



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

### Brief Measure Information

**NQF #:** 0028

**Corresponding Measures:** 0028e

**De.2. Measure Title:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

**Co.1.1. Measure Steward:** PCPI Foundation

**De.3. Brief Description of Measure:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Three rates are reported:

- a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
- b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention
- c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

**1b.1. Developer Rationale:** This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

**S.4. Numerator Statement:** Population 1:

Patients who were screened for tobacco use at least once within 24 months

Population 2:

Patients who received tobacco cessation intervention

Population 3:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

**S.6. Denominator Statement:** Population 1:

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Population 2:

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user

Population 3:

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

**S.8. Denominator Exclusions:** Denominator Exclusions: not applicable

**Denominator Exceptions:**

Population 1:

Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

<p>Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (eg, limited life expectancy, other medical reason)</p> <p>Population 3: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (eg, limited life expectancy, other medical reason)</p>
<p><b>De.1. Measure Type:</b> Process</p> <p><b>S.17. Data Source:</b> Claims, Registry Data</p> <p><b>S.20. Level of Analysis:</b> Clinician : Group/Practice, Clinician : Individual</p>
<p><b>IF Endorsement Maintenance – Original Endorsement Date:</b> Aug 10, 2009 <b>Most Recent Endorsement Date:</b> Jun 28, 2017</p>
<p><b>IF this measure is included in a composite, NQF Composite#/title:</b></p> <p><b>IF this measure is paired/grouped, NQF#/title:</b></p> <p><b>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</b> This measure is not paired/grouped.</p>

<p><b>1. Evidence, Performance Gap, Priority – Importance to Measure and Report</b></p> <p>Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. <b>Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</b></p> <p><b>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form</b> 0028_and_3185_Evidence_MSF5.0_Updated_for_2016_Submission-636162857333556000.doc</p> <p><b>1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?</b> Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence. Yes</p>
<p><b>1b. Performance Gap</b> Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:</p> <ul style="list-style-type: none"> <li>considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or</li> <li>Disparities in care across population groups.</li> </ul> <p><b>1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)</b> <i>If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.</i> This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.</p> <p><b>1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.)</b> This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use. 2014 Physician Quality Reporting System (PQRS) Experience Report 2014 is the most recent year for which PQRS Experience Report measure data are available. The average performance rates on Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention over the last several years are as follows:</p> <ul style="list-style-type: none"> <li>2011: 81.6%</li> </ul>

- 2012: 84.1%
- 2013: 89.7%
- 2014: 88.9%

It is important to note that PQRS has been and remains a voluntary reporting program. In the early years of the PQRS program, participants received an incentive for satisfactorily reporting. However, beginning in 2015, the program imposed payment penalties for non-participants based on 2013 performance. For 2014, only 21.7% of eligible professionals reported on the measure. As a result, performance rates may not be nationally representative.

Reference: Center for Medicare and Medicaid Services. 2014 Reporting Experience Including Trends. Available: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/analysisandpayment.html>

2015 PQRS Claims Performance Rate:

Mean: 96.24%

Minimum: 0.00%

Maximum: 100.00%

Decile	Result %
1	90.0%
2	95.3%
3	98.3%
4	100.0%
5	100.0%
6	100.0%
7	100.0%
8	100.0%
9	100.0%
10	100.0%

2015 PQRS Registry Performance Rate:

Mean: 84.36%

Minimum: 0.00%

Maximum: 100.00%

Decile	Result %
1	51.35%
2	76.92%
3	85.71%
4	90.16%
5	93.25%
6	95.66%
7	98.02%
8	100.00%
9	100.00%
10	100.00%

Report Title: PQRS Ad Hoc Analysis PQ3783, 2015 PQRS Measure Data for PCPI

Report includes 2015 Part B Claims Data for services rendered between January 1, 2015 and December 31, 2015 and processed through February 2016 TAP.

Report also includes PQRS Final Action Registry data and 2015 PQRS Final Action EHR data.

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

A number of studies have documented low rates of tobacco use screening and cessation intervention during primary care and other office/outpatient visits, missing key opportunities for intervention.

