



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 #: 0389

Corresponding Measures: 0389e

De.2. Measure Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer

1b.1. Developer Rationale: Multiple studies have indicated that a bone scan is not clinically necessary for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. For patients who are categorized as low-risk, bone scans are unlikely to identify their disease. Furthermore, bone scans are not necessary for low-risk patients who have no history or if the clinical examination suggests no bony involvement. Less than 1% of low-risk patients are at risk of metastatic disease.

While clinical practice guidelines do not recommend bone scans in low-risk prostate cancer patients, overuse is still common. An analysis of prostate cancer patients in the SEER-Medicare database diagnosed from 2004-2007 found that 43% of patients for whom a bone scan was not recommended received it (1). The analysis also found that the use of bone scans in low-risk patients leads to an annual cost of \$4 million dollars to Medicare. The overuse of bone scan imaging for low-risk prostate cancer patients is a concept included on the American Urological Association's list in the Choosing Wisely Initiative as a means to promote adherence to evidence-based imaging practices and to reduce health care dollars wasted (2). This measure is intended to promote adherence to evidence-based imaging practices, lessen the financial burden of unnecessary imaging, and ultimately to improve the quality of care for prostate cancer patients in the United States.

Citations:

1. Falchook AD, Hendrix LH, Chen RC. Guideline-discordant use of imaging during work-up of newly diagnosed prostate cancer. J Oncol Pract. 2015. doi: 10.1200/JOP.2014.001818.

2. American Urological Association. A routine bone scan is unnecessary in men with low-risk prostate cancer. Choosing Wisely Initiative. Released February 21, 2013. Accessed February 25, 2016.

S.4. Numerator Statement: Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer

S.6. Denominator Statement: All patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy

S.8. Denominator Exclusions: Denominator Exceptions:

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)

De.1. Measure Type: Process

S.17. Data Source: Registry Data

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 **Most Recent Endorsement Date:** Oct 26, 2016

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? This measure is not included in a composite.

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

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. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0389_Evidence_MSF5.0_Data-635278494960508026-635932939997439723.doc](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

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.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

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)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Multiple studies have indicated that a bone scan is not clinically necessary for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. For patients who are categorized as low-risk, bone scans are unlikely to identify their disease. Furthermore, bone scans are not necessary for low-risk patients who have no history or if the clinical examination suggests no bony involvement. Less than 1% of low-risk patients are at risk of metastatic disease.

While clinical practice guidelines do not recommend bone scans in low-risk prostate cancer patients, overuse is still common. An analysis of prostate cancer patients in the SEER-Medicare database diagnosed from 2004-2007 found that 43% of patients for whom a bone scan was not recommended received it (1). The analysis also found that the use of bone scans in low-risk patients leads to an annual cost of \$4 million dollars to Medicare. The overuse of bone scan imaging for low-risk prostate cancer patients is a concept included on the American Urological Association's list in the Choosing Wisely Initiative as a means to promote adherence to evidence-based imaging practices and to reduce health care dollars wasted (2). This measure is intended to promote adherence to evidence-based imaging practices, lessen the financial burden of unnecessary imaging, and ultimately to improve the quality of care for prostate cancer patients in the United States.

Citations:

1. Falchook AD, Hendrix LH, Chen RC. Guideline-discordant use of imaging during work-up of newly diagnosed prostate cancer. J Oncol Pract. 2015. doi: 10.1200/JOP.2014.001818.
2. American Urological Association. A routine bone scan is unnecessary in men with low-risk prostate cancer. Choosing Wisely Initiative. Released February 21, 2013. Accessed February 25, 2016.

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.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Report Title: PQRS Ad Hoc Analysis PQ3394, 2014 PQRS Measure Data for PCPI

Report includes Final Action 2014 EHR data, Final Action 2014 Registry Data and Part B Claims data for services rendered between January 1, 2014 and December 31, 2014 and processed into NCH by February 27, 2015.

