TO: NQF Members and Public

FR: NQF Staff

RE: Pre-voting review for National Voluntary Consensus Standards: Cancer Endorsement Maintenance

DA: April 17, 2012

Cancer refers to a group of more than 100 diseases characterized by uncontrolled cellular growth, proliferation, and spread. This group of diseases has an enormous impact on health in the US. As the second leading cause of death, cancer was responsible for an estimated 569,490 deaths among adults and children in 2010. Measuring quality of care for the many patients diagnosed with any of these diseases is important to ensure safe, cost-effective care consistent with the current evidence base. The recommended measures include measures endorsed prior to 2009 that have undergone maintenance. The majority of measures considered focus on melanoma, hematology, general oncology, prostate, lung, and palliative and end-of-life care.

A 21-member Steering Committee representing a range of stakeholder perspectives was appointed to review a total of 26 candidate and endorsement maintenance standards for quality performance in melanoma, hematology, general oncology, prostate, lung, and palliative and end-of-life care in this phase. The Steering Committee is recommending 21 measures, 2 of which are being recommended for time-limited endorsement.

The draft document, National Voluntary Consensus Standards: Cancer Endorsement Maintenance is posted on the NQF website along with the following additional information:

- Measure submission forms
- Meeting and call transcripts and recordings from the Steering Committee’s discussions.

Pursuant to section II.A of the Consensus Development Process v. 1.9, this draft document, along with the accompanying material, is being provided to you at this time for purposes of review and comment only and is not intended to be used for voting purposes. You may post your comments and view the comments of others on the NQF website.

NQF Member and Public comments must be submitted no later than 6:00 pm ET, May 16, 2012.

Thank you for your interest in NQF’s work. We look forward to your review and comments.
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INTRODUCTION
Cancer refers to a group of more than 100 diseases characterized by uncontrolled cellular growth, proliferation, and spread. This group of diseases has an enormous impact on health in the US. As the second leading cause of death, cancer was responsible for an estimated 569,490 deaths among adults and children in 2010. The National Cancer Institute estimates that half of all men and one-third of all women in the US will develop cancer during their lifetimes. Diagnosis and treatment of cancer also has great economic impact as well. In 2010, the estimated total annual costs of cancer reached $263.8 billion: $102.8 billion in direct medical costs; $20.9 billion in loss of productivity from illness; and $140.1 billion in lost productivity from premature death. Despite enormous focus on prevention and treatment of disease, inconsistencies in cancer care exist, with many patients not receiving care that follows clinical practice guidelines. Studies demonstrate persistent socioeconomic disparities in treatment and survival for many different types of cancer, including gastric, breast, prostate, and lung cancers.

Cancer care is complicated for many reasons: treatment regimens are complex, often involving multiple providers, settings of care, and levels of treatment; patients with cancer often require individualized therapies; an evolving evidence base for treatment exists; and care can be hampered by a sometimes limited supply of highly specialized personnel or technologies. There is a need for measures that address the quality of cancer care, taking into account the nuances mentioned.

The Cancer Endorsement Maintenance Project seeks to evaluate for endorsement measures for accountability and quality improvement that address breast, colorectal, lung, prostate, hematologic and skin cancers, as well as symptom management and end of life care. Cancer care consensus standards that have been endorsed by NQF before 2009 are evaluated under the maintenance process. Endorsement maintenance ensures the currency of NQF’s portfolio of voluntary consensus standards, provides the opportunity to harmonize specifications, and ensures that endorsed measures represent the best in class. Measures that address specific aspects of the National Quality Strategy (NQS)—particularly those focused on person and family engagement, communication, coordination and safety are a priority.

MEASURE EVALUATION
To facilitate the evaluation the project is divided into two phases. For the first phase the Cancer Endorsement Maintenance Steering Committee reviewed candidate standards relating to hematologic, lung, esophageal, skin, prostate, and colon cancer as well as palliative care. Committee members were divided into four workgroups. The workgroups conducted a preliminary review of measures against the evaluation sub-criteria prior to consideration by the entire Steering Committee. At its in-person meeting on March 13-14, 2012 the Committee evaluated four new measures and 22 measures undergoing maintenance review against NQF’s measure evaluation criteria. The Committee’s discussion and rating of the criteria are summarized in the evaluation tables beginning on page 7.
TABLE 1: CANCER ENDORSEMENT MAINTENANCE SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>MAINTENANCE</th>
<th>NEW</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures under consideration</td>
<td>23</td>
<td>4*</td>
<td>27</td>
</tr>
<tr>
<td>Withdrawn from consideration</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Recommended</td>
<td>17</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Not recommended</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Reasons for Not Recommending</td>
<td>Importance - 4</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Scientific Acceptability - 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Includes two untested measures eligible for time-limited endorsement.

Overarching Issues

During the Steering Committee’s discussion of the measures, several overarching issues emerged that were factored into their ratings and recommendations. These issues are discussed in detail in the following sections.

Palliative Measures

The Steering Committee noted that several of the palliative care measures including receipt of chemotherapy (#0210), having more than one emergency room visit (#0211) and admission to the ICU in the last days of life (#0213) can and should happen in some cases. The Committee agreed that the measures would be useful for detecting patterns in practice, variation in performance and identifying outliers when comparing similar practices with similar patient populations; addressing patient preference and overtreatment at the end of life; and, reflecting disparities in access to care and the capacity of the local healthcare system to treat patients appropriately at the end of life. The Committee also noted that two measures related to admission to hospice and hospice length of stay were important as they could indicate a need for more hospice facilities or a need for greater physician and patient education around using this resource, leading to improved patient-centered quality of care. The Committee also noted that the area of palliative care and the concept of hospice and the settings in which hospice care is given are evolving and that future measures should consider that palliative care may be provided in the home, special facility, or in a hospital.

Harmonization of Related Measures

The Steering Committee recommended that the developer harmonize measures related to pain assessment and pain treatment. There was a preference for a standardized quantitative pain tool that could be used across measures. It was also suggested that in the future, measures relating to care plans for pain should be broadly specified to include all patients regardless of the type of modality of treatment as additional data collection methods become more common, including registry reporting and EHR reporting. The related measure comparison table is in Appendix C. Comments are requested.

Electronic Health Record Specifications

One measure recommended for endorsement in this phase was submitted with additional electronic specifications: #0389 Prostate Cancer: Avoidance of Overuse Measure - Bone Scan for Staging Low
Risk Patients. This was one of the measures retooled in 2010 and updated in 2011. The submitted e-specifications were reviewed by NQF health IT staff.

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MEASURES RECOMMENDED

Hematology and Melanoma Measures

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<th>Numerator Statement</th>
<th>Denominator Statement</th>
<th>Exclusions</th>
<th>Adjustment/Stratification</th>
<th>Level of Analysis</th>
<th>Type of Measure</th>
<th>Data Source</th>
<th>Measure Steward</th>
<th>Other organizations</th>
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</thead>
<tbody>
<tr>
<td>0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow.</td>
<td>Patients who had baseline cytogenetic testing* performed on bone marrow</td>
<td>All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia</td>
<td>Documentation of medical reason(s) for not performing baseline cytogenetic testing</td>
<td>No risk adjustment or risk stratification</td>
<td>Clinician : Group/Practice, Clinician : Individual, Clinician : Team</td>
<td>Process</td>
<td>Administrative claims, Electronic Clinical Data : Laboratory</td>
<td>American Medical Association - Physician Consortium for Performance Improvement</td>
<td>The American Society of Hematology</td>
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</tbody>
</table>

Rationale: Myelodysplastic Syndrome (MDS) is increasingly common in an aging population and associated with high morbidity and mortality; baseline cytogenetic testing performed on bone marrow is important to measure and report due to its role in evaluating and managing this patient population. There is a striking performance gap: 48% non-compliance was demonstrated in the CMS 2008 Physician Quality Reporting System (PQRS). Measurement of cytogenetics at the time of diagnosis or prior to treatment has become the standard of care since therapies are stratified based on the cytogenetic profile. There was concern that the literature cited and rationale provided by measure authors focuses mainly on the use of cytogenetics in MDS and its evolution to acute myelogenous leukemia (AML) and does not include much information on de novo AML. Although much of the literature presented in the application is based on retrospective reviews, there is some prospective randomized literature in AML that is stratified based on prognostic factors (including cytogenetics) to indicate that cytogenetic abnormalities predict outcome. However, this measure is based mainly on a consensus guideline from the National Comprehensive Cancer Network (NCCN). The authors grade the literature as 2A based on lower level evidence.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) Rationale: The PCPI Testing Project shows interobserver variability is minimal. Face validity is well demonstrated. The measure directs that the data be gathered in the ambulatory setting. For acute leukemia, much of the care is in the hospital setting. The Steering Committee recommended reporting the measure with a CPT procedure code or CPT-2 code in order to capture the inpatient setting.
0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow

- Extraction of data from separate EHRs was not addressed. The number of patients analyzed for these measures was small, and the sample needed to be extended beyond the scope of the measure to achieve an adequate sample for analysis.

3. Usability: H-10; M-6; L-1; I-0
(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

**Rationale:**
- The measure has been in use in the CMS Physician Quality Reporting System (PQRS) since 2007
- The data presented demonstrate a high failure rate to meet the measure, and since treatment is stratified based on the presence of cytogenetic information prior to initiating therapy this measure represents a highly useful measure for quality improvement.

4. Feasibility: H-5; M-11; L-1; I-0
(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)

**Rationale:**
- Collection of this data is a routine part of care.
- Data can be extracted, but may exist in different EHRs.

Steering Committee Recommendation for Endorsement: Y-17; N-0

**Rationale:**
- The measure represents standard of care measure that is useful to stratify treatments, possibly decrease toxicities and costs and assure appropriate therapies. The measure appears to be reliable, valid, useful and feasible.

RECOMMENDATIONS:
- This measure is becoming outdated, as diagnostic panels for MDS and acute leukemias rely heavily upon molecular panels and FISH in addition to standard cytogenetics. The responsibility for these assays is also divided between pathologists (who have no ongoing relationship with patients) and hematologists, who provide ongoing care. The Steering Committee recommended that the measure developer consider specifying this measure in the future to capture FISH and other tests.
- The Steering Committee recommended the measure developer consider specifying the measure to capture patients with MDS, acute myelogenous leukemia and acute lymphoblastic leukemia. The Committee believed that karyotypic data, stratified appropriately, might provide a way to make major therapeutic decisions with respect to the patient population.

0378 Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

**Maintenance Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy

**Numerator Statement:** Patients with documentation* of iron stores within 60 days prior to initiating erythropoietin therapy

*Definition: documentation of iron stores which includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC

**Denominator Statement:** All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy

**Exclusions:** Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy

**Adjustment/Stratification:** No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Society of Hematology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-3; M-11; L-1; I-0; 1b. Performance Gap: H-5; M-7; L-3; I-0; 1c. Evidence: Y-15, N-0, I-0
### 0378 Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

**Rationale:**
- This is an increasingly common condition, with diagnosis rising as the population continues to age.
- There is a significant performance gap: 58% of patients did not meet the measure as demonstrated in the PQRS testing information.
- The measure is based on a National Comprehensive Cancer Network (NCCN) consensus guideline.
- The measure only requires that iron stores be checked, not that an intervention as a result of the iron level occur (it would be far more important to document and supplement iron in patients receiving erythropoietin therapy). This is an area for future measure development.
- This patient population falls outside of FDA regulations for testing of iron stores; this may make this measure more important.

#### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

**2a. Reliability:**
- **H-4**; **M-10**; **L-0**; **I-1**

**Rationale:**
- Numerator and denominator are precisely specified; clarification of the definition of “iron stores” in the numerator statement and specification of a 60-day time window the denominator allow for the measure to be precisely captured.
- Reliability data supports that the measure is reliable.
- Face validity has been demonstrated.

**2b. Validity:**
- **H-5**; **M-9**; **L-0**; **I-1**

**Rationale:**
- Numerator and denominator are precisely specified; clarification of the definition of “iron stores” in the numerator statement and specification of a 60-day time window the denominator allow for the measure to be precisely captured.
- Reliability data supports that the measure is reliable.
- Face validity has been demonstrated.

#### 3. Usability: **H-5; M-8; L-2; I-0**

*(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

**Rationale:**
- The measure has been in use in PQRS since 2007.
- The measure should be moderately understandable for public reporting.

#### 4. Feasibility: **H-7; M-8; L-0; I-0**

*(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)*

**Rationale:**
- Collection of this data is a routine part of care.
- Data can be extracted but may exist in different EHRs.

### Steering Committee Recommendation for Endorsement:

**Rationale:**
- The Committee’s initial evaluation supported endorsement with clarification of iron measurements, which were addressed by the developer.
- The Committee noted that erythropoietin works sub optimally without adequate iron stores, and that the measure reflects FDA recommendations.
- The measure was improved with the addition of a testing time window, as the diagnosis of MDS may precede decision to use erythropoietin by many months if not years.
- This measure does not carry a high risk of unintended consequences.

**RECOMMENDATIONS:**
- The measure was not voted on at the in-person meeting due to ambiguity in the measure specifications. The Steering Committee asked the developer to clarify the definition of “iron stores” in the numerator statement and to specify time window the denominator. On a follow up call, the Steering Committee reviewed the measure with the clarified numerator and the addition of a 60-day time window to the denominator for the documentation of iron stores prior to the initiation of erythropoietin therapy. The Committee agreed with the changes and recommended the measure for endorsement.

### 0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

**Maintenance Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

**Numerator Statement:** Patients who had baseline flow cytometry* studies performed

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**NATIONAL QUALITY FORUM**

**NQF REVIEW DRAFT—DO NOT CITE OR QUOTE**

Comments due by May 16, 2012 by 6:00 PM ET
0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy.

**Denominator Statement:** All patients aged 18 years and older seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period

**Exclusions:**
- Documentation of medical reason(s) for not performing baseline flow cytometry
- Documentation of patient reason(s) for not performing baseline flow cytometry
- Documentation of system reason(s) for not performing baseline flow cytometry

**Adjustment/Stratification:** No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician: Group/Practice, Clinician: Individual, Clinician: Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Laboratory

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement

**Other organizations:** American Society of Hematology

**Steering Committee In-Person March 13-14, 2012**

1. Importance to Measure and Report: The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-7; M-5; L-3; I-0; 1b. Performance Gap: H-2; M-10; L-2; I-1; 1c. Evidence: Y-14, N-0, I-1
   **Rationale:**
   - This is the most common leukemia and involves high resource use.
   - There is a performance gap: a 38% failure to perform shown in PQRS testing.
   - Flow cytometry is important in diagnosis and treatment planning, but the data provided do not provide adequate rationale for measure. They discuss delays in diagnosis but measure is for flow cytometry following diagnosis or before treatment. So it is unclear how this would shorten time to diagnosis.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-5; M-9; L-0; I-1; 2b. Validity: H-5; M-9; L-0; I-1
   **Rationale:**
   - The measure is confusing. It specifies a 12-month reporting period in which all patients with CLL are captured in the denominator. However, flow cytometry may have been performed years prior to the initiation of treatment and reporting event. The numerator therefore may not correspond to the same reporting period as the denominator. The measure may be relying upon interventions done many years earlier. Per the Steering Committee’s recommendation, the developer will clarify the time window for flow cytometry studies to be performed.
   - The Steering Committee noted that the clarification that flow cytometry baseline studies should take place at the time of diagnosis or prior to initiating treatment, and not necessarily within the time window for the measure, adds the necessary clarity to the measure specifications to make it easily captured.

3. Usability: H-5; M-7; L-2; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
   **Rationale:**
   - The measure has been in use in PQRS since 2007.
   - The measure should be moderately understandable for public reporting.

4. Feasibility: H-3; M-11; L-1; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)
   **Rationale:**
   - Collection of this data is a routine part of care.
   - Data can be extracted but may exist in different EHRs.

**Steering Committee Recommendation for Endorsement**

**Rationale:** Y-13; N-2
- The measure is improved with clarification of numerator/denominator.
- There is some concern about use as a quality measure as diagnosis is made based on flow cytometry results.
**0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry**

- Flow cytometry is sensitive and specific for diagnosis, impacts prognosis and decisions regarding follow-up; questions about time frames have been addressed.
- Even with the caveats discussed, the measure provides a reasonable assessment of quality care.
- Important to measure, and developer clarified numerator and denominator for more reliable measurement.

