentation issue rather an indication of poor performance.

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**NATIONAL VOLUNTARY CONSENSUS STANDARDS AMBULATORY CARE:  
 ADDITIONAL EYE CARE AND MELANOMA PERFORMANCE MEASURES, 2009  
 APPENDIX A: MEASURE SPECIFICATIONS**

Measure	Numerator	Denominator	Exclusions	Data Source
<b>MELANOMA</b>				
<b>AED-003-08</b>  <b>Melanoma Coordination of Care</b>  IP Owner: ©AAD/PCPI/ NCQA <sup>1</sup>	<p>Patients who have a treatment plan* documented in the chart that was communicated** to the physician(s) providing continuing care within a month of diagnosis</p> <p>*A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.</p> <p>**Communication may include: documentation in the medical record indicating that the physician treating the melanoma communicated (eg, verbally, by letter, copy of treatment plan sent) with the physician(s) providing continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma</p> <p>CPT Category II code: 5050F-Treatment plan communicated to provider(s) managing continuing care within one month of diagnosis</p>	<p>All patients, regardless of age, diagnosed with a new occurrence of melanoma            ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9            AND            CPT E/M codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245  <del>CPT Category II code: 1127F-New episode for condition</del>  <b>OR</b>  <u>172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9</u>  <b>AND</b>  <u>11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14300, 17311, 17313</u></p>	<p>Documentation of patient reason(s) for not communicating treatment plan (eg, patient asks that treatment plan not be communicated physician(s) providing continuing care)            Append modifier to CPT Category II code: 5050F-2P</p> <p>Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (eg, patient does not have a PCP or referring physician)            Append modifier to CPTII Category II code: 5050-3P</p>	<p>Paper Medical Record,            Electronic Claims,            Electronic Health/Medical Record, Other</p>

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**NQF VOTING DRAFT—DO NOT CITE OR QUOTE**  
**NQF MEMBER VOTING CLOSSES WEDNESDAY, JULY 22, 2009 6:00PMET**

Measure	Numerator	Denominator	Exclusions	Data Source
<b>AED-004-08</b>  <b>Appropriate Use of Imaging Studies in Stage 0-IA Melanoma</b>  IP Owner: ©AAD/PCPI/ NCQA	<p>Patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies* were ordered</p> <p>*Diagnostic imaging studies include CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans. "Ordering any of these imaging studies during the one-year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exclusion.</p> <p>CPT Category II code:            3320F–None of the following diagnostic imaging studies ordered: chest x-ray, CT, Ultrasound, MRI, PET, and nuclear medicine scans            OR            3319F- One of the following diagnostic imaging studies ordered: chest X-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans</p>	<p>All patients, regardless of age, with stage 0 or 1A melanoma, seen for an office visit during the one-year measurement period.</p> <p>ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82</p> <p>AND</p> <p>CPT E/M codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245</p> <p>AND</p> <p>CPT Category II code: 3321F–AJCC Melanoma Cancer Stage 0-1A, documented</p> <p>OR</p> <p>3322F- Melanoma greater than AJCC Stage 0 or IA</p> <p><b>Note: Only patients with Melanoma Stage 0 or IA will be counted in the performance denominator of this measure; if patient has Melanoma greater than AJCC Stage 0 or IA, numerator does not apply.</b></p>	<p>Documentation of medical reason(s) for ordering diagnostic imaging studies (e.g., patient has signs or symptoms that justify imaging studies)</p> <p>Append modifier to CPT Category II code: 3319F-1P</p> <p>Documentation of system reason(s) for ordering diagnostic imaging studies (e.g., requirement for clinical trial enrollment, ordered by another provider)</p> <p>Append modifier to CPT Category II code: 3319F-3P</p>	<p>Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other</p>
<b>EYE CARE</b>				
<b>AED-005-08</b>  <b>Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care</b>	<p>Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months</p> <p>Plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or</p>	<p>All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma</p> <p>ICD-9 diagnosis codes: 365.01, 365.10, 365.11, 365.12, 365.15</p> <p>AND</p> <p>CPT E/M Codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99215, 99241, 99242, 99243, 99244, 99245, 99307, 99308, 99309, 99310, 99324, 99325,</p>	<p>Documentation of system reason(s) for not reducing the IOP by at least 15% from the pre-intervention level or not documenting a plan of care.</p> <p>Append modifier to CPT Category II code: 0517F-3P</p>	<p>Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other</p>

Measure	Numerator	Denominator	Exclusions	Data Source
IP Owner: ©AAO/PCPI/ NCQA <sup>2</sup>	referral to a specialist CPT Category II code: 3284F- Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level OR A. CPT Category II code: 3285F- Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level AND B. CPT Category II code: 0517F- Glaucoma plan of care documented	99326, 99327, 99328, 99334, 99335, 99336, 99337 AND Patients aged 18 years and older		
<b>AED-007-08</b>  <b>Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures</b>  IP Owner: ©AAO/PCPI/ NCQA	Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence CPT Procedure Codes: 65920, 66820, 66830, 66852, 65235, 67005, 67010, 67015, 67025, 67028, 65800, 65810, 65815, 67030, 67031, 67036, 67038, 67039, 66825, 66986, 67101, 67105, 67107, 67036, 67038, 67039, 67108, 67110, 67112, 67141, 67145, 66250, 67250, 67255, 65860, 65880, 65900, 65930, 66030	All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate  CPT Procedure Codes: 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984 AND Patients aged 18 years and older	Patients with any of the following comorbid conditions impacting the surgical complication rate (see Denominator Exclusions spreadsheet- attached)	Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other

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Measure	Numerator	Denominator	Exclusions	Data Source
<b>AED-010-08</b> <b>Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement</b>  IP Owner: ©AAO/PCPI/ NCQA	<p>Patients with AMD or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD</p> <p>CPT Category II code: 4177F-Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s)</p> <p>Definition of counseling: Documentation in the medical record should include a discussion of the risks and/or benefits of the AREDS formulation. This can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk of cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given some of the purported risks associated with antioxidant use, patients should be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate about overuse as well as appropriate use.</p>	<p>All patients aged 50 years and older with a diagnosis of age-related macular degeneration</p> <p>ICD-9 diagnosis codes: 362.50, 362.51, 362.52</p> <p>AND</p> <p>CPT E/M codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99215, 99241, 99242, 99243, 99244, 99245, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337</p> <p>AND</p> <p>Patients aged 50 years and older</p>	<p>Documentation of system reason(s) for not counseling on the benefits and/or risks of the AREDS formulation with the patient or caregiver(s)</p> <p>Append modifier to CPT Category II code: 4177F-3P</p>	<p>Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other</p>
<b>AED-008-08</b> <b>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</b> IPOwner:©AAO/ PCPI/NCQA	<p>Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery</p> <p>CPT Category II code: 4175F-Best-corrected visual acuity of 20/40 or better (distance or near) achieved within the 90 days following cataract surgery</p>	<p>All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the visual outcome of surgery</p> <p>CPT Procedure Codes (with or without modifiers): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984</p> <p>AND</p> <p>Patients aged 18 years and older</p>	<p>Patients with any of the following comorbid conditions that impact the visual outcome of surgery (See Denominator Exclusions Spreadsheet-attached)</p>	<p>Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other</p>