01/01/2014 – 12/31/2014 EHR Performance Rate:

Mean: 90.76%

Maximum: 100.00%

Minimum: 50.00%

01/01/2014 – 12/31/2014 Registry Performance Rate:

Mean: 90.24%

Minimum: 0.00%

Maximum: 100.00%

2013 PQRS Experience Report by Individual Measure:

2013 is the most recent year for which PQRS Experience Report measure data is available. The average performance rates on over Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients the last several years are as follows:

2010: 71.60%

2011: 90.50%

2012: 92.50%

2013: 88.50%

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 will impose payment penalties for non-participants based on 2013 performance. For 2013, 8.2% of eligible professionals reported on Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients for claims, registry, and electronic health records. As a result, performance rates may not be nationally representative.

Reference: Center for Medicare and Medicaid Services. 2013 Reporting Experience Including Trends. Available:

<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/analysisandpayment.html>

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.

An analysis conducted by Falchook and colleagues of prostate cancer patients in the SEER-Medicare database diagnosed from 2004-2007 found that 43% of patients for whom a bone scan was not recommended received it. Given that low-risk patients have a less than 1% chance of developing a metastatic disease, the authors suggest that bone scan imaging in low-risk prostate cancer patients contributes to poor quality care and is a large contributor of health care dollars wasted in the United States (1). The literature recommends clinician education on guideline recommendations to spur improvement. These findings support the need for an NQF endorsed performance measure along with targeted initiatives to improve adherence to appropriate imaging.

Citation:

1. Falchook AD, Hendrix LH, Chen RC. Guideline-discordant use of imaging during work-up of newly diagnosed prostate cancer. J Oncol Pract. 2015. doi: 10.1200/JOP.2014.001818.

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 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

African American/Black men have the highest incidence rate of prostate cancer in the United States and are more than twice as likely as white men to die from the disease (1). Between 2008-2012, the average annual prostate cancer incidence rate among African American men was 208.7 cases per 100,000 men, which was 70% higher than the rate in white men. Although prostate cancer incidence and mortality rates have been declining in African American and white men since 1991, the incidence, prevalence, and death rates remain comparably higher among African American men as compared to white men (2).

An analysis of the SEER Medicare database conducted by Falchook and colleagues found that imaging overuse was associated with nonwhite race, higher comorbidity, and regional education and income measures (3). An additional analysis SEER Medicare database found there was regional variation in the use of bone scans in low- and intermediate- risk patients with the highest use in the Northeast and lowest use in the West (4).

Citations:

1. National Cancer Institute. Cancer health disparities. <http://www.cancer.gov/about-nci/organization/crchd/cancer-health-disparities-fact-sheet>. Accessed February 12, 2016.

2. American Cancer Society Cancer Facts and Figures for African Americans 2016-2018. <http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-047403.pdf>. Accessed February 26, 2016.

3. Falchook AD, Hendrix LH, Chen RC. Guideline-discordant use of imaging during work-up of newly diagnosed prostate cancer. J Oncol Pract. 2015. doi: 10.1200/JOP.2014.001818.

4. Falchook AD, Salloum RG, Hendrix LH, Chen RC. Use of bone scan during initial prostate cancer workup, downstream procedures, and associated Medicare costs. Int J Radiat Oncol Biol Phys. 2014;89(2):243-248.

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):

Cancer, Cancer : Prostate

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

Safety : Overuse

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

Elderly

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 form. Additional measure details may be found at the PCPI website: <https://www.thepcpi.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:](#)

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).

[Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer](#)

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 any time after diagnosis of prostate cancer](#)

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](#)

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

[All patients, regardless of age, with a diagnosis of prostate cancer at low \(or very low\) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy](#)

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: Once per episode of treatment of prostate cancer (ie, interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy) during the measurement period

Definitions:

Risk Strata Definitions: Very Low, Low, Intermediate, High, or Very High-

Very Low/Low Risk - PSA < 10 ng/mL; AND Gleason score 6 or less/Gleason grade group 1; AND clinical stage T1 to T2a.

Intermediate Risk - PSA 10 to 20 ng/mL; OR Gleason score 7/Gleason grade group 2-3; OR clinical stage T2b to T2c.

High/Very High Risk - PSA > 20 ng/mL; OR Gleason score 8 to 10/Gleason grade group 4-5; OR clinically localized stage T3 to T4 (adapted from the National Comprehensive Cancer Network, 2018).

External beam radiotherapy – external beam radiotherapy refers to 3D conformal radiation therapy (3D- CRT), intensity modulated radiation therapy (IMRT), stereotactic body radiotherapy (SBRT), and proton beam therapy.