**RECOMMENDATIONS:** The Steering Committee did not recommend the measure at the in-person meeting; voting ended at 2.a Reliability. The Committee noted that the numerator should be clarified to identify patients who had documentation of the study having been performed, and that the denominator should be clarified regarding the time window. On a follow up call, the developer provided clarifications to the numerator and denominator for review and consideration by the Committee. The Committee agreed with the changes presented and recommended the measure for endorsement.

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**0380 Multiple Myeloma – Treatment with Bisphosphonates**

**Maintenance Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period

**Numerator Statement:** Patients who were prescribed or received intravenous bisphosphonate therapy* within the 12 month reporting period.

**Definition:** *Bisphosphonate Therapy: Includes the following medications: pamidronate and zoledronate*

**Denominator Statement:** All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission

**Exclusions:** Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency)

Documentation of patient reason(s) for not prescribing bisphosphonates

**Adjustment/Stratification:** No risk adjustment or risk stratification

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement

**Other organizations:** American Society of Hematology

**Steering Committee In-Person March 13-14, 2012**

1. **Importance to Measure and Report:** The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-9; M-8; L-0; I-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-13, N-1, I-3

**Rationale:**
- The measure developer cites an American Cancer Society publication to show that this is an issue of high impact that affects large numbers of patients (approximately 20,000 patients diagnosed annually)
- The gap in care for prescribing bisphosphonates for patients in the measure was striking, with 47.4% of patients reported on not meeting the measure.
- Supporting literature is of moderate to high quality and quantity.
- Use of bisphosphonates increases quality of life, though it does not decrease mortality.
- Intervention should occur more often; however, reporting annually on the measure is acceptable.

2. **Scientific Acceptability of Measure Properties:** The measure meets the Scientific Acceptability criteria.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-7; M-9; L-1; I-0; 2b. Validity: H-8; M-9; L-0; I-0

**Rationale:**
- Previously endorsed measure; interval study data demonstrated a high degree of reliability (100%)
- Face validity of the measure was well demonstrated.
- The measure is well specified and will be easy to extract.

3. **Usability:** H-7; M-10; L-0; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

**Rationale:**

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NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Comments due by May 16, 2012 by 6:00 PM ET
### 0380 Multiple Myeloma – Treatment with Bisphosphonates

- The measure will be useful for QI, particularly given the performance gap.
- The measure should be moderately understandable for public reporting.

#### 4. Feasibility: H-5; M-12; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

**Rationale:** Data easily extracted from EHR or paper chart

**Steering Committee Recommendation for Endorsement:** Y-17; N-0

**Rationale:** The Steering Committee found the intervention addressed by this measure affects a large patient population and is important in improving patient quality of life. There is a significant performance gap in meeting the measure, allowing room for improvement in patient care.

### 0650 Melanoma Continuity of Care – Recall System

**Maintenance Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month reporting period into a recall system that includes:
- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

**Numerator Statement:** Patients whose information is entered, at least once within a 12 month period, into a recall system* that includes:
- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

**Denominator Statement:** All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma.

**Exclusions:** Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider)

**Adjustment/Stratification:** No risk adjustment or risk stratification. Not applicable. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician: Group/Practice, Clinician: Individual, Clinician: Team

**Type of Measure:** Structure

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Registry, Other, Paper Records

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Academy of Dermatology and National Committee for Quality Assurance

**Steering Committee In-Person March 13-14, 2012**

1. **Importance to Measure and Report:** The measure meets the Importance criteria.

   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)

   **1a. Impact:** H-9; M-8; L-0; I-0
   **1b. Performance Gap:** H-4; M-11; L-1; I-1
   **1c. Evidence:** Y-7, N-1, I-9

   **Rationale:**
   - Studies presented do not specifically address the melanoma recall system.
   - Measure is likely an opportunity for improvement but data is unclear about performance gap with regard to a recall system. Authors cite that 9% did not meet measure; however, the Steering Committee views this as a “never event.”
   - The body of evidence as noted above is larger for the general group of all patients when looking at hospital to outpatient settings. If this is restricted to melanoma patients and if it involves outpatient to outpatient settings, the body of evidence is low. However, there is no evidence for harm.
   - Steering Committee members stated that the link between the process of utilizing a recall system and increased screening/examination of patients can be inferred.
   - Steering Committee members stated that this is a valuable intervention because of the prevalence of the diagnosis, the increasing incidence of melanoma and the opportunity for impacting the outcome of patients by early diagnosis of a new primary melanoma, and chose to invoke
Oncology Measures

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0381 Oncology: Treatment Summary Communication – Radiation Oncology</td>
<td></td>
<td>Percentage of patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment.</td>
</tr>
</tbody>
</table>

**Numerator Statement:**

Patients who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment.

**Definition:**

*Treatment Summary:* a report that includes mention of all of the following components: 1) dose delivered; 2) relevant assessment of tolerance to and progress towards the treatment goals; and 3) subsequent care plans.

**Numerator Instructions:**

This measure should be reported once per course of radiation treatment – less than or equal to 30 days from the end of treatment.

**Denominator Statement:**

All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy.

**Exclusions:**

Documentation of a patient reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient requests that report not be sent) and to the patient within one month of completing treatment.

Documentation of a system reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment.

**Adjustment/Stratification:**

No risk adjustment or risk stratification. None.

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:**

Clinician : Group/Practice, Clinician : Individual, Clinician : Team.

**Type of Measure:**

Process.

**Data Source:**

Oncology: Treatment Summary Communication – Radiation Oncology

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: The measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-7; M-10; L-0; I-0; 1b. Performance Gap: H-4; M-10; L-1; I-2; 1c. Evidence: Y-9, N-1, I-7

Rationale:
- Radiation therapy treatment summaries have been a routine practice for years and are a requirement for payment.
- Many radiation therapy treatment summaries currently lack critical information, such as the site of radiation.
- Summary of evidence of impact is not specific to the focus of the measure. Most evidence is related to incidence, cancer-related death rates, and cancer costs. The most closely related statistic is that two-thirds of all cancer patients will receive radiation. However, there is no data on outcomes associated with the lack of a treatment summary.
- Steering Committee members noted that the information from a treatment summary is very important to disseminate amongst providers caring for the patient receiving radiation therapy.
- The measure affects a large number of patients, and there is demonstrated evidence of a performance gap.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-7; M-10; L-0; I-0; 2b. Validity: H-1; M-14; L-1; I-1

Rationale:
- Inter-rater reliability is described as 100% accurate.
- Measure addresses an important priority area: coordination of care. The proximal relationship between performance on the measure and desired outcome is not addressed by available data, however, face validity was demonstrated.

3. Usability: H-6; M-10; L-1; I-0
(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

Rationale:
- The measure is being used in a QI program with plans for use in PQRS.

4. Feasibility: H-5; M-10; L-2; I-0
(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:
- Data elements are available in an EHR and generated during the provision of care.

Steering Committee Recommendation for Endorsement: Y-14; N-3

Rationale: The intervention addressed by this measure affects a large patient population and is important in ensuring continuity of care.

RECOMMENDATIONS:
The Steering Committee recommended the measure developer consider including the site and stage in the measure in the future.

Oncology: Radiation Dose Limits to Normal Tissues

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Numerator Statement: Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Denominator Statement: All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE
Comments due by May 16, 2012 by 6:00 PM ET
Oncology: Radiation Dose Limits to Normal Tissues

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Clinician: Team
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Records
Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Oncology: Radiation Dose Limits to Normal Tissues

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-12; M-4; L-0; I-0; 1b. Performance Gap: H-2; M-12; L-2; I-0; 1c. Evidence: Y-14, N-2, I-0

Rationale:
- The measure applies to lung and pancreatic cancer, with lung especially being a prevalent cancer with high morbidity and mortality.
- Radiation is a commonly used treatment.
- There was evidence cited showing 89% compliance with the PQRS measure, which highlights some, but not much room for improvement.
- The Steering Committee considered this a “never event” and felt compliance should be 100%.
- The Steering Committee stated the importance of calculating dose limits when giving radiation to a patient and noted that there is evidence to support this practice.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-11; M-5; L-0; I-0; 2b. Validity: H-7; M-9; L-0; I-0

Rationale:
- The measure contains specifications that allow for reliable ascertainment and data on reliability.
- The measure includes data on face validity from an expert panel.

3. Usability: H-10; M-6; L-0; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

Rationale:
- The measure has been successfully implemented in PQRS.
- The measure should be easily understood for public reporting.

4. Feasibility: H-11; M-5; L-0; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:
- The data elements are all feasibly extracted from an EHR and generated during routine care delivery.

Steering Committee Recommendation for Endorsement: Y-16; N-0
Rationale: The Steering Committee noted that there is near universal concordance from an expert panel, excellent reliability, usability, and feasibility, and the target population comprises large numbers. There is no contradictory evidence for the measure.

Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

Numerator Statement: Patient visits that included a documented plan of care* to address pain
Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain
0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)

Exclusions: None
Adjustment/Stratification: No risk adjustment or risk stratification. None. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Clinician: Team
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Other, Paper Records
Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-15; M-2; L-0; I-0; 1b. Performance Gap: H-12; M-5; L-0; I-0; 1c. Evidence: Y-15, N-0, I-2
   Rationale:
   • It is well documented that many cancer patients will experience pain during the course of treatment. The measure affects a large patient population.
   • A performance gap was demonstrated, with performance in the ASCO QOPI study achieving the measure at 78.29% and in PQRS for 2009 at 91.24%.
   • Concern that including any report of pain, even mild, may dilute the impact of this measure. However, the Steering Committee stated that simply noting that the patient was experiencing mild pain and the need to follow up on it would be sufficient to meet this measure, alleviating concerns.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-4; M-12; L-1; I-0; 2b. Validity: H-3; M-12; L-1; I-1
   Rationale:
   • Reliability was adequately demonstrated, albeit with a small sample size.
   • Face validity was demonstrated.

3. Usability: H-6; M-9; L-2; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
   Rationale:
   • The measure is currently being used in PQRS 2012; also used from 2009-2011.
   • The measure is currently in use in ASCO’s Quality Oncology Practice Initiative (QOPI®) program and ASTRO’s Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program.

4. Feasibility: H-4; M-13; L-0; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
   Rationale:
   • Data elements are available in an EHR and generated during the provision of care.

Steering Committee Recommendation for Endorsement: Y-16; N-1
Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population. There is room for improvement in performance of this measure.

0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

Maintenance Measure
Measure Evaluation and Specifications
Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified
Numerator Statement: Patient visits in which pain intensity is quantified*
* Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE
Comments due by May 16, 2012 by 6:00 PM ET

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0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy
Exclusions: None
Adjustment/Stratification: No risk adjustment or risk stratification
We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records
Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-16; M-1; L-0; I-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-16, N-1, I-0
   Rationale:
   • Measure developer presented good evidence showing the prevalence of pain; the measure will impact a large number of patients.
   • Performance was documented at 89.49% in the ASCO QOPI study, 57% in ASTRO’s PAAROT program, and 66.83% in PQRS. There is an opportunity for improvement.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-7; M-10; L-0; I-0; 2b. Validity: H-6; M-11; L-0; I-0
   Rationale:
   • The measure is precisely specified.
   • Reliability testing demonstrates almost perfect reliability.
   • Face validity is demonstrated.

3. Usability: H-10; M-7; L-0; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
   Rationale:
   • The measure is currently in use in PQRS.

4. Feasibility: H-9; M-8; L-0; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
   Rationale:
   • Data elements are available in an EHR and generated during the provision of care.

Steering Committee Recommendation for Endorsement: Y-17; N-0
Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population. There is room for improvement in performance of this measure.

RECOMMENDATIONS: The Steering Committee recommended that the developer harmonize the definition of a standardized quantitative pain tool with that used in measure 1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits and measure 1634: Hospice and Palliative Care – Pain Screening. The definition used by those measures is as follows: Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.

0386 Oncology: Cancer Stage Documented

Maintenance Measure
Measure Evaluation and Specifications
Description: Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period.
Oncology: Cancer Stage Documented

Numerator Statement: Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period

Numerator Instructions: *Cancer stage refers to stage at diagnosis

Denominator Statement: All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification

None. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Clinician: Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Pharmacy, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Other organizations: This measure is jointly copyrighted by the AMA-PCPI and American Society of Clinical Oncology. The measure set was also developed in collaboration with the American Society for Radiation Oncology.

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-14; M-2; L-1; I-0
1b. Performance Gap: H-13; M-4; L-0; I-0
1c. Evidence: Y-12, N-2, I-3

Rationale:

• Breast and colorectal cancer affect large numbers of patients and are leading causes of morbidity/mortality.
• Information presented related to the impact of the measure is specific to the general topic area (breast and colorectal cancer) rather than specific to importance of documenting stage of disease or to the consequences of poor quality in this area. Steering Committee agreed that documentation of stage is essential for any treatment planning in oncology, representing a “floor” for improvement, however.
• The developer provided data from the QOPI measure showing an average performance rate of 83%, with a range of 35% to 100%. Data was also presented from ASTRO’s PAAROT program, which has an average performance rate of 87% with a range of 10% to 100%.
• Evidence for the measure is exclusively based on clinical practice guidelines; however, there is uniform NCCN consensus that the intervention is appropriate.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-9; M-13; L-1; I-1
2b. Validity: H-2; M-13; L-1; I-1

Rationale:

• Staging is critical for any cancer diagnosis; the measure specifications should be broadened to include all patients with a cancer diagnosis.
• The Steering Committee was concerned that while it is important to know the stage of cancer at diagnosis, it is also important to know the stage over the course of treatment.
• The Steering Committee agreed that it is important to include clinical and pathological stage wherever possible.
• The measure is clearly specified.
• Reliability testing was adequate.
• Face validity was demonstrated.

3. Usability: H-10; M-7; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

Rationale:

• The measure developer has collected performance data; however, the measure has not been publicly reported.
• The measure is currently only being used in QI initiatives.
• The Steering Committee was concerned that patients do not always understand the concept of staging, which could limit use of the measure for public reporting.

4. Feasibility: H-7; M-9; L-1; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

• Data is generated during the provision of care and all data elements are found in an EHR.

Steering Committee Recommendation for Endorsement: Y-17; N-0

Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population and is important in...
**Oncology: Cancer Stage Documented**

Ensuring that patients are treated appropriately based on diagnosis. This measure is important for treatment planning.

**RECOMMENDATIONS:**

The Steering Committee recommended the developer consider broadening measure specifications to include all patients with a cancer diagnosis. Additional experience with the measure should begin to show stronger evidence related to important outcomes.

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**1854 Barrett’s Esophagus (eligible for Time-Limited endorsement)**

**New Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients with esophageal biopsy reports for Barrett's esophagus that contain a statement about dysplasia.

**Numerator Statement:** Numerator: Esophageal biopsy reports with the histologic finding of Barrett’s mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.)

3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite)

**Denominator Statement:** Denominator (Eligible Population): All esophageal biopsy reports that document the presence of Barrett’s mucosa.

**CPT codes:**

- 88305 Level IV – Surgical pathology, gross and microscopic examination

AND

**ICD-9 codes:**

- 530.85 Barrett’s esophagus

**Exclusions:** Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia).

**Adjustment/Stratification:** No risk adjustment or risk stratification

**Level of Analysis:** Clinician: Group/Practice, Clinician: Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Other, Paper Records

**Measure Steward:** College of American Pathologists

**Steering Committee In-Person March 13-14, 2012**

1. **Importance to Measure and Report: The measure meets the Importance criteria.**

   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)

   **1a. Impact:** H-6; M-10; L-1; I-0; 1b. Performance Gap: H-2; M-12; L-1; I-2; 1c. Evidence: Y-11, N-2, I-4

   **Rationale:**

   - A clear link between Barrett's Esophagus and esophageal adenocarcinoma was demonstrated. Identifying those at risk could allow for appropriate screening of high risk patients.
   - This measure will have a substantial impact for a smaller patient population (those diagnosed with Barrett's Esophagus).

2. **Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability requirement for untested measures.**

   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

   **Precise Specifications: Y-16; N-1**

   **Rationale:**

   - The measure is well specified; however, the Steering Committee noted the importance of reporting not only the presence or absence of dysplasia, but also the grade of dysplasia. The measure developer addressed this recommendation and modified the numerator.
   - Plans for reliability and validity testing are in process.

3. **Usability: H-3; M-14; L-0; I-0**

   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

   **Rationale:**

   - The measure has been included in the 2012 PQRS program with plans to publicly report performance results.

