TO: NQF Members and Public

FR: NQF Staff

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

DA: April 17, 2012

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

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

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

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

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

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

Thank you for your interest in NQF's work. We look forward to your review and comments.

NATIONAL QUALITY FORUM

CANCER ENDORSEMENT MAINTENANCE, 2011

DRAFT TECHNICAL REPORT FOR COMMENT

April 17, 2012

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CANCER ENDORSEMENT MAINTENANCE, 2011
Draft Technical Report

INTRODUCTION

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

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

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

MEASURE EVALUATION

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

TABLE 1: CANCER ENDORSEMENT MAINTENANCE SUMMARY

	MAINTENANCE	NEW	TOTAL
Measures under consideration	23	4*	27
Withdrawn from consideration	1	0	1
Recommended	17	4	21
Not recommended	5	0	5
Reasons for Not Recommending	Importance - 4 Scientific Acceptability - 1	N/A	

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

Overarching Issues

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

Palliative Measures

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

Harmonization of Related Measures

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

Electronic Health Record Specifications

One measure recommended for endorsement in this phase was submitted with additional electronic specifications: #0389 Prostate Cancer: Avoidance of Overuse Measure - Bone Scan for Staging Low

Risk Patients. This was one of the measures retooled in 2010 and updated in 2011. The submitted e-specifications were reviewed by NQF health IT staff.

MEASURE EVALUATION SUMMARY TABLES

MEASURES RECOMMENDED

Hematology and Melanoma Measures

0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenic testing performed on bone marrow. Numerator Statement: Patients who had baseline cytogenetic testing* performed on bone marrow Definition: *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis. Denominator Statement: All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia Exclusions: Documentation of medical reason(s) for not performing baseline cytogenetic testing Documentation of patient reason(s) for not performing baseline cytogenetic testing Denominator Exclusions: Documentation of system reason(s) for not performing baseline cytogenetic testing Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data : Laboratory Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: The American Society of Hematology
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-9; M-8; L-0; I-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-13, N-1, I-3 Rationale: • Myelodysplastic Syndrome (MDS) is increasingly common in an aging population and associated with high morbidity and mortality; baseline cytogenic testing performed on bone marrow is important to measure and report due to its role in evaluatiing and managing this patient population. • There is a striking performance gap: 48% non-compliance was demonstrated in the CMS 2008 Physician Quality Reporting System (PQRS). • Measurement of cytogenetics at the time of diagnosis or prior to treatment has become the standard of care since therapies are stratified based on the cytogenetic profile. • There was concern that the literature cited and rationale provided by measure authors focuses mainly on the use of cytogenetics in MDS and its evolution to acute myelogenous leukemia (AML) and does not include much information on *de novo* AML. Although much of the literature presented in the application is based on retrospective reviews, there is some prospective randomized literature in AML that is stratified based on prognostic factors (including cytogenetics) to indicate that cytogenetic abnormalities predict outcome. However, this measure is based mainly on a consensus guideline from the National Comprehensive Cancer Network (NCCN). The authors grade the literature as 2A based on lower level evidence.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-7; M-9; L-1; I-0; 2b. Validity: H-8; M-9; L-0; I-0 Rationale: • The PCPI Testing Project shows interobserver variability is minimal. • Face validity is well demonstrated. • The measure directs that the data be gathered in the ambulatory setting. For acute leukemia, much of the care is in the hospital setting. The Steering Committee recommended reporting the measure with a CPT procedure code or CPT-2 code in order to capture the inpatient setting.

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

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

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

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

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

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

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

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

RECOMMENDATIONS:

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

0378 Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

Maintenance Measure
Measure Evaluation and Specifications
Description: Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy
Numerator Statement: Patients with documentation* of iron stores within 60 days prior to initiating erythropoietin therapy
*Definition: documentation of iron stores which includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC
Denominator Statement: All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy
Exclusions: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy
Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory
Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Society of Hematology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-3 ; M-11 ; L-1 ; I-0; 1b. Performance Gap: H-5 ; M-7 ; L-3 ; I-0 ; 1c. Evidence: Y-15 , N-0 , I-0

0378 Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

Rationale:

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

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-4 ; M-10 ; L-0 ; I-1 ; 2b. Validity: H-5 ; M-9 ; L-0 ; I-1
Rationale:

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

3. Usability: H-5; M-8; L-2; I-0
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
Rationale:

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

4. Feasibility: H-7; M-8; L-0; I-0
(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:

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

Steering Committee Recommendation for Endorsement:
Rationale: Y-14; N-1

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

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

0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

Maintenance Measure
Measure Evaluation and Specifications
Description: Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed
Numerator Statement: Patients who had baseline flow cytometry* studies performed

0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy.
Denominator Statement: All patients aged 18 years and older seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period
Exclusions: Documentation of medical reason(s) for not performing baseline flow cytometry
Documentation of patient reason(s) for not performing baseline flow cytometry
Documentation of system reason(s) for not performing baseline flow cytometry
Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory
Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Society of Hematology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-7; M-5; L-3; I-0; 1b. Performance Gap: H-2; M-10; L-2; I-1; 1c. Evidence: Y-14, N-0, I-1
Rationale:

- This is the most common leukemia and involves high resource use.
- There is a performance gap: a 38% failure to perform shown in PQRS testing.
- Flow cytometry is important in diagnosis and treatment planning, but the data provided do not provide adequate rationale for measure. They discuss delays in diagnosis but measure is for flow cytometry following diagnosis or before treatment. So it is unclear how this would shorten time to diagnosis.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-5; M-9; L-0; I-1; 2b. Validity: H-5 ; M-9 ; L-0 ; I-1
Rationale:

- The measure is confusing. It specifies a 12-month reporting period in which all patients with CLL are captured in the denominator. However, flow cytometry may have been performed years prior to the initiation of treatment and reporting event. The numerator therefore may not correspond to the same reporting period as the denominator. The measure may be relying upon interventions done many years earlier. Per the Steering Committee's recommendation, the developer will clarify the time window for flow cytometry studies to be performed.
- The Steering Committee noted that the clarification that flow cytometry baseline studies should take place at the time of diagnosis or prior to initiating treatment, and not necessarily within the time window for the measure, adds the necessary clarity to the measure specifications to make it easily captured.

3. Usability: H-5; M-7; L-2; I-0
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
Rationale:

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

4. Feasibility: H-3; M-11; L-1; I-0
(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:

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

Steering Committee Recommendation for Endorsement
Rationale: Y-13; N-2

- The measure is improved with clarification of numerator/denominator.
- There is some concern about use as a quality measure as diagnosis is made based on flow cytometry results.

0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
• Flow cytometry is sensitive and specific for diagnosis, impacts prognosis and decisions regarding follow-up; questions about time frames have been addressed. • Even with the caveats discussed, the measure provides a reasonable assessment of quality care. • Important to measure, and developer clarified numerator and denominator for more reliable measurement. RECOMMENDATIONS: The Steering Committee did not recommend the measure at the in-person meeting; voting ended at 2.a Reliability. The Committee noted that the numerator should be clarified to identify patients who had documentation of the study having been performed, and that the denominator should be clarified regarding the time window. On a follow up call, the developer provided clarifications to the numerator and denominator for review and consideration by the Committee. The Committee agreed with the changes presented and recommended the measure for endorsement.

0380 Multiple Myeloma – Treatment with Bisphosphonates
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period Numerator Statement: Patients who were prescribed or received intravenous bisphosphonate therapy* within the 12 month reporting period. Definition: *Bisphosphonate Therapy: Includes the following medications: pamidronate and zoledronate Denominator Statement: All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission Exclusions: Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) Documentation of patient reason(s) for not prescribing bisphosphonates Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Society of Hematology
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-9; M-8; L-0; I-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-13, N-1, I-3 Rationale: • The measure developer cites an American Cancer Society publication to show that this is an issue of high impact that affects large numbers of patients (approximately 20,000 patients diagnosed annually) • The gap in care for prescribing bisphosphonates for patients in the measure was striking, with 47.4% of patients reported on not meeting the measure. • Supporting literature is of moderate to high quality and quantity. • Use of bisphosphonates increases quality of life, though it does not decrease mortality. • Intervention should occur more often; however, reporting annually on the measure is acceptable.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-7; M-9; L-1; I-0; 2b. Validity: H-8; M-9; L-0; I-0 Rationale: • Previously endorsed measure; interval study data demonstrated a high degree of reliability (100%) • Face validity of the measure was well demonstrated. • The measure is well specified and will be easy to extract.
3. Usability: H-7; M-10; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale:

0380 Multiple Myeloma – Treatment with Bisphosphonates
• The measure will be useful for QI, particularly given the performance gap. • The measure should be moderately understandable for public reporting.
4. Feasibility: H-5; M-12; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data easily extracted from EHR or paper chart
Steering Committee Recommendation for Endorsement: Y-17; N-0 Rationale: The Steering Committee found the intervention addressed by this measure affects a large patient population and is important in improving patient quality of life. There is a significant performance gap in meeting the measure, allowing room for improvement in patient care.

0650 Melanoma Continuity of Care – Recall System
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month reporting period into a recall system that includes: • A target date for the next complete physical skin exam , AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment Numerator Statement: Patients whose information is entered, at least once within a 12 month period, into a recall system* that includes: • A target date for the next complete physical skin exam , AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment Denominator Statement: All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma. Exclusions: Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider) Adjustment/Stratification: No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Structure Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Registry, Other, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Academy of Dermatology and National Committee for Quality Assurance
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-9; M-8; L-0; I-0; 1b. Performance Gap: H-4; M-11; L-1; I-1; 1c. Evidence: Y-7, N-1, I-9; Evidence Exception: Y-16, N-1 Rationale: • Studies presented do not specifically address the melanoma recall system. • Measure is likely an opportunity for improvement but data is unclear about performance gap with regard to a recall system. Authors cite that 9% did not meet measure; however, the Steering Committee views this as a "never event." • The body of evidence as noted above is larger for the general group of all patients when looking at hospital to outpatient settings. If this is restricted to melanoma patients and if it involves outpatient to outpatient settings, the body of evidence is low. However, there is no evidence for harm. • Steering Committee members stated that the link between the process of utilizing a recall system and increased screening/examination of patients can be inferred. • Steering Committee members stated that this is a valuable intervention because of the prevalence of the diagnosis, the increasing incidence of melanoma and the opportunity for impacting the outcome of patients by early diagnosis of a new primary melanoma, and chose to invoke

0650 Melanoma Continuity of Care – Recall System
the exception to empirical evidence rule because of this.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-7; M-9; L-0; I-1; 2b. Validity: H-4; M-12; L-0; I-1 Rationale: • The measure developer reports moderate reliability regarding a diagnosis of melanoma but high reliability for all other data elements including documentation of enrollment in a recall system • Measure specifications are reasonably precise. • Face validity was demonstrated.
3. Usability: H-4; M-12; L-1; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • Measure is currently in use for PQRS. • Measure is easily understood.
4. Feasibility: H-6; M-11; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data elements relate to office procedures, not directly to care. • Recall procedure may not be in EHR, may be in practice management software, other tracking software, or non-electronic. • All criteria should be feasible within an EHR, but extracting information may be difficult.
Steering Committee Recommendation for Endorsement: Y-15; N-2 Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population and is important in ensuring continuity of care.