A 2012 Morbidity and Mortality Weekly Report (MMWR) summarized data from 2005-2008 National Ambulatory Medical Care Survey (NAMCS) and the National Health Interview Survey (NHIS) to determine progress toward Healthy People 2020 objectives calling for increased screening, cessation counseling and cessation success. The following key findings were reported:

- During the study period, adults aged 18 years and older made an estimated annual average of approximately 771 million outpatient visits (an estimated total of 3.08 billion visits during 2005–2008 combined) to office-based physicians.
- Tobacco use screening occurred during the majority of adult visits to outpatient physician offices (62.7%)
- Of the visits that included tobacco use screening, 17.6% (340 million visits) were made by current tobacco users.
- Among patients who were identified as current tobacco users, only 20.9% received tobacco cessation counseling and 7.6% received tobacco cessation medication
- Patients who visited their primary care physician were more likely to receive tobacco screening (66.6% of visits) than patients who visited a physician who was not their primary care physician (61.6% of visits). Screening also varied by physician specialty. Patients visiting general or family practitioners (66.4%) and obstetricians/gynecologists (69.6%) were more likely to receive screening than patients who visited physicians in other specialties (58.2%), excluding internal medicine, cardiovascular disease, and psychiatry. (1)

Given that hospital outpatient visits account for approximately 1 in 10 outpatient visits, Jamal and colleagues sought to assess the rates of tobacco use screening and cessation assistance offered to US adults during their hospital outpatient clinic visits analyzing data from the 2005–2010 NAMCS. The following key findings were reported:

- During the study period, adults aged 18 years or older made, on average, 71.8 million hospital outpatient visits annually to hospital outpatient physicians or an estimated 431 million visits from 2005 through 2010 combined.
- On average, 45.2 million (63.0%) hospital outpatient visits included tobacco use screening each year.
- Of the visits that included tobacco use screening, 25.7% (11.6 million annual average visits) were made by current tobacco users.
- Among patients who screened positive for current tobacco use, 24.5% (or an estimated 17.1 million visits) received any cessation assistance, including tobacco counseling, a prescription or order for a cessation medication at the visit, or both.
- Patients who made visits to general medicine clinics (67.1%) were more likely to receive tobacco use screening than those who made visits to surgical clinics (55.7%) or clinics with other specialties (45.2%), excluding obstetrics and gynecology (62.8%) and substance abuse clinics (68.3%). (2)

Citations:

1. Jamal A1, Dube SR, Malarcher AM, Shaw L, Engstrom MC; Centers for Disease Control and Prevention (CDC). Tobacco use screening and counseling during physician office visits among adults--National Ambulatory Medical Care Survey and National Health Interview Survey, United States, 2005-2009. MMWR Suppl. 2012 Jun 15;61(2):38-45.
2. Jamal A, Dube SR, King BA. Tobacco Use Screening and Counseling During Hospital Outpatient Visits Among US Adults, 2005–2010. Prev Chronic Dis 2015;12:140529.

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

While this measure is included in several federal reporting programs, those programs have not yet made disparities data available for us to analyze and report.

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4**

The MMWR noted that rates of tobacco screening and intervention varied by patients’ race, age and insurance status. Overall, patients classified as non-Hispanic whites were more likely to receive counseling than Hispanic patients (64.1 versus 57.8%). Among current tobacco users, younger patients (aged 25 to 44 years) reported receiving less counseling (17.9%) than patients aged 45 to 64 years (22.7%). Patients with workers’ compensation, and those whose insurance status was unknown were less likely to receive counseling than those with private insurance, self-payers, Medicaid, and Medicare patients.

Similar racial/ethnic disparities were reported for hospital outpatient visits. Tobacco use screening varied by patient's race/ethnicity - visits made by Hispanics (55.4%) were less likely to receive tobacco use screening than those by non-Hispanic whites (65.1%). For tobacco users, cessation assistance was higher for visits made by those with Medicaid/SCHIP (27.6%) than those with private insurance (21.8%) or Medicare (21.4%). Patients living in a high poverty zone were more likely to receive cessation than those living in a low poverty zone. (2)

1. Jamal A1, Dube SR, Malarcher AM, Shaw L, Engstrom MC; Centers for Disease Control and Prevention (CDC). Tobacco use screening and counseling during physician office visits among adults--National Ambulatory Medical Care Survey and National Health Interview Survey, United States, 2005-2009. MMWR Suppl. 2012 Jun 15;61(2):38-45.
2. Jamal A, Dube SR, King BA. Tobacco Use Screening and Counseling During Hospital Outpatient Visits Among US Adults, 2005-2010. Prev Chronic Dis 2015;12:140529.