4. **Feasibility: H-8; M-9; L-0; I-0**

   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

   **Rationale:**

   - The data elements are generated during patient care; the measure should be feasible to implement.
1854 Barrett’s Esophagus (eligible for Time-Limited endorsement)

Steering Committee Recommendation for Time-Limited Endorsement: Y-15; N-2

Rationale: The Steering Committee found that the intervention addressed by this measure will greatly impact the target patient population, albeit a smaller population. The link between dysplasia in Barrett’s Esophagus patients and incidence of esophageal adenocarcinoma is well substantiated.

RECOMMENDATIONS: The Steering Committee asked the developer to require reporting of the grade of dysplasia (high or low) as part of the numerator. The measure developer addressed this recommendation and provided updated the numerator to capture this information. The Steering Committee agreed with the changes and recommended the measure for time limited endorsement.

The measure has not yet been tested for reliability and validity and is being considered for time limited endorsement. The measure developer will have 12 months to provide testing data if time limited endorsement is granted.

Prostate and Lung Measures

039 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer

Numerator Statement: Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer

Denominator Statement: All patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

Exclusions: Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons)

Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician)

Adjustment/Stratification: No risk adjustment or risk stratification. Not applicable. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Urological Association and American Society for Therapeutic Radiology & Oncology

039 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-8; M-8; L-0; I-0; 1b. Performance Gap: H-7; M-9; L-0; I-0; 1c. Evidence: Y-14, N-2, I-0

Rationale:

• The measure affects a high number of patients: those with low-risk prostate cancer, and the evidence presented shows the intervention is unnecessary for these patients.

• Data submitted demonstrates significant overuse of bone scans (84.31% of patients from 2008 PQRS did not meet this measure). There is an opportunity for improvement.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-9; M-6; L-1; I-0; 2b. Validity: H-7; M-8; L-1; I-0

Rationale:

• The measure is specified with ICD-9 and CPT codes that can be ascertained consistently.

• Reliability testing presented was appropriate and demonstrated reliability of the measure.

• Validity was shown using results from an expert panel, and demonstrated strong face validity.

3. Usability: H-6; M-8; L-2; I-0
0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

(Meansignificant, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

Rationale:
- This measure has been included in the CMS Physician Quality Reporting System (PQRS) from 2008 through 2011. The measure is also included in PQRS 2012.
- A plan for public reporting has been outlined by the measure developer.

4. Feasibility: H-6; M-8; L-2; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:
- Data is generated during the provision of care and all data elements are found in an EHR.

Steering Committee Recommendation for Endorsement: Y-15; N-1

Rationale: The Steering Committee found that the measure addresses an intervention that is currently overused for the target patient population; improved performance on this measure will likely reduce the use of unnecessary bone scans and decrease overall costs.

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

Numerator Statement: Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

Denominator Statement: All patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate

Note: Only patients with prostate cancer with high risk of recurrence will be counted in the denominator of this measure

Exclusions: Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy)

Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Urological Association and American Society for Therapeutic Radiology & Oncology

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-12; M-4; L-0; I-0

1b. Performance Gap: H-9; M-7; L-0; I-0

1c. Evidence: Y-16, N-0, I-0

Rationale:
- The measure addresses appropriateness of care for patients with high-risk prostate cancer, a prevalent condition affecting a large number of patients.
- The evidence provided is high level and supportive of the measure focus.
- The Steering Committee noted that the survival benefit has been better documented than the evidence submitted suggests.
- Adherence is low: 83.41% of patients from 2008 PQRS did not meet this measure; there is an opportunity for improvement.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-8; L-1; I-0

2b. Validity: H-4; M-11; L-1; I-0

Rationale:
- The specifications are clear. The time window for reporting the measure is at each time adjuvant hormonal therapy occurs.
0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

- The Steering Committee agreed it is important that proton beam therapy is included in the denominator for this measure.
- The reliability testing presented was appropriate and demonstrated the reliability of the measure.
- Face validity was confirmed with near universal agreement from an expert panel.

3. Usability: H-11; M-4; L-1; I-0
(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

**Rationale:**
- This measure has been included in the PQRS from 2008 through 2011. The measure is also included in PQRS 2012.
- A plan for public reporting has been outlined by the measure developer.

4. Feasibility: H-6; M-9; L-1; I-0
(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

**Rationale:**
- Steering Committee was concerned that the low number of patients meeting the measure in 2008 PQRS may be a result of difficulties reporting the measure rather than low performance of the measure intervention. The developer agreed that as the denominator requires both ICD codes and CPT category 2 codes, it likely complicated reporting for some providers reporting on the measure. The developer expects reporting to improve as providers become more familiar with the reporting requirements.
- The information in the measure can be abstracted from EHRs.

**Steering Committee Recommendation for Endorsement:** Y-15; N-1

**Rationale:** The Steering Committee found that this is a prevalent condition with a level of mortality that renders it a public health priority. The measure is supported by two randomized controlled trials, bolstered by expert opinion. The measure should be able to be reliably ascertained with EHR inputs.

1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

**New Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients = 18 years of age undergoing elective lung resection (Open or VATS wedge resection, segmentectomy, lobectomy, bilobectomy, sleeve lobectomy, pneumonectomy) for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.

**Numerator Statement:** Number of patients = 18 years of age undergoing elective lung resection for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.

**Denominator Statement:** Number of patients = 18 years of age undergoing elective lung resection for lung cancer.

**Exclusions:** Emergency procedures

**Adjustment/Stratification:** Statistical risk model Bayesian hierarchical modeling was used to assess the statistical reliability of hospital-specific standardized incidence ratio (SIR) estimates derived from the January 1, 2008 – December 31, 2010 STS data. All hospitals regardless of sample size were included in the estimation of model parameters. Reliability measures were initially calculated including all the hospitals and were subsequently calculated in subsets of hospitals having at least 10, 20, 30, 50, 100, or 200 eligible cases. Three separate multivariable risk models were constructed (mortality, major morbidity, and composite mortality or major morbidity). The risk-adjustment models created for this measure and study have excellent performance characteristics and identify important predictors of mortality and major morbidity for lung cancer resections. These models may be used to inform clinical decisions and to compare risk-adjusted outcomes for quality improvement purposes. For additional information see the attachment:


**Level of Analysis:** Clinician: Group/Practice, Clinician: Team, Facility

**Type of Measure:** Outcome

**Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Records

**Measure Steward:** Society of Thoracic Surgeons

**Steering Committee In-Person March 13-14, 2012**

**NQF REVIEW DRAFT—DO NOT CITE OR QUOTE**
Comments due by May 16, 2012 by 6:00 PM ET
1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

1. Importance to Measure and Report: The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-17; M-0; L-0; I-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-17, N-0, I-0
   **Rationale:**
   - Developer presented solid evidence for importance of the measure.
   - The measure provides a good look at the spectrum of procedures done across a spectrum of hospitals, and a wide range of morbidities/mortalities.
   - Evidence was submitted demonstrating substantial variation in morbidity and mortality after lung cancer surgery.
   - The measure is a first step in developing a measure capturing long term survival rates.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-8; M-9; L-0; I-0; 2b. Validity: H-9; M-8; L-0; I-0
   **Rationale:**
   - The measure is clearly defined and well specified.
   - Reliability of the measure was well demonstrated with a signal to noise ratio.
   - Validity was demonstrated through testing, as well as having face validity assessed by an expert panel.
   - The Steering Committee noted that many of these surgeries are performed by non-thoracic surgeons, a population this measure may not capture.

3. Usability: H-15; M-1; L-0; I-1
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
   **Rationale:**
   - The developer has provided a detailed plan for representation of measure results, usability for QI, and public reporting of the measure within the next 2-3 years.

4. Feasibility: H-10; M-7; L-0; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)
   **Rationale:**
   - The Steering Committee noted that this is somewhat arduous to capture, but the data add significant value

**Steering Committee Recommendation for Endorsement: Y-17; N-0**
**Rationale:** The Steering Committee found that the measure will capture the spectrum of procedures done in a spectrum of hospitals-wide range of morbidities/mortalities. The evidence for the measure is high level, and capturing the measure will allow for development of an outcome measure in the future.

1853 Radical Prostatectomy Pathology Reporting (eligible for Time-Limited endorsement)

**New Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.

**Numerator Statement:** Numerator: Radical prostatectomy pathology reports that include the pT category, the pN category, Gleason score and a statement about margin status

**Denominator Statement:** All radical prostatectomy pathology reports

**Exclusions:** Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, and transurethral resections of the prostate (TURP)

**Adjustment/Stratification:** No risk adjustment or risk stratification

**Level of Analysis:** Clinician: Group/Practice, Clinician: Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Other, Paper Records

**Measure Steward:** College of American Pathologists

1853 Radical Prostatectomy Pathology Reporting
Radical Prostatectomy Pathology Reporting (eligible for Time-Limited endorsement)

1. Importance to Measure and Report: The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-9; M-7; L-0; I-0; 1b. Performance Gap: H-3; M-12; L-1; I-0; 1c. Evidence: Y-15, N-1, I-0
   Rationale:
   • The Steering Committee agreed the measure would have a high impact as a large number of men are affected by this disease; this is a major health issue with significant mortality.
   • The measure developer presented two studies that showed a performance gap of 11.6% noncompliance. The Steering Committee agreed compliance should be 100% on the measure, and so there is an opportunity for improvement.
   • The measure developer presented consistent evidence that a variation exists in pathological reporting that impacts the quality of care provided to patients.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability requirement for untested measures.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   Precise Specifications: Y-16; N-0
   Rationale:
   • The measure is precisely specified.
   • The Steering Committee agreed that it is highly likely that testing of the measure will demonstrate a high rate of reliability and validity.

3. Usability: H-9; M-7; L-0; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
   Rationale:
   • Usability has not yet been demonstrated; however, the Steering Committee believes that the measure will be useful for QI.
   • The measure is useful for public reporting: there is high interest, and there is ongoing active surveillance.

4. Feasibility: H-12; M-4; L-0; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
   Rationale:
   • The data elements are all available and may be implemented using an EHR.
   • Steering Committee members agreed that the measure will be feasible due to the availability of this information in tumor registries and pathology reports.

Steering Committee Recommendation for Time-Limited Endorsement: Y-16; N-0
Rationale: Steering Committee noted that staging information and a Gleason score are very important for patients with prostate cancer. There is a strong evidence base for this measure. There is a performance gap in meeting the measure and a need for improvement.

RECOMMENDATIONS: The measure has not yet been tested for reliability and validity and is being considered for time limited endorsement. The measure developer will have 12 months to provide testing data if time limited endorsement is granted.

Palliative Measures

0210 Proportion receiving chemotherapy in the last 14 days of life

Maintenance Measure
Measure Evaluation and Specifications
Description: Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life
Numerator Statement: Patients who died from cancer and received chemotherapy in the last 14 days of life
Denominator Statement: Patients who died from cancer.
Exclusions: None
Adjustment/Stratification: No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None
Proportion receiving chemotherapy in the last 14 days of life

**Level of Analysis:** Clinician: Group/Practice, Facility, Health Plan, Integrated Delivery System, Population: County or City, Population: National, Population: Regional, Population: State

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Pharmacy, Electronic Clinical Data: Registry, Management Data, Paper Records

**Measure Steward:** American Society of Clinical Oncology

**Steering Committee In-Person March 13-14, 2012**

1. **Importance to Measure and Report: The measure meets the Importance criteria.**
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-12; M-4; L-0; I-1; 1b. Performance Gap: H-9; M-8; L-0; I-0; 1c. Evidence: Y-13, N-3, I-1

   **Rationale:**
   - The measure affects a large number of patients and will have a high impact.
   - The Steering Committee noted that in some cases it is appropriate for a patient to receive chemotherapy in the last 14 days of life. The measure is useful for detecting variation in performance and identifying outliers when comparing similar practices with similar patient populations.
   - The measure is important because it addresses patient preferences and over-treatment at the end of life.
   - The struggle between aggressive care and futile care often plays out in the amount of chemotherapy delivered to patients with advanced disease and poor performance status.
   - The measure also reflects disparities in access to care and the capacity of a local healthcare system to treat patients appropriately at the end of life.

2. **Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.**
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-9; M-6; L-2; I-0; 2b. Validity: H-4; M-9; L-3; I-1

   **Rationale:**
   - Steering Committee members agreed that the measure was well specified.
   - The Steering Committee members raised concerns about how case mix would be accounted for in the measure. The also questioned whether facilities with a high number of patients enrolled in clinical trials would skew the measure results, so that those facilities would appear not to do as well on the measure. It was explained that the measure is intended for use in comparing like facilities, such as major cancer centers to other major cancer centers, where the case mix would be expected to be very similar.
   - The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure.
   - Face validity of the measure was demonstrated.

3. **Usability:** H-6; M-7; L-2; I-2
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

   **Rationale:**
   - The Steering Committee agreed the measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure.
   - The measure is easily understandable for public reporting.
   - The measure is currently in use in ASCO’s QOPI program.

4. **Feasibility:** H-7; M-6; L-2; I-2
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)

   **Rationale:**
   - The measure is reported using claims data and is feasible to implement.

**Steering Committee Recommendation for Endorsement: Y-15; N-2**

**Rationale:** The Steering Committee found that the measure is important because it addresses patient preferences and over-treatment at the end of life.
<table>
<thead>
<tr>
<th>Measure Evaluation and Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> Percentage of patients who died from cancer with more than one emergency room visit in the last days of life</td>
</tr>
<tr>
<td><strong>Numerator Statement:</strong> Patients who died from cancer and had &gt;1 ER visit in the last 30 days of life</td>
</tr>
<tr>
<td><strong>Denominator Statement:</strong> Patients who died from cancer.</td>
</tr>
<tr>
<td><strong>Exclusions:</strong> None</td>
</tr>
<tr>
<td><strong>Adjustment/Stratification:</strong> No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one provider's patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. No risk adjustment is necessary. The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting 'Cancer' as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate. No stratification was used in the measure's development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992) to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.</td>
</tr>
<tr>
<td><strong>Level of Analysis:</strong> Clinician: Group/Practice, Facility, Health Plan, Integrated Delivery System, Population: County or City, Population: National, Population: Regional, Population: State</td>
</tr>
<tr>
<td><strong>Type of Measure:</strong> Process</td>
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<tr>
<td><strong>Data Source:</strong> Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Management Data, Paper Records</td>
</tr>
<tr>
<td><strong>Measure Steward:</strong> American Society of Clinical Oncology</td>
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</tbody>
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### 1. Importance to Measure and Report:

**The measure meets the Importance criteria.**

1. **Impact:** H-10; M-4; L-1; I-1; 1b. **Performance Gap:** H-10; M-3; L-3; I-0; 1c. **Evidence:** Y-11, N-3, I-2

**Rationale:**
- The Steering Committee agreed the measure affects a large number of patients and is high impact.
- In most cases, overutilization of emergency department services for the actively dying is inappropriate and distressing for patients.
- The Steering Committee noted that in some cases more than one visit to the ER during the last days of life is appropriate. The measure is useful for detecting variations in performance and identifying outliers when comparing similar practices with similar patient populations.
- The measure is important because it addresses patient preferences and overtreatment at the end of life.
- The measure also reflects disparities in access to care and the capacity of a local healthcare system to treat patients appropriately at the end of life.

### 2. Scientific Acceptability of Measure Properties:

**The measure meets the Scientific Acceptability criteria.**

2a. **Reliability:** H-7; M-3; L-5; I-1; 2b. **Validity:** H-5; M-5; L-5; I-1

**Rationale:**
- The Steering Committee members raised concerns about use of the measure given the current systemic issues with access to quality hospice facilities. The Committee believed patients may utilize emergency department services when good hospice care is not available. In areas where performance of the measure is poor, it will call attention to a lack of resources available for patients at the end of life.
- The measure is well specified.
- The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure is demonstrated.

### 3. Usability:

**H-5; M-4; L-6; I-1**

**Rationale:**
- The measure is usable for public reporting, as it captures the preference of patients to die in a setting other than the emergency department, or to avoid distressing ER visits at the end of life.
- The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure.
- The measure is in use in Cancer Care Ontario’s Cancer System Quality Index.

### 4. Feasibility:

**H-6; M-7; L-3; I-1**

**Rationale:**
- The clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented.
0211 Proportion with more than one emergency room visit in the last days of life

**Rationale:**
- The measure is reported using claims data and is feasible to implement.

**Steering Committee Recommendation for Endorsement:** Y-10; N-6

**Rationale:** The Steering Committee found that the measure is important because it addresses patient preferences and overtreatment at the end of life.