Oncology Measures

0381 Oncology: Treatment Summary Communication – Radiation Oncology
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment Numerator Statement: Patients who have a treatment summary* report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment Definition: *Treatment Summary: a report that includes mention of all of the following components: 1) dose delivered; 2) relevant assessment of tolerance to and progress towards the treatment goals; and 3)subsequent care plans Numerator Instructions: This measure should be reported once per course of radiation treatment – less than or equal to 30 days from the end of treatment. Denominator Statement: All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy Exclusions: Documentation of a patient reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient requests that report not be sent) and to the patient within one month of completing treatment Documentation of a system reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records

0381 Oncology: Treatment Summary Communication – Radiation Oncology
Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: The measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-7; M-10; L-0; I-0; 1b. Performance Gap: H-4; M-10; L-1; I-2; 1c. Evidence: Y-9, N-1, I-7 Rationale: • Radiation therapy treatment summaries have been a routine practice for years and are a requirement for payment. • Many radiation therapy treatment summaries currently lack critical information, such as the site of radiation. • Summary of evidence of impact is not specific to the focus of the measure. Most evidence is related to incidence, cancer-related death rates, and cancer costs. The most closely related statistic is that two-thirds of all cancer patients will receive radiation. However, there is no data on outcomes associated with the lack of a treatment summary. • Steering Committee members noted that the information from a treatment summary is very important to disseminate amongst providers caring for the patient receiving radiation therapy. • The measure affects a large number of patients, and there is demonstrated evidence of a performance gap.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-7; M-10; L-0; I-0; 2b. Validity: H-1; M-14; L-1; I-1 Rationale: • Inter-rater reliability is described as 100% accurate. • Measure addresses an important priority area: coordination of care. The proximal relationship between performance on the measure and desired outcome is not addressed by available data, however, face validity was demonstrated.
3. Usability: H-6; M-10; L-1; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure is being used in a QI program with plans for use in PQRS.
4. Feasibility: H-5; M-10; L-2; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data elements are available in an EHR and generated during the provision of care.
Steering Committee Recommendation for Endorsement: Y-14; N-3 Rationale: The intervention addressed by this measure affects a large patient population and is important in ensuring continuity of care. RECOMMENDATIONS: The Steering Committee recommended the measure developer consider including the site and stage in the measure in the future.

0382 Oncology: Radiation Dose Limits to Normal Tissues
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues Numerator Statement: Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues Denominator Statement: All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

0382 Oncology: Radiation Dose Limits to Normal Tissues
Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
0382 Oncology: Radiation Dose Limits to Normal Tissues
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-12; M-4; L-0; I-0; 1b. Performance Gap: H-2; M-12; L-2; I-0; 1c. Evidence: Y-14, N-2, I-0 Rationale: • The measure applies to lung and pancreatic cancer, with lung especially being a prevalent cancer with high morbidity and mortality. Radiation is a commonly used treatment. • There was evidence cited showing 89% compliance with the PQRS measure, which highlights some,but not much room for improvement. The Steering Committee considered this a "never event" and felt compliance should be 100%. • The Steering Committee stated the importance of calculating dose limits when giving radiation to a patient and noted that there is evidence to support this practice.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-11; M-5; L-0; I-0; 2b. Validity: H-7; M-9; L-0; I-0 Rationale: • The measure contains specifications that allow for reliable ascertainment and data on reliability. • The measure includes data on face validity from an expert panel.
3. Usability: H-10; M-6; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure has been succesfully implemented in PQRS. • The measure should be easily understood for public reporting.
4. Feasibility: H-11; M-5; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The data elements are all feasibly extracted from an EHR and generated during routine care delivery.
Steering Committee Recommendation for Endorsement: Y-16; N-0 Rationale: The Steering Committee noted that there is near universal concordance from an expert panel, excellent reliability, usability, and feasibility, and the target population comprises large numbers. There is no contradictory evidence for the measure.

0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain Numerator Statement: Patient visits that included a documented plan of care* to address pain Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval. Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-15; M-2; L-0; I-0; 1b. Performance Gap: H-12; M-5; L-0; I-0; 1c. Evidence: Y-15, N-0, I-2 Rationale: • It is well documented that many cancer patients will experience pain during the course of treatment. The measure affects a large patient population. • A performance gap was demonstrated, with performance in the ASCO QOPI study achieving the measure at 78.29% and in PQRS for 2009 at 91.24%. • Concern that including any report of pain, even mild, may dilute the impact of this measure. However, the Steering Committee stated that simply noting that the patient was experiencing mild pain and the need to follow up on it would be sufficient to meet this measure, alleviating concerns.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-4; M-12; L-1; I-0; 2b. Validity: H-3; M-12; L-1; I-1 Rationale: • Reliability was adequately demonstrated, albeit with a small sample size. • Face validity was demonstrated.
3. Usability: H-6; M-9; L-2; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure is currently being used in PQRS 2012; also used from 2009-2011. • The measure is currently in use in ASCO's Quality Oncology Practice Initiative (QOPI ®) program and ASTRO's Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program.
4. Feasibility: H-4; M-13; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data elements are available in an EHR and generated during the provision of care.
Steering Committee Recommendation for Endorsement: Y-16; N-1 Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population. There is room for improvement in performance of this measure.

0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified Numerator Statement: Patient visits in which pain intensity is quantified* * Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale

0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-16; M-1; L-0; I-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-16, N-1, I-0 Rationale: • Measure developer presented good evidence showing the prevalence of pain; the measure will impact a large number of patients. • Performance was documented at 89.49% in the ASCO QOPI study, 57% in ASTRO's PAAROT program, and 66.83% in PQRS. There is an opportunity for improvement.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-7; M-10; L-0; I-0; 2b. Validity: H-6; M-11; L-0; I-0 Rationale: • The measure is precisely specified. • Reliability testing demonstrates almost perfect reliability. • Face validity is demonstrated.
3. Usability: H-10; M-7; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure is currently in use in PQRS.
4. Feasibility: H-9; M-8; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data elements are available in an EHR and generated during the provision of care..
Steering Committee Recommendation for Endorsement: Y-17; N-0 Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population. There is room for improvement in performance of this measure. RECOMMENDATIONS: The Steering Committee recommended that the developer harmonize the definition of a standardized quantitative pain tool with that used in measure 1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits and measure 1634: Hospice and Palliative Care – Pain Screening. The definition used by those measures is as follows: Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.

0386 Oncology: Cancer Stage Documented
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting

0386 Oncology: Cancer Stage Documented

period
Numerator Statement: Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period
Numerator Instructions: *Cancer stage refers to stage at diagnosis
Denominator Statement: All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting
Exclusions: None
Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Paper Records
Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure is jointly copyrighted by the AMA-PCPI and American Society of Clinical Oncology. The measure set was also developed in collaboration with the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-14; M-2; L-1; I-0; 1b. Performance Gap: H-13; M-4; L-0; I-0; 1c. Evidence: Y-12, N-2, I-3
Rationale:

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

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)
2a. Reliability: H-5; M-9; L-1; I-2; 2b. Validity: H-2; M-13; L-1; I-1
Rationale:

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

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

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

4. Feasibility: H-7; M-9; L-1; I-0
(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:

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

Steering Committee Recommendation for Endorsement: Y-17; N-0
Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population and is important in

0386 Oncology: Cancer Stage Documented
ensuring that patients are treated appropriately based on diagnosis. This measure is important for treatment planning. RECOMMENDATIONS: The Steering Committee recommended the developer consider broadening measure specifications to include all patients with a cancer diagnosis. Additional experience with the measure should begin to show stronger evidence related to important outcomes.

1854 Barrett´s Esophagus (eligible for Time-Limited endorsement)
New Measure Measure Evaluation and Specifications Description: Percentage of patients with esophageal biopsy reports for Barrett's esophagus that contain a statement about dysplasia. Numerator Statement: Numerator: Esophageal biopsy reports with the histologic finding of Barrett's mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.) 3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite) Denominator Statement: Denominator (Eligible Population): All esophageal biopsy reports that document the presence of Barrett's mucosa. CPT codes: • 88305 Level IV – Surgical pathology, gross and microscopic examination AND ICD-9 codes: • 530.85 Barrett's esophagus Exclusions: Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia). Adjustment/Stratification: No risk adjustment or risk stratification Not applicable Not applicable Level of Analysis: Clinician : Group/Practice, Clinician : Individual Type of Measure: Process Data Source: Administrative claims, Other, Paper Records Measure Steward: College of American Pathologists
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-6; M-10; L-1; I-0; 1b. Performance Gap: H-2; M-12; L-1; I-2; 1c. Evidence: Y-11, N-2, I-4 Rationale: • A clear link between Barrett's Esophagus and esophageal adenocarcinoma was demonstrated. Identifying those at risk could allow for appropriate screening of high risk patients. • This measure will have a substantial impact for a smaller patient population (those diagnosed with Barrett's Esophagus).
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability requirement for untested measures. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) Precise Specifications: Y-16; N-1 Rationale: • The measure is well specified; however, the Steering Committee noted the importance of reporting not only the presence or absence of dysplasia, but also the grade of dyplasia. The measure developer addressed this recommendation and modified the numerator. • Plans for reliability and validity testing are in process.
3. Usability: H-3; M-14; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure has been included in the 2012 PQRS program with plans to publicly report performance results.
4. Feasibility: H-8; M-9; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The data elements are generated during patient care; the measure should be feasible to implement.

1854 Barrett´s Esophagus (eligible for Time-Limited endorsement)
Steering Committee Recommendation for Time-Limited Endorsement: Y-15; N-2 Rationale: The Steering Committee found that the intervention addressed by this measure will greatly impact the target patient population, albeit a smaller population. The link between dysplasia in Barrett's Esophagus patients and incidence of esophageal adenocarcinoma is well substantiated. RECOMMENDATIONS: The Steering Committee asked the developer to require reporting of the grade of dysplasia (high or low) as part of the numerator. The measure developer addressed this recommendation and provided updated the numerator to capture this information. The Steering Committee agreed with the changes and recommended the measure for time limited endorsement. The measure has not yet been tested for reliability and validity and is being considered for time limited endorsement. The measure developer will have 12 months to provide testing data if time limited endorsement is granted.