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

**De.6. Non-Condition Specific**(check all the areas that apply):

Primary Prevention

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk, Populations at Risk : Individuals with multiple chronic conditions

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

The measure specifications are included with this submission. Additional measure details may be found at <https://www.thehcpi.org/page/PCPI-Stewarded-Measures>

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment: NQF0028\_CMS138v5\_ValueSets\_Details-637262743113954447.xlsx

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

**S.3.1. For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update

the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

**S.3.2. For maintenance of endorsement**, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) **DO NOT** include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Population 1:

Patients who were screened for tobacco use at least once within 24 months

Population 2:

Patients who received tobacco cessation intervention

Population 3:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

**S.5. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Time Period for Data Collection: At least once during the 24-month period

Definitions:

Tobacco Use - Includes any type of tobacco

Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

Numerator Note:

To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 24-month period. If a patient has multiple tobacco use screenings during the 24-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.

If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906 (for population criteria 1) and CPT Category II code 4004F (for population criteria 3).

Population 1:

Report quality data code:

G9902: Patient screened for tobacco use AND identified as a tobacco user

OR

G9903: Patient screened for tobacco use AND identified as a tobacco non-user

Population 2:

Report quality data code:

G9906: Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)

Population 3:

Report CPT Category II code:

4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

1036F: Current tobacco non-user

**S.6. Denominator Statement** (Brief, narrative description of the target population being measured)

Population 1:

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Population 2:

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user

Population 3:

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Time Period for Data Collection: 12 consecutive months

Definitions:

Tobacco Use - Includes any type of tobacco

Denominator Note:

The denominator of submission criteria 2 is a subset of the resulting numerator for submission criteria 1, as submission criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, submission criteria 1 and 3 are applicable, but submission criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for submission criteria 1 and 3, whereas data submitted for submission criteria 2 will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as tobacco users.

Population 1:

Patients aged >= 18 years on date of encounter

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439



WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

Population 2:

Patients aged  $\geq 18$  years on date of encounter

AND

All eligible instances when (G9902) Patient screened for tobacco use AND identified as a tobacco user that are utilized in submission of Performance Met Patient Screened for Tobacco Use, Identified as a Tobacco User in the numerator for population one

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

Population 3:

Patients aged  $\geq 18$  years on date of encounter

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

**S.8. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

Denominator Exclusions: not applicable

Denominator Exceptions:

Population 1:

Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

Population 2:

Documentation of medical reason(s) for not providing tobacco cessation intervention (eg, limited life expectancy, other medical reason)

Population 3:

Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (eg, limited life expectancy, other medical reason)

**S.9. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Time Period for Data Collection: At least once during the 24-month period

The PCPI distinguishes between denominator exceptions and denominator exclusions.



Denominator exclusions arise when the clinical action indicated in the numerator is not appropriate for a particular group of patients who otherwise meet the denominator criteria. These are absolute and would be removed from the denominator of a measure in order to determine the eligible population.

Denominator exceptions are used to remove a patient from the denominator when the patient does not receive the action(s) required in the numerator AND that action(s) would not be appropriate due to a patient-specific reason(s). The patient would otherwise meet the denominator criteria. Exceptions are not absolute and are based on provider judgment or individual patient characteristics or preferences. The PCPI methodology includes two categories of exceptions for which a patient may be removed from the denominator of an individual measure: 1) medical OR 2) patient or non-medical reasons. These exception categories are not uniformly relevant across all measures. The denominator exception language may include specific examples of instances that may constitute an exception, which are intended to serve as a guide to providers. Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eCQM.

Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that providers 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 provider's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details: This measure includes denominator exceptions.