0213 Proportion admitted to the ICU in the last 30 days of life

**Maintenance Measure**

**Measure Evaluation and Specifications**
- **Description:** Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life
- **Numerator Statement:** Patients who died from cancer and were admitted to the ICU in the last 30 days of life
- **Denominator Statement:** Patients who died from cancer.
- **Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one provider's patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered.

The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting ‘Cancer’ as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate. No stratification was used in the measure’s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992) to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.

**Level of Analysis:** Clinician: Group/Practice, Facility, Health Plan, Integrated Delivery System, Population: County or City, Population: National, Population: Regional, Population: State

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Management Data, Paper Records

**Measure Steward:** American Society of Clinical Oncology

**Steering Committee In-Person March 13-14, 2012**

1. **Importance to Measure and Report: The measure meets the Importance criteria.**
   - (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   - **1a. Impact:** H-14; M-2; L-0; I-0; 1b. Performance Gap: H-8; M-8; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0

**Rationale:**
- The Steering Committee agreed the measure affects a large number of patients and will have a high impact.
- Patients overwhelmingly would prefer to not die in the ICU; it is distressing for the patient and the patient's family.
- The Steering Committee noted that in some cases occurrence of this event is appropriate. The measure is useful for detecting variation in performance and identifying outliers when comparing similar practices with similar patient populations.
- The measure is important because it addresses patient preferences and over-treatment at the end of life.
- The measure also reflects disparities in access to care and the capacity of a local healthcare system to treat patients appropriately at the end of life.

2. **Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.**
   - (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   - **2a. Reliability:** H-12; M-4; L-0; I-0; 2b. Validity: H-11; M-5; L-0; I-0

**Rationale:**
- Steering Committee members were concerned about use of the measure given current issues related to access to quality hospice facilities. Patients may utilize ICU at the end of life when quality hospice care is not available. In areas where performance of the measure is poor, it will call attention to the lack of resources available for patients at the end of life.
- The measure is well specified.
- The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure.
0213 Proportion admitted to the ICU in the last 30 days of life

- Face validity of the measure was demonstrated.

3. Usability: H-9; M-7; L-0; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
   **Rationale:**
   - The measure is usable for public reporting, as it captures the preference of patients to die in a setting other than the emergency department, or to avoid distressing ER visits at the end of life.
   - The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure.
   - The measure is in use in [Cancer Care Ontario’s Cancer System Quality Index](#).

4. Feasibility: H-13; M-3; L-0; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)
   **Rationale:**
   - The measure is reported using claims data and is feasible to implement.

**Steering Committee Recommendation for Endorsement:** Y-16; N-0
   **Rationale:** The Steering Committee strongly agreed that patients generally do not wish to die in the ICU and believe this intervention should be avoided if at all possible. The measure captures patient preference as well as disparities in access to quality hospice care at the end of life.

0215 Proportion not admitted to hospice

**Maintenance Measure**

**Measure Evaluation and Specifications**

- **Description:** Percentage of patients who died from cancer not admitted to hospice
- **Numerator Statement:** Patients who died from cancer without being admitted to hospice
- **Denominator Statement:** Patients who died from cancer.
- **Exclusions:** None
- **Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None
- **Level of Analysis:** Clinician: Group/Practice, Facility, Health Plan, Integrated Delivery System, Population: County or City, Population: National, Population: Regional, Population: State
- **Type of Measure:** Process
- **Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Management Data, Paper Records
- **Measure Steward:** American Society of Clinical Oncology

**Steering Committee In-Person March 13-14, 2012**

1. **Importance to Measure and Report:** The measure meets the Importance criteria.
   - (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
     - 1a. Impact: H-10; M-3; L-2; I-1
     - 1b. Performance Gap: H-9; M-5; L-1; I-2
     - 1c. Evidence: Y-10, N-2, I-5
   **Rationale:**
   - The Steering Committee agreed the measure affects a large number of patients and has a high impact.
   - Many cancer patients die in a hospital receiving futile care until the end. Referring patients to hospice, when appropriate, addresses patient preferences, improves quality of care, and reduces cost of care.
   - The Steering Committee noted that poor performance on the measure would indicate that providers may be failing to have direct conversations with patients about the futility of further treatment and the benefits of hospice care.
   - The Committee agreed the measure developer provided good evidence to support that hospice referral would mean increased quality of care.

2. **Scientific Acceptability of Measure Properties:** The measure meets the Scientific Acceptability criteria.
   - (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
     - 2a. Reliability: H-4; M-9; L-3; I-1
     - 2b. Validity: H-6; M-7; L-3; I-1
### Maintenance Measure

#### Measure Evaluation and Specifications

**Description:** Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there. 

**Numerator Statement:** Patients who died from cancer and spent fewer than three days in hospice. 

**Denominator Statement:** Patients who died from cancer who were admitted to hospice. 

**Exclusions:** None. 

**Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because: (a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one provider's patients have significantly different risks than others, it will not affect relative comparisons, and (b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None. 


**Type of Measure:** Process. 

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Management Data, Paper Records. 

**Measure Steward:** American Society of Clinical Oncology. 

### Rationale:

- The measure is well specified. 
- The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure. 
- Face validity of the measure is demonstrated. 

### 3. Usability: H-6; M-5; L-3; I-3

*(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

**Rationale:** The measure is usable for public reporting, as it captures the use of hospice for appropriate patients. The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving this measure. The measure is in use through ASCO’s QOPI program. 

### 4. Feasibility: H-6; M-8; L-2; I-1

*(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)*

**Rationale:** The measure is reported using claims data and is feasible to implement. Steering Committee members noted that this measure—in conjunction with measure #0216: Proportion admitted to hospice for less than 3 days—would prevent providers from making patient care decisions about sending patients to hospice based on measure performance. 

**Steering Committee Recommendation for Endorsement:** Y-11; N-6 

**Rationale:** The Steering Committee noted that the measure affects a large patient population and will help identify when facilities are providing overly aggressive, futile care to patients rather than referring patients to hospice. 

**RECOMMENDATIONS:** Steering Committee members recommended that the developer consider stratifying patients with hematologic cancers, as the patient population is different from most other cancer patient populations and their responsiveness to therapies varies. 

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**0216 Proportion admitted to hospice for less than 3 days**

1. **Importance to Measure and Report:** The measure meets the Importance criteria. 


   **1a. Impact:** H-14; M-3; L-0; I-0. 

   **1b. Performance Gap:** H-13; M-3; L-1; I-0. 

   **1c. Evidence:** Y-16, N-1, I-0

   **Rationale:**
   - It is well documented that short lengths of stay in hospice compromises patients’ quality of care and that there is a substantial portion of hospice patients that are referred within 1-3 days of death. 
   - The measure affects a large number of patients and is high impact.
0216 Proportion admitted to hospice for less than 3 days

- Many cancer patients die in a hospital receiving futile care until the end. Referring patients to hospice, when appropriate, addresses patient preferences, improves quality of care, and reduces health care costs.
- The Steering Committee noted that poor performance on this measure would indicate that providers are failing to have direct conversations with their patients about the futility of further treatment and the benefits of hospice care.
- The committee felt the measure developer provided good evidence to support that the concept that hospice referral would mean increased quality of care.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-14; M-3; L-1; I-0; 2b. Validity: H-13; M-4; L-0; I-0

Rationale:
- Steering Committee members questioned why three days was selected as the numerator. The developer noted that three days is the minimum lowest bar; seven days may be a better indicator of quality of care. Also, data was more easily obtained with the three day threshold than the seven day threshold.
- The measure is well specified.
- The reliability testing for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure was demonstrated.

3. Usability: H-11; M-6; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

Rationale:
- The measure is usable for public reporting, as it captures the use of hospice for appropriate patients.
- The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving this measure.
- The measure is in use through ASCO's QOPI program.

4. Feasibility: H-12; M-5; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:
- The measure is reported using claims data and is feasible to implement.
- Steering Committee members noted that this measure in conjunction with measure #0215 would prevent providers from not sending patients to hospice because of the fear that the patient would die in the next 3 days and prevents providers from making patient care decisions about sending patients to hospice based on measure performance.

Steering Committee Recommendation for Endorsement: Y-17; N-0

Rationale: The Steering Committee found that the measure affects a large patient population and will help identify when facilities are providing overly aggressive, futile care to patients rather than referring them to hospice.

1822 External Beam Radiotherapy for Bone Metastases

New Measure

Measure Evaluation and Specifications

Description: This measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme as defined by the guideline.

Numerator Statement: All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn.

Denominator Statement: All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT

Exclusions: The medical reasons for denominator exclusions are:
1) Previous radiation treatment to the same anatomic site;
2) Patients with femoral axis cortical involvement greater than 3 cm in length;
3) Patients who have undergone a surgical stabilization procedure; and
4) Patients with spinal cord compression, cauda equina compression or radicular pain.
1822 External Beam Radiotherapy for Bone Metastases

**Adjustment/Stratification:** No risk adjustment or risk stratification. Not applicable. Stratification of the measure is not required.

**Level of Analysis:** Clinician: Group/Practice, Clinician: Individual, Clinician: Team, Facility, Health Plan

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Records

**Measure Steward:** American Society for Radiation Oncology (ASTRO) Other organizations: None

Steering Committee In-Person March 13-14, 2012

1. **Importance to Measure and Report:** The measure meets the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-15; M-1; L-0; I-0; 1b. Performance Gap: H-13; M-3; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0
   **Rationale:**
   - The measure has high impact.
   - There is a high opportunity for improvement, with nearly a 20% performance gap noted.
   - The measure represents quality care.
   - There is a strong supportive evidence base for this intervention.

2. **Scientific Acceptability of Measure Properties:** The measure meets the Scientific Acceptability criteria.
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H-13; M-3; L-0; I-0; 2b. Validity: H-11; M-5; L-0; I-0
   **Rationale:**
   - The measure is well specified and exclusions are appropriate, except the patient reason exclusions. The Steering Committee asked the developer to remove those exclusions, and the developer agreed to do so.
   - The reliability testing for the measure is appropriate and demonstrates the reliability of the measure.
   - Face validity of the measure was demonstrated.

3. **Usability:** H-13; M-3; L-0; I-0
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)
   **Rationale:**
   - The developer has provided a detailed plan for representation of measure results, usability for QI, and public reporting of the measure through PQRS.

4. **Feasibility:** H-14; M-2; L-0; I-0
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified; 4d. Data collection strategy can be implemented)
   **Rationale:**
   - Data elements are in EHR and generated during the provision of care.

Steering Committee Recommendation for Endorsement: Y-16; N-0

**Rationale:** The Steering Committee stated that this measure represents good care with a strong evidence base supporting the focus of the measure. The patients affected by this measure suffer from severe pain and the intervention will help alleviate their discomfort.

**RECOMMENDATIONS:** The Steering Committee asked the developer to remove the patient reason exclusions from the measure denominator. The developer agreed to do so, and the Steering Committee reviewed the changes on a follow up call. The Committee agreed with the changes and recommended the measure for endorsement.

MEASURES NOT RECOMMENDED

Hematology and Melanoma Measures

0561 Melanoma Coordination of Care
Maintenance Measure
### 0561 Melanoma Coordination of Care

**Measure Evaluation and Specifications**

**Description:** Percentage of patient visits, regardless of age, seen with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

**Numerator Statement:** Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

**Denominator Statement:** All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma.

**Exclusions:**
- Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care);
- Documentation of system reason(s) for not communicating treatment plan to the primary care provider(s) (e.g., patient does not have a primary care provider or referring physician).

**Adjustment/Stratification:** No risk adjustment or risk stratification.

**Level of Analysis:** Clinician: Group/Practice, Clinician: Individual, Clinician: Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Records

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement

**Other organizations:** American Academy of Dermatology and National Committee for Quality Assurance

**Steering Committee In-Person March 13-14, 2012**

1. **Importance to Measure and Report:** The measure does not meet the Importance criteria.

   **1a. Impact:** H-4; M-7; L-3; I-3
   **1b. Performance Gap:** H-1; M-10; L-3; I-3
   **1c. Evidence:** Y-1, N-4, I-10

   **Rationale:**
   - The measure demonstrates good clinical care; however, there was concern that this was not important for devoting resources for performance measurement.
   - The measure developers presented data that about 12% of the charts did not have evidence regarding the documentation of treatment plans directed to the primary care physicians. However, there is no supporting evidence that this communication would improve the quality of care of a melanoma patient. This is compounded by the fact that patients are already being seen by a “treating” physician which suggests that they are receiving adequate oncology specific care.
   - The Steering Committee agreed communication among providers is important but were not sure that this measure improves quality of care or outcomes, especially based on data provided since primary care provider not likely to be directly involved in the treatment of a patient with melanoma. A better measure would be documentation of follow up by an oncology-specific provider.

2. **Scientific Acceptability of Measure Properties:** N/A

   **2a. Reliability:** H- ; M- ; L- ; I- ;
   **2b. Validity:** H- ; M- ; L- ; I-.

3. **Usability:** N/A

   **3a. Public Reporting and 3b. Quality Improvement**

4. **Feasibility:** N/A

   **4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented**

**Steering Committee Recommendation for Endorsement:** The measure failed the Importance criteria and will not be recommended for endorsement.

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### 0562 Overutilization of Imaging Studies in Melanoma

**Maintenance Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no

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**NQF REVIEW DRAFT—DO NOT CITE OR QUOTE**

**Comments due by May 16, 2012 by 6:00 PM ET**
Overutilization of Imaging Studies in Melanoma

diagnostic imaging studies were ordered

Numerator Statement: Patients for whom no diagnostic imaging studies* were ordered

Denominator Statement: All patients, regardless of age, with a current diagnosis of stage 0 through IIIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period

Exclusions: Documentation of medical reason(s) for ordering diagnostic imaging studies (e.g., patient has comorbid condition that warrants imaging, other medical reasons); Documentation of system reason(s) for ordering diagnostic imaging studies (e.g., requirement for clinical trial enrollment, ordered by another provider, other system reasons)

Adjustment/Stratification: No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Clinician: Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Imaging/Diagnostic Study, Electronic Clinical Data: Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Academy of Dermatology and National Committee for Quality Assurance

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report:
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-9; M-4; L-2; I-0; 1b. Performance Gap: H-7; M-7; L-1; I-0; 1c. Evidence: Y-8, N-4, I-3

Rationale:
- The Steering Committee agree that there is no question that imaging use and cost are rising; however, it is less clear to what extent that is true for this population.
- Measure is based mainly on consensus guidelines with a high volume of studies cited and limited data presented to specifically support measure. Literature is graded according NCCN guidelines and recommendations are not based solely on literature support.
- The body of evidence as noted above is larger for the general group of all patients when looking at hospital to outpatient settings. If this is restricted to melanoma patients and if it involves outpatient to outpatient settings, the body of evidence is low. However, there is no evidence for harm.
- The Steering Committee discussed that the measure assumes that treatment for metastatic melanoma is futile therapy, but two new agents have been FDA-approved for melanoma since this measure was adopted and future studies may indicate a new role for surveillance in the future.

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability Criteria
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-2; M-4; L-6; I-2; 2b. Validity: H-1; M-4; L-5; I-2

3. Usability: N/A
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

4. Feasibility: N/A
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)

Steering Committee Recommendation for Endorsement: The measure failed the Scientific Acceptability criteria and will not be recommended for endorsement.
- The Steering Committee expressed concerns regarding the reliability of the measure: the measure does not adequately address the distinction between initial stage and recurrence, and the definitions of these in data sources
- The measure reflects updated NCCN guidelines, impacts large numbers, and is important to address overuse.
- The topic is too narrow; one could argue for this type of measure for every type of primary cancer.
- The Committee disagreed with inclusion of downstream patients in the measure, as they felt it confounds reliability; data presented by the developers appears to show this.

RATIONALE: The Steering Committee did not recommend the measure at the in-person meeting; voting ended at 1.c Evidence. The Committee noted that the denominator should be limited to patients with a new diagnosis and asked the developer for analysis of the data on newly diagnosed patients versus patients with a history of melanoma. The developer presented reliability testing analysis showing an approximately 10% difference in
Prostate Measures

0625 History of Prostate Cancer - Cancer Surveillance

Maintenance Measure

Measure Evaluation and Specifications

Description: The percentage of men with definitively treated localized prostate cancer who had at least one PSA level in the past 12 months.

Numerator Statement: Men who had at least one PSA level in the past 12 months.

Denominator Statement: Men with localized prostate cancer who were treated with curative intent.

Exclusions:
1. Surgical treatment for prostate cancer in the past year
2. Drug treatment for prostate cancer in the past year
3. Radiation therapy for prostate cancer in the past year
4. Prostate MRI in past year
5. Prostate biopsy in the past year
6. Metastatic prostate cancer
7. Provider or patient feedback stating patient does not have a diagnosis of prostate cancer.
8. General exclusions
   a. Terminal Illness
   b. Active treatment of malignancy (chemotherapy or radiation therapy) in the past 6 months.
   c. Patients who were admitted to a skilled nursing facility in the past 3 months.

Adjustment/Stratification: No risk adjustment or risk stratification. No risk adjustment is done with our measures, therefore, we do not have a risk model. This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.


Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Healthcare Provider Survey, Patient Reported Data/Survey

Measure Steward: ActiveHealth Management

0625 History of Prostate Cancer - Cancer Surveillance

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure does not meet the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-2; M-1; L-8; I-5; 1b. Performance Gap: H- ; M- ; L- ; I- ; 1c. Evidence: Y- , N- , I-

Rationale:

- The Steering Committee agreed prostate cancer is a prevalent disease and surveillance care and survivorship care are important areas for measuring quality, however the presented evidence did not demonstrate a link between process and a prostate cancer specific desired outcome.
- There was no evidence presented that management of recurrence is associated with high resource use.
- There was low level evidence that delay in detection of recurrence was associated with adverse outcomes.
- There was no evidence presented that there is variation or suboptimal performance with regard to PSA testing in these patients.
**History of Prostate Cancer - Cancer Surveillance**

- The Steering Committee was concerned with unintended harm, as overtreatment of patients with relapses of prostate cancer is a current problem.

**2. Scientific Acceptability of Measure Properties: N/A**

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

**2a. Reliability:** H- ; M- ; L- ; I- ;  
**2b. Validity:** H- ; M- ; L- ; I- ;

**Rationale:**
- The Steering Committee was concerned about the lack of results data presented on the reliability and validity of the measure. The Steering Committee felt that the testing database was inappropriate for evaluating reliability and validity for prostate cancer, due in part to the young age of the cohort.
- The Steering Committee was concerned about the open-ended time window.
- The Steering Committee was concerned that the exclusions for the measure eliminated the patients who would require more rigorous follow up after a diagnosis of prostate cancer. Although one exclusion was mis-stated, this concern extended to other exclusions in the measure.
- The Steering Committee stated that patients who are asymptomatic and not eligible for salvage therapies may not need to be followed.

**3. Usability: N/A**

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

- The Steering Committee was concerned that although the developer indicated that 20 percent of patients lack surveillance PSA levels within one year of their treatment, the developer does not document the lower level of care or worse outcomes for that group.

**4. Feasibility: N/A**

(4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

**Rationale:**
- The Steering Committee was concerned about attribution to a provider following the care of the patient. The developer stated they had a database that would pull the most recent test during a 1-year window and using an algorithm, determine the care provider. The Steering Committee was concerned that users of the measure would not be able to do this without the developer’s database.

Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

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**Palliative Measures**

**0212 Proportion with more than one hospitalization in the last 30 days of life**

**Maintenance Measure**

**Measure Evaluation and Specifications**

**Description:** Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life

**Numerator Statement:** Patients who died from cancer and had >1 hospitalization in the last 30 days of life

**Denominator Statement:** Patients who died from cancer.

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered.

None. No risk adjustment is necessary. The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting ‘Cancer’ as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate. No stratification was used in the measure’s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992)to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.

**Level of Analysis:** Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
0212 Proportion with more than one hospitalization in the last 30 days of life

Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Management Data, Paper Records
Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure does not meet the Importance criteria.
   (1a. High Impact; 1b. Performance Gap; 1c. Evidence)
   1a. Impact: H-4; M-10; L-2; I-0; 1b. Performance Gap: H-4; M-8; L-3; I-1; 1c. Evidence: Y-6, N-6, I-4
   Rationale:
   • The measure affects a large number of patients and is high impact.
   • The Steering Committee noted that repeated hospitalizations for a dying patient are indicative that a trajectory of care to deal with end of life issues has not been established.
   • The Steering Committee was concerned that this measure did not take into account the increase in Palliative Care Units in hospitals, which provide appropriate care for dying patients in pain and should be utilized.
   • The Steering Committee raised concerns that the evidence base for this measure needs to evolve with the use of palliation in inpatient facilities.
   • There was concern that not recommending this measure for endorsement would not allow capture of the full spectrum of hospitalizations for cancer patients at the end of life (emergency department, hospitalization, and ICU).

2. Scientific Acceptability of Measure Properties: N/A
   (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
   2a. Reliability: H- ; M- ; L- ; I- ; 2b. Validity: H- ; M- ; L- ; I- 

3. Usability: N/A
   (Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)

4. Feasibility: N/A
   (4a. Clinical data generated during care process; 4b. Electronic data; 4c. Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

0214 Proportion dying from Cancer in an acute care setting

Maintenance Measure

Measure Evaluation and Specifications
Description: Percentage of patients who died from cancer dying in an acute care setting
Numerator Statement: Patients who died from cancer in an acute care hospital
Denominator Statement: Patients who died from cancer.
Exclusions: None
Adjustment/Stratification: No risk adjustment or risk stratification
   No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. None
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry,
WITHDRAWN FROM CONSIDERATION

Changing practice prompted the AMA-PCPI to withdraw from consideration measure #0388 Prostate Cancer: Three Dimensional Radiotherapy. The measure focused on patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy) who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT). The developer explained that high clinician performance and a change in the standard of care meant the measure no longer represented an opportunity for quality improvement. The Steering Committee agreed with this assessment, noting that two-dimensional radiotherapy is now uncommon.

NOTES


APPENDIX A: MEASURE SPECIFICATIONS

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</tr>
<tr>
<td>------------</td>
</tr>
</tbody>
</table>

### 0211 Proportion with more than one emergency room visit in the last days of life

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Steward</td>
<td>American Society of Clinical Oncology</td>
</tr>
<tr>
<td>Description</td>
<td>Percentage of patients who died from cancer with more than one emergency room visit in the last days of life</td>
</tr>
<tr>
<td>Type</td>
<td>Process</td>
</tr>
<tr>
<td>Data Source</td>
<td>Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Management Data, Paper Records Medicare claims and denominator file</td>
</tr>
<tr>
<td>Setting</td>
<td>Hospital/Acute Care Facility</td>
</tr>
<tr>
<td>Numerator Statement</td>
<td>Patients who died from cancer and had &gt;1 ER visit in the last 30 days of life</td>
</tr>
<tr>
<td>Numerator Details</td>
<td>Time Window: 30 days prior to death ER visits documented in MEDPAR claims</td>
</tr>
<tr>
<td>Denominator Statement</td>
<td>Patients who died from cancer.</td>
</tr>
<tr>
<td>Denominator Details</td>
<td>Time Window: None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.</td>
</tr>
<tr>
<td>Exclusions</td>
<td>None</td>
</tr>
<tr>
<td>Exclusion Details</td>
<td>N/A</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it w</td>
</tr>
<tr>
<td>Stratification</td>
<td>No stratification was used in the measure’s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administ</td>
</tr>
<tr>
<td>Type Score</td>
<td>Rate/proportion better quality = lower score</td>
</tr>
</tbody>
</table>

### 0213 Proportion admitted to the ICU in the last 30 days of life

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Steward</td>
<td>American Society of Clinical Oncology</td>
</tr>
<tr>
<td>Description</td>
<td>Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life</td>
</tr>
<tr>
<td>Type</td>
<td>Process</td>
</tr>
<tr>
<td>Data Source</td>
<td>Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Management Data, Paper Records Medicare claims and denominator file</td>
</tr>
</tbody>
</table>
### 0213 Proportion admitted to the ICU in the last 30 days of life

<table>
<thead>
<tr>
<th>Setting</th>
<th>Hospital/Acute Care Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator Statement</td>
<td>Patients who died from cancer and were admitted to the ICU in the last 30 days of life</td>
</tr>
<tr>
<td>Numerator Details</td>
<td>Time Window: 30 days before death</td>
</tr>
</tbody>
</table>
|                        | MEDPAR only:  
|                        | did not include SNF claims  
|                        | did not include pediatric, psychiatric, burn or trauma ICUs (MEDPAR variable increind ne 3,4,7,8)  
|                        | • variable in MEDPAR called incrdays, which is number of ICU days per visit  
|                        | • used hospital admission date variable (admitdate) and then checked if incrdays was >0 for admissions occurring in the last 30 days before death |
| Denominator Statement  | Patients who died from cancer. |
| Denominator Details    | Time Window: None |
|                        | Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets. |
| Exclusions             | None |
| Exclusion Details      | N/A |
| Risk Adjustment        | No risk adjustment or risk stratification |
|                        | No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, it w |
| Stratification         | No stratification was used in the measure’s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM admin |
| Type Score             | Rate/proportion  better quality = lower score |

### 0215 Proportion not admitted to hospice

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Steward</td>
<td>American Society of Clinical Oncology</td>
</tr>
<tr>
<td>Description</td>
<td>Percentage of patients who died from cancer not admitted to hospice</td>
</tr>
<tr>
<td>Type</td>
<td>Process</td>
</tr>
<tr>
<td>Data Source</td>
<td>Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Medicare claims and denominator file</td>
</tr>
<tr>
<td>Setting</td>
<td>Hospice</td>
</tr>
<tr>
<td>Numerator Statement</td>
<td>Patients who died from cancer without being admitted to hospice</td>
</tr>
</tbody>
</table>
| Numerator Details       | Time Window: None  
|                        | Those without claims in Medicare HOSPICE file. No codes used.                          |
| Denominator Statement   | Patients who died from cancer.                                                         |
### 0215 Proportion not admitted to hospice

**Denominator Details**
- **Time Window:** None
  - Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.

**Exclusions**
- None

**Exclusion Details**
- None

**Risk Adjustment**
- No risk adjustment or risk stratification
  - No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, i

**Stratification**
- None

**Type Score**
- Rate/proportion  better quality = lower score

### 0216 Proportion admitted to hospice for less than 3 days

**Status**

**Steward**
- American Society of Clinical Oncology

**Description**
- Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there

**Type**
- Process

**Data Source**
- Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Medicare claims and denominator file

**Level**

**Setting**
- Hospice

**Numerator Statement**
- Patients who died from cancer and spent fewer than three days in hospice.

**Numerator Details**
- **Time Window:** 3 days
  - Medicare HOSPICE file only:
    - Subtracted hospice admission date (admndate) from death date variable to get hospice length of stay
    - No codes used.

**Denominator Statement**
- Patients who died from cancer who were admitted to hospice

**Denominator Details**
- **Time Window:** None
  - Patients in the death registry with cancer as their cause of death who also appear in the Medicare hospice file. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.

**Exclusions**
- None

**Exclusion Details**
- None

**Risk Adjustment**
- No risk adjustment or risk stratification
  - No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers’ patients have significantly different risks than others, i

**Stratification**
- None
### 0216 Proportion admitted to hospice for less than 3 days

<table>
<thead>
<tr>
<th>n</th>
</tr>
</thead>
</table>

**Type Score**  
Rate/proportion  
better quality = lower score

#### 0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow

|---|---|
| Steward | American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)  
**Other organizations:** The American Society of Hematology |
| Description | Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow. |
| Type | Process |
| Data Source | Administrative claims, Electronic Clinical Data : Laboratory  
**Attachment:** 0377 Cytogenetic Testing Data Elements_FINAL.pdf |
| Level | Clinician : Group/Practice, Clinician : Individual, Clinician : Team |
| Setting | Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Laboratory |
| Numerator Statement | Patients who had baseline cytogenetic testing* performed on bone marrow  
**Definition:** *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis.* |
| Numerator Details | **Time Window:** At least once during measurement period  
**Definition:** *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis.*  
For EHR: specification currently under development. Data elements (using Quality Data Model) required for the measure attached.  
Administrative claims.  
Report the CPT Category II code: 3155F – Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment |
| Denominator Statement | All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia |
| Denominator Details | **Time Window:** 12 consecutive months  
For EHR: specification currently under development. Data elements (using Quality Data Model) required for the measure attached.  
Administrative claims data  
AGE:  18 years and older  
AND  
Diagnosis: Myelodysplastic Syndrome (MDS) and Acute Leukemias  
ICD-9-CM diagnosis codes: 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75  
ICD-10-CM diagnosis codes: C91.00, C91.02, C92.00, C92.02, C92.40, C92.42, C92.50, C92.52, C92.60, C92.62, C92.a0, C92.a2, C93.00, C93.02, C94.00, C94.02, C94.20, C94.22, C95.00, C95.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.a, D46.b, D46.c, D46.z  
AND  
CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 |

**Exclusions**  
Documentation of medical reason(s) for not performing baseline cytogenetic testing  
Documentation of patient reason(s) for not performing baseline cytogenetic testing  
Denominator Exclusions: Documentation of system reason(s) for not performing baseline cytogenetic testing

**Exclusion Details**  
The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all...
## Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow

Measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason, patient or system reason for not performing baseline cytogenetic testing. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows:

### For EHR:
- Specification currently under development. Data elements (using Quality Data Model) required for the measure attached.
- Administrative claims:
  - **Denominator Exceptions:**
    - Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow)
      - Append modifier to CPT Category II code: 3155F-1P
    - Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above)
      - Append modifier to CPT Category II code: 3155F-2P
    - Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., patient previously treated by another physician at the time of cytogenetic testing performed)
      - Append modifier to CPT Category II code: 3155F-3P

### Risk Adjustment
- No risk adjustment or risk stratification.

### Stratification
- We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

### Type Score
- Rate/proportion  better quality = higher score

### Algorithm
To calculate performance rates:
1. Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
2. From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
3. From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [e.g., medical, system or patient reason for not performing baseline cytogenetic testing]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment Generic Measure Logic.pdf

---

## 0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE
Comments due by May 16, 2012 by 6:00 PM ET
| **0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy** |
| **Status** | Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008 |
| **Steward** | American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Society of Hematology |
| **Description** | Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy |
| **Type** | Process |
| **Data Source** | Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Laboratory Not Applicable Attachment 0378 MDS_Iron Stores Data Elements_FINAL.pdf |
| **Level** | Clinician: Group/Practice, Clinician: Individual, Clinician: Team |
| **Setting** | Ambulatory Care: Clinic/Urgent Care, Ambulatory Care: Clinician Office, Laboratory |
| **Numerator Statement** | Patients with documentation* of iron stores prior to initiating erythropoietin therapy *Definition: documentation of iron stores which includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC |
| **Numerator Details** | Time Window: At least once during measurement period *Definition: documentation of iron stores which includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC Definition: Erythropoietin Therapy: Includes the following medications: epoetin and darbepoetin for the purpose of this measure. For EHR: specification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: CPT Category II code: 3160F: Documentation of iron stores prior to initiating erythropoietin therapy |
| **Denominator Statement** | All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy |
| **Denominator Details** | Time Window: 12 consecutive months For EHR: specification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: AGE: >= 18 years and older ICD-9-CM diagnosis codes: 238.72, 238.73, 238.74, 238.75 ICD-10-CM diagnosis codes: D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.a, D46.b, D46.c, D46.z Diagnosis: MDS AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 AND CPT category II 4090F: Patient receiving erythropoietin therapy |
| **Exclusions** | Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy |
| **Exclusion Details** | The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include system reasons, e.g. for not documenting iron stores prior to initiating erythropoietin therapy. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes |

**NATIONAL QUALITY FORUM**

**NQF REVIEW DRAFT—DO NOT CITE OR QUOTE**
Comments due by May 16, 2012 by 6:00 PM ET
0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

<table>
<thead>
<tr>
<th>Risk Adjustment</th>
<th>No risk adjustment or risk stratification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stratification</td>
<td>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</td>
</tr>
<tr>
<td>Type Score</td>
<td>Rate/proportion  better quality = higher score</td>
</tr>
<tr>
<td>Algorithm</td>
<td>To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: or system reason(s) (eg, for not documenting iron stores prior to initiating erythropoietin therapy)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See attached calculation algorithm in 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634631931846113738.pdf</td>
</tr>
</tbody>
</table>

### 0379: Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

**Description**

Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

**Numerator**

Patients who had baseline flow cytometry studies performed and documented in the chart

Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy.*

**Numerator Details**

Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy.*

For EHR: specification currently under development. Data elements (using Quality Data Model) required for the measure attached.

Administrative claims:

CPT Category II code: 3170F – Baseline flow cytometry studies performed
### 0379: Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

**Denominator**

All patients aged 18 years and older seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period.

**Denominator Details**

For EHR: specification currently under development. Data elements (using Quality Data Model) required for the measure attached.

- **AGE:** >= 18 years and older
- **AND**
  - Diagnosis: Chronic Lymphocytic Leukemia
  - ICD-9-CM diagnosis codes: 204.10, 204.12
  - ICD-10-CM diagnosis codes: C91.10, C91.12
  - AND
  - CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

**Exclusions**

- Documentation of medical reason(s) for not performing baseline flow cytometry
- Documentation of patient reason(s) for not performing baseline flow cytometry
- Documentation of system reason(s) for not performing baseline flow cytometry

**Exclusion details**

The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason, e.g. for not performing baseline flow cytometry; patient reason, e.g. for not performing baseline flow cytometry (for example, receiving palliative care or not receiving treatment as defined above) or system reason, e.g. for not performing baseline flow cytometry (for example, patient previously treated by another physician at the time baseline flow cytometry studies were performed). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows:

For EHR: specification currently under development. Data elements (using Quality Data Model) required for the measure attached.

**Administrative claims**

**Denominator Exceptions:**

- Documentation of medical reason(s) for not performing baseline flow cytometry studies
  - Append modifier to CPT Category II code: 3170F-1P

- Documentation of patient reason(s) for not performing baseline flow cytometry studies (e.g., receiving palliative care or not receiving treatment as defined above)
  - Append modifier to CPT Category II code: 3170F-2P

- Documentation of system reason(s) for not performing baseline flow cytometry studies (e.g., patient previously treated by another physician at the time baseline flow cytometry studies were performed)
<table>
<thead>
<tr>
<th><strong>0379: Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Adjustment</strong></td>
</tr>
<tr>
<td><strong>Stratification</strong></td>
</tr>
<tr>
<td><strong>Numerator Time window</strong></td>
</tr>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td><strong>Type of Score</strong></td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
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<tr>
<td><strong>Level</strong></td>
</tr>
<tr>
<td><strong>Setting</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>0380 Multiple Myeloma – Treatment with Bisphosphonates</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status</strong></td>
</tr>
<tr>
<td><strong>Steward</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
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<td><strong>Type</strong></td>
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<td><strong>Data Source</strong></td>
</tr>
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<td><strong>Level</strong></td>
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<tr>
<td><strong>Setting</strong></td>
</tr>
<tr>
<td><strong>Numerator Statement</strong></td>
</tr>
<tr>
<td><strong>Numerator Details</strong></td>
</tr>
<tr>
<td><strong>Denominator Statement</strong></td>
</tr>
<tr>
<td><strong>Denominator Details</strong></td>
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</tbody>
</table>

NATIONAL QUALITY FORUM

Comments due by May 16, 2012 by 6:00 PM ET
<table>
<thead>
<tr>
<th>0380 Multiple Myeloma – Treatment with Bisphosphonates</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE: &gt;=18 years and older</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>Diagnosis: Multiple Myeloma</td>
</tr>
<tr>
<td>ICD-9-CM diagnosis codes: 203.00, 203.02</td>
</tr>
<tr>
<td>ICD-10-CM diagnosis codes: C90.00, C90.02</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>CPT codes: 99201, 99202, 99203, 99204, 99212, 99213,</td>
</tr>
<tr>
<td>99214, 99215, 99241, 99242, 99243, 99244, 99245</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of medical reason(s) for not prescribing</td>
</tr>
<tr>
<td>bisphosphonates (eg, patients who do not have bone</td>
</tr>
<tr>
<td>disease, patients with dental disease, patients with</td>
</tr>
<tr>
<td>renal insufficiency)</td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not prescribing</td>
</tr>
<tr>
<td>bisphosphonates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PCPI methodology uses three categories of</td>
</tr>
<tr>
<td>reasons for which a patient may be excluded from the</td>
</tr>
<tr>
<td>denominator of an individual measure. These measure</td>
</tr>
<tr>
<td>exception categories are not uniformly relevant across</td>
</tr>
<tr>
<td>all measures; for each measure, there must be a clear</td>
</tr>
<tr>
<td>rationale to permit an exception for a medical, patient,</td>
</tr>
<tr>
<td>or system reason. Examples are provided in the</td>
</tr>
<tr>
<td>measure exception language of instances that may</td>
</tr>
<tr>
<td>constitute an exception and are intended to serve as</td>
</tr>
<tr>
<td>a guide to clinicians. For this measure, exceptions</td>
</tr>
<tr>
<td>may include medical reason(s), e.g. for not</td>
</tr>
<tr>
<td>prescribing bisphosphonates (patients who do not have</td>
</tr>
<tr>
<td>bone disease, patients with dental disease, patients</td>
</tr>
<tr>
<td>with renal insufficiency) or patient reason(s), e.g.</td>
</tr>
<tr>
<td>for not prescribing bisphosphonates. Where examples</td>
</tr>
<tr>
<td>of exceptions are included in the measure language,</td>
</tr>
<tr>
<td>these examples are coded and included in the</td>
</tr>
<tr>
<td>eSpecifications. Although this methodology does not</td>
</tr>
<tr>
<td>require the external reporting of more detailed</td>
</tr>
<tr>
<td>exception data, the PCPI recommends that physicians</td>
</tr>
<tr>
<td>document the specific reasons for exception in</td>
</tr>
<tr>
<td>patients’ medical records for purposes of optimal</td>
</tr>
<tr>
<td>patient management and audit-readiness. The PCPI</td>
</tr>
<tr>
<td>also advocates the systematic review and analysis of</td>
</tr>
<tr>
<td>each physician’s exceptions data to identify</td>
</tr>
<tr>
<td>practice patterns and opportunities for quality</td>
</tr>
<tr>
<td>improvement. For example, it is possible for</td>
</tr>
<tr>
<td>implementers to calculate the percentage of</td>
</tr>
<tr>
<td>physicians that have identified as meeting the</td>
</tr>
<tr>
<td>criteria for exception. Additional details by data</td>
</tr>
<tr>
<td>source are as follows:</td>
</tr>
<tr>
<td>For EHR: eSpecifications currently under development.</td>
</tr>
<tr>
<td>Data elements (using Quality Data Model) required for</td>
</tr>
<tr>
<td>the measure attached.</td>
</tr>
<tr>
<td>Administrative claims:</td>
</tr>
<tr>
<td>Denominator Exceptions:</td>
</tr>
<tr>
<td>Documentation of medical reason(s) for not</td>
</tr>
<tr>
<td>prescribing bisphosphonates (eg, patients who do not</td>
</tr>
<tr>
<td>have bone disease, patients with dental disease,</td>
</tr>
<tr>
<td>patients with renal insufficiency)</td>
</tr>
<tr>
<td>Append modifier to CPT Category II code: 4100F-1P</td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not</td>
</tr>
<tr>
<td>prescribing bisphosphonates</td>
</tr>
<tr>
<td>Append modifier to CPT Category II code: 4100F-2P</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk adjustment or risk stratification</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stratification</th>
</tr>
</thead>
<tbody>
<tr>
<td>We encourage the results of this measure to be</td>
</tr>
<tr>
<td>stratified by race, ethnicity, gender, and primary</td>
</tr>
<tr>
<td>language, and have included these variables as</td>
</tr>
<tr>
<td>recommended data elements to be collected.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate/proportion better quality = higher score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Algorithm</th>
</tr>
</thead>
<tbody>
<tr>
<td>To calculate performance rates:</td>
</tr>
<tr>
<td>1) Find the patients who meet the initial patient</td>
</tr>
<tr>
<td>population (ie, the general group of patients that</td>
</tr>
<tr>
<td>the performance measure is designed to address).</td>
</tr>
<tr>
<td>2) From the patients within the initial patient</td>
</tr>
<tr>
<td>population criteria, find the patients who qualify</td>
</tr>
<tr>
<td>for the denominator (ie, the specific group of patients</td>
</tr>
<tr>
<td>for inclusion in a specific performance measure based</td>
</tr>
<tr>
<td>on defined criteria). Note: in some cases the initial</td>
</tr>
<tr>
<td>patient population and denominator are identical.</td>
</tr>
<tr>
<td>3) From the patients within the denominator, find</td>
</tr>
<tr>
<td>the patients who qualify for the Numerator (ie, the</td>
</tr>
<tr>
<td>group of patients in the denominator for whom a</td>
</tr>
<tr>
<td>process or outcome of care occurs). Validate that the</td>
</tr>
<tr>
<td>number of patients in the numerator is less than or</td>
</tr>
<tr>
<td>equal to the number of patients in the denominator.</td>
</tr>
<tr>
<td>4) From the patients who did not meet the numerator</td>
</tr>
<tr>
<td>criteria, determine if the physician has documented</td>
</tr>
<tr>
<td>that the patient meets any criteria for denominator</td>
</tr>
<tr>
<td>exception when exceptions have been specified for this</td>
</tr>
<tr>
<td>measure: exceptions may include medical reason(s), e.g.</td>
</tr>
<tr>
<td>for not prescribing bisphosphonates (patients who do</td>
</tr>
<tr>
<td>not have bone disease, patients with dental disease,</td>
</tr>
</tbody>
</table>
| patients with renal insufficiency) or patient reason(s)|, e.g. for not
### 0380 Multiple Myeloma – Treatment with Bisphosphonates

- If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.
- Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment Generic Measure Logic-634620584294869354.pdf

### 0381 Oncology: Treatment Summary Communication – Radiation Oncology

**Status**

**Steward**
- American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: The measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

**Description**
- Percentage of patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment.

**Type**
- Process

**Data Source**
- Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not Applicable
- Attachment AMA-PCPI_0381_DataElements_AppendixA.pdf

**Level**
- Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Setting**
- Ambulatory Care : Clinician Office, Other Radiation Oncology Dept/Clinic

**Numerator Statement**
- Patients who have a treatment summary* report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment.

**Numerator Details**
- **Time Window:** <= one month after completion of therapy during measurement period
  - For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached.
  - For Claims/Administrative: Report CPT Category II code: 5020F - Treatment summary report communicated to physician(s) managing continuing care and to the patient within one month of completing treatment

**Denominator Statement**
- All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy within 12 consecutive months

**Denominator Details**
- **Time Window:** Each course of brachytherapy or external beam radiation therapy within 12 consecutive months
  - For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached.
  - For Claims/Administrative: CPT® codes for external beam radiation therapy, weekly management or brachytherapy: 77427, 77431, 77432, 77435, 77470, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787 AND ICD-9-CM diagnosis codes: See Attached Code List (Appendix A in attachment)
### 0381 Oncology: Treatment Summary Communication – Radiation Oncology

| Exclusions | Documentation of a patient reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (e.g., patient requests that report not be sent) and to the patient within one month of completing treatment. Documentation of a system reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (e.g., patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment. |

| Exclusion Details | The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include patient (e.g., patient requests that report not be sent) or system reason(s) (e.g., patient does not have any physician responsible for providing continuing care) for not communicating the treatment summary report to the physician(s) providing continuing care and to the patient within one month of completing treatment. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: Documentation of patient reason(s) for not having a treatment summary report in the chart that was communicated to the physician(s) providing continuing care (e.g., patient requests that report not be sent) and to the patient within one month of completing treatment. • Append modifier to CPT Category II code: 5020F-2P Documentation of system reason(s) for not having a treatment summary report in the chart that was communicated to the physician(s) providing continuing care (e.g., patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment. • Append modifier to CPT Category II code: 5020F-3P |

| Risk Adjustment | No risk adjustment or risk stratification |

| Stratification | We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. |

| Type Score | Rate/proportion better quality = higher score |

| Algorithm | To calculate performance rates: 1) Find the patients who meet the initial patient population (i.e., the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: patient reason(s) (e.g., patient requests that report not be sent) or system reason(s) (e.g., patient does not have any physician responsible for providing continuing care)]. If the patient meets any exception criteria, they |

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Comments due by May 16, 2012 by 6:00 PM ET

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**ICD-10-CM diagnosis codes: See Attached Code List (Appendix A in attachment)**
# 0381 Oncology: Treatment Summary Communication – Radiation Oncology

should be removed from the denominator for performance calculation.
--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

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## 0382 Oncology: Radiation Dose Limits to Normal Tissues

### Status

### Steward
American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

### Description
Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

### Type
Process

### Data Source
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not Applicable
Attachment NQF#0382_DataElements-634620692307678721.xls

### Level
Clinician : Group/Practice, Clinician : Individual, Clinician : Team

### Setting
Ambulatory Care : Clinician Office, Other Radiation Oncology Dept/Clinic

### Numerator Statement
Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

### Numerator Details
Time Window: Once, prior to start of 3D conformal radiation therapy
0382 Oncology: Radiation Dose Limits to Normal Tissues

For EHR:
eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached.

For Claims/Administrative Data:
To submit the numerator option for patients who had documentation in the medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues, report the following CPT Category II code:

0520F – Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues or organs

<table>
<thead>
<tr>
<th>Denominator Statement</th>
<th>All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator Details</td>
<td>Time Window: Each course of 3D conformal radiation therapy within 12 consecutive months</td>
</tr>
<tr>
<td></td>
<td>For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative Data:</td>
</tr>
<tr>
<td></td>
<td>ICD-10-CM diagnosis codes: C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92</td>
</tr>
<tr>
<td></td>
<td>AND • CPT code for radiation therapy 3D simulation: 77295</td>
</tr>
</tbody>
</table>

Exclusions
None

Exclusion Details
There are no exceptions for this measure.

Risk Adjustment
No risk adjustment or risk stratification
None

Stratification
We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Type Score
Rate/proportion better quality = higher score

Algorithm
To calculate performance rates:
1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard
## 0382 Oncology: Radiation Dose Limits to Normal Tissues

<table>
<thead>
<tr>
<th>Copyright/Disclaimer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance ImprovementTM (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures. THE MEASURES ARE PROVIDED &quot;AS IS&quot; WITHOUT WARRANTY OF ANY KIND © 2007 American Medical Association. All Rights Reserved Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND. See copyright statement above.</td>
</tr>
</tbody>
</table>

## 0383 Oncology: Plan of Care for Pain—Medical Oncology and Radiation Oncology (paired with 0384)

<table>
<thead>
<tr>
<th>Status</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records Attachment NQF_0383_DataElements_AppendixA.pdf</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician : Group/Practice, Clinician : Individual, Clinician : Team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient visits that included a documented plan of care* to address pain Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Window: At each visit within the measurement period</td>
</tr>
</tbody>
</table>

For EHR:
eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data:
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<table>
<thead>
<tr>
<th>0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator Statement</strong></td>
</tr>
<tr>
<td><strong>Denominator Details</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Exclusions</td>
</tr>
<tr>
<td>Exclusion Details</td>
</tr>
<tr>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>Stratification</td>
</tr>
<tr>
<td>Type Score</td>
</tr>
<tr>
<td>Algorithm</td>
</tr>
</tbody>
</table>

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Comments due by May 16, 2012 by 6:00 PM ET
A-19

0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)

4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.


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0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

Status

Steward
American Medical Association – Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Description
Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

Type
Process

Data Source
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records Not Applicable

Attachment NQF_0384_DataElements_AppendixA.pdf

Level
Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Setting
Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic

Numerator
Patient visits in which pain intensity is quantified*
### Statement

* Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale.

### Numerator Details

**Time Window:** At each visit within the measurement period

For EHR:
eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A).

For Claims/Administrative Data:
To submit the numerator option for number of patient visits in which pain intensity was quantified, report one of the following CPT Category II codes:
- 1125F – Pain severity quantified; pain present
- OR
- 1126F – Pain severity quantified; no pain present

**Time Window:** 12 consecutive months

For EHR:
No changes to this section.

For Claims/Administrative Data:
- All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy
- Eligible patients for this measure are identified by:
  - ICD-9-CM diagnosis codes:
    - Please refer to attached Excel file titled, Appendix A, for the applicable ICD-9-CM codes
  - ICD-10-CM diagnosis codes:
    - Please refer to attached Excel file titled, Appendix A, for the applicable ICD-10-CM codes
- AND either option 1 or 2
  1. Chemotherapy
    - CPT codes:
      - 99201, 99202, 99203, 99204, 99205,
      - 99212, 99213, 99214, 99215
    - AND
    - CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration)
    - OR
  2. Radiation therapy
    - CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470

### Exclusions

* None

### Exclusion Details

There are no exceptions for this measure.

### Risk Adjustment

* No risk adjustment or risk stratification

### Stratification

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

### Type Score

* Rate/proportion  better quality = higher score

### Algorithm

To calculate performance rates:
0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria).
Note: in some cases the initial patient population and denominator are identical.
3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.
4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.
If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.


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0386 Oncology: Cancer Stage Documented


Steward American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure is jointly copyrighted by the AMA-PCPI and American Society of Clinical Oncology. The measure set was also developed in collaboration with the American Society for Radiation Oncology.

Description Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the
**0386 Oncology: Cancer Stage Documented**

<table>
<thead>
<tr>
<th>Type</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source</strong></td>
<td>Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Paper Records Not Applicable Attachment Data_Elements_0386.xls</td>
</tr>
<tr>
<td><strong>Level</strong></td>
<td>Clinician : Group/Practice, Clinician : Individual, Clinician : Team</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic;</td>
</tr>
<tr>
<td><strong>Numerator Statement</strong></td>
<td>Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period Numerator Instructions: *Cancer stage refers to stage at diagnosis</td>
</tr>
<tr>
<td><strong>Numerator Details</strong></td>
<td><strong>Time Window:</strong> At least once during the measurement period</td>
</tr>
<tr>
<td></td>
<td>For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: To submit the numerator option for patients who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period, report one of the following CPT Category II codes: 3300F – American Joint Committee on Cancer (AJCC) stage documented and reviewed OR 3301F – Cancer stage documented in medical record as metastatic and reviewed</td>
</tr>
<tr>
<td><strong>Denominator Statement</strong></td>
<td>All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting</td>
</tr>
<tr>
<td><strong>Denominator Details</strong></td>
<td><strong>Time Window:</strong> 12 consecutive months</td>
</tr>
</tbody>
</table>
### 0386 Oncology: Cancer Stage Documented

| Exclusions | None |
| Exclusion Details | There are no exceptions for this measure. |
| Risk Adjustment | No risk adjustment or risk stratification |
| Stratification | We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. |
| Type Score Algorithm | Rate/proportion better quality = higher score |
| Algorithm | To calculate performance rates:  
1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).  
2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria).  
Note: in some cases the initial patient population and denominator are identical.  
3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator  
4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.  
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### 0386 Oncology: Cancer Stage Documented

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### 0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Steward</td>
<td>American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Urological Association and American Society for Therapeutic Radiology &amp; Oncology</td>
</tr>
<tr>
<td>Description</td>
<td>Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer</td>
</tr>
<tr>
<td>Type</td>
<td>Process</td>
</tr>
<tr>
<td>Data Source</td>
<td>Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not applicable.</td>
</tr>
<tr>
<td>Level</td>
<td>Clinician : Group/Practice, Clinician : Individual, Clinician : Team</td>
</tr>
<tr>
<td>Setting</td>
<td>Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office, Other Radiation Oncology Clinic/Department</td>
</tr>
</tbody>
</table>

#### Numerator Statement

Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer

#### Numerator Details

**Time Window:** Once for each procedure for treatment of prostate cancer (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy)

For EHR:
See attached eMeasure
For Claims/Administrative Data:
To submit the numerator option for patients who did not have a bone scan performed at any time since diagnosis of prostate cancer, report the following CPT Category II code:
3270F – Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer

#### Denominator Statement

All patients, regardless of age, with a diagnosis of prostate cancer, at low risk* of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

#### Denominator Details

**Time Window:** Each procedure for treatment of prostate cancer (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy)

Risk strata definitions:
- **Low Risk:** PSA =10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a2
- **Intermediate Risk:** PSA >10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk2
- **High Risk:** PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinical stage T2c or greater; and not qualifying for very high risk2

Note: Only patients with prostate cancer with low risk of recurrence will be counted in the denominator of this measure

For EHR:
See attached eMeasure
For Claims/Administrative Data:
All patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy
ICD-9-CM diagnosis code: 185
ICD-10-CM diagnosis code: C61

AND
CPT codes: 55810, 55812, 55815 (perineal prostatectomies); 55840, 55842, 55845 (retropubic prostatectomies); 55866 (laparoscopic prostatectomy); 55873 (cryotherapy); 77427 (radiation treatment management); 77776,
### 0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

| Exclusions | Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons)  
| Exclusion Details | The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) for having a bone scan performed (e.g. documented pain, salvage therapy, other medical reasons) or system reason(s) for having a bone scan performed (e.g., bone scan ordered by someone other than reporting physician). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows:

For EHR:
See attached eMeasure

For Claims/Administrative Data:
Document documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons)

Append modifier to CPT Category II code: 3269F-1P – Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer (including documented pain, salvage therapy, other medical reasons)

Document documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician)

Append modifier to CPT Category II code: 3269F-3P – Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer (including bone scan ordered by someone other than reporting physician)

### Risk Adjustment

No risk adjustment or risk stratification
Not applicable

### Stratification

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

### Type Score

Rate/proportion better quality = higher score

### Algorithm

For measures with exceptions:

To calculate performance rates:

1) Find the patients who meet the initial patient population (i.e., the general group of patients that the performance measure is designed to address).

2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.

3) From the patients within the denominator, find the patients who qualify for the Numerator (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this...
Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

measure: medical reason(s) (eg, documented pain, salvage therapy, other medical reasons) or system reason(s) (eg, bone scan ordered by someone other than reporting physician). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment Measure Calculation_0389.pdf

Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Status

Steward
American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Urological Association and American Society for Therapeutic Radiology & Oncology

Description
Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

Type
Process

Data Source
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not applicable
Attachment NQF_0390_DataElements.xls

Level
Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Setting
Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office, Other Radiation Oncology Clinic/Department

Numerator Statement
Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

Numerator Details
Time Window: Once for each procedure for treatment of prostate cancer (i.e., external beam radiotherapy to the prostate)
<table>
<thead>
<tr>
<th>0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients</th>
</tr>
</thead>
</table>
| **For EHR:**  
  eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached.  
  **For Claims/Administrative Data:**  
  To submit the numerator option for patients who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist), report the following CPT Category II code:  
  4164F – Adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered |
| **Denominator Statement**  
  All patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate  
  **Note:** Only patients with prostate cancer with high risk of recurrence will be counted in the denominator |
| **Denominator Details**  
  **Time Window:** Each procedure for treatment of prostate cancer (i.e., external beam radiotherapy to the prostate)  
  **Risk strata definition:**  
  • High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinically localized stage T3a1  
  **For EHR:**  
  eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached.  
  **For Claims/Administrative Data:**  
  All patients with a diagnosis of prostate cancer, at high risk of recurrence receiving external beam radiotherapy to the prostate  
  ICD-9-CM diagnosis code: 185  
  ICD-10-CM diagnosis code: C61  
  AND  
  CPT code: 77427 (radiation treatment management)  
  AND  
  Report the following CPT Category II code to identify the risk of recurrence:  
  • 3273F – High risk of recurrence, prostate cancer |
| **Exclusions**  
  Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy)  
  Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy |
| **Exclusion Details**  
  The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy) or patient reason(s). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows:  
  **For EHR:**  
  eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached.  
  **For Claims/Administrative Data:**  
  Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy)  
  Append modifier to CPT Category II code: 4164F-1P  
  Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy  
  Append modifier to CPT Category II code: 4164F-2P |
### 0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

| Risk Adjustment | No risk adjustment or risk stratification  
|                 | Not applicable |
| Stratification  | We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. |
| Type Score      | Rate/proportion  
|                 | better quality = higher score  

#### Algorithm

To calculate performance rates:
1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.
4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy) or patient reason(s)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment Measure Calculation_0390.pdf

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### 0650 Melanoma Continuity of Care – Recall System

<table>
<thead>
<tr>
<th>Status</th>
<th>Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steward</td>
<td>American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other</td>
</tr>
</tbody>
</table>

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### 0650 Melanoma Continuity of Care – Recall System

**organizations:** American Academy of Dermatology and National Committee for Quality Assurance

#### Description
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month reporting period into a recall system that includes:
- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

#### Type
Structure

#### Data Source
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Registry, Other, Paper Records Not Applicable

#### Level
Clinician : Group/Practice, Clinician : Individual, Clinician : Team

#### Setting
Ambulatory Care : Clinician Office

#### Numerator Statement
Patients whose information is entered, at least once within a 12 month period, into a recall system* that includes:
- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

#### Numerator Details
**Time Window:** At least once during measurement period

**Numerator Instructions:**
To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum; patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

For Claims/Administrative:
Report CPT Category II code: 7010F -- Patient information entered into a recall system with the target date for the next complete physical skin exam specified

For EHR:
This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.

#### Denominator Statement
All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma.

#### Denominator Details
**Time Window:** 12 consecutive months

**For EHR:**
This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.

For Claims/Administrative:
ICD-10-CM diagnosis codes: C41.10, C41.11, C41.12, C41.13, C42.9, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C44.60, C44.61, C44.62, C44.70, C44.71, C44.72, C44.8, C44.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820
AND
CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

#### Exclusions
Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider)

**Exclusion**
The PCPI methodology uses three categories of reasons for which a patient may be excluded from the
### 0650 Melanoma Continuity of Care – Recall System

#### Details

Denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include system reason(s) for not entering patients into a recall system (e.g., melanoma being monitored by another physician provider). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows:

- **For EHR:**
  - This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.

- **For Claims/Administrative:**
  - Documentation of system reason exception
    - Append modifier to CPT Category II code: 7010F-3P

#### Risk Adjustment

No risk adjustment or risk stratification

Not applicable

#### Stratification

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

#### Type Score

Rate/proportion better quality = higher score

#### Algorithm

To calculate performance rates:

1. Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
2. From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
3. From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.
4. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: system reason(s) (e.g., melanoma being monitored by another physician provider)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment AMA-PCPI_Measure Calculation-Standard Measures650.pdf

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### 0650 Melanoma Continuity of Care – Recall System

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### 1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

<table>
<thead>
<tr>
<th>Status</th>
<th>New Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steward</td>
<td>Society of Thoracic Surgeons</td>
</tr>
<tr>
<td>Description</td>
<td>Percentage of patients = 18 years of age undergoing elective lung resection (Open or VATS wedge resection, segmentectomy, lobectomy, bilobectomy, sleeve lobectomy, pneumonectomy) for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support &gt; 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.</td>
</tr>
<tr>
<td>Type</td>
<td>Outcome</td>
</tr>
<tr>
<td>URL Data Collection Form</td>
<td><a href="http://www.sts.org/sites/default/files/documents/STSThoracicDCF_V2_2_MajorProc_Annotated_0.pdf">http://www.sts.org/sites/default/files/documents/STSThoracicDCF_V2_2_MajorProc_Annotated_0.pdf</a></td>
</tr>
<tr>
<td>Level</td>
<td>Clinician : Group/Practice, Clinician : Team, Facility</td>
</tr>
<tr>
<td>Setting</td>
<td>Hospital/Acute Care Facility</td>
</tr>
</tbody>
</table>

**Numerator Statement**

Number of patients = 18 years of age undergoing elective lung resection for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.

**Numerator Details**

**Time Window:** During hospitalization regardless of length of stay or within 30 days of surgery if discharged from the hospital.

Number of patients undergoing elective lung resection for lung cancer for whom:
1. Postoperative events (POEvents - STS GTS Database, v 2.2, sequence number 1710) is marked “Yes” and one of the following items is marked:
   a. Reintubation (Reintube - STS GTS Database, v 2.2, sequence number 1850)
   b. Need for tracheostomy (Trach - STS GTS Database, v 2.2, sequence number 1860)
### 1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>c.</td>
<td>Initial ventilator support &gt; 48 hours (Vent - STS GTS Database, v 2.2, sequence number 1840)</td>
</tr>
<tr>
<td>d.</td>
<td>Adult Respiratory Distress Syndrome (ARDS - STS GTS Database, v 2.2, sequence number 1790)</td>
</tr>
<tr>
<td>e.</td>
<td>Pneumonia (Pneumonia - STS GTS Database, v 2.2, sequence number 1780)</td>
</tr>
<tr>
<td>f.</td>
<td>Pulmonary Embolus (PE - STS GTS Database, v 2.2, sequence number 1820)</td>
</tr>
<tr>
<td>g.</td>
<td>Bronchopleural Fistula (Bronchopleural - STS GTS Database, v 2.2, sequence number 1810)</td>
</tr>
<tr>
<td>h.</td>
<td>Myocardial infarction (MI - STS GTS Database, v 2.2, sequence number 1900)</td>
</tr>
</tbody>
</table>

**Or**

2. Unexpected return to the operating room (ReturnOR - STS GTS Database, Version 2.2, sequence number 1720) is marked “yes” and primary reason for return to OR (ReturnORRsn – STS GTS Database, Version 2.2, sequence number 1730) is marked “bleeding”

**Or**

3. One of the following fields is marked “dead”
   a. Discharge status (MtDCStat - STS GTS Database, Version 2.2, sequence number 2200);
   b. Status at 30 days after surgery (Mt30Stat - STS GTS Database, Version 2.2, sequence number 2240)


### Denominator Statement

**Number of patients = 18 years of age undergoing elective lung resection for lung cancer.**

### Denominator Details

**Time Window:** 36 months

1. Lung cancer (LungCancer - STS GTS Database, v 2.2, sequence number 830) is marked “yes” and Category of Disease – Primary (CategoryPrim - STS GTS Database, v 2.2, sequence number 1300) is marked as one of the following:
   - ICD-9, ICD-10
   - Lung cancer, main bronchus, carina (162.2, C34.00)
   - Lung cancer, upper lobe (162.3, C34.10)
   - Lung cancer, middle lobe (162.4, C34.2)
   - Lung cancer, lower lobe (162.5, C34.30)
   - Lung cancer, location unspecified (162.9, C34.90)

2. Patient has lung cancer (as defined in #1 above) and primary procedure is one of the following CPT codes:
   - Thoracoscopy, surgical; with lobectomy (32663)
   - Thoracoscopy with therapeutic wedge resection (eg mass or nodule) initial, unilateral (3266X)
   - Thoracoscopy with therapeutic wedge resection (eg mass or nodule) each additional resection, ipsilateral (3266X1)
   - Thoracoscopy with diagnostic wedge resection followed by anatomic lung resection (3266X2)
   - Thoracoscopy with removal of a single lung segment (segmentectomy) (3266X4)
   - Thoracoscopy with removal of two lobes (bilobectomy) (3266X3)
   - Thoracoscopy with removal of lung, pneumonectomy (3266X5)
   - Thoracotomy with therapeutic wedge resection (eg mass nodule) initial (3250X)
   - Thoracotomy with therapeutic wedge resection (eg mass nodule) each additional resection, ipsilateral (+3250X1)
   - Thoracotomy with diagnostic wedge resection followed by anatomic lung resection (+3250X2)
   - Removal of lung, total pneumonectomy; (32440)
   - Removal of lung, sleeve (carinal) pneumonectomy (32442)
   - Removal of lung, total pneumonectomy; extrapleural (32445)
   - Removal of lung, single lobe (lobectomy) (32480)
   - Removal of lung, two lobes (bilobectomy) (32482)
   - Removal of lung, single segment (segmentectomy) (32484)
   - Removal of lung, sleeve lobectomy (32486)
   - Removal of lung, completion pneumonectomy (32488)
   - Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, without chest wall reconstruction(s) (32503)
   - Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, with chest wall
### 1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

<table>
<thead>
<tr>
<th>Exclusions</th>
<th>Emergency procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Details</td>
<td>n/a</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>Statistical risk model</td>
</tr>
<tr>
<td>Bayesian hierarchical modeling was used to assess the statistical reliability of hospital-specific standardized incidence ratio (SIR) estimates derived from the January 1, 2008 – December 31, 2010 STS data. All hospitals regardless of sample size were included. Attachment Kozower et al.pdf</td>
<td></td>
</tr>
<tr>
<td>Stratification</td>
<td>n/a</td>
</tr>
<tr>
<td>Type Score</td>
<td>Rate/proportion</td>
</tr>
<tr>
<td>Algorithm</td>
<td>Target population is patients 18 years of age or older undergoing elective lung resection for lung cancer. Emergency procedures were excluded. Outcome is occurrence of postoperative complications: reintubation, need for tracheostomy, initial ventilator support &gt; 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality. Analysis considered 22,677 patients with procedures between 01/01/2008 and 12/31/2010 (36 months). Risk adjustment was achieved with a Bayesian hierarchical model with composite of the above postoperative complications as the outcome. The measure score was estimated with this model. For additional information review risk model in attachment.</td>
</tr>
</tbody>
</table>