Prostate and Lung Measures

0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer Numerator Statement: Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer Denominator Statement: All patients, regardless of age, with a diagnosis of prostate cancer, at low risk* of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy Exclusions: Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons) Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician) Adjustment/Stratification: No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Urological Association and American Society for Therapeutic Radiology & Oncology
0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-8; M-8; L-0; I-0; 1b. Performance Gap: H-7; M-9; L-0; I-0; 1c. Evidence: Y-14, N-2, I-0 Rationale: • The measure affects a high number of patients: those with low-risk prostate cancer, and the evidence presented shows the intervention is unnecessary for these patients. • Data submitted demonstrates significant overuse of bone scans (84.31% of patients from 2008 PQRS did not meet this measure). There is an opportunity for improvement.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-9; M-6; L-1; I-0; 2b. Validity: H-7; M-8; L-1; I-0 Rationale: • The measure is specified with ICD-9 and CPT codes that can be ascertained consistently. • Reliability testing presented was appropriate and demonstrated reliabitly of the measure. • Validity was shown using results from an expert panel, and demonstrated strong face validity.
3. Usability: H-6; M-8; L-2; I-0

0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • This measure has been included in the CMS Physician Quality Reporting System (PQRS) from 2008 through 2011. The measure is also included in PQRS 2012. • A plan for public reporting has been outlined by the measure developer.
4. Feasibility: H-6; M-8; L-2; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data is generated during the provision of care and all data elements are found in an EHR.
Steering Committee Recommendation for Endorsement: Y-15; N-1 Rationale: The Steering Committee found that the measure addresses an intervention that is currently overused for the target patient population; improved performance on this measure will likely reduce the use of unnecessary bone scans and decrease overall costs.

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist) Numerator Statement: Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) Denominator Statement: All patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate Note: Only patients with prostate cancer with high risk of recurrence will be counted in the denominator of this measure Exclusions: Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy) Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy Adjustment/Stratification: No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Measure Steward: American Medical Association - Physician Consortium for Performance Improvement Other organizations: American Urological Association and American Society for Therapeutic Radiology & Oncology
0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-12; M-4; L-0; I-0; 1b. Performance Gap: H-9; M-7; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0 Rationale: • The measure addresses appropriateness of care for patients with high-risk prostate cancer, a prevalent condition affecting a large number of patients. • The evidence provided is high level and supportive of the measure focus. • The Steering Committee noted that the survival benefit has been better documented than the evidence submitted suggests. • Adherence is low: 83.41% of patients from 2008 PQRS did not meet this measure; there is an opportunity for improvement.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-7; M-8; L-1; I-0; 2b. Validity: H-4; M-11; L-1; I-0 Rationale: • The specifications are clear. The time window for reporting the measure is at each time adjuvant hormonal therapy occurs.

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
• The Steering Committee agreed it is important that proton beam therapy is included in the denominator for this measure. • The reliability testing presented was appropriate and demonstrated the reliability of the measure. • Face validity was confirmed with near universal agreement from an expert panel.
3. Usability: H-11; M-4; L-1; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • This measure has been included in the PQRS from 2008 through 2011. The measure is also included in PQRS 2012. • A plan for public reporting has been outlined by the measure developer.
4. Feasibility: H-6; M-9; L-1; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Steering Committee was concerned that the low number of patients meeting the measure in 2008 PQRS may be a result of difficulties reporting the measure rather than low performance of the measure intervention. The developer agreed that as the denominator requires both ICD codes and CPT category 2 codes, it likely complicated reporting for some providers reporting on the measure. The developer expects reporting to improve as providers become more familiar with the reporting requirements. • The information in the measure can be abstracted from EHRs.
Steering Committee Recommendation for Endorsement: Y-15; N-1 Rationale: The Steering Committee found that this is a prevalent condition with a level of mortality that renders it a public health priority. The measure is supported by two randomized controlled trials, bolstered by expert opinion. The measure should be able to be reliably ascertained with EHR inputs.

1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
New Measure Measure Evaluation and Specifications Description: Percentage of patients = 18 years of age undergoing elective lung resection (Open or VATS wedge resection, segmentectomy, lobectomy, bilobectomy, sleeve lobectomy, pneumonectomy) for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality. Numerator Statement: Number of patients = 18 years of age undergoing elective lung resection for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality. Denominator Statement: Number of patients = 18 years of age undergoing elective lung resection for lung cancer. Exclusions: Emergency procedures Adjustment/Stratification: Statistical risk model Bayesian hierarchical modeling was used to assess the statistical reliability of hospital-specific standardized incidence ratio (SIR) estimates derived from the January 1, 2008 – December 31, 2010 STS data. All hospitals regardless of sample size were included in the estimation of model parameters. Reliability measures were initially calculated including all the hospitals and were subsequently calculated in subsets of hospitals having at least 10, 20, 30, 50, 100, or 200 eligible cases. Three separate multivariable risk models were constructed (mortality, major morbidity, and composite mortality or major morbidity). The risk-adjustment models created for this measure and study have excellent performance characteristics and identify important predictors of mortality and major morbidity for lung cancer resections. These models may be used to inform clinical decisions and to compare risk-adjusted outcomes for quality improvement purposes. For additional information see the attachment: Kozower BD, Sheng S, O'Brien SM, Liptay MJ, Lau CL, Jones DR, Shahian DM, Wright CD. STS Database Risk Models: Predictors of Mortality and Major Morbidity for Lung Cancer Resection. Ann Thorac Surg. 2010;90:875–83. n/a Level of Analysis: Clinician : Group/Practice, Clinician : Team, Facility Type of Measure: Outcome Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Measure Steward: Society of Thoracic Surgeons
1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
Steering Committee In-Person March 13-14, 2012

1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-17; M-0; L-0; I-0; 1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-17, N-0, I-0 Rationale: • Developer presented solid evidence for importance of the measure. • The measure provides a good look at the spectrum of procedures done across a spectrum of hospitals, and a wide range of morbidities/mortalities. • Evidence was submitted demonstrating substantial variation in morbidity and mortality after lung cancer surgery. • The measure is a first step in developing a measure capturing long term survival rates.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-8; M-9; L-0; I-0; 2b. Validity: H-9; M-8; L-0; I-0 Rationale: • The measure is clearly defined and well specified. • Reliability of the measure was well demonstrated with a signal to noise ratio. • Validity was demonstrated through testing, as well as having face validity assessed by an expert panel. • The Steering Committee noted that many of these surgeries are performed by non-thoracic surgeons, a population this measure may not capture.
3. Usability: H-15; M-1; L-0; I-1 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The developer has provided a detailed plan for representation of measure results, usability for QI, and public reporting of the measure within the next 2-3 years.
4. Feasibility: H-10; M-7; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The Steering Committee noted that this is somewhat arduous to capture, but the data add significant value
Steering Committee Recommendation for Endorsement: Y-17; N-0 Rationale: The Steering Committee found that the measure will capture the spectrum of procedures done in a spectrum of hospitals-wide range of morbidities/mortalities. The evidence for the measure is high level, and capturing the measure will allow for development of an outcome measure in the future.

1853 Radical Prostatectomy Pathology Reporting (eligible for Time-Limited endorsement)
New Measure Measure Evaluation and Specifications Description: Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status. Numerator Statement: Numerator: Radical prostatectomy pathology reports that include the pT category, the pN category, Gleason score and a statement about margin status ? Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F –pathology report Denominator Statement: All radical prostatectomy pathology reports Exclusions: Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, and transurethral resections of the prostate (TURP) Adjustment/Stratification: No risk adjustment or risk stratification Not applicable Not applicable Level of Analysis: Clinician : Group/Practice, Clinician : Individual Type of Measure: Process Data Source: Administrative claims, Other, Paper Records Measure Steward: College of American Pathologists
1853 Radical Prostatectomy Pathology Reporting

1853 Radical Prostatectomy Pathology Reporting (eligible for Time-Limited endorsement)
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-9; M-7; L-0; I-0; 1b. Performance Gap: H-3; M-12; L-1; I-0; 1c. Evidence: Y-15, N-1, I-0 Rationale: • The Steering Committee agreed the measure would have a high impact as a large number of men are affected by this disease; this is a major health issue with significant mortality. • The measure developer presented two studies that showed a performance gap of 11.6% noncompliance. The Steering Committee agreed compliance should be 100% on the measure, and so there is an opportunity for improvement. • The measure developer presented consistent evidence that a variation exists in pathological reporting that impacts the quality of care provided to patients.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability requirement for untested measures. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) Precise Specifications: Y-16; N-0 Rationale: • The measure is precisely specified. • The Steering Committee agreed that it is highly likely that testing of the measure will demonstrate a high rate of reliability and validity.
3. Usability: H-9; M-7; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • Usability has not yet been demonstrated; however, the Steering Committee believes that the measure will be useful for QI. • The measure is useful for public reporting: there is high interest, and there is ongoing active surveillance
4. Feasibility: H-12; M-4; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The data elements are all available and may be implemented using an EHR. • Steering Committee members agreed that the measure will be feasible due to the availability of this information in tumor registries and pathology reports.
Steering Committee Recommendation for Time-Limited Endorsement: Y-16; N-0 Rationale: Steering Committee noted that staging information and a Gleason score are very important for patients with prostate cancer. There is a strong evidence base for this measure. There is a performance gap in meeting the measure and a need for improvement. RECOMMENDATIONS: The measure has not yet been tested for reliability and validity and is being considered for time limited endorsement. The measure developer will have 12 months to provide testing data if time limited endorsement is granted.

Palliative Measures

0210 Proportion receiving chemotherapy in the last 14 days of life
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life Numerator Statement: Patients who died from cancer and received chemotherapy in the last 14 days of life Denominator Statement: Patients who died from cancer. Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None

0210 Proportion receiving chemotherapy in the last 14 days of life
Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Management Data, Paper Records Measure Steward: American Society of Clinical Oncology
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-12; M-4; L-0; I-1; 1b. Performance Gap: H-9; M-8; L-0; I-0; 1c. Evidence: Y-13, N-3, I-1 Rationale: • The measure affects a large number of patients and will have a high impact. • The Steering Committee noted that in some cases it is appropriate for a patient to receive chemotherapy in the last 14 days of life. The measure is useful for detecting variation in performance and identifying outliers when comparing similar practices with similar patient populations. • The measure is important because it addresses patient preferences and over-treatment at the end of life. • The struggle between aggressive care and futile care often plays out in the amount of chemotherapy delivered to patients with advanced disease and poor performance status. • The measure also reflects disparities in access to care and the capacity of a local healthcare system to treat patients appropriately at the end of life.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-9; M-6; L-2; I-0; 2b. Validity: H-4; M-9; L-3; I-1 Rationale: • Steering Committee members agreed that the measure was well specified. • The Steering Committee members raised concerns about how case mix would be accounted for in the measure. The also questioned whether facilities with a high number of patients enrolled in clinical trials would skew the measure results, so that those facilities would appear not to do as well on the measure. It was explained that the measure is intended for use in comparing like facilities, such as major cancer centers to other major cancer centers, where the case mix would be expected to be very similar. • The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure. • Face validity of the measure was demonstrated.
3. Usability: H-6; M-7; L-2; I-2 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The Steering Committee agreed the measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure. • The measure is easily understandable for public reporting. • The measure is currently in use in ASCO's QOPI program.
4. Feasibility: H-7; M-6; L-2; I-2 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The measure is reported using claims data and is feasible to implement.
Steering Committee Recommendation for Endorsement: Y-15; N-2 Rationale: The Steering Committee found that the measure is important because it addresses patient preferences and over-treatment at the end of life.