Population 1:

Report quality data code:

G9904: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

Population 2:

Report quality data code:

G9907: Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)

Population 3:

Append modifier to CPT Category II code or report quality data code:

4004F-1P: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)  
OR

G9909: Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (e.g., limited life expectancy, other medical reason)

**S.10. Stratification Information** *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**S.13. Interpretation of Score** *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

**S.14. Calculation Algorithm/Measure Logic** (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Calculating the performance rate:

1. Define the initial population. The initial population is identified through a common set of characteristics that define the overall group of patients – or other unit of measurement – targeted for evaluation
2. Define the denominator by identifying the subset of the initial population that meets the denominator criteria. Note: in some cases, the initial population and denominator are identical
3. Determine the numerator by identifying the subset of the denominator that meets the numerator criteria
4. From the patients who did not meet the numerator criteria, determine if the provider has documented whether each patient represents an exception. Subtract from the denominator those patients that meet the conditions for a denominator exception; although the exception cases are removed from the denominator for the measure calculation, the exception rate (i.e., percentage of patients with valid exceptions) should be calculated and reported along with performance rates to highlight variations in care
5. Calculate the performance rate

A patient not meeting the numerator criteria and without a valid and documented exception represents a quality failure.

**S.15. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Not applicable. This measure is not based on a sample.

**S.16. Survey/Patient-reported data** (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

Not applicable. This measure is not based on a survey.

**S.17. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Registry Data

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Not applicable.

**S.19. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

**S.20. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

**S.21. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Home Care, Other:Occupational therapy evaluation, speech and hearing evaluation, ophthalmological services visit, Outpatient Services

If other:

**S.22. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not applicable. The measure is not a composite.

**2. Validity – See attached Measure Testing Submission Form**

NQF0028\_TobaccoTesting\_Attachment\_Final.doc

**2.1 For maintenance of endorsement**

*Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.*

Yes

## 2.2 For maintenance of endorsement

*Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.*

Yes

## 2.3 For maintenance of endorsement

*Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.*

No - This measure is not risk-adjusted

## 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

#### 3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition  
If other:

### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)** Update this field for **maintenance of endorsement**.

Some data elements are in defined fields in electronic sources

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.** For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

Although the claims data is captured electronically with encounter codes for the denominator and CPT II codes for the numerator, registry implementation may vary.

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.**

Attachment:

### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements

and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Required for maintenance of endorsement.** Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

**IF instrument-based,** consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

We have not identified any areas of concern or made any modifications as a result of testing and operational use of the measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).**

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## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Specific Plan for Use	Current Use (for current use provide URL)

#### 4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Physician Quality Reporting System (PQRS)-Sponsored by the Centers for Medicare and Medicaid Services (CMS)  
PQRS is a national reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the program also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services in 2013. Source: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> CMS has implemented

a phased approach to public reporting performance information on the Physician Compare Web site.

CMS has implemented a phased approach to publicly reporting performance information on the Physician Compare Web Site. Beginning with PQRS 2014 reporting, this measure is one of 14 group practice PQRS measures reported via the Web interface that are currently available for public reporting. This measure is also one of 6 individual EP PQRS measures reported via claims that are currently available for public reporting. CMS also announced through rulemaking their plans to make all PQRS individual EP level PQRS measures available for public reporting annually, including making the 2016 PQRS individual EP level data available for public reporting on Physician Compare in 2017. Beginning in 2017, the Merit-based Incentive Payment System (MIPS) consolidates PQRS and other existing quality reporting programs. This measure has been finalized as an individual quality measure available for MIPS reporting in 2017.

#### Million Hearts

Million Hearts™ is a national initiative to prevent 1 million heart attacks and strokes in the U.S. over the next 5 years. Launched by the Department of Health and Human Services (HHS) in September 2011, it aligns existing efforts, as well as creates new programs, to improve health across communities and help Americans live longer, more productive lives. The Centers for Disease Control and Prevention (CDC) and Centers for Medicare & Medicaid Services (CMS), co-leaders of Million Hearts™ within HHS, are working alongside other federal agencies and private-sector organizations to make a long-lasting impact against cardiovascular disease.

The Million Hearts® Clinical Quality Measures (CQM) Dashboard is designed to display quality reporting measures focused on the Million Hearts®ABCS (Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation) and is based on information from the following available data systems, where possible.

HRSA UDS - Health Resources and Services Administration Uniform Data System

NCQA HEDIS - National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set

CMS PQRS - Centers for Medicare & Medicaid Services Physician Quality Reporting System

**4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

Not applicable

**4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

Not applicable

**4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

**4a2.2.2. Summarize the feedback obtained from those being measured.**

**4a2.2.3. Summarize the feedback obtained from other users**

**4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

**Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**

**If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

Although the PQRS program has demonstrated increasing performance rates over time which would indicate progress on improvement, it's important to note that the percentage of eligible professional reporting on PQRS measures overall and on this measure, in particular, continues to grow but remains low. In 2014, for example, only 21.7% of eligible professionals reported on the measure. As a result, performance rates may not be nationally representative.