### 1822 External Beam Radiotherapy for Bone Metastases

<table>
<thead>
<tr>
<th>Status</th>
<th>New Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steward</td>
<td>American Society for Radiation Oncology (ASTRO)</td>
</tr>
<tr>
<td>Other organizations:</td>
<td>None</td>
</tr>
<tr>
<td>Description</td>
<td>This measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme as defined by the guideline.</td>
</tr>
<tr>
<td>Type</td>
<td>Process</td>
</tr>
<tr>
<td>Data Source</td>
<td>Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records The data sources for this measure include: Radiation oncologist consultation note, physician office progress note, radiation flow sheet, radiology report</td>
</tr>
<tr>
<td>Attachment bone metastases DATA COLLECTION INSTRUMENT.docx</td>
<td>Attachment DATA ELEMENTS.docx</td>
</tr>
<tr>
<td>Level</td>
<td>Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan</td>
</tr>
<tr>
<td>Setting</td>
<td>Ambulatory Care : Clinician Office, Hospital/Acute Care Facility</td>
</tr>
<tr>
<td>Numerator Statement</td>
<td>All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn.</td>
</tr>
<tr>
<td>Numerator Details</td>
<td>Time Window: Once per reporting period</td>
</tr>
<tr>
<td>Bone metastases diagnosis (198.5- Secondary malignant neoplasm of bone and bone marrow) Use of EBRT (Therapeutic radiology treatment planning: CPT 77261; simple, CPT 77262; Intermediate, CPT 77263; complex)</td>
<td></td>
</tr>
<tr>
<td>Denominator Statement</td>
<td>All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT</td>
</tr>
</tbody>
</table>
### 1822 External Beam Radiotherapy for Bone Metastases

**Denominator Details**
- **Time Window:** Once per reporting period
- Bone metastases diagnosis (198.5- Secondary malignant neoplasm of bone and bone marrow)
- Use of EBRT (Therapeutic radiology treatment planning:
  - CPT 77261; simple,
  - CPT 77262; Intermediate,
  - CPT 77263; complex)

**Exclusions**
- The medical reasons for denominator exclusions are:
  1. Previous radiation treatment to the same anatomic site;
  2. Patients with femoral axis cortical involvement greater than 3 cm in length;
  3. Patients who have undergone a surgical stabilization procedure; and
  4. Patients with spinal cord compression, cauda equina compression or radicular pain

**Exclusion Details**
- **A. Medical Reasons (Data Source)**
  1. Previous radiation treatment to the same anatomic site (Medical Record)
  2. Patients with femoral axis cortical involvement greater than 3 cm in length (Imaging Studies)
  3. Patients who have undergone a surgical stabilization procedure (Operative Report)
  4. Patients with spinal cord compression, cauda equina compression or radicular pain (Diagnosis/Problem list)

**Risk Adjustment**
- No risk adjustment or risk stratification
- Not applicable

**Stratification**
- Stratification of the measure is not required.

**Type Score**
- Rate/proportion  better quality = higher score

**Algorithm**
- **Denominator Calculation**
  
  Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT
  
  Step 2: Identify patients with no history of previous radiation therapy to the same anatomic site
  
  Step 3: Identify patients with specified exceptions and exclude from denominator calculation

- **Numerator Calculation**:
  
  Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT
  
  Step 2: Identify patients prescribed with one of the recommended fractionation schemes: 30Gy/10fxns or 24Gy/6fxns or 20Gy/5fxns or 8Gy/1fxn

### 1853 Radical Prostatectomy Pathology Reporting

**Status**
- New Submission  **Time-limited**

**Steward**
- College of American Pathologists

**Description**
- Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.

**Type**
- Process

**Data Source**
- Administrative claims, Other, Paper Records

| Medical records/Pathology Report and Claims forms are used as the specific data sources. |

**Level**
- Clinician : Group/Practice, Clinician : Individual

**Setting**
- Laboratory

**Numerator Statement**
- Numerator: Radical prostatectomy pathology reports that include the pT category, the pN category, Gleason score and a statement about margin status

- Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F – pathology report

**Numerator Details**
- **Time Window:** Each event is reported

- Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F – pathology report
### 1853 Radical Prostatectomy Pathology Reporting

<table>
<thead>
<tr>
<th>Denominator Statement</th>
<th>All radical prostatectomy pathology reports</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator Details</strong></td>
<td><strong>Time Window:</strong> Each event is recorded; measurement time period is not specified and can be determined by program.</td>
</tr>
<tr>
<td>Denominator (Eligible Population): All radical prostatectomy pathology reports</td>
<td></td>
</tr>
<tr>
<td>CPT code: 88309 - Level VI - Surgical pathology, gross and microscopic examination</td>
<td></td>
</tr>
<tr>
<td>AND</td>
<td></td>
</tr>
<tr>
<td>ICD-9 code: 185 – malignant neoplasm of prostate</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, and transurethral resections of the prostate (TURP))</td>
</tr>
<tr>
<td><strong>Exclusion Details</strong></td>
<td>Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, or transurethral resections of the prostate (TURP) [For patient with appropriate exclusion criteria, report 3267F with modifier 1P.])</td>
</tr>
<tr>
<td><strong>Risk Adjustment</strong></td>
<td>No risk adjustment or risk stratification</td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td><strong>Stratification</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Type Score</strong></td>
<td>Rate/proportion better quality = higher score</td>
</tr>
<tr>
<td><strong>Algorithm</strong></td>
<td>Performance Measure: 3267F/Claims using CPT code 88309 and ICD-9 code 185</td>
</tr>
</tbody>
</table>

### 1854 Barrett’s Esophagus

| Status | New Submission **Time-limited** |
| Steward | College of American Pathologists |
| Description | Percentage of patients with esophageal biopsy reports for Barrett’s esophagus that contain a statement about dysplasia. |
| Type | Process |
| Data Source | Administrative claims, Other, Paper Records Medical records/pathology report/Claims forms |
| Level | Clinician : Group/Practice, Clinician : Individual |
| Setting | Laboratory |
| Numerator Statement | Numerator: Esophageal biopsy reports with the histologic finding of Barrett’s mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.) 3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite) |
| Numerator Details | **Time Window:** Report once per patient per date of service |
| Numerator: Esophageal biopsy reports with the histologic finding of Barrett’s mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.) 3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite) |
| Denominator Statement | Denominator (Eligible Population): All esophageal biopsy reports that document the presence of Barrett’s mucosa. CPT codes: • 88305 Level IV – Surgical pathology, gross and microscopic examination AND |
### Barrett’s Esophagus

<table>
<thead>
<tr>
<th>Denominator Details</th>
<th>Time Window: Once per patient per date of service; time period not specified in the measure and can be determined by the program (typically one year.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The pathology report is needed as well as access to correct coding of claims to identify patients: CPT codes: 88305 Level IV – Surgical pathology, gross and microscopic examination AND ICD-9 codes: 530.85 Barrett’s esophagus</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
<th>Documentation of medical reason for not reporting the histologic finding of Barrett’s mucosa (e.g., malignant neoplasm or absence of intestinal metaplasia).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Details</td>
<td>Documentation of medical reason for not reporting the histologic finding of Barrett’s mucosa (e.g., malignant neoplasm or absence of intestinal metaplasia). [For patient with appropriate exclusion criteria, report 3125F with modifier 1P]</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>No risk adjustment or risk stratification  Not applicable</td>
</tr>
<tr>
<td>Stratification</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Type Score</td>
<td>Rate/proportion  better quality = higher score</td>
</tr>
</tbody>
</table>

#### Algorithm
Performance Measure: 3125F/CPT codes 88305 and ICD-9 codes 530.85

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APPENDIX B: STEERING COMMITTEE and NQF STAFF

STEERING COMMITTEE

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Colorado PERA, Denver, CO

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Eugene Cunningham, MS  
Project Manager, Performance Measures
Appendix C – MEASURE GAPS

Disease Specific Gaps
- PSA screenings for patients diagnosed with prostate cancer
- Measure addressing malignant hematologies, particularly first line therapies
- Measures addressing targeted therapies for kidney and lung cancer, as well as other solid tumor cancers
- Measures capturing deviations in care for the CMS priority areas of prostate, lung, breast, and colon cancers

Pathology and Treatment Reports
- Measures ensuring that reporting details in pathology reports are standardized across all tumor types
- Measures ensuring that treatment summaries are standardized across medical and radiation oncologists

Appropriateness of Care
- Measures capturing enrollment of patients in clinical trials at appropriate times
- Measures addressing whether appropriate patients are offered enrollment in clinical trials
- Measures capturing access of patients to high quality hospice care facilities
- Measures addressing readmissions and value-based care
- Measures capturing Patient Reported Outcomes
- Care coordination measures

Surgical Care
- Measures capturing operating room procedures or processes that need to take place in the surgical theater

Other Measures
- Measures submitted by patient advocacy groups or other multidisciplinary stakeholders
- Prevention measures
- Screening measures
- Combined measures to be used in “toolkits” to ensure a process is associated with an improved outcome
### Appendix D – RELATED MEASURE COMPARISON TABLE

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Data Source</th>
<th>Type</th>
<th>Level</th>
<th>Setting</th>
<th>Numerator Statement</th>
<th>Numerator Details</th>
<th>Time Window: At the time of outpatient visit(s)</th>
<th>Time Window: At each visit within the measurement period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1628</td>
<td>Patients with Advanced Cancer Screened for Pain at Outpatient Visits</td>
<td>Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit</td>
<td>Electronic Clinical Data</td>
<td>Facility, Health Plan, Integrated Delivery System</td>
<td>Ambulatory Care: Clinician Office</td>
<td>Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool</td>
<td>Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.</td>
<td>Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.</td>
<td>Hospice admission evaluation / initial clinical encounter for palliative care</td>
</tr>
<tr>
<td>1634</td>
<td>Hospice and Palliative Care -- Pain Screening</td>
<td>Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.</td>
<td>Electronic Clinical Data</td>
<td>Clinician: Group/Practice, Facility</td>
<td>Hospice, Hospital/Acute Care Facility</td>
<td>Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.</td>
<td>Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.</td>
<td>Hospice admission evaluation / initial clinical encounter for palliative care</td>
<td></td>
</tr>
<tr>
<td>0384</td>
<td>Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)</td>
<td>Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified</td>
<td>Administrative claims</td>
<td>Clinician: Group/Practice, Clinician: Individual, Clinician: Team</td>
<td>Ambulatory Care: Clinician Office, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic</td>
<td>Patient visits in which pain intensity is quantified*</td>
<td>Patient visits in which pain intensity is quantified*</td>
<td>Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale</td>
<td>Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale</td>
</tr>
</tbody>
</table>

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* Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale.
<table>
<thead>
<tr>
<th>Denominator Statement</th>
<th>Time Window: At the time of outpatient visit(s)</th>
<th>Time Window: Hospice admission evaluation / palliative care initial encounter</th>
<th>Time Window: 12 consecutive months</th>
</tr>
</thead>
</table>
| Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion | Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion | The Pain Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Pain Assessment quality measure to ensure that all patients who report pain are clinically assessed.] | For EHR:
eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A).
For Claims/Administrative Data:
All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy Eligible patients for this measure are identified by:
ICD-9-CM diagnosis codes:  PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-9-CM CODES
ICD-10-CM diagnosis codes:  PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-10-CM CODES
AND either option 1 or 2
1. Chemotherapy
   • CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
   AND
   o CPT procedure codes:  51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96444, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration) OR
2. Radiation therapy
   • CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470

1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits

1634 Hospice and Palliative Care -- Pain Screening

0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

1125F – Pain severity quantified; pain present
1126F – Pain severity quantified; no pain present

Comments due by May 16, 2012 by 6:00 PM ET
<table>
<thead>
<tr>
<th>Patients with Advanced Cancer Screened for Pain at Outpatient Visits</th>
<th>1634 Hospice and Palliative Care -- Pain Screening</th>
<th>0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusions</strong></td>
<td>None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)</td>
<td>Patients with length of stay &lt; 7 days in hospice, or &lt; 1 day in palliative care.</td>
</tr>
<tr>
<td><strong>Exclusion Details</strong></td>
<td>Calculation of length of stay; discharge date - date of initial encounter.</td>
<td>There are no exceptions for this measure.</td>
</tr>
<tr>
<td><strong>Risk Adjustment</strong></td>
<td>No risk adjustment or risk stratification</td>
<td>No risk adjustment or risk stratification</td>
</tr>
<tr>
<td><strong>Stratification</strong></td>
<td>N/A</td>
<td>We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.</td>
</tr>
<tr>
<td><strong>Type Score</strong></td>
<td>Rate/proportion better quality = higher score</td>
<td>Rate/proportion better quality = higher score</td>
</tr>
<tr>
<td><strong>Algorithm</strong></td>
<td>1. Identify patients at least 18 years of age with Stage IV cancer 2. Identify patients who have had at least 1 primary care or cancer-related visit. Exclude patients who are not alive 30 or more days after diagnosis. 3. For each applicable visit, determine if a screening for pain was performed using a quantitative standardized tool. 4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits</td>
<td>Screened for pain: a. Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care b. Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) using a standardized tool. Quality Measure = Numerator: Patients screened for pain in Step 3 / Denominator: Patients in Step 1-Patients excluded in Step 2</td>
</tr>
</tbody>
</table>

To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of
<table>
<thead>
<tr>
<th>Submission items</th>
<th>1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits</th>
<th>1634 Hospice and Palliative Care -- Pain Screening</th>
<th>0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Identified measures:</td>
<td></td>
<td></td>
<td>patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620671516608159.pdf</td>
</tr>
<tr>
<td>5a.1 Are specs completely harmonized?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5a.2 If not completely harmonized, identify difference, rationale, impact:</td>
<td></td>
<td></td>
<td>5a.1 Are specs completely harmonized? No</td>
</tr>
<tr>
<td>5b.1 If competing, why superior or rationale for additive value:</td>
<td>This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundled measures for description of the selection and harmonization of the Key Palliative Measures Bundle. Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure. It is unclear exactly what the scope of measure 0420 is, however it appears to be directed at ancillary, non-physician professionals. It is unclear what “initiation of therapy” is referring to. The measure’s endorsement is time limited (endorsed July 31, 2008) Measure 0384 (paired with 0383) also has a time-limited endorsement (endorsed July 31, 2008). This measure targets only patients who are currently receiving chemotherapy or radiation therapy, and by definition, excludes some patients with advanced cancer who are not receiving this type of treatment. The proposed measure targets patients with Stage IV cancer and includes more venues of care than the existing measure.</td>
<td>This measure is part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle. This measure has been harmonized with ACOVE / ASSIST Measure 1628: Patients with advanced cancer screened for pain at outpatient visits. The two measures have the same focus, populations are different (although both include patients with advanced cancer), apply in different settings with different timing.</td>
<td>5a.2 If not completely harmonized, identify difference, rationale, impact: There are a number of NQF-endorsed measure focusing on the assessment of pain in a variety of unique settings and circumstances. Several of these measures (0523 and 0420) refer to conducting the assessment using a standardized tool. Similarly, our measure suggests that pain should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale. Two of the measures are specific to the pediatric intensive care unit and do not require use of a standardized instrument.</td>
</tr>
<tr>
<td>5b.1 If competing, why superior or rationale for additive value:</td>
<td>No competing measure.</td>
<td>No competing measure.</td>
<td>No competing measure.</td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
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<td>1634</td>
<td>Hospice and Palliative Care -- Pain Screening</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

where it would be applied (primary care and all cancer-related outpatient visits). This is in keeping with the reality that pain and pain control becomes a central focus for patients with late-stage cancer, and regular pain assessment should occur in multiple outpatient care settings. The developers propose that measure 0383 be limited to patients with Stage I-III cancer and endorse the proposed measure which targets Stage IV cancer patients.

Proposed measure 1634: Hospice and Palliative Care - Pain Screening: Proposed measure 1634 targets patients with serious conditions who are entering hospice or hospital-based palliative care. The measure proposed here targets a sub-population (advanced cancer). However, the setting and timing of 1634 is hospice/palliative care admission and is a one-time screen. 1628 focuses on pain screening at all outpatient visits. Although the 2 measures focus on different venues of care (and 1 is a time measure and the other every visit), they are completely harmonized in content.

SC Evaluation