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

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

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer with more than one emergency room visit in the last days of life

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

Denominator Statement: Patients who died from cancer.

Exclusions: None

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

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

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

Type of Measure: Process

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

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

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

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

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

Rationale:

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

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

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

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

Rationale:

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

3. Usability: H-5; M-4; L-6; I-1

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

Rationale:

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

4. Feasibility: H-6; M-7; L-3; I-1

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

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

Rationale:

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

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

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

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

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life

Numerator Statement: Patients who died from cancer and were admitted to the ICU in the last 30 days of life

Denominator Statement: Patients who died from cancer.

Exclusions: None

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

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

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

Type of Measure: Process

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

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

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

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

1a. Impact: H-14; M-2; L-0; I-0; 1b. Performance Gap: H-8; M-8; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0

Rationale:

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

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

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

2a. Reliability: H-12; M-4; L-0; I-0; 2b. Validity: H-11; M-5; L-0; I-0

Rationale:

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

0213 Proportion admitted to the ICU in the last 30 days of life
• Face validity of the measure was demonstrated.
3. Usability: H-9; M-7; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure is usable for public reporting, as it captures the preference of patients to die in a setting other than the emergency department, or to avoid distressing ER visits at the end of life. • The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure. • The measure is in use in Cancer Care Ontario´s Cancer System Quality Index.
4. Feasibility: H-13; M-3; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The measure is reported using claims data and is feasible to implement.
Steering Committee Recommendation for Endorsement: Y-16; N-0 Rationale: The Steering Committee strongly agreed that patients generally do not wish to die in the ICU and believe this intervention should be avoided if at all possible. The measure captures patient preference as well as disparities in access to quality hospice care at the end of life.

0215 Proportion not admitted to hospice
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients who died from cancer not admitted to hospice Numerator Statement: Patients who died from cancer without being admitted to hospice Denominator Statement: Patients who died from cancer. Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Measure Steward: American Society of Clinical Oncology
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-10; M-3; L-2; I-1; 1b. Performance Gap: H-9; M-5; L-1; I-2; 1c. Evidence: Y-10, N-2, I-5 Rationale: • The Steering Committee agreed the measure affects a large number of patients and has a high impact. • Many cancer patients die in a hospital receiving futile care until the end. Referring patients to hospice, when appropriate, addresses patient preferencrs, improves quality of care, and reduces cost of care. • The Steering Committee noted that poor performance on the measure would indicate that providers may be failing to have direct conversations with patients about the futility of further treatment and the benefits of hospice care. • The Committee agreed the measure developer provided good evidence to support that hospice referral would mean increased quality of care.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-4; M-9; L-3; I-1; 2b. Validity: H-6; M-7; L-3; I-1

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

3. Usability: H-6; M-5; L-3; I-3
(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
Rationale:
- The measure is usable for public reporting, as it captures the use of hospice for appropriate patients.
- The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving this measure.
- The measure is in use through ASCO's QOPI program.

4. Feasibility: H-6; M-8; L-2; I-1
(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)
Rationale:
- The measure is reported using claims data and is feasible to implement.
- Steering Committee members noted that this measure—in conjunction with measure #0216: Proportion admitted to hospice for less than 3 days—would prevent providers from making patient care decisions about sending patients to hospice based on measure performance.

Steering Committee Recommendation for Endorsement: Y-11; N-6
Rationale: The Steering Committee noted that the measure affects a large patient population and will help identify when facilities are providing overly aggressive, futile care to patients rather than referring patients to hospice.

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

0216 Proportion admitted to hospice for less than 3 days

Maintenance Measure
Measure Evaluation and Specifications
Description: Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there
Numerator Statement: Patients who died from cancer and spent fewer than three days in hospice.
Denominator Statement: Patients who died from cancer who were admitted to hospice
Exclusions: None
Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None
Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records
Measure Steward: American Society of Clinical Oncology

Workgroup Preliminary Evaluations

1. Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact; 1b. Performance Gap; 1c. Evidence)
1a. Impact: H-14; M-3; L-0; I-0; 1b. Performance Gap: H-13; M-3; L-1; I-0; 1c. Evidence: Y-16, N-1, I-0
Rationale:
- It is well documented that short lengths of stay in hospice compromises patients' quality of care and that there is a subsantial portion of hospice patients that are referred within 1-3 days of death.
- The measure affects a large number of patients and is high impact.

0216 Proportion admitted to hospice for less than 3 days
• Many cancer patients die in a hospital receiving futile care until the end. Referring patients to hospice, when appropriate, addresses patient preferences, improves quality of care, and reduces health care costs. • The Steering Committee noted that poor performance on this measure would indicate that providers are failing to have direct conversations with their patients about the futility of further treatment and the benefits of hospice care. • The committee felt the measure developer provided good evidence to support that the concept that hospice referral would mean increased quality of care.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-14; M-3; L-1; I-0; 2b. Validity: H-13; M-4; L-0; I-0 Rationale: • Steering Committee members questioned why three days was selected as the numerator. The developer noted that three days is the minimum lowest bar; seven days may be a better indicator of quality of care. Also, data was more easily obtained with the three day threshold than the seven day threshold. • The measure is well specified. • The reliability testing for the measure is appropriate and demonstrates the reliability of the measure. • Face validity of the measure was demonstrated.
3. Usability: H-11; M-6; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The measure is usable for public reporting, as it captures the use of hospice for appropriate patients. • The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving this measure. • The measure is in use through ASCO's QOPI program.
4. Feasibility: H-12; M-5; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The measure is reported using claims data and is feasible to implement. • Steering Committee members noted that this measure in conjunction with measure #0215 would prevent providers from not sending patients to hospice because of the fear that the patient would die in the next 3 days and prevents providers from making patient care decisions about sending patients to hospice based on measure performance.
Steering Committee Recommendation for Endorsement: Y-17; N-0 Rationale: The Steering Committee found that the measure affects a large patient population and will help identify when facilities are providing overly aggressive, futile care to patients rather than referring them to hospice.

1822 External Beam Radiotherapy for Bone Metastases
New Measure Measure Evaluation and Specifications Description: This measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme as defined by the guideline. Numerator Statement: All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn. Denominator Statement: All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT Exclusions: The medical reasons for denominator exclusions are: 1) Previous radiation treatment to the same anatomic site; 2) Patients with femoral axis cortical involvement greater than 3 cm in length; 3) Patients who have undergone a surgical stabilization procedure; and 4) Patients with spinal cord compression, cauda equina compression or radicular pain

1822 External Beam Radiotherapy for Bone Metastases
Adjustment/Stratification: No risk adjustment or risk stratification Not applicable Stratification of the measure is not required. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan Type of Measure: Process Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records Measure Steward: American Society for Radiation Oncology (ASTRO) Other organizations: None
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-15; M-1; L-0; I-0; 1b. Performance Gap: H-13; M-3; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0 Rationale: • The measure has high impact. • There is a high opportunity for improvement, with nearly a 20% performance gap noted. • The measure represents quality care. • There is a strong supportive evidence base for this intervention.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria. (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H-13; M-3; L-0; I-0; 2b. Validity: H-11 ; M-5 ; L-0 ; I-0 Rationale: • The measure is well specified and exclusions are appropriate, except the patient reason exclusions. The Steering Committee asked the developer to remove those exclusions, and the developer agreed to do so. • The reliability testing for the measure is appropriate and demonstrates the reliability of the measure. • Face validity of the measure was demonstrated.
3. Usability: H-13; M-3; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* Rationale: • The developer has provided a detailed plan for representation of measure results, usability for QI, and public reporting of the measure through PQRS.
4. Feasibility: H-14; M-2; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • Data elements are in EHR and generated during the provision of care.
Steering Committee Recommendation for Endorsement: Y-16; N-0 Rationale: The Steering Committee stated that this measure represents good care with a strong evidence base supporting the focus of the measure. The patients affected by this measure suffer from severe pain and the intervention will help alleviate their discomfort. RECOMMENDATIONS: The Steering Committee asked the developer to remove the patient reason exclusions from the measure denominator. The developer agreed to do so, and the Steering Committee reviewed the changes on a follow up call. The Committee agreed with the changes and recommended the measure for endorsement.

MEASURES NOT RECOMMENDED

Hematology and Melanoma Measures

0561 Melanoma Coordination of Care
Maintenance Measure

0561 Melanoma Coordination of Care

Measure Evaluation and Specifications

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

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

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

Exclusions: Documentation of patient reason(s) for not communicating treatment plan (eg, patient asks that treatment plan not be communicated physician(s) providing continuing care);

Documentation of system reason(s) for not communicating treatment plan to the primary care provider(s) (eg, patient does not have a primary care provider or referring physician)

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

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

Type of Measure: Process

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

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

Steering Committee In-Person March 13-14, 2012

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

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

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

Rationale:

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

2. Scientific Acceptability of Measure Properties: N/A

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

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

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3. Usability: N/A

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

4. Feasibility: N/A

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

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

0562 Overutilization of Imaging Studies in Melanoma

Maintenance Measure

Measure Evaluation and Specifications

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

0562 Overutilization of Imaging Studies in Melanoma

diagnostic imaging studies were ordered

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

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

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

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

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

Type of Measure: Process

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

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

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report:

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

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

Rationale:

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

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability Criteria

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

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

3. Usability: N/A

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

4. Feasibility: N/A

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

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

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

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

0562 Overutilization of Imaging Studies in Melanoma
reliability, but the SC noted that the testing was done on a relatively small sample size of 148. On a follow up call, the Committee reviewed the analysis presented by the developer again and discussed the measure. The Committee noted that cancer staging follows patients from the point of diagnosis; the stage should not migrate as the patient's disease changes. Instead the stage carries with notations denoting clinical or pathological observations. Because of this, the testing analysis demonstrating reliability of the measure was not persuasive, as the stage is from diagnosis and thus cannot be easily extracted for measurement. The Committee found that the information provided by developer did not allay concerns about ambiguities in the measure and did not recommend the measure for endorsement.

Prostate Measures

0625 History of Prostate Cancer - Cancer Surveillance
Maintenance Measure Measure Evaluation and Specifications Description: The percentage of men with definitively treated localized prostate cancer who had at least one PSA level in the past 12 months. Numerator Statement: Men who had at least one PSA level in the past 12 months. Denominator Statement: Men with localized prostate cancer who were treated with curative intent. Exclusions: 1. Surgical treatment for prostate cancer in the past year 2. Drug treatment for prostate cancer in the past year 3. Radiation therapy for prostate cancer in the past year 4. Prostate MRI in past year 5. Prostate biopsy in the past year 6. Metastatic prostate cancer 7. Provider or patient feedback stating patient does not have a diagnosis of prostate cancer. 8. General exclusions a. Terminal Illness b. Active treatment of malignancy (chemotherapy or radiation therapy) in the past 6 months. c. Patients who were admitted to a skilled nursing facility in the past 3 months. Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment is done with our measures, therefore, we do not have a risk model. This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Population : County or City, Population : National, Population : State Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Healthcare Provider Survey, Patient Reported Data/Survey Measure Steward: ActiveHealth Management
0625 History of Prostate Cancer - Cancer Surveillance
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure does not meet the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-2; M-1; L-8; I-5; 1b. Performance Gap: H- ; M- ; L- ; I- ; 1c. Evidence: Y- , N- , I- Rationale: • The Steering Committee agreed prostate cancer is a prevalent disease and surveillance care and survivorship care are important areas for measuring quality, however the presented evidence did not demonstrate a link between process and a prostate cancer specific desired outcome. • There was no evidence presented that management of recurrence is associated with high resource use. • There was low level evidence that delay in detection of recurrence was associated with adverse outcomes. • There was no evidence presented that there is variation or suboptimal performance with regard to PSA testing in these patients.

0625 History of Prostate Cancer - Cancer Surveillance
• The Steering Committee was concerned with unintended harm, as overtreatment of patients with relapses of prostate cancer is a current problem.
2. Scientific Acceptability of Measure Properties: N/A (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H- ; M- ; L- ; I- ; 2b. Validity: H- ; M- ; L- ; I- Rationale: • The Steering Committee was concerned about the lack of results data presented on the reliability and validity of the measure. The Steering Committee felt that the testing database was inappropriate for evaluating reliability and validity for prostate cancer, due in part to the young age of the cohort. • The Steering Committee was concerned about the open-ended time window. • The Steering Committee was concerned that the exclusions for the measure eliminated the patients who would require more rigorous follow up after a diagnosis of prostate cancer. Although one exclusion was mis-stated, this concern extended to other exclusions in the measure. • The Steering Committee stated that patients who are asymptomatic and not eligible for salvage therapies may not need to be followed.
3. Usability: N/A (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* • The Steering Committee was concerned that although the developer indicated that 20 percent of patients lack surveillance PSA levels within one year of their treatment, the developer does not document the lower level of care or worse outcomes for that group.
4. Feasibility: N/A *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* Rationale: • The Steering Committee was concerned about attribution to a provider following the care of the patient. The developer stated they had a database that would pull the most recent test during a 1-year window and using an algorithm, determine the care provider. The Steering Committee was concerned that users of the measure would not be able to do this without the developer's database.
Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

Palliative Measures

0212 Proportion with more than one hospitalization in the last 30 days of life
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life Numerator Statement: Patients who died from cancer and had >1 hospitalization in the last 30 days of life Denominator Statement: Patients who died from cancer. Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks coule increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. None. No risk adjustment is necessary. The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting 'Cancer' as a comorbid condition in the calcluation, and used as an independent variable in a regression model to predict an adjusted rate. No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992)to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+. Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

0212 Proportion with more than one hospitalization in the last 30 days of life
Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Measure Steward: American Society of Clinical Oncology
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure does not meet the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-4; M-10; L-2; I-0; 1b. Performance Gap: H-4; M-8; L-3; I-1; 1c. Evidence: Y-6, N-6, I-4 Rationale: • The measure affects a large number of patients and is high impact. • The Steering Committee noted that repeated hospitalizations for a dying patient are indicative that a trajectory of care to deal with end of life issues has not been established. • The Steering Committee was concerned that this measure did not take into account the increase in Palliative Care Units in hospitals, which provide appropriate care for dying patients in pain and should be utilized. • The Steering Committee raised concerns that the evidence base for this measure needs to evolve with the use of palliation in inpatient facilities. • There was concern that not recommending this measure for endorsement would not allow capture of the full spectrum of hospitalizations for cancer patients at the end of life (emergency department, hospitalization, and ICU).
2. Scientific Acceptability of Measure Properties: N/A (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H- ; M- ; L- ; I- ; 2b. Validity: H- ; M- ; L- ; I-
3. Usability: N/A (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
4. Feasibility: N/A *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)*
Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

0214 Proportion dying from Cancer in an acute care setting
Maintenance Measure Measure Evaluation and Specifications Description: Percentage of patients who died from cancer dying in an acute care setting Numerator Statement: Patients who died from cancer in an acute care hospital Denominator Statement: Patients who died from cancer. Exclusions: None Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks coule increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks coule increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. None Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry,

Management Data, Paper Records Measure Steward: American Society of Clinical Oncology
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure does not meet the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) 1a. Impact: H-7; M-8; L-0; I-2; 1b. Performance Gap: H-6; M-7; L-0; I-4; 1c. Evidence: Y-6, N-6, I-4 Rationale: • The measure affects a large number of patients and is high impact. • The Steering Committee noted that most patients prefer to die at home, not in an acute care setting. • The Steering Committee was concerned that this measure did not take into account the increase in Palliative Care Units in hospitals, which provide appropriate care for dying patients in pain and should be utilized. • The Steering Committee stated that this measure does not take into account that the majority of patients want to die comfortably, and in many circumstances an acute care setting may be the most appropriate place for that to occur.
2. Scientific Acceptability of Measure Properties: N/A (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) 2a. Reliability: H- ; M- ; L- ; I- ; 2b. Validity: H- ; M- ; L- ; I-
3. Usability: N/A (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
4. Feasibility: N/A *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)*
Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

WITHDRAWN FROM CONSIDERATION

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

NOTES

[i] U.S. Department of Health and Human Services (DHHS), National Institutes of Health (NIH), National Cancer Institute (NCI), Defining Cancer. Updated 07/12/2010. Bethesda, MD:NCI, 2010. Available at www.cancer.gov/cancertopics/cancerlibrary/what-is-cancer. Last accessed February 2011.

[ii] American Cancer Society. Cancer Facts & Figures 2010. Atlanta, GA. 2009. Last Medical Review: 05/20/2009. Last Revised: 05/20/2009. Available at http://www.cancer.org/Research/CancerFactsFigures/CancerFactsFigures/cancer-facts-and-figures-2010. Last accessed February 2011.

[iii] Ibid. Available at http://www.cancer.org/Research/CancerFactsFigures/CancerFactsFigures/cancer-facts-and-figures-2010. Last accessed February 2011.

[iv] McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. [see comment]. New England Journal of Medicine. 2003;348(26):2635-2645, and Harlan LC, Greene AL, Clegg LX, Mooney M, Stevens JL, Brown ML. Insurance status and the use of guideline therapy in the treatment of selected cancers. [see comment]. Journal of Clinical Oncology. 2005;23(36):9079-9088, as cited in National Quality Forum (NQF). The Current State of Cancer Quality Measurement 2008: A White Paper. Washington, DC: NQF; 2008.

[v] Du XL, Lin CC, Johnson NJ et al., Effects of individual-level socioeconomic factors on racial disparities in cancer treatment and survival: findings from the National Longitudinal Mortality Study, 1979-2003, Cancer, 2011.

[vi] Byers T, Two decades of declining cancer mortality: progress with disparity, Annu Rev Public Health, 2010;31:121.132.

[vii] Sherr DL, Stessin AM, Demographic disparities in patterns of care and survival outcomes for patients with resected gastric adenocarcinoma. Cancer Epidemiol Biomarkers Prev. 2011 Mar;20(2):223-33.

[viii] Slatore CG, Au DH, Gould MK; American Thoracic Society Disparities in Healthcare Group, An official American Thoracic Society systematic review: insurance status and disparities in lung cancer practices and outcomes. Am J Respir Crit Care Med. 2010 Nov 1;182(9):1195-205.

NATIONAL QUALITY FORUM

APPENDIX A: MEASURE SPECIFICATIONS

MEASURES

	0210 Proportion receiving chemotherapy in the last 14 days of life
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 10, 2009
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Management Data, Paper Records Medicare claims and denominator file
Level	Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and received chemotherapy in the last 14 days of life
Numerator Details	**Time Window:** 14 days prior to death ICD-9: 140 – 239 Chemotherapy administration codes: ICD-9 diagnosis codes: V58.1 OR ICD-9 procedure codes: 99.25 OR CPT codes: 964xx, 965xx OR HCPCS codes: J7150, J85xx, J86xx, J87xx, J8999, J9xxx, Q0083, Q0084, Q0085 OR DRG codes: 410 OR Revenue center codes: 0331, 0332, 0335 OR BETOS codes: O1D OR NDC Brand descriptions: Alkeran, Cytoxan, Methotrexate Sodium, Temodar, VePesid, Xeloda
Denominator Statement	Patients who died from cancer.
Denominator Details	**Time Window:** None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, i
Stratification	None

Type Score	Rate/proportion better quality = lower score

	0211 Proportion with more than one emergency room visit in the last days of life
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 10, 2009
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Medicare claims and denominator file
Level	Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and had >1 ER visit in the last 30 days of life
Numerator Details	**Time Window:** 30 days prior to death ER visits documented in MEDPAR claims
Denominator Statement	Patients who died from cancer.
Denominator Details	**Time Window:** None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it w
Stratification	No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administ
Type Score	Rate/proportion better quality = lower score

	0213 Proportion admitted to the ICU in the last 30 days of life
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 10, 2009
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Medicare claims and denominator file
Level	Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City,

	0213 Proportion admitted to the ICU in the last 30 days of life
	Population : National, Population : Regional, Population : State
Setting	Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and were admitted to the ICU in the last 30 days of life
Numerator Details	**Time Window:** 30 days before death MEDPAR only: did not include SNF claims did not include pediatric, psychiatric, burn or trauma ICUs (MEDPAR variable increind ne 3,4,7,8) • variable in MEDPAR called incrdays, which is number of ICU days per visit • used hospital admission date variable (admitdate) and then checked if incrdays was >0 for admissions occurring in the last 30 days before death
Denominator Statement	Patients who died from cancer.
Denominator Details	**Time Window:** None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it w
Stratification	No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administ
Type Score	Rate/proportion better quality = lower score

	0215 Proportion not admitted to hospice
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 10, 2009
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer not admitted to hospice
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Medicare claims and denominator file
Level	Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Hospice
Numerator Statement	Patients who died from cancer without being admitted to hospice
Numerator Details	**Time Window:** None Those without claims in Medicare HOSPICE file. No codes used.
Denominator Statement	Patients who died from cancer.

	0215 Proportion not admitted to hospice
Denominator Details	**Time Window:** None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	None
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, i
Stratification	None
Type Score	Rate/proportion better quality = lower score

	0216 Proportion admitted to hospice for less than 3 days
Status	Maintenance, Original Endorsement: Oct 01, 2007, Most Recent Endorsement: Oct 01, 2007
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records Medicare claims and denominator file
Level	Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Hospice
Numerator Statement	Patients who died from cancer and spent fewer than three days in hospice.
Numerator Details	**Time Window:** 3 days Medicare HOSPICE file only: Subtracted hospice admission date (admndate) from death date variable to get hospice length of stay No codes used.
Denominator Statement	Patients who died from cancer who were admitted to hospice
Denominator Details	**Time Window:** None Patients in the death registry with cancer as their cause of death who also appear in the Medicare hospice file. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, i
Stratificatio	None

	0216 Proportion admitted to hospice for less than 3 days
n	
Type Score	Rate/proportion better quality = lower score

	0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** The American Society of Hematology
Description	Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenic testing performed on bone marrow.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Laboratory Not Applicable Attachment 0377 Cytogenetic Testing Data Eelements_FINAL.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Laboratory
Numerator Statement	Patients who had baseline cytogenetic testing* performed on bone marrow Definition: *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis.
Numerator Details	**Time Window:** At least once during measurement period Definition: *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis. For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims. Report the CPT Category II code: 3155F – Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment
Denominator Statement	All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia
Denominator Details	**Time Window:** 12 consecutive months For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims data AGE: >= 18 years and older AND Diagnosis: Myelodysplastic Syndrome (MDS) and Acute Leukemias ICD-9-CM diagnosis codes: 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75 ICD-10-CM diagnosis codes: C91.00, C91.02, C92.00, C92.02, C92.40, C92.42, C92.50, C92.52, C92.60, C92.62, C92.a0, C92.a2, C93.00, C93.02, C94.00, C94.02, C94.20, C94.22, C95.00, C95.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.a, D46.b, D46.c, D46.z AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of medical reason(s) for not performing baseline cytogenetic testing Documentation of patient reason(s) for not performing baseline cytogenetic testing Denominator Exclusions: Documentation of system reason(s) for not performing baseline cytogenetic testing
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all

	0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
	measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason, patient or system reason for not performing baseline cytogenetic testing. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: Denominator Exceptions: Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow) Append modifier to CPT Category II code: 3155F-1P Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above) Append modifier to CPT Category II code: 3155F-2P Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., patient previously treated by another physician at the time of cytogenetic testing performed) Append modifier to CPT Category II code: 3155F-3P
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [e.g., medical, system or patient reason for not performing baseline cytogenetic testing). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment Generic Measure Logic.pdf

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

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

	0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
	of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: Denominator Exceptions: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy Append modifier to CPT Category II code: 3160F-3P
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: or system reason(s) (eg, for not documenting iron stores prior to initiating erythropoietin therapy)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See attached calculation algorithm in 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634631931846113738.pdf

	0379: Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
Description	Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed
Numerator	Patients who had baseline flow cytometry studies performed and documented in the chart Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy.
Numerator Details	Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy. For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: CPT Category II code: 3170F – Baseline flow cytometry studies performed

	0379: Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
Denominator	All patients aged 18 years and older seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period
Denominator Details	For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. AGE: >= 18 years and older AND Diagnosis: Chronic Lymphocytic Leukemia ICD-9-CM diagnosis codes: 204.10, 204.12 ICD-10-CM diagnosis codes: C91.10, C91.12 AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of medical reason(s) for not performing baseline flow cytometry Documentation of patient reason(s) for not performing baseline flow cytometry Documentation of system reason(s) for not performing baseline flow cytometry
Exclusion details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason, e.g. for not performing baseline flow cytometry; patient reason, e.g. for not performing baseline flow cytometry (for example, receiving palliative care or not receiving treatment as defined above) or system reason, e.g. for not performing baseline flow cytometry (for example, patient previously treated by another physician at the time baseline flow cytometry studies were performed). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims Denominator Exceptions: Documentation of medical reason(s) for not performing baseline flow cytometry studies Append modifier to CPT Category II code: 3170F-1P Documentation of patient reason(s) for not performing baseline flow cytometry studies (e.g., receiving palliative care or not receiving treatment as defined above) Append modifier to CPT Category II code: 3170F-2P Documentation of system reason(s) for not performing baseline flow cytometry studies (e.g., patient previously treated by another physician at the time baseline flow cytometry studies were performed)

	0379: Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
	Append modifier to CPT Category II code: 3170F-3P
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Numerator Time window	At least once during the measurement period
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Laboratory

	0380 Multiple Myeloma – Treatment with Bisphosphonates
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** American Society of Hematology
Description	Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records Attachment 0380_multiple myeloma DE.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office
Numerator Statement	Patients who were prescribed or received intravenous bisphosphonate therapy* within the 12 month reporting period. Definition: *Bisphosphonate Therapy: Includes the following medications: pamidronate and zoledronate
Numerator Details	**Time Window:** At least once during the measurement period Definition: *Bisphosphonate Therapy: Includes the following medications: pamidronate and zoledronate Definition: Prescribed: Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: CPT Category II code: 4100F – Intravenous bisphosphonate therapy prescribed or received
Denominator Statement	All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission
Denominator Details	**Time Window:** 12 consecutive months For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached.

	0380 Multiple Myeloma – Treatment with Bisphosphonates
	AGE: >=18 years and older AND Diagnosis: Multiple Myeloma ICD-9-CM diagnosis codes: 203.00, 203.02 ICD-10-CM diagnosis codes: C90.00, C90.02 AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) Documentation of patient reason(s) for not prescribing bisphosphonates
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s), e.g. for not prescribing bisphosphonates (patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) or patient reason(s), e.g. for not prescribing bisphosphonates. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: Denominator Exceptions: Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) Append modifier to CPT Category II code: 4100F-1P Documentation of patient reason(s) for not prescribing bisphosphonates Append modifier to CPT Category II code: 4100F-2P
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: exceptions may include medical reason(s), e.g. for not prescribing bisphosphonates (patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) or patient reason(s), e.g. for not

	0380 Multiple Myeloma – Treatment with Bisphosphonates
	prescribing bisphosphonates]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment Generic Measure Logic-634620584294869354.pdf

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** The measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not Applicable Attachment AMA-PCPI_0381_DataElements_AppendixA.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other Radiation Oncology Dept/Clinic
Numerator Statement	Patients who have a treatment summary* report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment Definition: *Treatment Summary: a report that includes mention of all of the following components: 1) dose delivered; 2) relevant assessment of tolerance to and progress towards the treatment goals; and 3)subsequent care plans Numerator Instructions: This measure should be reported once per course of radiation treatment – less than or equal to 30 days from the end of treatment.
Numerator Details	**Time Window:** <= one month after completion of therapy during measurement period For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: Report CPT Category II code: 5020F - Treatment summary report communicated to physician(s) managing continuing care and to the patient within one month of completing treatment
Denominator Statement	All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy
Denominator Details	**Time Window:** Each course of brachytherapy or external beam radiation therapy within 12 consecutive months For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: CPT® codes for external beam radiation therapy, weekly management or brachytherapy: 77427, 77431, 77432, 77435, 77470, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787 AND ICD-9-CM diagnosis codes: See Attached Code List (Appendix A in attachment)

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
	ICD-10-CM diagnosis codes: See Attached Code List (Appendix A in attachment)
Exclusions	Documentation of a patient reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient requests that report not be sent) and to the patient within one month of completing treatment Documentation of a system reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include patient (eg, patient requests that report not be sent) or system reason(s)(eg, patient does not have any physician responsible for providing continuing care) for not communicating the treatment summary report to the physician(s) providing continuing care and to the patient within one month of completing treatment. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: Documentation of patient reason(s) for not having a treatment summary report in the chart that was communicated to the physician(s) providing continuing care (eg, patient requests that report not be sent) and to the patient within one month of completing treatment • Append modifier to CPT Category II code: 5020F-2P Documentation of system reason(s) for not having a treatment summary report in the chart that was communicated to the physician(s) providing continuing care (eg, patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment • Append modifier to CPT Category II code: 5020F-3P
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: patient reason(s) (eg, patient requests that report not be sent) or system reason(s)(eg, patient does not have any physician responsible for providing continuing care)]. If the patient meets any exception criteria, they

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
	should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620643896118889.pdf
Copyright/ Disclaimer	Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance ImprovementTM (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures. THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND © 2007 American Medical Association. All Rights Reserved Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND. See copyright statement above.

	0382 Oncology: Radiation Dose Limits to Normal Tissues
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not Applicable Attachment NQF#0382_DataElements-634620692307678721.xls
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other Radiation Oncology Dept/Clinic
Numerator Statement	Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues
Numerator Details	**Time Window:** Once, prior to start of 3D conformal radiation therapy

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	For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative Data: To submit the numerator option for patients who had documentation in the medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues, report the following CPT Category II code: 0520F – Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues or organs
Denominator Statement	All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy
Denominator Details	**Time Window:** Each course of 3D conformal radiation therapy within 12 consecutive months For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative Data: ICD-9-CM diagnosis codes: 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9 ICD-10-CM diagnosis codes: C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92 AND • CPT code for radiation therapy 3D simulation: 77295
Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard

	0382 Oncology: Radiation Dose Limits to Normal Tissues
	Measures-634620693236747167.pdf
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	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records Attachment NQF_0383_DataElements_AppendixA.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic
Numerator Statement	Patient visits that included a documented plan of care* to address pain Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.
Numerator Details	**Time Window:** At each visit within the measurement period For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data:

	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
	To submit the numerator option for patient visits that included a documented plan of care to address pain, report the following CPT Category II code: 0521F – Plan of care to address pain documented
Denominator Statement	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain
Denominator Details	**Time Window:** 12 consecutive months For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain Eligible patients for this measure are identified by: ICD-9-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-9-CM CODES ICD-10-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-10-CM CODES AND Report CPT Category II code: 1125F: Pain severity quantified; pain present AND either option 1 or 2: 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215, AND o CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration) OR 2. Radiation therapy • CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470
Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
	4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620662541238217.pdf
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	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records Not Applicable Attachment NQF_0384_DataElements_AppendixA.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic
Numerator	Patient visits in which pain intensity is quantified*

	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Statement	* Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale
Numerator Details	**Time Window:** At each visit within the measurement period For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: To submit the numerator option for number of patient visits in which pain intensity was quantified, report one of the following CPT Category II codes: 1125F – Pain severity quantified; pain present OR 1126F – Pain severity quantified; no pain present
Denominator Statement	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy
Denominator Details	**Time Window:** 12 consecutive months For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy Eligible patients for this measure are identified by: ICD-9-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-9-CM CODES ICD-10-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-10-CM CODES AND either option 1 or 2 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215 AND o CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration) OR 2. Radiation therapy • CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470
Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates:

	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
	1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620671516608159.pdf
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	0386 Oncology: Cancer Stage Documented
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure is jointly copyrighted by the AMA-PCPI and American Society of Clinical Oncology. The measure set was also developed in collaboration with the American Society for Radiation Oncology.
Description	Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the

	0386 Oncology: Cancer Stage Documented
	ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Paper Records Not Applicable Attachment Data_Elements_0386.xls
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic;
Numerator Statement	Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period Numerator Instructions: *Cancer stage refers to stage at diagnosis
Numerator Details	**Time Window:** At least once during the measurement period For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: To submit the numerator option for patients who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period, report one of the following CPT Category II codes: 3300F – American Joint Committee on Cancer (AJCC) stage documented and reviewed OR 3301F – Cancer stage documented in medical record as metastatic and reviewed
Denominator Statement	All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting
Denominator Details	**Time Window:** 12 consecutive months For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting AND ICD-9-CM diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9 (malignant neoplasm of colon), 154.0, 154.1, 154.2, 154.3, 154.8 (malignant neoplasm of rectum and anus), 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 (malignant neoplasm of female breast), V10.3, V10.05, V10.06 ICD-10-CM diagnosis codes: C18.3, C18.4, C18.6, C18.7, C18.0, C18.1, C18.2, C18.5, C18.8, C18.9, C19, C20, C21.1, C21.0, C21.2, C21.8, C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, Z85.3, Z85.038, Z85.048 AND either option 1 or 2 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215, o 99241, 99242, 99243, 99244, 99245, o 99024 OR 2. Radiation therapy • CPT codes for radiation treatment planning: 77261, 77262, 77263

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Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620735019045822.pdf
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	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** American Urological Association and American Society for Therapeutic Radiology & Oncology
Description	Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not applicable.
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office, Other Radiation Oncology Clinic/Department
Numerator Statement	Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer
Numerator Details	**Time Window:** Once for each procedure for treatment of prostate cancer (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) For EHR: See attached eMeasure For Claims/Administrative Data: To submit the numerator option for patients who did not have a bone scan performed at any time since diagnosis of prostate cancer, report the following CPT Category II code: 3270F – Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer
Denominator Statement	All patients, regardless of age, with a diagnosis of prostate cancer, at low risk* of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy
Denominator Details	**Time Window:** Each procedure for treatment of prostate cancer (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) Risk strata definitions: • Low Risk: PSA =10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a2 • Intermediate Risk: PSA >10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk2 • High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinical stage T2c or greater; and not qualifying for very high risk2 Note: Only patients with prostate cancer with low risk of recurrence will be counted in the denominator of this measure For EHR: See attached eMeasure For Claims/Administrative Data: All patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy ICD-9-CM diagnosis code: 185 ICD-10-CM diagnosis code: C61 AND CPT codes: 55810, 55812, 55815 (perineal prostatectomies); 55840, 55842, 55845 (retropubic prostatectomies); 55866 (laparoscopic prostatectomy); 55873 (cryotherapy); 77427 (radiation treatment management); 77776,

	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
	77777, 77778, 77787 (brachytherapy) AND Report the following CPT Category II Code to identify the risk of recurrence: • 3271F – Low risk of recurrence, prostate cancer
Exclusions	Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons) Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician)
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) for having a bone scan performed(eg documented pain, salvage therapy, other medical reasons) or system reason(s) for having a bone scan performed (eg, bone scan ordered by someone other than reporting physician). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: See attached eMeasure For Claims/Administrative Data: Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons) Append modifier to CPT Category II code: 3269F-1P – Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer (including documented pain, salvage therapy, other medical reasons) Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician) Append modifier to CPT Category II code: 3269F-3P – Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer (including bone scan ordered by someone other than reporting physician)
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	For measures with exceptions: To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this

	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
	measure: medical reason(s) (eg, documented pain, salvage therapy, other medical reasons)or system reason(s) (eg, bone scan ordered by someone other than reporting physician)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment Measure Calculation_0389.pdf
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	0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** American Urological Association and American Society for Therapeutic Radiology & Oncology
Description	Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not applicable Attachment NQF_0390_DataElements.xls
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office, Other Radiation Oncology Clinic/Department
Numerator Statement	Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)
Numerator Details	**Time Window:** Once for each procedure for treatment of prostate cancer (i.e., external beam radiotherapy to the prostate)

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

	0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy)or patient reason(s). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment Measure Calculation_0390.pdf
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	0650 Melanoma Continuity of Care – Recall System
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: May 05, 2010
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other**

	0650 Melanoma Continuity of Care – Recall System
	organizations: American Academy of Dermatology and National Committee for Quality Assurance
Description	Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month reporting period into a recall system that includes: • A target date for the next complete physical skin exam , AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment
Type	Structure
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Registry, Other, Paper Records Not Applicable
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office
Numerator Statement	Patients whose information is entered, at least once within a 12 month period, into a recall system* that includes: • A target date for the next complete physical skin exam , AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment
Numerator Details	**Time Window:** At least once during measurement period Numerator Instructions: To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum; patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam. For Claims/Administrative: Report CPT Category II code: 7010F -- Patient information entered into a recall system with the target date for the next complete physical skin exam specified For EHR: This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.
Denominator Statement	All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma.
Denominator Details	**Time Window:** 12 consecutive months For EHR: This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems. For Claims/Administrative: ICD-9-CM diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 ICD-10-CM diagnosis codes: C41.10, C41.11, C41.12, C43.0, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820 AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider)
Exclusion	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the

	0650 Melanoma Continuity of Care – Recall System
Details	denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: This measure does not lend itself to a "traditional specification" for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems. For Claims/Administrative: Documentation of system reason exception • Append modifier to CPT Category II code: 7010F-3P
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: system reason(s) (eg, melanoma being monitored by another physician provider)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment AMA-PCPI_Measure Calculation-Standard Measures650.pdf
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	0650 Melanoma Continuity of Care – Recall System
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	1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
Status	New Submission
Steward	Society of Thoracic Surgeons
Description	Percentage of patients = 18 years of age undergoing elective lung resection (Open or VATS wedge resection, segmentectomy, lobectomy, bilobectomy, sleeve lobectomy, pneumonectomy) for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records STS General Thoracic Surgery Database, Version 2.2 URL Data Collection Form- http://www.sts.org/sites/default/files/documents/STSThoracicDCF_V2_2_MajorProc_Annotated_0.pdf URL http://www.sts.org/sites/default/files/documents/STSThoracicDataSpecsV2_2.pdf
Level	Clinician : Group/Practice, Clinician : Team, Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Number of patients = 18 years of age undergoing elective lung resection for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.
Numerator Details	**Time Window:** During hospitalization regardless of length of stay or within 30 days of surgery if discharged from the hospital. Number of patients undergoing elective lung resection for lung cancer for whom: 1. Postoperative events (POEvents - STS GTS Database, v 2.2, sequence number 1710) is marked "Yes" and one of the following items is marked: a. Reintubation (Reintube - STS GTS Database, v 2.2, sequence number 1850) b. Need for tracheostomy (Trach - STS GTS Database, v 2.2, sequence number 1860)

	1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
	c. Initial ventilator support > 48 hours (Vent- STS GTS Database, v 2.2, sequence number 1840) d. Adult Respiratory Distress Syndrome (ARDS - STS GTS Database, v 2.2, sequence number 1790) e. Pneumonia (Pneumonia - STS GTS Database, v 2.2, sequence number 1780) f. Pulmonary Embolus (PE - STS GTS Database, v 2.2, sequence number 1820) g. Bronchopleural Fistula (Bronchopleural - STS GTS Database, v 2.2, sequence number 1810) h. Myocardial infarction (MI - STS GTS Database, v 2.2, sequence number 1900) Or 2. Unexpected return to the operating room (ReturnOR - STS GTS Database, Version 2.2, sequence number 1720) is marked "yes" and primary reason for return to OR (ReturnORRsn – STS GTS Database, Version 2.2, sequence number 1730) is marked "bleeding" Or 3. One of the following fields is marked "dead" a. Discharge status (MtDCStat - STS GTS Database, Version 2.2, sequence number 2200); b. Status at 30 days after surgery (Mt30Stat - STS GTS Database, Version 2.2, sequence number 2240) Please see STS General Thoracic Surgery Database Data Collection Form, Version 2.2- http://www.sts.org/sites/default/files/documents/STSThoracicDCF_V2_2_MajorProc_Annotated_0.pdf
Denominator Statement	Number of patients = 18 years of age undergoing elective lung resection for lung cancer.
Denominator Details	**Time Window:** 36 months 1. Lung cancer (LungCancer - STS GTS Database, v 2.2, sequence number 830) is marked "yes" and Category of Disease – Primary (CategoryPrim - STS GTS Database, v 2.2, sequence number 1300) is marked as one of the following: (ICD-9, ICD-10) Lung cancer, main bronchus, carina (162.2, C34.00) Lung cancer, upper lobe (162.3, C34.10) Lung cancer, middle lobe (162.4, C34.2) Lung cancer, lower lobe (162.5, C34.30) Lung cancer, location unspecified (162.9, C34.90) 2. Patient has lung cancer (as defined in #1 above) and primary procedure is one of the following CPT codes: Thoracoscopy, surgical; with lobectomy (32663) Thoracoscopy with therapeutic wedge resection (eg mass or nodule) initial, unilateral (3266X) Thoracoscopy with therapeutic wedge resection (eg mass or nodule) each additional resection, ipsilateral (3266X1) Thoracoscopy with diagnostic wedge resection followed by anatomic lung resection (3266X2) Thoracoscopy with removal of a single lung segment (segmentectomy) (3266X4) Thoracoscopy with removal of two lobes (bilobectomy) (3266X3) Thoracoscopy with removal of lung, pneumonectomy (3266X5) Thoracotomy with therapeutic wedge resection (eg mass nodule) initial (3250X) Thoracotomy with therapeutic wedge resection (eg mass nodule) each additional resection, ipsilateral (+3250X1) Thoracotomy with diagnostic wedge resection followed by anatomic lung resection (+3250X2) Removal of lung, total pneumonectomy; (32440) Removal of lung, sleeve (carinal) pneumonectomy (32442) Removal of lung, total pneumonectomy; extrapleural (32445) Removal of lung, single lobe (lobectomy) (32480) Removal of lung, two lobes (bilobectomy) (32482) Removal of lung, single segment (segmentectomy) (32484) Removal of lung, sleeve lobectomy (32486) Removal of lung, completion pneumonectomy (32488) Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, without chest wall reconstruction(s) (32503) Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, with chest wall

	1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
	reconstruction (32504) 3. Status of Operation (Status - STS General Thoracic Surgery Database, Version 2.2, sequence number 1420) is marked as "Elective" 4. Only analyze the first operation of the hospitalization meeting criteria 1-3
Exclusions	Emergency procedures
Exclusion Details	n/a
Risk Adjustment	Statistical risk model Bayesian hierarchical modeling was used to assess the statistical reliability of hospital-specific standardized incidence ratio (SIR) estimates derived from the January 1, 2008 – December 31, 2010 STS data. All hospitals regardless of sample size were inc Attachment Kozower et al.pdf
Stratification	n/a
Type Score	Rate/proportion better quality = lower score
Algorithm	Target population is patients 18 years of age or older undergoing elective lung resection for lung cancer. Emergency procedures were excluded. Outcome is occurrence of postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality. Analysis considered 22,677 patients with procedures between 01/01/2008 and 12/31/2010 (36 months). Risk adjustment was achieved with a Bayesian hierarchical model with composite of the above postoperative complications as the outcome. The measure score was estimated with this model. For additional information review risk model in attachment.

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

	1822 External Beam Radiotherapy for Bone Metastases
Denominator Details	**Time Window:** Once per reporting period Bone metastases diagnosis (198.5- Secondary malignant neoplasm of bone and bone marrow) Use of EBRT (Therapeutic radiology treatment planning: CPT 77261; simple, CPT 77262; Intermediate, CPT 77263; complex)
Exclusions	The medical reasons for denominator exclusions are: 1) Previous radiation treatment to the same anatomic site; 2) Patients with femoral axis cortical involvement greater than 3 cm in length; 3) Patients who have undergone a surgical stabilization procedure; and 4) Patients with spinal cord compression, cauda equina compression or radicular pain
Exclusion Details	A. Medical Reasons (Data Source) 1) Previous radiation treatment to the same anatomic site (Medical Record) 2) Patients with femoral axis cortical involvement greater than 3 cm in length(Imaging Studies) 3) Patients who have undergone a surgical stabilization procedure (Operative Report) 4) Patients with spinal cord compression, cauda equina compression or radicular pain (Diagnosis/Problem list)
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Stratification of the measure is not required.
Type Score	Rate/proportion better quality = higher score
Algorithm	Denominator Calculation Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT Step 2: Identify patients with no history of previous radiation therapy to the same anatomic site Step 3: Identify patients with specified exceptions and exclude from denominator calculation Numerator Calculation: Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT Step 2: Identify patients prescribed with one of the recommended fractionation schemes: 30Gy/10fxns or 24Gy/6fxns or 20Gy/5fxns or 8Gy/1fxn

	1853 Radical Prostatectomy Pathology Reporting
Status	New Submission **Time-limited**
Steward	College of American Pathologists
Description	Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.
Type	Process
Data Source	Administrative claims, Other, Paper Records Medical records/Pathology Report and Claims forms are used as the specific data sources.
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Laboratory
Numerator Statement	Numerator: Radical prostatectomy pathology reports that include the pT category, the pN category, Gleason score and a statement about margin status ? Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F –pathology report
Numerator Details	**Time Window:** Each event is reported Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F –pathology report

	1853 Radical Prostatectomy Pathology Reporting
Denominator Statement	All radical prostatectomy pathology reports
Denominator Details	**Time Window:** Each event is recorded; measurement time period is not specified and can be determined by program. Denominator (Eligible Population): All radical prostatectomy pathology reports CPT code: 88309 - Level VI - Surgical pathology, gross and microscopic examination AND ICD-9 code: 185 – malignant neoplasm of prostate
Exclusions	Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, and transurethral resections of the prostate (TURP)
Exclusion Details	Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, or transurethral resections of the prostate (TURP) [For patient with appropriate exclusion criteria, report 3267F with modifier 1P.]
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = higher score
Algorithm	Performance Measure: 3267F/Claims using CPT code 88309 and ICD-9 code 185
Copyright/ Disclaimer	© 2007 College of American Pathologists. All Rights Reserved Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The College of American Pathologists disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

	1854 Barrett´s Esophagus
Status	New Submission **Time-limited**
Steward	College of American Pathologists
Description	Percentage of patients with esophageal biopsy reports for Barrett's esophagus that contain a statement about dysplasia.
Type	Process
Data Source	Administrative claims, Other, Paper Records Medical records/pathology report/Claims forms
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Laboratory
Numerator Statement	Numerator: Esophageal biopsy reports with the histologic finding of Barrett's mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.) 3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite)
Numerator Details	**Time Window:** Report once per patient per date of service Numerator: Esophageal biopsy reports with the histologic finding of Barrett's mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.) 3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite)
Denominator Statement	Denominator (Eligible Population): All esophageal biopsy reports that document the presence of Barrett's mucosa. CPT codes: • 88305 Level IV – Surgical pathology, gross and microscopic examination AND

	1854 Barrett´s Esophagus
	ICD-9 codes: • 530.85 Barrett's esophagus
Denominator Details	**Time Window:** Once per patient per date of service; time period not specified in the measure and can be determined by the program (typically one year.) The pathology report is needed as well as access to correct coding of claims to identify patients: CPT codes: • 88305 Level IV – Surgical pathology, gross and microscopic examination AND ICD-9 codes: • 530.85 Barrett's esophagus
Exclusions	Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia).
Exclusion Details	Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia). [For patient with appropriate exclusion criteria, report 3125F with modifier 1P]
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = higher score
Algorithm	Performance Measure: 3125F/CPT codes 88305 and ICD-9 codes 530.85
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APPENDIX B: STEERING COMMITTEE and NQF STAFF

STEERING COMMITTEE

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City of Hope, Duarte, CA

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Project Manager, Performance Measures

Appendix C – MEASURE GAPS

Disease Specific Gaps

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

Pathology and Treatment Reports

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

Appropriateness of Care

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

Surgical Care

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

Other Measures

- Measures submitted by patient advocacy groups or other multidisciplinary stakeholders
- Prevention measures
- Screening measures
- Combined measures to be used in "toolkits" to ensure a process is associated with an improved outcome

Appendix D – RELATED MEASURE COMPARISON TABLE

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care -- Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Steward	RAND Corporation	University of North Carolina-Chapel Hill	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified
Type	Process	Process	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Registry, Paper Records Patients were identified via the testing organizations´ cancer registries. At one institution, outpatient pain vital sign scores were extracted electronically from the patient EHR. At other institutions, quantitative pain scores were collected via medical record abstraction.	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Structured medical record abstraction tool with separate collection of numerator and denominator data values. URL PEACE Project Data Dictionary http://www.thecarolinascenter.org/default.aspx?pageid=46 URL PEACE Project Data Dictionary http://www.thecarolinascenter.org/default.aspx?pageid=46	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records Not Applicable Attachment NQF_0384_DataElements_AppendixA.pdf
Level	Facility, Health Plan, Integrated Delivery System	Clinician : Group/Practice, Facility	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office	Hospice, Hospital/Acute Care Facility	Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic
Numerator Statement	Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool	Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.	Patient visits in which pain intensity is quantified* * Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale
Numerator Details	Time Window: At the time of outpatient visit(s) Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.	Time Window: Hospice admission evaluation / initial clinical encounter for palliative care Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized tool during the admission evaluation for hospice / initial encounter for hospital-based palliative care. Screening may be completed using verbal, numeric, visual analog, rating scales designed for use the non-verbal patients, or other standardized tools.	Time Window: At each visit within the measurement period For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: To submit the numerator option for number of patient visits in which pain intensity was quantified, report one of the following CPT Category II codes:

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care -- Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
			1125F – Pain severity quantified; pain present OR 1126F – Pain severity quantified; no pain present
Denominator Statement	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy
Denominator Details	Time Window: At the time of outpatient visit(s) Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion	Time Window: Hospice admission evaluation / palliative care initial encounter The Pain Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Pain Assessment quality measure to ensure that all patients who report pain are clinically assessed.]	Time Window: 12 consecutive months For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy Eligible patients for this measure are identified by: ICD-9-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-9-CM CODES ICD-10-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-10-CM CODES AND either option 1 or 2 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215 AND o CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration) OR 2. Radiation therapy • CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care -- Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Exclusions	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.	None
Exclusion Details		Calculation of length of stay; discharge date - date of initial encounter.	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification None
Stratification		N/A	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	1. Identify patients at least 18 years of age with Stage IV cancer 2. Identify patients who have had at least 1 primary care or cancer-related visit. Exclude patients who are not alive 30 or more days after diagnosis. 3. For each applicable visit, determine if a screening for pain was performed using a quantitative standardized tool. 4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits	Screened for pain : a. Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care b. Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) using a standardized tool. Quality Measure = Numerator: Patients screened for pain in Step 3 / Denominator: Patients in Step 1-Patients excluded in Step 2	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care -- Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
			patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620671516608159.pdf
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundled measures for description of the selection and harmonization of the Key Palliative Measures Bundle. Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure. It is unclear exactly what the scope of measure 0420 is, however it appears to be directed at ancillary, non-physician professionals. It is unclear what "initiation of therapy" is referring to. The measure´s endorsement is time limited (endorsed July 31, 2008) Measure 0384 (paired with 0383) also has a time-limited endorsement (endorsed July 31, 2008). This measure targets only patients who are currently receiving chemotherapy or radiation therapy, and by definition, excludes some patients with advanced cancer who are not receiving this type of treatment. The proposed measure targets patients with Stage IV cancer and includes more venues of care than the existing measure	5.1 Identified measures: 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle. This measure has been harmonized with ACOVE / ASSIST Measure 1628: Patients with advanced cancer screened for pain at outpatient visits. The two measures have the same focus, populations are different (although both include patients with advanced cancer), apply in different settings with different timing.	5.1 Identified measures: 0420 : Pain Assessment Prior to Initiation of Patient Therapy 0341 : PICU Pain Assessment on Admission 0342 : PICU Periodic Pain Assessment 0523 : Pain Assessment Conducted 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: There are a number of NQF-endorsed measure focusing on the assessment of pain in a variety of unique settings and circumstances. Several of these measures (0523 and 0420) refer to conducting the assessment using a standardized tool. Similarly, our measure suggests that pain should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale. Two of the measures are specific to the pediatric intensive care unit and do not require use of a standardized instrument. 5b.1 If competing, why superior or rationale for additive value: No competing measure.

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care -- Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
	where it would be applied (primary care and all cancer-related outpatient visits). This is in keeping with the reality that pain and pain control becomes a central focus for patients with late-stage cancer, and regular pain assessment should occur in multiple outpatient care settings. The developers propose that measure 0383 be limited to patients with Stage I-III cancer and endorse the proposed measure which targets Stage IV cancer patients. Proposed measure 1634: Hospice and Palliative Care - Pain Screening: Proposed measure 1634 targets patients with serious conditions who are entering hospice or hospital-based palliative care. The measure proposed here targets a sub-population (advanced cancer). However, the setting and timing of 1634 is hospice/palliative care admission and is a one-time screen. 1628 focuses on pain screening at all outpatient visits. Although the 2 measures focus on different venues of care (and 1 is a time measure and the other every visit), they are completely harmonized in content.		
SC Evaluation			