Additionally, while the PCPI creates measures with an ultimate goal of improving the quality of care, measurement is a mechanism to drive improvement but does not equate with improvement. Measurement can help identify opportunities for improvement with actual improvement requiring making changes to health care processes and structure. In order to promote improvement, quality measurement systems need to provide feedback to front-line clinical staff in as close to real time as possible and at the point of care whenever possible. (1)

1. Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013 Jun 5;309(21):2215-6.

**4b2. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

We are not aware of any unintended consequences related to this measure.

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

We are not yet aware of any unexpected benefits related to this measure.

**5. Comparison to Related or Competing Measures**

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

**5. Relation to Other NQF-endorsed Measures**

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

**5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

0027 : Medical Assistance With Smoking and Tobacco Use Cessation

0027 : Medical Assistance With Smoking and Tobacco Use Cessation

1651 : TOB-1 Tobacco Use Screening

1651 : TOB-1 Tobacco Use Screening

1654 : TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment

1654 : TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment

1656 : TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge

1656 : TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge

2600 : Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

2600 : Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

2803 : Tobacco Use and Help with Quitting Among Adolescents

2803 : Tobacco Use and Help with Quitting Among Adolescents

**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

**5a. Harmonization of Related Measures**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications harmonized to the extent possible?**

No

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

Related measures have differing target populations and/or levels of measurement from the PCPI's Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure. 0028 focuses on routine tobacco screening for all adults and tobacco cessation interventions for those who use tobacco products and is intended to assess clinician level performance towards these objectives. The cessation intervention required by the PCPI measure includes brief counseling and/or pharmacotherapy in light of the strong support for these interventions in the guidelines and the feasibility of implementing these practices as part of routine care. Measure 0027 is a patient survey measure assessing health plan performance and includes one additional component of the cessation intervention beyond our measure (ie, discussion of methods or strategies other than medication). Measures 1651, 1654 and 1656 assess hospital level performance at providing tobacco use and treatment to patients being discharged from hospitals. Measure 2803 is focused on assessing clinical level performance on tobacco cessation counseling among adolescents. Finally, measure 2600 represents an adaptation of the PCPI measure and is limited to a subset of the population of patients with serious mental illness.

**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

No competing measures.



**Appendix**

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**No appendix Attachment:**

**Contact Information**

**Co.1 Measure Steward (Intellectual Property Owner):** PCPI Foundation

**Co.2 Point of Contact:** Samantha, Tierney, [Samantha.Tierney@ama-assn.org](mailto:Samantha.Tierney@ama-assn.org), 312-464-5524-

**Co.3 Measure Developer if different from Measure Steward:** PCPI Foundation

**Co.4 Point of Contact:** Samantha, Tierney, [Samantha.Tierney@ama-assn.org](mailto:Samantha.Tierney@ama-assn.org), 312-464-5524-

**Additional Information****Ad.1 Workgroup/Expert Panel involved in measure development**

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

Gail M. Amundson, MD, FACP (internal medicine/geriatrics)

Joel V. Brill MD, AGAF, FASGE, FACG (gastroenterology)

Steven B. Clauser, PhD

Will Evans, DC, PhD, CHES (chiropractic)

Ellen Giarelli, EdD, RN, CRNP (nurse practitioner)

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Kay Jewell, MD, ABHM (internal medicine/geriatrics)

Daniel Kivlahan, PhD (psychology)

Paul Knechtges, MD (radiology)

George M. Lange, MD, FACP (internal medicine/geriatrics)

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Jacqueline W. Miller, MD, FACS (general surgery)

Adrienne Mims, MD, MPH (geriatric medicine)

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G. Timothy Petito, OD, FAAO (optometry)

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Samina Shahabbudin, MD (emergency medicine)

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PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study must be equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at

least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2001

**Ad.3 Month and Year of most recent revision:** 11, 2015

**Ad.4 What is your frequency for review/update of this measure?** Supporting guidelines, specifications, and coding for this measure are reviewed annually

**Ad.5 When is the next scheduled review/update for this measure?** 11, 2016

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