Bone scan - bone scan refers to the conventional technetium-99m-MDP bone scan as well as 18F-NaF PET (or PET/CT) scan.

Note: Only patients with prostate cancer with low (or very low) risk of recurrence will be counted in the denominator of this measure.

Any male patient, regardless of age

AND

Diagnosis for prostate cancer (ICD-10-CM): C61

AND

Patient encounter during the performance period (CPT): 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55875, 77427, 77435, 77772, 77778, 77799

AND

Low (or very low) risk of recurrence, prostate cancer: G9706

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

Denominator Exceptions:

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)

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 any time after diagnosis of prostate cancer

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 three categories of exceptions for which a patient may be removed from the denominator of an individual measure: 1) medical, 2) patient OR 3) system 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.

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.

Append a modifier to CPT Category II code:

3269F with 1P: Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons)

OR

3269F with 3P: Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than the reporting physician)

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. The 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. The 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.

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)

Other: Radiation Oncology Clinic/Department, 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

0389_Avoidance_of_Overuse_of_Bone_Scans_Updated_Testing.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.

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.

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.

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 or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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.

ALL data elements are in defined fields in a combination of 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).

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: [NQF_389_Feasibility_Assessment_and_Bonnie_attachment.pdf](#)

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).

The Measures, 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 the American Medical

Association (AMA). Neither the American Medical Association (AMA), nor the AMA-convened Physician Consortium for Performance Improvement® (AMA-PCPI), now known as the PCPI, nor their members shall be responsible for any use of the Measures.

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

1. Physician Quality Reporting System (PQRS) – Sponsored by the Centers for Medicare and Medicaid Services (CMS)

Purpose: 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 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 late 2017.

2. Meaningful Use Stage 2 (EHR Incentive Program) – Sponsored by the Centers for Medicare and Medicaid Services (CMS)

Purpose: The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Eligibility for incentive payments for the “meaningful use” of certified EHR technology is established if all program requirements are met, including successful implementation and reporting of program measures, which include this measure, to demonstrate meaningful use of EHR technology.

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?)

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.*)

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.

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 at this time, but we take unintended consequences very seriously and therefore continuously monitor to identify actions that can be taken to mitigate them.

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

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

0390 : Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer

1853 : Radical Prostatectomy Pathology Reporting

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.

The related measure 1853, Radical Prostatectomy Pathology Reporting, addresses the percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status, which is a different action than measure 0389. The two measures do not share similar target populations and address different aspects of prostate cancer care. The related measure 0390, Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer Patients addresses the use of adjuvant hormonal therapy and external beam radiation therapy in high-risk prostate cancer patients which is a different quality action from measure 0389. The two measures do not share similar target populations and address different aspects of prostate cancer care.

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.)

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): Centers for Medicare & Medicaid Services

Co.2 Point of Contact: Helen, Dollar-Maples, helen.dollar-maples@cms.hhs.gov

Co.3 Measure Developer if different from Measure Steward: Mathematica

Co.4 Point of Contact: Madeline, Pearse, mpearse@mathematica-mpr.com, 510-830-3729-

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.

Ian Thompson, MD (Co-Chair, urology)

Steven Clauser, PhD (Co-Chair, methodology)

Peter Albertsen, MD (urology)

Colleen Lawton, MD (radiation oncology)

Charles Bennett, MD, PhD, MPP (clinical oncology)

W. Robert Lee, MD, MS, Med (radiation oncology)

Michael Cookson, MD (urology)

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Gregory W. Cotter, MD (radiation oncology)

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Theodore L. DeWeese, MD (radiation oncology)

Stephen Permut, MD (family medicine)

Mario Gonzalez, MD (pathology)

Howard Sandler, MD (radiation oncology)

Louis Kavoussi, MD (urology)

Bill Steirman, MA (consumer representative)

Eric A. Klein, MD (urology)

John T. Wei, MD (urology)

Carol Wilhoit, MD (health plan representative)

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: 2007

Ad.3 Month and Year of most recent revision: 09, 2015

Ad.4 What is your frequency for review/update of this measure? Annually

Ad.5 When is the next scheduled review/update for this measure? 07, 2017

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Ad.8 Additional Information/Comments: