# NQF-Endorsed Measures for Endocrine Conditions: Cycle 2, 2014

DRAFT REPORT FOR COMMENT

August 8, 2014

NATIONAL QUALITY FORUM

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## Contents

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DRAFT REPORT

## Executive Summary

This is the second in a series of three reports describing NQF's 2014-2015 measure evaluation project for Endocrine conditions. This project was selected by NQF to pilot more frequent submission and evaluation of measures than what is possible in our current 3-year measure maintenance process. This 22-month project will include three full endorsement "cycles," allowing for the submission and evaluation of both new and previously-endorsed measures every six months. The background and description of the project, review of NQF's Endocrine portfolio, and the results of the Cycle 1 evaluation are available on NQF's project web page.

In Cycle 2 of this project, the Standing Committee evaluated six measures undergoing maintenance review against NQF's standard measure evaluation criteria. The Committee initially recommended all six measures as suitable for endorsement. The six measures recommended by the Standing Committee include:

- 0037: Osteoporosis Testing in Older Women
- 0045: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older
- 0046: Screening for Osteoporosis for Women 65-85 Years of Age
- 0053: Osteoporosis Management in Women Who Had a Fracture
- 0416: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear
- 0417: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

Measure #0417 is a competing measure with a measure recommended for endorsement in Cycle 1 of the pilot (#0056). Committee members have been asked to give a recommendation about which of the two measures is superior. If they agree that one measure is superior, only that measure will be recommended for continued endorsement. Although the Committee has discussed the issue briefly and provided a preliminary recommendation, members will discuss the issue more fully on an upcoming call after considering comments submitted during the from the public and member comment period. ***NQF requests comments indicating whether one measure is superior to the other or whether endorsement of both measures is justified.***

Brief summaries of the measures currently under review are included in the body of this report; detailed summaries of the Committee's discussion and ratings of the criteria are included in Appendix A.

## Endocrine Measure Evaluation: Cycle 2 Review: June 2013 – August 2014

In Cycle 2 of the Endocrine Measure Evaluation pilot, the Endocrine Standing Committee evaluated six measures undergoing maintenance review against NQF's standard evaluation criteria. Two of the measures were process measures of diabetes foot care that were withdrawn from consideration in Cycle 1 of the pilot but brought back in Cycle 2 with revised specifications. The remaining four measures were process measures related to osteoporosis. The Committee discussed these measures during two conference calls held on July 8 and 11, 2014. The Committee's discussion and ratings of the criteria are summarized in the evaluation tables beginning on page 10.

**Endocrine Cycle 2 Measure Review Summary**

| | Maintenance | New | Total |
|---|---|---|---|
| Measures under consideration | 6 | 0 | 6 |
| Measures withdrawn from consideration | 0 | 0 | 0 |
| Measures recommended | 6 | 0 | 0 |
| Measures recommended with reserve status | 0 | 0 | 0 |
| Measures not recommended | 0 | 0 | 0 |
| Reasons for not recommending | N/A | N/A | N/A |

### Comments Received Prior to Committee Evaluation

The pre-evaluation comment period was open from June 16-30, 2014. No pre-evaluation comments were received for the measures under review in this cycle of the project.

### Overarching Issue

The only overarching issue for the measures evaluated in this cycle of the project was that of related and competing measures. All four of the osteoporosis measures are either competing or related to each other and/or to the two facility-level osteoporosis measures evaluated in Cycle 1 of the pilot. Because the competing measures have different levels of accountability (e.g., clinician vs. health plan or facility), NQF did not ask the Committee to select a superior measure; instead, as with the related measures, Committee members were asked to make recommendations, as appropriate, for harmonization. For the most part, Committee members agreed that differences in specifications were justified. However, they did recommend that measure #0053 (Osteoporosis Management in Women Who Had a Fracture) be re-specified so as to include men as well as women; they also suggested adding linkage to a fracture liaison service to the measure numerator as an alternative management approach as a way to meet the measure.

One of the diabetes foot care measures evaluated in this cycle of the pilot (#0417) is a competing measure to a measure recommended for endorsement in Cycle 1 of the pilot (#0056). Because both measures apply to the clinician office setting and hold the individual clinician or clinician group/ practice accountable, NQF has asked the Committee to identify which of the two they considered the superior

measure. *Preliminary results* from the Committee indicate that a majority of members agree that measure #0056 is superior and therefore measure #0417 should **not** be put forward for continued endorsement; however, a sizeable minority has indicated that neither measure is superior and recommends endorsement of both measures. ***NQF requests comments indicating whether one measure is superior to the other or whether endorsement of both measures is justified.***

## Summary of Measure Evaluation

The following brief summaries of the measures and the evaluation highlight the major issues that were considered by the Committee. Details of the Committee's discussion and ratings of the criteria are included in Appendix A.

### *Osteoporosis—Screening*

#### 0037: Osteoporosis Testing in Older Women

***Description:*** *The number of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis.* ***Measure Type****: Process;* ***Level of Analysis****: Health Plan, Integrated Delivery System;* ***Setting of Care****: Ambulatory Care : Clinician Office/Clinic;* ***Data Source****: Patient Reported Data/Survey*

This measure has been NQF-endorsed since 2009 and is publicly reported by NCQA and Consumer Reports. When reviewing this measure, the Committee agreed osteoporosis is a high priority condition due to the high prevalence of osteoporosis in the United States, the high risk for osteoporotic fracture, as well as the dangers of fracture due to osteoporosis. The Committee agreed that the reliability testing results, which were based on a signal-to-noise analysis of 495 plans participating in HEDIS in 2012, were acceptable. Validity testing, which was done at the measure score level by correlating the results of this measure with the Osteoporosis Management in Women Who Had a Fracture (#0053), explored the hypothesis that plans that perform well with screening also perform well with testing/treatment. Results of this analysis indicate a positive and statistically significant correlation between the two measures, which the Committee agreed demonstrated the validity of the measure. Given the sufficient evidence, reliability and validity of the measure, the Committee recommended the measure as suitable for continued endorsement.

#### 0046: Screening for Osteoporosis for Women 65-85 Years of Age

***Description:*** *Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis.* ***Measure Type****: Process;* ***Level of Analysis****: Clinician : Group/Practice, Clinician : Individual, Clinician : Team;* ***Setting of Care****: Ambulatory Care : Clinician Office/Clinic;* ***Data Source****: Electronic Clinical Data, Paper Medical Records*

This measure has been NQF-endorsed since 2009 and is used by CMS in the Physician Quality Reporting System (PQRS) program. The measure is specified for the clinician level. When reviewing the measure, the Committee expressed concerns that there was no time limitation on the measure (that is, any bone mineral density test done over the course of a women's lifetime would meet the requirements of the measure) but concurred with the developer that there is no clear evidence nor guidelines on how frequently screening should occur and that, by setting a timeframe, there is a potential for overuse of testing. The specifications of the measure have been changed since it was last endorsed; it now requires

both the date when the test was conducted and the results of the test. The developer noted that testing using the new specifications has not been conducted and that further testing of the measure is not planned; instead, they are developing an eMeasure that will eventually replace this measure. Committee members noted that reliability and validity testing results likely would be lower with this change in specifications, as data may be hard or impossible to find. The Committee found the developer's assumption that if reviewers can accurately identify whether or not a DXA was ordered, they would be able to accurately identify whether or not a DXA was performed, to be acceptable enough to recommend the measure as suitable for continued endorsement.

### *Osteoporosis—Post-fracture treatment*

#### 0045: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older

***Description:*** *Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that th* ***Measure Type****: Process;* ***Level of Analysis****: Clinician : Group/Practice, Clinician : Individual, Clinician : Team;* ***Setting of Care****: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Ambulatory Care : Urgent Care;* ***Data Source****: Electronic Clinical Data, Paper Medical Records*

This measure has been NQF-endorsed since 2007 and is used by CMS for payment through the PQRS program. When reviewing this measure, the Committee agreed that evidence indicates that communication leads to increased rates of osteoporosis testing and treatment. The Committee agreed that the reliability testing results, which were based on comparing the findings of two abstractors who reviewed the full medical record, were acceptable. Committee members also agreed that the AMA-PCPI development and review process was an acceptable indicator of face validity. Given the sufficient evidence, reliability and validity of the measure, the Committee recommended the measure as suitable for continued endorsement.

#### 0053: Osteoporosis Management in Women Who Had a Fracture (NCQA): Recommended

***Description*** *The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.* ***Measure Type****: Process;* ***Level of Analysis****: Clinician: Group/Practice, Clinician: Individual, Clinician: Team;* ***Setting of Care****: Ambulatory Care Clinician Office/Clinic;* ***Data Source****: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Imaging/Diagnostic Study, Electronic Clinical Data: Pharmacy, Paper Medical Records*

This measure has been NQF-endorsed since 2009 and is used by CMS for public reporting and payment incentives, by NCQA for public reporting and health plan accreditation, and by Consumer Reports for public reporting. The measure is specified for both the health plan and clinician levels of analysis. When reviewing the measure, Committee members agreed that the evidence presented supports the utility of bone density testing to predict fracture risk and pharmacologic treatment to reduce fracture risk. The Committee agreed that the reliability and validity of the measure is acceptable. The Committee recommended the measure for continued endorsement, while noting the large difference in

performance rates in health plans versus clinicians, possibly due to the voluntary nature of the PQRS program.

### *Diabetes—Foot care*

#### 0416: Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear (APMA): Recommended

***Description*** *Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing* ***Measure Type****: Process;* ***Level of Analysis****: Clinician: Individual;* ***Setting of Care****: Ambulatory Care: Clinician Office/Clinic;* ***Data Source****: Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records*

This measure has been NQF-endorsed since 2008 and is used by CMS for payment through the PQRS program; it also is included in the US Wound Registry and in the American Board of Podiatric Surgeon's maintenance of certification program. It has been specified as an eMeasure. When reviewing the measure, Committee members acknowledged that the evidence supporting this measure is indirect, indicating only that many people with diabetes wear poorly fitting shoes, that diabetics with foot ulcers are more likely to have poorly fitting shoes, and that poorly-fitting (tight) shoes contribute to foot ulcers. However, members agreed that promoting proper shoe fit likely would decrease rates of foot ulceration and amputation. Several Committee members agreed that, per the evidence algorithm, invoking the exception to the evidence subcriterion is appropriate. Some members expressed concern about the validity of the measure, given the small sample size used in testing (particularly given that only podiatric practices were included in the testing). However, Committee members agreed that the testing results demonstrated adequate reliability and validity and ultimately recommended the measure as suitable for continued endorsement.

#### 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation

***Description:*** *Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months* ***Measure Type****: Process;* ***Level of Analysis****: Clinician: Individual;* ***Setting of Care****: Ambulatory Care : Clinician Office/Clinic;* ***Data Source****: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records*

This measure has been NQF-endorsed since 2008 and is used by CMS for payment through the PQRS program; it also is included in the US Wound Registry and in the American Board of Podiatric Surgeon's maintenance of certification program. It has been specified as an eMeasure. When reviewing the measure, the Committee agreed that that the poor foot outcomes that are targeted by this measure (ulcers, amputations) are high-priority conditions. Committee members noted that the evidence presented is supportive of the measure, citing the 2013 American Diabetes Association Grade B recommendation for conducting an annual comprehensive foot exam for diabetic patients. Some Committee members agreed that the testing results demonstrated adequate reliability and validity, while others expressed concern about the validity of the measure, given the small sample size used in testing (particularly given that only podiatric practices were included in the testing). Nonetheless, Committee members agreed that the testing results demonstrated adequate reliability and validity and ultimately recommended the measure as suitable for continued endorsement. Committee members also briefly discussed the merits of this measure in comparison to the competing foot care measure stewarded by NCQA (#0056). In a preliminary round of voting, a majority of Committee members

agreed that the NCQA measure is superior and recommended that this measure (#0417) **not** be put forward for endorsement; however, a sizeable minority thought that neither measure is superior and recommended that both endorsed. ***Comments on this issue are requested***.

# Appendix A: Details of Measure Evaluation



## Measures Recommended



## Measures Recommended

**Rating Scale**: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

| **0037 Osteoporosis Testing in Older Women** |
|---|
| Submission \| Specifications |
| **Description**: The number of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis.<br>**Numerator Statement**: The number of women who report having ever received a bone mineral density test of the hip or spine.<br>**Denominator Statement**: Women age 65-85.<br>**Exclusions**: N/A<br>**Adjustment/Stratification**:<br>**Level of Analysis:** Health Plan, Integrated Delivery System<br>**Setting of Care:** Ambulatory Care : Clinician Office/Clinic<br>**Type of Measure**: Process<br>**Data Source**: Patient Reported Data/Survey<br>**Measure Steward**: National Committee for Quality Assurance |
| **STANDING COMMITTEE MEETING [07/06/2014]**<br>**1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>**<br>(1a. Evidence, 1b. Performance Gap, 1c. High Impact)<br>1a. Evidence: **H-11**; **M-5**; **L-2**; **I-0; IE-0**; 1b. Performance Gap: **H-10**; **M-8**; **L-0**; **I-0;** 1c. Impact: **H-12**; **M-4**; **L-2**; **I-0**<br><u>Rationale</u>:<br>• Evidence presented by the developer included a 2011 United States Preventive Services Task Force (USPSTF) recommendation (Grade B, signifying moderate certainty the net benefit of screening for osteoporosis by using DXA is at least moderate). Committee members agreed that the evidence clearly supports the linkage between bone density testing and subsequent treatment, which leads to prevention of fractures.<br>• HEDIS data provided by the developer indicate that the average performance rate for the 495 |

participating plans in 2012 is 73.1%. Committee members noted the variation in performance across plans, as well as the information provided by the developer from the literature indicating disparities in offering osteoporosis screening or treatment to racial and ethnic minority women.

- Developers noted the high prevalence of osteoporosis in the US, the high risk for osteoporotic fracture, as well as the dangers of fracture due to osteoporosis. Members agreed osteoporosis is a high priority condition.

**2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>**
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **H-3**; **M-12**; **L-3**; **I-0** 2b. Validity: **H-4**; **M-13**; **L-1**; **I-0**
<u>Rationale</u>:

- Data for this measure are obtained through the Health Outcome Survey. Changes to the measure since initial endorsement include adding an upper age limit of 85 years and specifying location of testing as hip or spine in the survey item.
- Reliability testing was done using a signal-to-noise analysis of 495 plans participating in HEDIS in 2012. The reliability across all health plans ranged from .920 to .99, with an average of .995. Committee members expressed no concerns about the results of the reliability testing.
- Validity testing was done at the measure score level by correlating the results of this measure with the Osteoporosis Management in Women Who Had a Fracture (#0053) to explore the hypothesis that plans that perform well with screening also perform well with testing/treatment; results indicate a positive and statistically significant correlation between the two measures. Developers also described the HEDIS development and review process as an indicator of face validity and noted additional face validity assessment by various workgroups that helped to develop the measure. Committee members voiced no concerns about the validity testing results.
- Committee members noted the possibility of recall bias and a concern that patients may not understand what is being asked in the survey. Another member noted the cognitive testing done for the survey item to ensure that the question could be understood. The developer clarified that the term "DXA" is not used in the survey; instead, the question is "have you ever had a bone density test to check for osteoporosis--sometimes thought of as brittle bones; this test would have been done to your back or hip".
- Committee members also expressed concern that patients with cognitive impairment might answer the survey. Developers noted that proxy response is allowed and that likely the question would be answered by the proxy. One member noted that proxy response isn't always accurate.
- Developers also provided an analysis of missing data that assessed the differences between responders, late responders, and non-responders. These analyses indicated a <5% missing response to the osteoporosis item in the survey. There were some differences between the responder groups, but these were not considered large or strong by the developer, based on additional analysis. Committee members did not express concern about non-response.

**3. Feasibility: H-5; M-12; L-1; I-0**
*(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)*
<u>Rationale</u>:

- Committee members noted that the survey used to obtain the data has been in use for a while and that it can be conducted via phone or mail.

**4. Use and Usability: H-5; M-12; L-1; I-0**

**0037 Osteoporosis Testing in Older Women**

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

Rationale:

- Committee members noted that the measure is used in public reporting applications, including Consumer Reports and on the NCQA website.
- HEDIS data submitted by the developer indicate an increase in health performance from 71.0% in 2010 to 73.1% in 2012.
- Committee members did not voice any concerns about potential unintended consequences.

**5. Related and Competing Measures**

- According to NQF definitions, the following six measures are considered competing and/or related:
  - 0037: Osteoporosis Testing in Older Women (NCQA)
  - 0046: Screening for Osteoporosis for Women 65-85 Years of Age (NCQA)
  - 0053: Osteoporosis Management in Women Who Had a Fracture (NCQA)
  - 2417: Risk Assessment/Treatment After Fracture (TJC)
  - 0045: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older (NCQA)
  - 2416: Laboratory Investigation for Secondary Causes of Fracture (TJC)
- Measures #0037 (accountability=health plan) and #0046 (accountability=clinician) each measure assess osteoporosis screening in older women and are thus considered competing. However, the level of analysis is different for the two measures (health plan vs clinician, respectively); therefore, having two competing measures is considered justified per NQF's harmonization protocol. Furthermore, measure #0037 relies on data obtained from the Health Outcomes Survey, while #0047 used data from medical records and claims. The developer noted that health plans may not have access to claims or medical records and thus obtaining data via survey is a reasonable alternative; conversely, clinicians do have access to claims and medical charts, but may not have the resources to conduct a survey. The developer acknowledged that the results from the two sources may be different if, for example, the provider's records are incomplete or there is recall bias in the survey. Committee members discussed potential recommendations for changing the specifications of either measure so as to make them more similar to each other or to the other osteoporosis measures.

  **Committee response**: Committee members noted that screening is for primary prevention of osteoporosis and testing/treatment is for secondary prevention of future fractures and that the differences in age groups specified for these measures are justified. Committee members agreed that screening is appropriate for women but the evidence for screening men is not strong.

**Standing Committee Recommendation for Endorsement**: **Y-15**; **N-3**

**6. Public and Member Comment**

-

**7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X**

**8. Board of Directors Vote: Y-X; N-X**

**9. Appeals**

**0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older**

Submission | Specifications

**Description**: Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.

**Numerator Statement**: Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment.

Communication may include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, through shared electronic health record, a bone mineral density test report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

**Denominator Statement**: Adults aged 50 years and older who experienced a fracture, except fractures of the finger, toe, face or skull.

**Exclusions**: None

**Adjustment/Stratification**:

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

**Setting of Care:** Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Ambulatory Care : Urgent Care

**Type of Measure**: Process

**Data Source**: Electronic Clinical Data, Paper Medical Records

**Measure Steward**: National Committee for Quality Assurance

**STANDING COMMITTEE MEETING [07/08/2014]**

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

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

1a. Evidence: **H-8**; **M-6**; **L-3**; **I-1; IE-0**; 1b. Performance Gap: **H-7**; **M-10**; **L-0**; **I-1;** 1c. Impact: **H-13**; **M-3**; **L-2**; **I-0**

Rationale:

- Evidence presented by the developer included a systematic review and meta-analysis of four models of care for secondary prevention of osteoporotic fracture. The focus of this measure most closely corresponds to the "Type C" intervention included in the review, which includes both educational and communication components. The review included nine studies from 1996-2011 that are pertinent to this measure. Results of the review indicate that communication leads to increased rates of testing and treatment. Committee members reviewed this evidence and agreed that it linked patient education and communication with additional testing and/or treatment of osteoporosis, given the clinically relevant and statistically significant differences between the intervention and control groups for the studies included in the review.
- Committee members also noted that evidence for communication is weaker than evidence for a fracture liaison service. The developer explained that this measure, along with measure #0053—which focuses on management following a fracture, including treatment or screening—includes the elements of a fracture liaison service (communication and management). Members questioned why the developer did not combine these two measures, given that users are not required to report both together, and that doing either without the other would be less effective than doing both. The developer explained that the level of accountability for communication (measure #0045) is the clinician

in the inpatient setting, while the level of accountability for the management (measure #0053) is the outpatient provider. The developer noted that the outpatient provider should be held accountable for management after fracture, but not held accountable for the inpatient provider communicating to them, hence their decision to develop two measures.

- PQRS data provided by the developer indicate that the average performance rate for the 0.4% of eligible professionals reporting the measure was 62.7%. Committee members noted the large variation in performance between the 25th and 75th percentile, and also noted that information provided by the developer from the literature suggest disparities in offering osteoporosis screening or treatment to racial and ethnic minority women.
- Developers noted the high prevalence of osteoporosis in the US and the high rate of under-diagnosis, as well as the dangers of fracture due to osteoporosis. Committee members agreed osteoporosis is a high priority condition.

**2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>**
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **H-6**; **M-10**; **L-2**; **I-0** 2b. Validity: **H-2**; **M-13**; **L-3**; **I-0**
<u>Rationale</u>:

- The reliability testing data presented by the developer was based on comparing the findings of two abstractors who reviewed the full medical record (paper or EHR) for 39 patients from each of the two practice sites examined (note that power calculations indicated a need for 38 patients per site). Percentage agreement statistics for the numerator and denominator were computed, as were kappa statistics when possible (to account for chance agreement). The testing results demonstrated 100% agreement between the abstractors for the denominator, and a 94.4% agreement for the numerator (kappa=.77), generally considered substantial agreement beyond what would be expected by chance alone). Developers also presented an overall agreement rate of 87% (kappa=.68, 95% CI=.43, .94), which also indicates moderate to substantial agreement above what would be expected by chance alone. Committee members expressed no concerns about the results of the reliability testing.
- Developers described the AMA-PCPI development and review process as an indicator of face validity; they also noted that various workgroups involved in the development of the measure agreed that the measure demonstrates quality of care. Committee members noted that adequate demonstration of face validity should result in a moderate rating for validity according to the NQF algorithm for rating validity.
- Committee members questioned how the numerator would be captured using ICD-9 codes for coordination of care and communication. The developer clarified that the measure numerator is captured through medical record review and the denominator is identified through claims that are used to identify patients who had a fracture.

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

- There was initial confusion among Committee members as to whether this measure is an eMeasure. The developer clarified that this is not an eMeasure and noted under the validity assumption that medical record review is required for the numerator.

**4. Use and Usability: H-5; M-11; L-2; I-0**

**0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older**

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

Rationale:

- Committee members noted that the measure is used in the PQRS system, although they acknowledged the very small percentage of providers who report on the measure.
- PQRS data submitted by the developer indicate an increase in performance from 49% in 2009 to 62.7% in 2012.
- Committee members did not voice any concerns about potential unintended consequences.

**5. Related and Competing Measures**

- According to NQF definitions, the following six measures are considered competing and/or related:
  - 0037: Osteoporosis Testing in Older Women (NCQA)
  - 0046: Screening for Osteoporosis for Women 65-85 Years of Age (NCQA)
  - 0053: Osteoporosis Management in Women Who Had a Fracture (NCQA)
  - 2417: Risk Assessment/Treatment After Fracture (TJC)
  - 0045: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older (NCQA)
  - 2416: Laboratory Investigation for Secondary Causes of Fracture (TJC)
- Regarding measures #0045, #0037, and #0046 (difference in age groups specified)

  **Committee response**: Committee members noted that screening is for primary prevention of osteoporosis and testing/treatment is for secondary prevention of future fractures and that the differences in age groups specified for these measures are justified.
- Regarding measures #0045 and #0053(differences in age/gender/and timing specifications):

  **Committee response**: Committee members noted the need for testing/treatment post-fracture for both men and women and questioned why both men and women are included in the communication measure but not in the testing/treatment measure.

  **Developer response**: The developer for measure #0053 (NCQA) explained that they previously maintained a post-fracture measure for both men and women, but that because the guidelines for testing and treatment are different for men compared to women (e.g., different medications; emphasis on treatment for any fragility fracture for women but only on spine/hip fracture for men), they decided to develop separate measures. The developer also explained that they did not have concerns about unintended consequences to men due to communication about a fracture, but were concerned about potential overuse of testing or treatment for men because fractures in men, particularly those aged 50-65, may not be indicative of osteoporosis. They also explained that the timeframe for the two measures (3 months for #0045 and 6 months for #0053) was to encourage earlier communication and to allow sufficient time for testing/treatment.

  **Committee response**: While some Committee members thought that separate management measures for men and women are appropriate, some noted that the TJC measure is specified to distinguish guideline/ treatment differences between men and women without having to split into two measures. Committee members noted that several medications can be used by both men and women and that there are ongoing trials in men for the two that currently are approved for women only.

  **Developer response**: NCQA agreed to take back to their clinical expert panel a recommendation to

| 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
|---|
| include men in measure #0053, potentially specifying different denominator criteria for selecting men with spine/hip fracture and women with any fracture. They cautioned, however, that #0053 is in use in PQRS, which may not allow this type of change in specification; they noted that if the change would result in not being able to use the measure in PQRS, they would not make the change. |
| **Standing Committee Recommendation for Endorsement**: **Y-16**; **N-2** |
| **6. Public and Member Comment**<br>• |
| **7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X** |
| **8. Board of Directors Vote: Y-X; N-X** |
| **9. Appeals** |

| 0046 Screening for Osteoporosis for Women 65-85 Years of Age |
|---|
| Submission \| Specifications |
| **Description**: Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis.<br>**Numerator Statement**: The number of women who have documentation in their medical record of having received a DXA test of the hip or spine.<br>**Denominator Statement**: Women age 65-85.<br>**Exclusions**: Diagnosis of osteoporosis at the time of the encounter.<br>**Adjustment/Stratification**:<br>**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team<br>**Setting of Care:** Ambulatory Care : Clinician Office/Clinic<br>**Type of Measure**: Process<br>**Data Source**: Electronic Clinical Data, Paper Medical Records<br>**Measure Steward**: National Committee for Quality Assurance |
| **STANDING COMMITTEE MEETING [07/08/2014]**<br>**1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>**<br>(1a. Evidence, 1b. Performance Gap, 1c. High Impact)<br>1a. Evidence: **H-10**; **M-7**; **L-1**; **I-0; IE-0**; 1b. Performance Gap: **H-13**; **M-5**; **L-0**; **I-0;** 1c. Impact: **H-14**; **M-4**; **L-0**; **I-0**<br><u>Rationale</u>:<br>• Evidence presented by the developer to support the measure is a 2011 Grade B recommendation from the US Preventive Services Task Force (signifying moderate certainty of the net benefit of screening for osteoporosis by using DXA is at least moderate). Overall, the committee agreed that there is strong evidence that screening bone density leads to treatment and treatment leads to prevention of fractures.<br>• The Committee expressed concerns that there was no time limitation on the measure, meaning that any bone mineral density test done over the course of a women's lifetime would meet the requirements of the measure. The developer noted that there is no clear evidence nor guidelines on how frequently screening should occur and that, in an effort to reduce the potential unintended consequence of overuse of testing (e.g., another screening at age 65 when one had been done previously), any test done over the course of a woman's lifetime is allowed, with no particular length of |

time between screenings required. One Committee member also noted that there is little evidence regarding the effectiveness of repeated screening.

- One member raised the concern that additional appropriate testing may not be covered by insurance; however, the developer noted that CMS covers the test on a bi-annual basis.
- PQRS data provided by the developer indicate that the average performance rate for the 6.1% of eligible professionals reporting the measure in 2012 was 58.7%. Committee members noted the large variation in performance between the 25th and 75th percentile, but also noted the decline in performance since 2011. Also data provided by the developer from the literature suggest disparities in offering osteoporosis screening or treatment to racial and ethnic minority women.
- Developers noted the high prevalence of osteoporosis in the US, the high risk for osteoporotic fracture, as well as the dangers of fracture due to osteoporosis. Members agreed osteoporosis is a high priority condition.

**2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>**
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **H-3**; **M-12**; **L-3**; **I-0** 2b. Validity: **H-6**; **M-11**; **L-1**; **I-0**
<u>Rationale</u>:

- The developer clarified that the term "fracture" is used as opposed to "fragility fracture" because the data collected in claims using ICD-9 coding does not differentiate between the two; thus, the fractures identified are those likely to be fragility fractures.
- Committee members voiced concern over the difficulty in obtaining medical records for patients who had the study performed in the more distant past, particularly when under the care of another provider. The developers noted that the measure specifications had changed from what was previously endorsed and now requires the date when the test was conducted and the results of the test. The developer also indicated that their clinical experts reasoned that if a patient has been treated for a year (the time frame of this measure), and the results of the previous test are still unknown, the physician cannot appropriately determine whether or not the patient should be treated for osteoporosis and should probably reorder the test.
- The developer noted that testing using the new specifications has not been conducted and that further testing of the measure is not planned; instead, they are developing an eMeasure that will eventually replace this measure. Committee members noted that reliability and validity testing results likely would be lower with this change in specifications, as data may be hard or impossible to find (a potential threat to the validity of the measure). The developer noted that they are making the assumption that if reviewers can accurately identify whether or not a DXA was ordered, they would be able to accurately identify whether or not a DXA was performed.
- The reliability testing data presented by the developer for the original specifications (DXA ordered, not performed) was based on comparing the findings of two abstractors who reviewed the full medical record (paper or EHR) for 30 patients from each of the two practice sites examined (note that power calculations indicated a need for 28 patients per site). Percentage agreement statistics for the numerator, denominator, and exceptions were computed, as were kappa statistics, when possible, to account for chance agreement. The testing results demonstrated 100% agreement between the abstractors for the denominator and exceptions, and a 90% agreement for the numerator (kappa=.77, generally considered substantial agreement beyond what would be expected by chance alone). Developers also presented an overall agreement rate of 90% (kappa=.77, 95% CI=.53, 1.00), which also indicates moderate to

substantial agreement above what would be expected by chance alone. Committee members questioned the small sample size but accepted the developer's explanation regarding the power calculation.

- The developer also acknowledged other changes to the specifications, including addition of an upper age limit of 85 years, removal of a lower age limit, exclusion of patients with a diagnosis of osteoporosis, and removal of medication therapy as a way to meet the measure.
- Developers described the AMA-PCPI development and review process as an indicator of face validity; they also noted that various workgroups involved in the development of the measure agreed that the measure demonstrates quality of care.

**3. Feasibility: H-3; M-12; L-3; I-0**

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

Rationale:

- Some Committee members questioned the feasibility of obtaining test results in a non-electronic environment (i.e., if the patient was under the care of another physician when the test was done). Members noted that those who report on the measure in PQRS likely have systems that will allow this data capture and that physicians without electronic capabilities may choose to not report on the measure in PQRS.

**3. Use and Usability: H-4; M-11; L-3; I-0**

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

Rationale:

- The measure is currently used in the PQRS program.
- Committee members were concerned that only 6% of providers were reporting on this measure. However, the developer pointed out that, of the NCQA measures in PQRS that are focused on the geriatric population, this measure is one of the more widely reported measures; thus, while a 6% reporting rate may seem low, it is relatively high for PQRS.
- PQRS data submitted by the developer indicate an increase in performance from 56.1% in 2009 to 58.7% in 2012.
- Committee members expressed concern that overuse of the bone mineral density testing may be an unintended consequence of the measure.

**5. Related and Competing Measures**

- According to NQF definitions, the following six measures are considered competing and/or related:
  - 0037: Osteoporosis Testing in Older Women (NCQA)
  - 0046: Screening for Osteoporosis for Women 65-85 Years of Age (NCQA)
  - 0053: Osteoporosis Management in Women Who Had a Fracture (NCQA)
  - 2417: Risk Assessment/Treatment After Fracture (TJC)
  - 0045: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older (NCQA)
  - 2416: Laboratory Investigation for Secondary Causes of Fracture (TJC)
- Measures #0037 (accountability=health plan) and #0046 accountability=clinician) each measure osteoporosis screening in older women and are thus considered competing. However, the level of analysis is different for the two measures (health plan vs clinician, respectively), and thus having two competing measures is considered justified. Furthermore, measure #0037 relies on data obtained from

| 0046 Screening for Osteoporosis for Women 65-85 Years of Age |
|---|
| the Health Outcomes Survey, while #0047 used data from medical records and claims. The developer noted that health plans may not have access to claims or medical records and thus obtaining data via survey is a reasonable alternative; conversely, clinicians do have access to claims and medical charts, but may not have the resources to conduct a survey. The developer acknowledged that the results from the two sources may be different if, for example, the provider's records are incomplete or there is recall bias in the survey. Committee members discussed potential recommendations for changing the specifications of either measure so as to make them more similar to each other or to the other osteoporosis measures.<br><br>**Committee response**: Committee members noted that screening is for primary prevention of osteoporosis and testing/treatment is for secondary prevention of future fractures and that the differences in age groups specified for these measures are justified. Committee members agreed that screening is appropriate for women but the evidence for screening men is not strong. |
| **Standing Committee Recommendation for Endorsement**: **Y-15**; **N-3** |
| **6. Public and Member Comment** |
| **7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X** |
| **8. Board of Directors Vote: Y-X; N-X** |
| **9. Appeals** |

| 0053 Osteoporosis Management in Women Who Had a Fracture |
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| Submission \| Specifications |
| **Description**: The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.<br>**Numerator Statement**: Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis after a fracture occurs<br>**Denominator Statement**: Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure:<br>Women age 50-64<br>Women age 65-85<br>Women age 50-85<br>**Exclusions**: 1) Exclude women who had a fracture in the 60 days prior to the index fracture<br>2) Exclude women who had a bone mineral density test in the 2 years prior to the index fracture<br>3) Exclude women who had received osteoporosis therapy or medication in the 12 months prior to the index fracture<br>**Adjustment/Stratification**:<br>**Level of Analysis:** Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Clinician : Team<br>**Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Imaging Facility, Pharmacy, Ambulatory Care : Urgent Care<br>**Type of Measure**: Process<br>**Data Source**: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Imaging/Diagnostic Study, Paper Medical Records, Electronic Clinical Data : Pharmacy<br>**Measure Steward**: National Committee for Quality Assurance |
| **STANDING COMMITTEE MEETING [07/08/2014]** |

**0053 Osteoporosis Management in Women Who Had a Fracture**

**1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>**

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

1a. Evidence: **H-10**; **M-7**; **L-1**; **I-0; IE-0**; 1b. Performance Gap: **H-9**; **M-8**; **L-0**; **I-0;** 1c. Impact: **H-14**; **M-3**; **L-1**; **I-0**

<u>Rationale</u>:

- Evidence presented by the developer for screening included an American Association of Clinical Endocrinologists (AACE) recommendation (Grade C, evidence based on clinical experience, descriptive studies, or clinical expert opinion) and a USPSTF recommendation (Grade B); and evidence for pharmacologic therapy included an AACE recommendation (Grade A, evidence based on well-designed RCTs or controlled cohort trails). The developer also summarized the quality, quantity, and consistency of evidence from three recent systematic reviews. Committee members agreed the evidence supports the utility of bone density testing to predict fracture risk and pharmacologic treatment to reduce fracture risk.
- HEDIS data provided by the developer for the health plan level of analysis indicate that the average performance rate for the 347 participating plans in 2013 was 23.1%. PQRS data provided by the developer for the clinician level of analysis indicate that the average performance rate in 2012 for the 0.8% of eligible professionals reporting the measure was 70.0%. Information provided by the developer from the literature suggests disparities in offering osteoporosis screening or treatment to racial and ethnic minority women. Committee members noted the large difference in performance rates in health plans vs. clinicians, possibly due to the voluntary nature of the PQRS program.
- Developers noted the high prevalence of osteoporosis in the US and the high rate of under-diagnosis, as well as the dangers of fracture due to osteoporosis. Members agreed osteoporosis is a high priority condition.

**2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>**

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

2a. Reliability: **H-11**; **M-7**; **L-0**; **I-0** 2b. Validity: **H-9**; **M-9**; **L-0**; **I-0**

<u>Rationale</u>:

- Reliability testing was done for the health plan level of analysis using a signal-to-noise analysis of 347 plans participating in HEDIS. The reliability across all health plans ranged from .81 (the 10$^{th}$ percentile) to .99 (the 90$^{th}$ percentile), with an average of .92. Developers state that the majority of plans met or exceeded the generally recognized minimal threshold of .7, signifying very good reliability.
- Validity testing was done for the health plan level of analysis by correlating the results of this measure with the Osteoporosis Testing in Older Women measure (#0037) to explore the hypothesis that plans that perform well with screening also perform well with testing/treatment; results indicate a positive and statistically significant correlation between the two measures. Data element validity testing also was conducted using data from 100 randomly selected patients from five health plans; data from claims were compared (using percentage agreement) to those from the medical record for the numerator and denominator, and results indicate good agreement. (NOTE: these testing results can serve as testing for the clinician level of analysis and be used as data element reliability testing results). Developers also described the HEDIS development and review process as an indicator of face validity for the health plan level of analysis and noted additional face validity assessment by various workgroups that helped to develop the measure. Committee members voiced no concerns about the reliability and validity of the measure.
- Committee members asked why women with a fracture within 60 days prior are excluded from the measure. The developer agreed that such patients likely were included in the measure anyway, but that

the exclusion is intended to help identify new fractures rather than follow-up visits for earlier fractures.

- Committee members also asked how new pharmaceutical agents are handled in the measure. The developer noted that they update the medical list on an annual basis.

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

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

Rationale:

- Committee members agreed that the measure is feasible, as it is used in several accountability programs.

**3. Use and Usability: H-9**; **M-9**; **L-0**; **I-0**

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

Rationale:

- Committee members noted that the health plan measure is used in several accountability applications, including health plan accreditation, Quality Compass, and the Medicare Advantage Star Rating program. The clinician-level measure is used in PQRS.
- HEDIS data submitted by the developer indicate an increase in health performance from 20.1% in 2011 to 23.1% in 2013. PQRS data submitted by the developer indicate an increase in clinician performance from 56.5% in 2009 to 70.0% in 2012.
- Committee members did not voice any concerns about potential unintended consequences.

**5. Related and Competing Measures**

- According to NQF definitions, the following six measures are considered competing and/or related:
  - 0037: Osteoporosis Testing in Older Women (NCQA)
  - 0046: Screening for Osteoporosis for Women 65-85 Years of Age (NCQA)
  - 0053: Osteoporosis Management in Women Who Had a Fracture (NCQA)
  - 2417: Risk Assessment/Treatment After Fracture (TJC)
  - 0045: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older (NCQA)
  - 2416: Laboratory Investigation for Secondary Causes of Fracture (TJC)
- Regarding measures #0045 and #0053 (differences in age/gender/and timing specifications):

  **Committee response**: Committee members noted the need for testing/treatment post-fracture for both men and women and asked why both men and women are included in the communication measure but not in the testing/treatment measure.

  **Developer response**: The developer for measure #0053 (NCQA) explained that they previously maintained a post-fracture measure for both men and women, but that because the guidelines for testing and treatment are different for men compared to women (e.g., different medications; emphasis on treatment for any fragility fracture for women but only on spine/hip fracture for men), they decided to develop separate measures for men and women. The developer also explained that they did not have concerns about unintended consequences to men due to communication about a fracture, but were concerned about potential overuse of testing or treatment for men because fractures in men, particularly those aged 50-65, may not be indicative of osteoporosis. They also explained that the timeframe for the two measures (3 months for #0045 and 6 months for #0053) was to encourage earlier communication but allow sufficient time for testing/treatment.

| 0053 Osteoporosis Management in Women Who Had a Fracture |
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| **Committee response**: While some Committee members thought that separate management measures for men and women are appropriate, some noted that the TJC measure is specified so as to distinguish guideline/ treatment differences between men and women without having to split into two measures. Committee members noted that several medications can be used by both men and women and that there are ongoing trials in men for the two that currently are approved for women only.<br><br>**Developer response**: NCQA agreed to take back to their clinical expert panel a recommendation to include men in measure #0053, potentially specifying different denominator criteria so as to select men with spine/hip fracture and women with any fracture. They cautioned, however, that #0053 is in use in PQRS, which may not allow this type of change in specification; they noted that if the change would result in not being able to use the measure in PQRS, they would not make the change.<br><br>• Regarding measures #0053 and #2417: Both measure testing and treatment in adults with a (presumed) fragility fracture and are thus are considered competing measures. However, the level of analysis is different for the two measures (clinician vs. facility, respectively), and thus having two competing measures is considered justified. However, measure #2417 has a more expansive set of options for the numerator.<br><br>**Committee response**: Committee members emphasized the strong evidence supporting fracture liaison service and asked NCQA if they had considered adding a link to a fracture liaison service to #0053.<br><br>**Developer response**: NQCA explained that the communication/coordination component of a fracture liaison service is covered by measure #0045. They also noted that their testing/treatment measure (#0053) measures delivery rather than referral. They will take back the suggestion to include this in their measure if their analyses indicate that referral to a fracture liaison service consistently translates to actual delivery of services. |
| **Standing Committee Recommendation for Endorsement**: **Y-17**; **N-1** |
| **6. Public and Member Comment**<br>• |
| **7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X** |
| **8. Board of Directors Vote: Y-X; N-X** |
| **9. Appeals** |

| 0416 Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear |
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| Submission \| Specifications |
| **Description**: Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing<br>**Numerator Statement**: Patients who were evaluated for proper footwear and sizing at least once within 12 months<br>Definition:<br>Evaluation for Proper Footwear – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device, and counseling on appropriate footwear should be based on risk categorization.<br>Numerator Quality-Data Coding Options for Reporting Satisfactorily:<br>Footwear Evaluation Performed |

**0416 Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear**

G8410: Footwear evaluation performed and documented
OR
Footwear Evaluation not Performed for Documented Reasons
G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure
OR
Footwear Evaluation not Performed
G8415: Footwear evaluation was not performed
**Denominator Statement**: All patients aged 18 years and older with a diagnosis of diabetes mellitus
**Exclusions**: Footwear evaluation not performed for documented reasons. For example bilateral amputee.
**Adjustment/Stratification**:
**Level of Analysis:** Clinician : Individual
**Setting of Care:** Ambulatory Care : Clinician Office/Clinic
**Type of Measure**: Process
**Data Source**: Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records
**Measure Steward**: American Podiatric Medical Association

**STANDING COMMITTEE MEETING [07/11/2014]**

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

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)
1a. Evidence: **H-0**; **M-2**; **L-1**; **I-3; IE-10**; 1b. Performance Gap: **H-10**; **M-5**; **L-1**; **I-0;** 1c. Impact: **H-10**; **M-4**; **L-1**; **I-1**
Rationale:

- Evidence provided by the developer included the 2008 American Diabetes Association expert-opinion recommendation that an assessment of footwear be included as part of a comprehensive foot exam for adult patients with diabetes and two articles that examined the prevalence of poorly-fitting shoes. Committee members acknowledged that the evidence supporting this measure is indirect, indicating only that many people with diabetes wear poorly fitting shoes, that diabetics with foot ulcers are more likely to have poorly fitting shoes, and that poorly-fitting (tight) shoes contribute to foot ulcers. However, members agreed that promoting proper shoe fit likely would decrease rates of foot ulceration and amputation. Several members agreed that, per the evidence algorithm, an exception to the evidence subcriterion would be appropriate.
- PQRS data provided by the developer indicate that the average performance rate (for the 1% of eligible professionals reporting the measure) was 69.2%. Committee members also noted that given the relatively low rate of diabetic foot exams overall, assessment of footwear would also be relatively infrequent.
- Developers noted that diabetes affects 26 million people in the US, that 60-70% of diabetics will develop peripheral neuropathy, that as many as 25% of diabetics will develop a foot ulcer, that more than half of these will become infected, and that 20% of infected ulcers will result in amputation. Accordingly, members agreed that the area of measure focus is high priority.

**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-0**; **M-9**; **L-6**; **I-0** 2b. Validity: **H-1**; **M-10**; **L-4**; **I-1**
Rationale:

- Committee members in general agreed that the measure was well-specified and included appropriate codes for documenting performance of the measure. Members did raise the concern that the specific

"standard measuring device" for measuring the foot was not identified, which may lead to inconsistencies in performance of the measure, particularly between podiatrists and non-podiatrists. Some Committee members noted that it may be possible for a medical assistant or nurse to perform this evaluation using a standard footwear assessment device.

- The testing data presented by the developer was based on comparing claims data submitted to the PQRS to the medical record. Data for 286 patients, from 3 practice sites, were examined. Percentage agreement statistics for the numerator, denominator, and exclusions were computed, as were kappa statistics when possible (to account for chance agreement). The testing results demonstrated 100% agreement between the clinical record and the codes captured in PQRS for the denominator and the exceptions, and a 93% agreement for the numerator (kappa=.256, generally considered fair agreement). Because this testing included a comparison against the gold standard (the medical chart), the results can be used to assess both data element reliability and data element validity. Committee members agreed that the testing results demonstrated adequate reliability and validity. However, some members expressed concern about the validity of the measure, given the small sample size used in testing (particularly given that only podiatric practices were included in the testing).

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

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

Rationale:

- Committee members noted that the required data elements are routinely generated during care delivery in podiatric practices, although some expressed concern about feasibility in non-podiatric practices.
- Members noted that once EHRs have a specified field designated for measuring shoe, this measure will become much more feasible to implement.

**4. Use and Usability: H-3; M-9; L-3; I-1**

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

Rationale:

- The measure has been in use in PQRS since 2008; however, few practices are reporting the measure. It is also included in the US Wound Registry and in the American Board of Podiatric Surgeon's maintenance of certification program.
- The developer provided PQRS data from 2008-2011, which show an increase in both the reporting of the measure and in average performance rate.
- Committee members were not concerned about potential unintended consequences, noting that information about better shoe fit could only benefit patients.

**5. Related and Competing Measures**

- No related or competing measures noted.

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

**6. Public and Member Comment**

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**7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X**

**8. Board of Directors Vote: Y-X; N-X**

**9. Appeals**

**0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation**

Submission | Specifications

**Description**: Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

**Numerator Statement**: Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Lower Extremity Neurological Exam Performed

G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons

G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure

OR

Lower Extremity Neurological Exam not Performed

G8405: Lower extremity neurological exam not performed

**Denominator Statement**: All patients aged 18 years and older with a diagnosis of diabetes mellitus

**Exclusions**: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer's, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation.

**Adjustment/Stratification**:

**Level of Analysis:** Clinician : Individual

**Setting of Care:** Ambulatory Care : Clinician Office/Clinic

**Type of Measure**: Process

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

**Measure Steward**: American Podiatric Medical Association

**STANDING COMMITTEE MEETING [07/11/2014]**

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

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

1a. Evidence: **H-0**; **M-2**; **L-1**; **I-3; IE-10**; 1b. Performance Gap: **H-10**; **M-5**; **L-1**; **I-0;** 1c. Impact: **H-10**; **M-4**; **L-1**; **I-1**

Rationale:

- Evidence provided by the developer included the 2013 American Diabetes Associatiation grade B recommendation for conduct of an anuual comprehensive foot exam for diabetic patients. Committee members noted that the evidence presented is supportive of the measure.
- PQRS data provided by the developer indicate that the average performance rate (for the 1.4% of eligible professionals reporting the measure ) was 86.6% in 2011 and 43.6% in 2012. The developer also cited an AMA/NCQA report indicating that only 55% of patients with diabetes obtain an annual foot exam and referenced CDC data indicating disparities in performance of foot exams by race, ethnicity, age, and educational status.
- Developers noted that diabetes affects 26 million people in the US, that 60-70% of diabetics will develop peripheral neuropathy, that as many as 25% of diabetics will develop a foot ulcer, that more

than half of these will become infected, and that 20% of infected ulcers will result in amputation. Accordingly, Committee members agreed that the area of measure focus is high priority.

**2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>**
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **H-0**; **M-9**; **L-6**; **I-1** 2b. Validity: **H-1**; **M-10**; **L-4**; **I-1**
<u>Rationale</u>:

- Committee members in general agreed that the measure was well-specified. Members noted that the measure specifications are consistent with the evidence presented, requiring performance of the 10g monofilament examination plus at least one of any of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold). The specifications caveat that the clinician should perform all necessary tests to make the proper evaluation.
- The testing data presented by the developer was based on comparing claims data submitted to the PQRS to the medical record. Data for 286 patients, from 3 practice sites, were examined. Percentage agreement statistics for the numerator, denominator, and exclusions were computed. The testing results demonstrated 100% agreement between the clinical record and the codes captured in PQRS for the denominator and the exceptions, and a 99.3% agreement for the numerator (kappa value not calculable) when percentage agreement is 100. Because this testing included a comparison against the gold standard (the medical chart), the results can be used to assess both data element reliability and data element validity. Committee members agreed that the testing results demonstrated adequate reliability and validity. However, some members expressed concern about the validity of the measure, given the small sample size used in testing (particularly given that only podiatric practices were included in the testing). Members also noted that the testing focused only on the Medicare population, although the measure is not limited to the 65+ age group; however, they were not concerned that the reliability and validity of the measure at the data element level would be different for younger patients.

**4. Feasibility: H-5; M-6; L-4; I-1**
*(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)*
<u>Rationale</u>:

- The Committee agreed that the required data elements are routinely generated during care delivery and are captured electronically.

**3. Use and Usability: H-3; M-8; L-3; I-1**
*(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*
<u>Rationale</u>:

- The measure has been in use in PQRS since 2008; however, few practices are reporting the measure. It is also included in the US Wound Registry and in the American Board of Podiatric Surgeon's maintenance of certification program.
- The developer provided PQRS data from 2008-2011, which show a slight increase in the reporting of the measure and a substantial increase in the average performance rate. However, the PQRS data reported by the developer for 2012 indicates a large drop in the performance rate; it is unclear why this may have occurred.
- Committee members expressed no concerns about potential unintended consequences of the measure

**5. Related and Competing Measures**

- This measure directly competes with measure #0056 (Diabetes: Foot exam). Both measures apply to the

clinician office setting and have the same level of analysis (clinician: individual, group/practice). The data sources for the two measures are comparable, though measure #0056 also includes pharmacy data that are used in identification of diabetic patients for the denominator. The requirements for meeting the numerator for the two measures differ slightly:

- Measure #0056 requires a visual inspection, a sensory exam using monofilament, and a pulse exam.
- Measure #0417 requires performance of the 10g monofilament examination plus at least one of any of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold.

**Committee response**: Committee members discussed which of these approaches (in the numerator) is more evidence-based and would be more likely to drive improvements in healthcare. Some members stated that the evidence supporting the numerator specifications for measure #0056 (performing a monofilament exam in conjunction with a sensory exam) is greater than the evidence for performing a monofilament exam in conjunction with any of the other options listed in the numerator for measure #0417. One member mentioned the pulse check required by measure #0056, noting its usefulness in assessing for vascular disease and increasing the value of the foot examination (because vascular disease is present in many diabetic patients and increases the risk for non-healing foot lesions). Another member suggested that #0417 is better at documenting diabetic peripheral neuropathy than #0056 but the latter is a relatively more inclusive exam assessing vascularity as well as dermatologic risk factors such as athlete's foot, calluses, and obvious structural changes. The Committee questioned why measure #0056 excludes patients with gestational and steroid-induced diabetes and the developer clarified that because the algorithm for specifying the measure denominator includes use of diabetes medications, patients with these conditions would be captured in the denominator, and thus need to be explicitly excluded. The Committee suggested that both measures would benefit from including an assessment of foot pain for the diabetic patient in future iterations of the measures; they also noted the importance of foot exams in patients under age 18, even though neither measure includes this population in their specifications.

In a preliminary round of voting, a majority of members agreed that the measure #0417 is superior and recommended that measure #0417 **not** be put forward for endorsement; however, a sizeable minority thought that neither measure is superior and recommended that both endorsed. The Committee will discuss these issues further on a call after the public- and member comment period closes.

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

**6. Public and Member Comment**

- 

**7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X**

**8. Board of Directors Vote: Y-X; N-X**

**9. Appeals**

## Appendix B: Endocrine Portfolio—Use in Federal Programs

| NQF # | Title | Federal Programs: Finalized as of August 1, 2014 |
|---|---|---|
| 0045 | Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older | Physician Quality Reporting System (PQRS) |
| 0046 | Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older | Physician Quality Reporting System (PQRS) |
| 0053 | Osteoporosis Management in Women Who Had a Fracture | Physician Quality Reporting System (PQRS) |
| 0416 | Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear | Physician Quality Reporting System (PQRS) |
| 0417 | Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | Physician Quality Reporting System (PQRS) |

## Appendix C: Measure Specifications

| | 0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation |
|---|---|
| Status | Steering Committee Review |
| Steward | American Podiatric Medical Association |
| Description | Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months |
| Type | Process |
| Data Source | Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records DATA COLLECTION TOOL<br>To assist with the data collection at each physician practice site, an On-Site Adjudication Tool (OSAT) was developed by Telligen. The tool was customized to capture the data elements for Evaluation of Footwear and Neurological Evaluation performance measures. In addition to assisting the auditor with verification of age, diabetes mellitus, and history of bilateral foot/leg amputation, the tool provided the ability to capture location of documentation for each individual data element. Upon completion of abstraction at each on-site visit, the auditors performed back-up onto an encrypted flash drive. At the completion of the audit, the case results were exported from the tool and analyzed. No patient or physician identifiable information was captured. The tool provided the ability to enter data for a maximum of 100 cases per practice site.<br>OSAT was developed using the Product Designer Module. The module is used to compose abstraction resource files which define abstraction components. The module allows for unique project creation, while tailoring features to each customer's needs. Questions, answers, and measures are added as defined by the project. In addition, the tool is sophisticated enough to allow for the creation of skip, edit, and measure logic, based on the needs of the project. Skip logic defines rules for enabling questions based on defined patterns. Edit logic defines validations to be performed on answers provided by users of the tool. During the design phase, functionality tests were conducted with ongoing abstractor recommendations being incorporated into the application. Once the design functionality was complete, an OSAT build was created and tested to ensure readiness for field use.<br>Available in attached appendix at A.1 Attachment NQF_0417_codes-635284935772565257.xlsx |
| Level | Clinician : Individual |
| Setting | Ambulatory Care : Clinician Office/Clinic |
| Time Window | January 1 – December 31, 20xx, i.e. 12 months |
| Numerator Statement | Patients who had a lower extremity neurological exam performed at least once within 12 months<br>Definition:<br>Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation.<br>Numerator Quality-Data Coding Options for Reporting Satisfactorily:<br>Lower Extremity Neurological Exam Performed<br>G8404: Lower extremity neurological exam performed and documented<br>OR<br>Lower Extremity Neurological Exam not Performed for Documented Reasons<br>G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure<br>OR<br>Lower Extremity Neurological Exam not Performed |

| | 0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation |
|---|---|
| | G8405: Lower extremity neurological exam not performed |
| Numerator Details | GXXXX- Lower extremity neurological exam performed, GXXXX Lower Extremity Neurologcial Exam not Performed for Documented Reasons, OR GXXXX Lower Extremity Neurological Exam not performed |
| Denominator Statement | All patients aged 18 years and older with a diagnosis of diabetes mellitus |
| Denominator Details | Denominator Criteria (Eligible Cases):<br>Patients aged = 18 years on date of encounter<br>AND<br>Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93<br>Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9<br>AND<br>Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 |
| Exclusions | Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer's, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation. |
| Exclusion details | 896.2<br>Amputation, foot, bilateral, partial or complete, traumatic, not complicated<br><br>896.3<br>Amputation, foot, bilateral, partial or complete, traumatic, complicated<br><br>897.0<br>Amputation, below knee, unilateral, traumatic, not complicated<br><br>897.1<br>Amputation, below knee, unilateral, traumatic, complicated |

| | 0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation |
|---|---|
| | 897.2<br>Amputation, at or above knee, unilateral, traumatic, not complicated<br><br>897.3<br>Amputation, at or above knee, unilateral, traumatic, complicated<br><br>897.6<br>Amputation, bilateral, any level, traumatic, not complicated<br><br>897.7<br>Amputation, bilateral, any level, traumatic, complicated |
| Risk Adjustment | No risk adjustment or risk stratification |
| Stratification | |
| Type Score | Ratio better quality = higher score |
| Algorithm | A (# of patients meeting numerator criteria)/<br>PD (# of patients in denominator) – C (# of patients with valid denominator exclusions)<br>Available in attached appendix at A.1 |
| Copyright / Disclaimer | 5.1 Identified measures: 0056 : Diabetes: Foot Exam<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: Age range of 18-75 years in measure 0056 limits data collection and leaves an vulnerable population unaddressed.<br><br>5b.1 If competing, why superior or rationale for additive value: The most significant factor related to the development of a diabetic foot ulceration is the loss of protective sensation related to peripheral neuropathy. Visual inspection and vascular evaluation have shown little predictive value related to development of diabetic foot ulcerations. Measure 0056 only requires a sensory exam by monofilament, yet the ADA 2014 Standards of Care under Foot Exam specify the following:<br>"For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and<br>amputations. The foot examination should include inspection,<br>assessment of foot pulses, and testing for loss of protective sensation (LOPS)<br>(10-g monofilament plus testing any one of the following: vibration using<br>128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration<br>perception threshold)."<br>The above description for a neurological examination is exactly reflected in measure 0417. With the discrepancy in age and the difference in the exams required, measure 0417 should be maintained. Ideally, a composite measure that incorporates all components of an annual diabetic foot exam should be implemented. APMA is working on the development of such a measure and it is included as part of the USWR QCDR for 2014. This should help with testing of this composite measure as well as developing measure specifications. Until such a measure is approved, it would make sense to maintain both measure 0056 and 0417. Also, measure 0056 previously in PQRS was described as doing one of the three components to report (either visual inspection, sensory exam or pulse evaluation) so any data reported prior to 2014 would not necessarily include a neurological examination. The measure has changed for PQRS 2014 |

| | 0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation |
|---|---|
| | to now require all three elements, but prior to 2014 could be achieved with just visual inspection--a very low level requirement with questionable value. |

| | 0416 Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear |
|---|---|
| Status | Steering Committee Review |
| Steward | American Podiatric Medical Association |
| Description | Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing |
| Type | Process |
| Data Source | Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records To assist with the data collection at each physician practice site, an On-Site Adjudication Tool (OSAT) was developed by Telligen. The tool was customized to capture the data elements for Evaluation of Footwear and Neurological Evaluation performance measures. In addition to assisting the auditor with verification of age, diabetes mellitus, and history of bilateral foot/leg amputation, the tool provided the ability to capture location of documentation for each individual data element. Upon completion of abstraction at each on-site visit, the auditors performed back-up onto an encrypted flash drive. At the completion of the audit, the case results were exported from the tool and analyzed. No patient or physician identifiable information was captured. The tool provided the ability to enter data for a maximum of 100 cases per practice site.<br>OSAT was developed using the Product Designer Module. The module is used to compose abstraction resource files which define abstraction components. The module allows for unique project creation, while tailoring features to each customer's needs. Questions, answers, and measures are added as defined by the project. In addition, the tool is sophisticated enough to allow for the creation of skip, edit, and measure logic, based on the needs of the project. Skip logic defines rules for enabling questions based on defined patterns. Edit logic defines validations to be performed on answers provided by users of the tool. During the design phase, functionality tests were conducted with ongoing abstractor recommendations being incorporated into the application. Once the design functionality was complete, an OSAT build was created and tested to ensure readiness for field use.<br>Available in attached appendix at A.1 Attachment NQF_Retooled_Measure_0416.xls |
| Level | Clinician : Individual |
| Setting | Ambulatory Care : Clinician Office/Clinic |
| Time Window | 12 months--measure should be performed at least once every 12 months |
| Numerator Statement | Patients who were evaluated for proper footwear and sizing at least once within 12 months<br>Definition:<br>Evaluation for Proper Footwear – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device, and counseling on appropriate footwear should be based on risk categorization.<br>Numerator Quality-Data Coding Options for Reporting Satisfactorily:<br>Footwear Evaluation Performed<br>G8410: Footwear evaluation performed and documented<br>OR<br>Footwear Evaluation not Performed for Documented Reasons<br>G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure |

| | 0416 Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear |
|---|---|
| | OR<br>Footwear Evaluation not Performed<br>G8415: Footwear evaluation was not performed |
| Numerator Details | See attached Excel file from S.2b. |
| Denominator Statement | All patients aged 18 years and older with a diagnosis of diabetes mellitus |
| Denominator Details | Denominator Criteria (Eligible Cases):<br>Patients aged = 18 years on date of encounter<br>AND<br>Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93<br>Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9<br>AND<br>Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 |
| Exclusions | Footwear evaluation not performed for documented reasons. For example bilateral amputee. |
| Exclusion details | 896.2<br>Amputation, foot, bilateral, partial or complete, traumatic, not complicated<br><br>896.3<br>Amputation, foot, bilateral, partial or complete, traumatic, complicated<br><br>897.0<br>Amputation, below knee, unilateral, traumatic, not complicated<br><br>897.1<br>Amputation, below knee, unilateral, traumatic, complicated<br><br>897.2 |

| | 0416 Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear |
|---|---|
| | Amputation, at or above knee, unilateral, traumatic, not complicated<br><br>897.3<br>Amputation, at or above knee, unilateral, traumatic, complicated<br><br>897.6<br>Amputation, bilateral, any level, traumatic, not complicated<br><br>897.7<br>Amputation, bilateral, any level, traumatic, complicated |
| Risk Adjustment | No risk adjustment or risk stratification |
| Stratification | See Excel file from S.2b. |
| Type Score | Ratio better quality = higher score |
| Algorithm | A (# of patients meeting numerator criteria)/<br>PD (# of patients in denominator) – C (# of patients with valid denominator exclusions)<br>Available in attached appendix at A.1 |
| Copyright / Disclaimer | 5.1 Identified measures:<br><br>5a.1 Are specs completely harmonized?<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact:<br><br>5b.1 If competing, why superior or rationale for additive value: |

| | 0037 Osteoporosis Testing in Older Women |
|---|---|
| Status | Steering Committee Review |
| Steward | National Committee for Quality Assurance |
| Description | The number of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis. |
| Type | Process |
| Data Source | Patient Reported Data/Survey This Health Outcome Survey can be administered by mail or telephone using a CATI protocol. It is offered in English, Spanish, and Chinese (mailed survey only). Detailed instructions for the administration of the Health Outcomes Survey and the complete survey can be found at, www.hosonline.org.<br>Available at measure-specific web page URL identified in S.1 No data dictionary |
| Level | Health Plan, Integrated Delivery System |
| Setting | Ambulatory Care : Clinician Office/Clinic |
| Time Window | 12 months |
| Numerator Statement | The number of women who report having ever received a bone mineral density test of the hip or spine. |
| Numerator Details | The number of female patients 65-85 years of age who responded “yes” to question 54 in the Medicare Health Outcomes Survey.<br>Question 54: “Have you ever had a bone density test to check for osteoporosis, sometimes thought of as ‘brittle bones’? This test would have been done to your back or hip.” |

| | 0037 Osteoporosis Testing in Older Women |
|---|---|
| Denominator Statement | Women age 65-85. |
| Denominator Details | The number of women 65-85 years of age who responded to question 54 on the Medicare Health Outcome Survey.<br>Question 54: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip." |
| Exclusions | N/A |
| Exclusion details | N/A |
| Risk Adjustment | N/A |
| Stratification | N/A |
| Type Score | Rate/proportion better quality = higher score |
| Algorithm | Step 1: Identify the eligible population – Of those who were selected to receive a survey (population identified in Step 1), identify all female patients age 65-85 who answered Question 54: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip."<br>Step 2: Determine the number of patients in the eligible population who responded "Yes".<br>Step 3: Calculate a rate (the number of patients who responded "yes" divided by the eligible population) No diagram provided |
| Copyright / Disclaimer | 5.1 Identified measures: 0046 : Screening for Osteoporosis for Women 65-85 Years of Age<br>0053 : Osteoporosis Management in Women Who Had a Fracture<br>0045 : Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: There are multiple NQF-endorsed measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0037) and the most closely related measure, 0046. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. Measure 0046 assesses the percentage of women who have a bone mineral density test to screen for osteoporosis, is collected using medical record review and is only specified for physician level reporting. Measure 0046 has the same focus and population as measure 0037 and therefore could be considered competing. These two measures are completely harmonized on all data elements with the exception of the following which could not be harmonized due to difference in data source: Type of Test: Because measure 0037 is a survey measure, the term "bone mineral density test" is used to refer to "dual energy x-ray absorptiometry test." This term is used because cognitive testing indicated the term was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however 0046 is able to capture more specificity about the type of test done due to the data source used for measure collection. Exclusions: Measure 0046 includes an exclusion for diagnosis of osteoporosis at the time of encounter. An exclusion for diagnosis of osteoporosis is not feasible in the survey measure (0037) due to the timing of data collection. Given the different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however, the two measures address the same quality gap for different levels of accountability. Measure 0037 addresses whether a health plan is addressing the risk for osteoporosis in the patient |

| | 0037 Osteoporosis Testing in Older Women |
|---|---|
| | population by determining the percent of the population that had a bone mineral density test regardless who their provider is. This test may have been done outside of the context of their primary care provider. Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction. Measures 0053 and 0045 address a different population than 0046, women who have experienced a fracture, and are focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and second prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures.<br><br>5b.1 If competing, why superior or rationale for additive value: Although 0037 and 0046 have the same measure focus and same target population, they are specified for different levels of analysis and use different data sources. The recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk. Therefore both measures 0046 and 0037 define the numerator as "ever" having a bone mineral density test. It is not feasible for a health plan to have access to enough historical claims data or medical record data to determine if its entire member population has ever had a bone mineral density test. Therefore, a survey method is the recommended data source for collecting this type of historical data for health plans. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, measure 0046 looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on past care.<br>We have described above the rationale for where the measures cannot be further harmonized in their technical specifications due to the level of analysis and data source. |

| | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
|---|---|
| Status | Steering Committee Review |
| Steward | National Committee for Quality Assurance |
| Description | Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that th |
| Type | Process |
| Data Source | Electronic Clinical Data, Paper Medical Records This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to patients to identify the numerator. In the PQRS program this measure is coded using CPT II codes specific to quality measurement.<br>No data collection instrument provided Attachment 0045_Fracture_Value_Set.xlsx |
| Level | Clinician : Group/Practice, Clinician : Individual, Clinician : Team |
| Setting | Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Ambulatory Care : Urgent Care |
| Time Window | Numerator: within 3 months of date of fracture<br>Denominator: the measurement year (12 months) |
| Numerator Statement | Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment.<br>Communication may include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, through shared electronic health record, a bone mineral density test report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis. |
| Numerator Details | Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing.<br>The numerator criteria is met by documentation in the medical record of communication (e.g., verbal, by letter, through shared electronic health record, or a bone mineral density test report was sent) that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. This measure is also collected in the Physician Quality Reporting System using a CPTII code specific to the quality measure:<br>- CPT Category II code: 5015F-Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis |
| Denominator Statement | Adults aged 50 years and older who experienced a fracture, except fractures of the finger, toe, face or skull. |
| Denominator Details | Adults who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set). See S.2b. (Data Dictionary Code Table) for all value sets.<br>Table 1: Patient encounter during the reporting period (CPT):<br>Services codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, G0402<br>Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248 |
| Exclusions | None |
| Exclusion details | N/A |

| | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
|---|---|
| Risk Adjustment | No risk adjustment or risk stratification<br>N/A |
| Stratification | N/A |
| Type Score | Rate/proportion better quality = higher score |
| Algorithm | Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.<br>-Age: 50 years and older<br>-Patient encounter during the reporting period (12 months) with a diagnosis of fracture<br>Step 2: Identify the number of patients who had documentation of communication with the physician or clinician managing the patient's on-going care that a fracture occurred and the patient was or should be considered for osteoporosis testing or treatment.<br>Step 3: Calculate the rate (The number of patients who had documentation of communication divided by the number of patients who had a fracture). No diagram provided |
| Copyright / Disclaimer | 5.1 Identified measures: 0037 : Osteoporosis Testing in Older Women<br>0046 : Screening for Osteoporosis for Women 65-85 Years of Age<br>0053 : Osteoporosis Management in Women Who Had a Fracture<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: There are multiple measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0045) and the most closely related measures, 0037, 0046, 0053, 2416, 2417. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. NCQA OWNED RELATED MEASURES: 0037: Osteoporosis Testing in Older Women & 0046: Screening for Osteoporosis for Women 65-85 Years of Age. Measures 0037 and 0046 assess the number of women 65-85 who report ever having received a bone density test to check for osteoporosis. These measures focus on screening for osteoporosis in the general population, whereas measure 0045 is focused on communication between the physician who treated the fracture and the provider who is responsible for managing the patient's care post fracture. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and second prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures. 0053: Osteoporosis Management in Women Who Had a Fracture. Measure 0053 looks at the percentage of women age 50 and older who experience a fracture and receive either a bone mineral density test to check for osteoporosis or treatment for osteoporosis. The intent of measure 0053 is to determine if screening or treatment occurred, whereas measure 0045 is focused on whether communication between providers took place so screening and treatment could be initiated. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different measure intents. Where it is appropriate to the measure focus and evidence, we have aligned the measures. We believe these two measures are complementary showing provider quality of care along multiple points along the continuum of care post-fracture. OTHER RELATED MEASURES: 2416: Laboratory Investigation for Secondary Causes of Fracture. Measure 2416 (currently under review for NQF endorsement) assesses the percentage of patients age 50 and over who had a fragility fracture and had the appropriate laboratory investigation for secondary causes of |

| | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
|---|---|
| | fracture ordered or performed prior to discharge from an inpatient hospitalization. This measure has a different focus from measure 0045 (identifying cause of fracture as opposed to communication and care coordination around fracture). While the target population of this measure overlaps with the target population of 0045, measure 2416 is restricted to fractures that require hospitalization whereas 0045 focuses on a broader population. Therefore we consider these measures to be related but not competing. The differences between this measure and 0045 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment, we have summarized where data elements in these two measures are aligned. 2417: Risk Assessment/Treatment after Fracture. Measure 2417 (currently under review for NQF endorsement) assesses the number of patients age 50+ who were hospitalized for a fragility fracture and have either a dual-energy x-ray absorptiometry (DXA) scan ordered or performed, a prescription for FDA-approved pharmacotherapy, or are linked to a fracture liaison service prior to discharge from an inpatient hospitalization. If DXA is not available and documented, then any other specified fracture risk assessment method may be ordered or performed. This measure has an overlapping target population (individuals hospitalized for a fragility fracture), but a different focus (screening and treatment provided in the hospital versus communication and care coordination). Therefore we consider these measures to be related but not competing. The differences between this measure and 0045 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment we have summarized where data elements in these two measures are aligned.<br><br>5b.1 If competing, why superior or rationale for additive value: N/A |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age |
|---|---|
| Status | Steering Committee Review |
| Steward | National Committee for Quality Assurance |
| Description | Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis. |
| Type | Process |
| Data Source | Electronic Clinical Data, Paper Medical Records This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the PQRS program this measure is coded using CPT Category II codes specific to quality measurement.<br>No data collection instrument provided No data dictionary |
| Level | Clinician : Group/Practice, Clinician : Individual, Clinician : Team |
| Setting | Ambulatory Care : Clinician Office/Clinic |
| Time Window | 12 months |
| Numerator Statement | The number of women who have documentation in their medical record of having received a DXA test of the hip or spine. |
| Numerator Details | Documentation that a central dual-energy x-ray absorptiometry (DXA) test was performed at least once.<br>The numerator criteria is met by documentation in the medical record that the patient has had a central dual-energy x-ray absorptiometry test. This measure is also collected in the Physician Quality Reporting System using the following code specific to the quality measure:<br>- CPT Category II code: 3095F-Central dual-energy x-ray absorptiometry test performed |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age |
|---|---|
| Denominator Statement | Women age 65-85. |
| Denominator Details | Women who had a documented patient encounter (See Table 1 for encounter codes) during the reporting period.<br>Table 1: Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 |
| Exclusions | Diagnosis of osteoporosis at the time of the encounter. |
| Exclusion details | The denominator exclusion criteria is met by documentation in the medical record of a diagnosis of osteoporosis at the time of the encounter.<br>In the Physician Quality Reporting System (PQRS) this exclusion can be collected using G-codes specific to quality measurement:<br>3095F-1P: Documentation of medical reason(s) for not performing a central dual energy x-ray absorptiometry (DXA) measurement (i.e. diagnosis of osteoporosis). |
| Risk Adjustment | No risk adjustment or risk stratification<br>N/A |
| Stratification | N/A |
| Type Score | Rate/proportion  better quality = higher score |
| Algorithm | Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.<br>-Sex: Females<br>-Age: 65-85 years of age<br>-Patient encounter during the reporting period (12 months)<br>Step 2: Exclude from the eligible population in step 1 patients who have a diagnosis of osteoporosis at time of encounter.<br>Step 3: Identify the number of patients with a central dual-energy x-ray absorptiometry test documented.<br>Step 4: Calculate the rate (number of patients who had a central dual-energy x-ray absorptiometry test documented divided by the eligible population). No diagram provided |
| Copyright / Disclaimer | 5.1 Identified measures: 0037 : Osteoporosis Testing in Older Women<br>0045 : Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older<br>0053 : Osteoporosis Management in Women Who Had a Fracture<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: There are multiple NQF-endorsed measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0046) and the most closely related measure, 0037. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts.<br>----------Measure 0037 assesses the percentage of women who report having received a bone mineral density test to screen for osteoporosis., is collected using a survey and is only specified for health plan level reporting. Measure 0037 has the same focus and target population as measure 0046 and therefore could be considered competing. The two measures are completed harmonized on all data elements with the exception of the following which could not be harmonized due to difference in data source: TYPE OF TEST: Because |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age |
|---|---|
| | measure 0037 is a survey measure, the term "bone mineral density test" is used to refer to "dual energy x-ray absorptiometry test." This term is used because cognitive testing indicated the term was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however, 0046 is able to capture more specific about the type of test done due to the data source used for measure collection. EXCLUSIONS: Measure 004 includes an exclusion for diagnosis of osteoporosis at the time of encounter. An exclusion for diagnosis of osteoporosis is not feasible in the survey measure (0046) due to the timing of data collection. ---------- Given the two different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however the two measures address the same quality gap for different levels of accountability. -Measure 0037 addresses whether a health plan is addressing the risk for osteoporosis in the patient population by determining the percent of the population that had a bone mineral density test regardless who their provider is. This test may have been done outside of the context of their primary care provider. Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction.---------- Measures 0045, 0053, 2416, and 2417 address a different population than 0046. These measures address women who have experienced a fracture, and are focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Therefore we consider these measures to be related but not competing. The differences between these measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence we have aligned the measures.<br><br>5b.1 If competing, why superior or rationale for additive value: Although 0037 and 0046 have the same measure focus and same target population, they are specified for different levels of analysis and use different data sources. The recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk. Therefore both measures 0046 and 0037 define the numerator as "ever" having a bone mineral density test. It is not feasible for a health plan to have access to enough historical claims data or medical record data to determine if its entire member population has ever had a bone mineral density test. Therefore, a survey method is the recommended data source for collecting this type of historical data for health plans. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, measure 0046 looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on past care.<br>We have described above the rationale for where the measures cannot be further harmonized in their technical specifications due to the level of analysis and data source. |

| | 0053 Osteoporosis Management in Women Who Had a Fracture |
|---|---|
| Status | Steering Committee Review |
| Steward | National Committee for Quality Assurance |
| Description | The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis. |
| Type | Process |
| Data Source | Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Imaging/Diagnostic Study, Paper Medical Records, Electronic Clinical Data : Pharmacy Health Plan Level: |

| | 0053 Osteoporosis Management in Women Who Had a Fracture |
|---|---|
| | This measure is based on administrative claims collected in the course of providing care to health plan patients. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.<br>Physician Level:<br>This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the PQRS program this measure is coded using G-codes specific to quality measurement.<br>No data collection instrument provided Attachment 0053_Value_Sets.xlsx |
| Level | Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Clinician : Team |
| Setting | Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Imaging Facility, Pharmacy, Ambulatory Care : Urgent Care |
| Time Window | Denominator: 12-month<br>Numerator: 6-months from the date of the initial fracture encounter<br>Exclusions: 24 months |
| Numerator Statement | Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis after a fracture occurs |
| Numerator Details | Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after a fracture. Appropriate testing or treatment for osteoporosis after the fracture is defined by any of the following criteria:<br>- A Bone Mineral Density test (see Table OMW-X below; see Bone Mineral Density Tests value set) during the inpatient stay for fracture or on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after that date.<br>- A dispensed prescription to treat osteoporosis (see Table OMW-C below; see Osteoporosis Medications value set) on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture.<br>Table OMW-X: Bone Mineral Density Tests<br>Central dual-energy x-ray absorptiometry, computed tomography, single energy x-ray absorptiometry, ultrasound<br>Table OMW-C: Osteoporosis Therapies<br>Alendronate, Alendronate-cholecalciferol, Calcium carbonate-risedronate, Ibandronate, Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Teriparatide<br>The numerator for this measure can be identified using either administrative claims or review of medical records. The following criteria are used to identify the numerator criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.<br>For Medical Record Review Methodology (Physician Level)<br>When using the medical record as the data source, the numerator criteria is met by documentation that a Bone Mineral Density Test was performed or an osteoporosis therapy was prescribed. This may include a prescription given to patient for treatment of osteoporosis at one or more encounters during the reporting period. This measure is also collected in the Physician Quality Reporting System using G-codes specific to the quality measure:<br>- 3095F Bone mineral density test performed<br>- 4005F Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed<br>For Administrative Methodology (Health Plan Level)<br>When using administrative claims as the data source, the numerator criteria is met by one or more codes in the following value sets: |

| | 0053 Osteoporosis Management in Women Who Had a Fracture |
|---|---|
| | Bone Mineral Density Tests Value Set<br>Osteoporosis Medications Value Set<br>A pharmacy claim for a medication listed in Table OMW-C<br>See S.2b. (Data Dictionary Code Table) |
| Denominator Statement | Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure:<br>Women age 50-64<br>Women age 65-85<br>Women age 50-85 |
| Denominator Details | The denominator for this measure is identified by administrative codes which are specific to the level of reporting. When reporting this measure at the health plan level include all individuals with fractures enrolled in the health plan (i.e. all individuals with encounters for fractures in the health plan – inpatient and outpatient). When reporting this measure at the physician level include all individuals with fractures seen by the eligible provider (i.e., all individuals with encounters for fracture with the eligible provider).<br>Health Plan Level Denominator Details:<br>Women who had an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. This is the index fracture. If the patient had more than one fracture during the intake period, include only the first fracture. See S.2b. (Data Dictionary Code Table) for all value sets.<br>Physician Level Denominator Details:<br>Women who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set).<br>Table 1: Patient encounter during the reporting period (CPT):<br>Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402<br>Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248 |
| Exclusions | 1) Exclude women who had a fracture in the 60 days prior to the index fracture<br>2) Exclude women who had a bone mineral density test in the 2 years prior to the index fracture<br>3) Exclude women who had received osteoporosis therapy or medication in the 12 months prior to the index fracture |
| Exclusion details | 1) Exclude patients with a previous fracture: patients with an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 60 days (2 months) prior to the earliest date of service with a diagnosis of fracture. For index fractures requiring an inpatient stay, use the admission date as the earliest date of service with a diagnosis of fracture. For direct transfers, use the first admission date as the earliest date of service with a diagnosis of fracture.<br>2) Exclude patients who had a Bone Mineral Density test (see Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the earliest date of service with a diagnosis of fracture.<br>3) Exclude patients who had a claim/encounter for osteoporosis therapy (see Osteoporosis Medications Value Set) or received a dispensed prescription to treat osteoporosis (see Table |

| | 0053 Osteoporosis Management in Women Who Had a Fracture |
|---|---|
| | OMW-C) during the 365 days (12 months) prior to the earliest date of service with a diagnosis of fracture.<br>Table OMW-C: Osteoporosis Therapies<br>Alendronate, Alendronate-cholecalciferol, Calcium carbonate-risedronate, Ibandronate, Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Teriparatide<br>The denominator exclusions for this measure can be identified using either administrative claims or review of medical record. The following criteria are used to identify the denominator exclusion criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.<br>For Medical Record Review Methodology (Physician Level)<br>When using the medical record as the data source, the denominator exclusion criteria can be met by documentation that a previous fracture occurred, a bone mineral density test was performed or an osteoporosis therapy was prescribed during the specified timeframe prior to the fracture. In the Physician Quality Reporting System (PQRS) this exclusion is collected using G-codes specific to quality measurement:<br>- 3095F or 4005F with 1P: Documentation of medical reason(s) for not performing a bone mineral density test or not prescribing pharmacologic therapy for osteoporosis (i.e. history of fracture in 60 days prior to index fracture, bone mineral density test in 24 months prior to index fracture, or pharmacologic treatment for osteoporosis in 12 months prior to index fracture).<br>For Administrative Methodology (Health Plan Level)<br>When using administrative claims as the data source, the denominator exclusion criteria is met using the following value sets referenced above during the specified time frame prior to the fracture.<br>Outpatient Value Set<br>ED Value Set<br>Nonacute Inpatient Value Set<br>Acute Inpatient Value Set<br>Fractures Value Set<br>Bone Mineral Density Tests Value Set<br>Osteoporosis Medications Value Set<br>See S.2b. (Data Dictionary Code Table) for all value sets. |
| Risk Adjustment | No risk adjustment or risk stratification<br>N/A |
| Stratification | N/A |
| Type Score | Rate/proportion better quality = higher score |
| Algorithm | Health Plan Level:<br>Step 1: Determine the eligible population.<br>Step 1A: Identify all female patients in each age strata who had any of the following visits with a diagnosis of fracture during the intake period: outpatient, observation or ED, nonacute inpatient encounter or an acute inpatient encounter. If the patient had more than one fracture, include only the first fracture. This is the index fracture.<br>Step 1B: Test for Negative Diagnosis History. Do not include patients with an outpatient visit, an observation visit, an ED visit, a nonacute inpatient encounter or an acute inpatient encounter for a fracture during the 60 days (2 months) prior to the index fracture.<br>Step 1C: Exclude patients who had a Bone Mineral Density test during the 730 days (24 months) prior to the fracture or a claim/encounter for osteoporosis therapy or received a dispensed prescription to treat osteoporosis during the 360 days (12 months) prior to the fracture. |

| | 0053 Osteoporosis Management in Women Who Had a Fracture |
|---|---|
| | Step 2: Identify Numerator: To do so, identify all patients who were given an appropriate Bone Mineral Density test or received the appropriate treatment to treat osteoporosis during the first 180 days (6 months) after the fracture.<br>Step 3: To calculate the rate, take the number of patients who received the appropriate screening or treatment within the 6-month period following a fracture divided by the number of people calculated to be in the eligible population (those remaining after Step 1C is complete).<br>Physician Level:<br>Step 1: Determine the eligible population.<br>Step1A: Identify all female patients in each age strata who had a documented patient encounter with the eligible provider with a diagnosis of fracture.<br>Step 1B: Exclude patients who had a fracture in the 60 days prior to the index fracture, a Bone Mineral Density test during the 24 months prior to the fracture or received a medication to treat osteoporosis during the 12 months prior to the fracture.<br>Step 2: Identify all patients who had a documented bone mineral density test or pharmacologic therapy after a fracture.<br>Step 3: To calculate the rate, take the number of patients who received screening or pharmacologic therapy and divide by the number of people in the eligible population (those remaining after Step 1B is complete). No diagram provided |
| Copyright / Disclaimer | 5.1 Identified measures: 0037 : Osteoporosis Testing in Older Women<br>0046 : Screening for Osteoporosis for Women 65-85 Years of Age<br>0045 : Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: There are multiple measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0053) and the most closely related measures, 0037, 0046, 0045, 2416, 2417. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. NCQA OWNED RELATED MEASURES: 0037: Osteoporosis Testing in Older Women & 0046: Screening for Osteoporosis for Women 65-85 Years of Age. Measures 0037 and 0046 assess the number of women 65-85 who report ever having received a bone density test to check for osteoporosis. These measures focus on screening for osteoporosis in the general population, whereas measure 0053 is focused on secondary prevention in a population of women who have experienced a fracture. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures. 0045 : Osteoporosis: Communication with the Physician or other Clinician Managing On-going Care Post Fracture for Men and Women Aged 50 Years and Older. Measure 0045 looks at the percentage of women and men age 50 and older who are treated for a fracture and have documentation of communication from the physician who treated the fracture to the physician or other clinician managing the patient's on-going care. The intent of measure 0045 is to measure whether communication took place between the physician who treated the fracture and the provider who is responsible for managing the patient's care post-fracture. The focus of the measure is on communication and care coordination, whereas the focus of 0053 is on treatment and/or screening in the same population. Therefore, we |

| | 0053 Osteoporosis Management in Women Who Had a Fracture |
|---|---|
| | consider these measures to be related but not competing. The differences between these two measures are reflective of the different measure intents. Where it is appropriate to the measure focus and evidence, we have aligned the measures. OTHER RELATED MEASURES: The other osteoporosis management related measures are more narrowly focused than the NCQA measures. These measures (2416, 2417) are hospital-level accountability measures and focus solely on women who were hospitalized for fractures. 2416: Laboratory Investigation for Secondary Causes of Fracture. Measure 2416 assesses the percentage of patients age 50 and over who were hospitalized for a fragility fracture and had the appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from an inpatient hospitalization. This measure has a different focus from measure 0053 (identifying cause of fracture as opposed to screening/treatment for osteoporosis). While the target population of this measure overlaps with the target population of 0053, measure 2416 is restricted to fractures that require hospitalization whereas 0053 focuses on a broader population. Therefore we consider these measures to be related but not competing. Measure 2416 captures some of the same quality focus as 0053 but is designed to be appropriate for hospital level accountability and is therefore restricted to hospitalized individuals. The differences between this measure and 0053 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment we have summarized where data elements in these two measures are aligned. 2417: Risk Assessment/Treatment After Fracture. Measure 2417 assesses the number of patients age 50+ who were hospitalized for a fragility fracture and have either a dual-energy x-ray absorptiometry (DXA) scan ordered or performed, a prescription for FDA-approved pharmacotherapy, or are linked to a fracture liaison service prior to discharge from an inpatient hospitalization. If DXA is not available and documented, then any other specified fracture risk assessment method may be ordered or performed. This measure has a similar focus to 0053 and an overlapping target population (individuals hospitalized for a fragility fracture). Therefore this measure could be considered competing with 0053; however, 2417 is designed to focus on hospital level accountability and therefore is only inclusive of populations and services provided within the hospital setting. Measure 0053 is designed to be broader and capture both outpatient and inpatient populations and services. In the attached memo on measure alignment we outline the specific data elements where these two measures are aligned.<br><br>5b.1 If competing, why superior or rationale for additive value: Measure 0053 is designed to be as broad as possible to include the largest possible population (all women age 50+ with a fracture other than face, finger, toe, and skull) and include the broadest possible settings of care (inpatient and outpatient). The measure is designed for both health plan and outpatient physician level accountability. It is focused on guideline recommended care for osteoporosis management after a fracture. A companion measure in development focuses on screening and treatment in men age 50+ (guideline recommendations for when men should receive treatment and screening for osteoporosis and the recommended treatment differ between men and women therefore a separate measure is necessary). Measure 2417 (under review for NQF endorsement) is designed to be appropriate for hospital level accountability and therefore focuses on a smaller population (all patients 50+ hospitalized for a fragility fracture) and includes a single setting of care (inpatient). While some post-fracture care occurs in the inpatient setting, much of the responsibility for providing follow-up care for osteoporosis management in women rests with the outpatient care system and providers. Additionally, many patients who suffer a fracture may not be treated with an inpatient hospitalization. Therefore it is important to have a measure that captures a broader population and settings of care for osteoporosis management following a fracture. |

## Appendix D: Related and Competing Measures

**Comparison of NQF # 0417 and NQF # 0056**

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
|---|---|---|
| Steward | American Podiatric Medical Association | National Committee for Quality Assurance |
| Description | Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months | The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year. |
| Type | Process | Process |
| Data Source | Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records DATA COLLECTION TOOL<br>To assist with the data collection at each physician practice site, an On-Site Adjudication Tool (OSAT) was developed by Telligen. The tool was customized to capture the data elements for Evaluation of Footwear and Neurological Evaluation performance measures. In addition to assisting the auditor with verification of age, diabetes mellitus, and history of bilateral foot/leg amputation, the tool provided the ability to capture location of documentation for each individual data element. Upon completion of abstraction at each on-site visit, the auditors performed back-up onto an encrypted flash drive. At the completion of the audit, the case results were exported from the tool and analyzed. No patient or physician identifiable information was captured. The tool provided the ability to enter data for a maximum of 100 cases per practice site.<br>OSAT was developed using the Product Designer Module. The module is used to compose abstraction resource files which define abstraction components. The module allows for unique project creation, while tailoring features to each customer's needs. Questions, answers, and measures are added as defined by the project. In addition, the tool is sophisticated enough to allow for the creation of skip, edit, and measure logic, based on the needs of the project. Skip logic defines rules for enabling questions based on defined patterns. Edit logic defines validations to be performed on | Administrative claims, Paper Medical Records, Electronic Clinical Data : Pharmacy<br>No data collection instrument provided Attachment 0056_CDC_Foot_Exam_Value_Sets-635219463363519462.xlsx |

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
|---|---|---|
| | answers provided by users of the tool. During the design phase, functionality tests were conducted with ongoing abstractor recommendations being incorporated into the application. Once the design functionality was complete, an OSAT build was created and tested to ensure readiness for field use.<br>Available in attached appendix at A.1 Attachment NQF_0417_codes-635284935772565257.xlsx | |
| Level | Clinician : Individual | Clinician : Group/Practice, Clinician : Individual |
| Setting | Ambulatory Care : Clinician Office/Clinic | Ambulatory Care : Clinician Office/Clinic |
| Numerator Statement | Patients who had a lower extremity neurological exam performed at least once within 12 months<br>Definition:<br>Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation.<br>Numerator Quality-Data Coding Options for Reporting Satisfactorily:<br>Lower Extremity Neurological Exam Performed<br>G8404: Lower extremity neurological exam performed and documented<br>OR<br>Lower Extremity Neurological Exam not Performed for Documented Reasons<br>G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure<br>OR<br>Lower Extremity Neurological Exam not Performed<br>G8405: Lower extremity neurological exam not performed | Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period. |
| Numerator Details | GXXXX- Lower extremity neurological exam performed, GXXXX Lower Extremity Neurologcial Exam not Performed for Documented Reasons, OR GXXXX Lower Extremity Neurological Exam not | ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value |

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
|---|---|---|
| | performed | sets located in question S.2b.<br>MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the exam was performed and the result. The patient is numerator compliant if a foot exam during the measurement year and result are documented. The patient is not numerator compliant if the result for the foot exam and result during the measurement year are missing. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result is required for numerator compliance. |
| Denominator Statement | All patients aged 18 years and older with a diagnosis of diabetes mellitus | Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year. |
| Denominator Details | Denominator Criteria (Eligible Cases):<br>Patients aged = 18 years on date of encounter<br>AND<br>Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93<br>Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, | PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES<br>Alpha-glucosidase inhibitors:<br>Acarbose, Miglitol<br>Amylin analogs:<br>Pramlinitide<br>Antidiabetic combinations:<br>Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin<br>Insulin:<br>Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human<br>Meglitinides:<br>Nateglinide, Repaglinide<br>Miscellaneous antidiabetic agents:<br>Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin<br>Sulfonylureas: |

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
|---|---|---|
| | E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9<br>AND<br>Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 | Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide<br>Thiazolidinediones:<br>Pioglitazone, Rosiglitazone<br>---<br>CODES TO IDENTIFY DIABETES<br>ICD-9-CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0 |
| Exclusions | Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer's, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation. | -A diagnosis of gestational or steroid-induced diabetes |
| Exclusion Details | 896.2<br>Amputation, foot, bilateral, partial or complete, traumatic, not complicated<br><br>896.3<br>Amputation, foot, bilateral, partial or complete, traumatic, complicated<br><br>897.0<br>Amputation, below knee, unilateral, traumatic, not complicated<br><br>897.1<br>Amputation, below knee, unilateral, traumatic, complicated<br><br>897.2 | ADMINISTRATIVE CLAIMS<br>CODES TO IDENTIFY EXCLUSIONS<br>Steroid induced: 249, 251.8, 962.0<br>Gestational diabetes: 648.8<br>---<br>MEDICAL RECORD<br>Exclusionary evidence in the medical record must include a note indicating a diagnosis of gestational or steroid-induced diabetes |

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
|---|---|---|
| | Amputation, at or above knee, unilateral, traumatic, not complicated<br><br>897.3<br>Amputation, at or above knee, unilateral, traumatic, complicated<br><br>897.6<br>Amputation, bilateral, any level, traumatic, not complicated<br><br>897.7<br>Amputation, bilateral, any level, traumatic, complicated | |
| Risk Adjustment | No risk adjustment or risk stratification | No risk adjustment or risk stratification<br>N/A |
| Stratification | | N/A |
| Type Score | Ratio better quality = higher score | Rate/proportion better quality = higher score |
| Algorithm | A (# of patients meeting numerator criteria)/<br>PD (# of patients in denominator) – C (# of patients with valid denominator exclusions) Available in attached appendix at A.1 | STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.<br>-AGES: 18-75 years as of December 31 of the reporting period.<br>-EVENT/DIAGNOSIS:<br>Identify patients who had a diagnosis of diabetes with a visit during the measurement period.<br>Claim/Encounter Data:<br>Codes to identify diabetes:<br>-ICD-9-CM Diagnosis: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04<br>-ICD-10-CM Diagnosis: E10.8, E10.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, |

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
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| | | E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.65, E11.69, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628<br>AND<br>Patient encounter (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439<br>-<br>STEP 2. Determine the number of patients in the eligible population who had a recent foot exam (visual inspection with a sensory exam and a pulse exam) exam during the measurement year through the search of administrative data systems.<br>STEP 3. Identify patients with a most recent foot exam performed and the result.<br>STEP 4. Identify the most recent foot exam with a result during the reporting period (numerator compliant). Identify the most recent result foot exam without a result or a missing foot exam (not numerator compliant).<br>STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured. *SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.10<br>STEP 6. Calculate the rate (number of patients that received a foot exam during the measurement year). No diagram provided |

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
|---|---|---|
| Submission items | 5.1 Identified measures: 0056 : Diabetes: Foot Exam<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: Age range of 18-75 years in measure 0056 limits data collection and leaves an vulnerable population unaddressed.<br><br>5b.1 If competing, why superior or rationale for additive value: The most significant factor related to the development of a diabetic foot ulceration is the loss of protective sensation related to peripheral neuropathy. Visual inspection and vascular evaluation have shown little predictive value related to development of diabetic foot ulcerations. Measure 0056 only requires a sensory exam by monofilament, yet the ADA 2014 Standards of Care under Foot Exam specify the following:<br>"For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (LOPS)<br>(10-g monofilament plus testing any one of the following: vibration using<br>128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold)."<br>The above description for a neurological examination is exactly reflected in measure 0417. With the discrepancy in age and the difference in the exams required, measure 0417 should be maintained. Ideally, a composite measure that incorporates all components of an annual diabetic foot exam should be implemented. APMA is working on the development of such a measure and it is included as part of the USWR QCDR for 2014. This should help with testing of this composite measure as well as developing measure specifications. Until such a measure is | 5.1 Identified measures: 0417 : Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0056 identifies adults with diabetes (age 18-75) that had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year. HARMONIZED ELEMENTS: Both measures are harmonized on the target population of diabetic adults and the measure focus of lower extremity exam. The denominator for each measure are harmonized to include all adult patients with a diagnosis of diabetes mellitus. The care setting is harmonized for measure 0056 and 0417 in at least one care setting (Ambulatory Care: Clinician Office/ Clinic). In addition, the data source (administrative claims) and level of analysis (clinicians: individual) are harmonized for both measures. UNHARMONIZED MEASURE ELEMENTS: Data Source: Measure 0056 is specified for paper medical records, administrative claims and electronic clinical data while measure 0417 is specified for administrative claims only. Measure 0056 is included in the CMS PQRS program and in NCQA's Diabetes Recognition Program (DRP) for physician reporting. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN: Measure 0056 provide more options for reporting based on available data sources. Measure 0417 is specified for only administrative claims.<br><br>5b.1 If competing, why superior or rationale for additive value: 0056 has a long history of use and is implemented in two national programs (PRQS and DRP). |

| | 0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | 0056: Diabetes: Foot Exam |
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| | approved, it would make sense to maintain both measure 0056 and 0417. Also, measure 0056 previously in PQRS was described as doing one of the three components to report (either visual inspection, sensory exam or pulse evaluation) so any data reported prior to 2014 would not necessarily include a neurological examination. The measure has changed for PQRS 2014 to now require all three elements, but prior to 2014 could be achieved with just visual inspection--a very low level requirement with questionable value. | |

**Comparison of NQF # 0037, NQF # 0045, NQF # 0046, NQF # 0053, NQF # 2416, and NQF # 2417**

| | 0037 Osteoporosis Testing in Older Women | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
|---|---|---|
| Steward | National Committee for Quality Assurance | National Committee for Quality Assurance |
| Description | The number of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis. | Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication. |
| Type | Process | Process |
| Data Source | Patient Reported Data/Survey This Health Outcome Survey can be administered by mail or telephone using a CATI protocol. It is offered in English, Spanish, and Chinese (mailed survey only). Detailed instructions for the administration of the Health Outcomes Survey and the complete survey can be found at, www.hosonline.org. Available at measure-specific web page URL identified in S.1 No data dictionary | Electronic Clinical Data, Paper Medical Records This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to patients to identify the numerator. In the PQRS program this measure is coded using CPT II codes specific to quality measurement. No data collection instrument provided Attachment 0045_Fracture_Value_Set.xlsx |
| Level | Health Plan, Integrated Delivery System | Clinician : Group/Practice, Clinician : Individual, Clinician : Team |
| Setting | Ambulatory Care : Clinician Office/Clinic | Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Ambulatory |

| | 0037 Osteoporosis Testing in Older Women | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
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| | | Care : Urgent Care |
| Numerator Statement | The number of women who report having ever received a bone mineral density test of the hip or spine. | Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment.<br>Communication may include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, through shared electronic health record, a bone mineral density test report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis. |
| Numerator Details | The number of female patients 65-85 years of age who responded "yes" to question 54 in the Medicare Health Outcomes Survey.<br>Question 54: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip." | Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing.<br>The numerator criteria is met by documentation in the medical record of communication (e.g., verbal, by letter, through shared electronic health record, or a bone mineral density test report was sent) that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. This measure is also collected in the Physician Quality Reporting System using a CPTII code specific to the quality measure:<br>- CPT Category II code: 5015F-Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis |
| Denominator Statement | Women age 65-85. | Adults aged 50 years and older who experienced a fracture, except fractures of the finger, toe, face or skull. |
| Denominator Details | The number of women 65-85 years of age who responded to question 54 on the Medicare Health Outcome Survey.<br>Question 54: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip." | Adults who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set). See S.2b. (Data Dictionary Code Table) for all value sets.<br>Table 1: Patient encounter during the reporting period (CPT):<br>Services codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, |

| | 0037 Osteoporosis Testing in Older Women | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
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| | | 99214, 99215, 99238, 99239, G0402<br>Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248 |
| Exclusions | N/A | None |
| Exclusion Details | N/A | N/A |
| Risk Adjustment | N/A | No risk adjustment or risk stratification<br>N/A |
| Stratification | N/A | N/A |
| Type Score | Rate/proportion better quality = higher score | Rate/proportion better quality = higher score |
| Algorithm | Step 1: Identify the eligible population – Of those who were selected to receive a survey (population identified in Step 1), identify all female patients age 65-85 who answered Question 54: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip."<br>Step 2: Determine the number of patients in the eligible population who responded "Yes".<br>Step 3: Calculate a rate (the number of patients who responded "yes" divided by the eligible population) No diagram provided | Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.<br>-Age: 50 years and older<br>-Patient encounter during the reporting period (12 months) with a diagnosis of fracture<br>Step 2: Identify the number of patients who had documentation of communication with the physician or clinician managing the patient's on-going care that a fracture occurred and the patient was or should be considered for osteoporosis testing or treatment.<br>Step 3: Calculate the rate (The number of patients who had documentation of communication divided by the number of patients who had a fracture). No diagram provided |
| Copyright / Disclaimer | 5.1 Identified measures: 0046 : Screening for Osteoporosis for Women 65-85 Years of Age<br>0053 : Osteoporosis Management in Women Who Had a Fracture<br>0045 : Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older | 5.1 Identified measures: 0037 : Osteoporosis Testing in Older Women<br>0046 : Screening for Osteoporosis for Women 65-85 Years of Age<br>0053 : Osteoporosis Management in Women Who Had a Fracture<br><br>5a.1 Are specs completely harmonized? No |

| | 0037 Osteoporosis Testing in Older Women | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
|---|---|---|
| | 5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: There are multiple NQF-endorsed measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0037) and the most closely related measure, 0046. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. Measure 0046 assesses the percentage of women who have a bone mineral density test to screen for osteoporosis, is collected using medical record review and is only specified for physician level reporting. Measure 0046 has the same focus and population as measure 0037 and therefore could be considered competing. These two measures are completely harmonized on all data elements with the exception of the following which could not be harmonized due to difference in data source: Type of Test: Because measure 0037 is a survey measure, the term "bone mineral density test" is used to refer to "dual energy x-ray absorptiometry test." This term is used because cognitive testing indicated the term was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however 0046 is able to capture more specificity about the type of test done due to the data source used for measure collection. Exclusions: Measure 0046 includes an exclusion for diagnosis of osteoporosis at the time of encounter. An exclusion for diagnosis of osteoporosis is not feasible in the survey measure (0037) due to the timing of data collection. Given the different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however, the two measures address the same quality gap for different levels of accountability. Measure 0037 addresses whether a health plan is addressing the risk | 5a.2 If not completely harmonized, identify difference, rationale, impact: There are multiple measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0045) and the most closely related measures, 0037, 0046, 0053, 2416, 2417. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. NCQA OWNED RELATED MEASURES: 0037: Osteoporosis Testing in Older Women & 0046: Screening for Osteoporosis for Women 65-85 Years of Age. Measures 0037 and 0046 assess the number of women 65-85 who report ever having received a bone density test to check for osteoporosis. These measures focus on screening for osteoporosis in the general population, whereas measure 0045 is focused on communication between the physician who treated the fracture and the provider who is responsible for managing the patient's care post fracture. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and second prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures. 0053: Osteoporosis Management in Women Who Had a Fracture. Measure 0053 looks at the percentage of women age 50 and older who experience a fracture and receive either a bone mineral density test to check for osteoporosis or treatment for osteoporosis. The intent of measure 0053 is to determine if screening or treatment occurred, whereas measure 0045 is focused on whether communication between providers took place so screening and treatment could be initiated. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different measure intents. Where it is appropriate to the measure focus and evidence, we have aligned the measures. We |

| | 0037 Osteoporosis Testing in Older Women | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
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| | for osteoporosis in the patient population by determining the percent of the population that had a bone mineral density test regardless who their provider is. This test may have been done outside of the context of their primary care provider. Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction. Measures 0053 and 0045 address a different population than 0046, women who have experienced a fracture, and are focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and second prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures.<br><br>5b.1 If competing, why superior or rationale for additive value: Although 0037 and 0046 have the same measure focus and same target population, they are specified for different levels of analysis and use different data sources. The recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk. Therefore both measures 0046 and 0037 define the numerator as "ever" having a bone mineral density test. It is not feasible for a health plan to have access to enough historical claims data or medical record data to determine if its entire member population has ever had a bone mineral density test. Therefore, a survey method is the recommended data source for collecting this type of historical data for health plans. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, measure 0046 looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on | believe these two measures are complementary showing provider quality of care along multiple points along the continuum of care post-fracture. OTHER RELATED MEASURES: 2416: Laboratory Investigation for Secondary Causes of Fracture. Measure 2416 (currently under review for NQF endorsement) assesses the percentage of patients age 50 and over who had a fragility fracture and had the appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from an inpatient hospitalization. This measure has a different focus from measure 0045 (identifying cause of fracture as opposed to communication and care coordination around fracture). While the target population of this measure overlaps with the target population of 0045, measure 2416 is restricted to fractures that require hospitalization whereas 0045 focuses on a broader population. Therefore we consider these measures to be related but not competing. The differences between this measure and 0045 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment, we have summarized where data elements in these two measures are aligned. 2417: Risk Assessment/Treatment after Fracture. Measure 2417 (currently under review for NQF endorsement) assesses the number of patients age 50+ who were hospitalized for a fragility fracture and have either a dual-energy x-ray absorptiometry (DXA) scan ordered or performed, a prescription for FDA-approved pharmacotherapy, or are linked to a fracture liaison service prior to discharge from an inpatient hospitalization. If DXA is not available and documented, then any other specified fracture risk assessment method may be ordered or performed. This measure has an overlapping target population (individuals hospitalized for a fragility fracture), but a different focus (screening and treatment provided in the hospital versus communication and care coordination). Therefore we consider these measures to be related but not competing. The differences between this measure and 0045 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment we |

| | 0037 Osteoporosis Testing in Older Women | 0045 Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older |
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| | past care.<br>We have described above the rationale for where the measures cannot be further harmonized in their technical specifications due to the level of analysis and data source. | have summarized where data elements in these two measures are aligned.<br><br>5b.1 If competing, why superior or rationale for additive value: N/A |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| Steward | National Committee for Quality Assurance | National Committee for Quality Assurance | The Joint Commission | The Joint Commission |
| Description | Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis. | The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis. | Patients age 50 or over with a fragility fracture who have either a dual-energy X-Ray absorptiometry (DXA) scan ordered or performed, or a prescription for FDA-approved pharmacotherapy for osteoporosis, or who are seen by or linked to a fracture liaison service prior to discharge from inpatient status,. If DXA is not available and documented as such, then any other specified fracture risk assessment method may be ordered or performed. | Percentage of patients age 50 and over with fragility fracture who have had appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from inpatient status. |
| Type | Process | Process | Process | Process |
| Data Source | Electronic Clinical Data, Paper Medical Records This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the | Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Imaging/Diagnostic Study, Paper Medical Records, Electronic Clinical Data : Pharmacy Health Plan Level: | Electronic Clinical Data : Electronic Health Record, Paper Medical Records A data collection instrument has been developed by The Joint Commission for the purpose of the pilot test. | Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records The data source is the medical record.<br>No data collection instrument |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | course of providing care to health plan patients to identify the numerator. In the PQRS program this measure is coded using CPT Category II codes specific to quality measurement.<br>No data collection instrument provided No data dictionary | This measure is based on administrative claims collected in the course of providing care to health plan patients. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.<br>Physician Level:<br>This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the PQRS program this measure is coded using G-codes specific to quality measurement.<br>No data collection instrument provided Attachment 0053_Value_Sets.xlsx | Contracted vendors will develop data collection tools specific to their performance measurement systems when the measures specifications are released to them.<br>No data collection instrument provided Attachment OAF_Appendix_Final-635231390001572897.xlsx | provided Attachment OAF_Appendix_Final.xlsx |
| Level | Clinician : Group/Practice, Clinician : Individual, Clinician : Team | Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Clinician : Team | Facility | Facility |
| Setting | Ambulatory Care : Clinician Office/Clinic | Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Imaging Facility, Pharmacy, Ambulatory Care : Urgent Care | Hospital/Acute Care Facility | Hospital/Acute Care Facility |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| Numerator Statement | The number of women who have documentation in their medical record of having received a DXA test of the hip or spine. | Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis after a fracture occurs | Patients who had either a DXA scan ordered or performed, OR a prescription for FDA-approved pharmacotherapy for osteoporosis treatment, OR those who were seen by, contacted by, or linked to a fracture liaison service prior to discharge OR had other fracture risk assessment method ordered or performed if DXA is not available. | Patients who have all the specified laboratory tests ordered or performed prior to discharge:<br>1. Complete blood cell count (CBC)<br>2. Kidney function test<br>3. Liver function test<br>4. Serum calcium<br>5. 25(OH) Vitamin D level<br>OR Oral Administration of Vitamin D |
| Numerator Details | Documentation that a central dual-energy x-ray absorptiometry (DXA) test was performed at least once.<br>The numerator criteria is met by documentation in the medical record that the patient has had a central dual-energy x-ray absorptiometry test. This measure is also collected in the Physician Quality Reporting System using the following code specific to the quality measure:<br>- CPT Category II code: 3095F-Central dual-energy x-ray absorptiometry test performed | Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after a fracture. Appropriate testing or treatment for osteoporosis after the fracture is defined by any of the following criteria:<br>- A Bone Mineral Density test (see Table OMW-X below; see Bone Mineral Density Tests value set) during the inpatient stay for fracture or on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after that date.<br>- A dispensed prescription to treat osteoporosis (see Table OMW-C below; see Osteoporosis Medications value set) on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the | Data Elements: (See attached Excel file for definitions and allowable values)<br>DXA Scan Ordered or Performed Prior to Discharge<br>Other Fracture Risk Assessment Method Ordered or Performed Prior to Discharge<br>FDA-approved Pharmacotherapy for Osteoporosis Treatment<br>Reason for No DXA Scan<br>Reason for No FDA-approved Pharmacotherapy for Treatment of Osteoporosis<br>Fracture liaison service | Data Elements:<br>Laboratory Tests Ordered or Performed Prior to Discharge - The specific laboratory tests are (all five):<br>Complete Blood Count (CBC)<br>and<br>Kidney Function Test - may be either:<br>Serum Creatinine<br>Kidney Function Panel<br>Kidney Panel<br>Renal Function Panel<br>and<br>Liver Function Test – may be either:<br>Liver Panel<br>Liver Profile<br>Liver Function Panel<br>Hepatic Panel<br>Hepatic Profile |


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| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | fracture.<br>Table OMW-X: Bone Mineral Density Tests<br>Central dual-energy x-ray absorptiometry, computed tomography, single energy x-ray absorptiometry, ultrasound<br>Table OMW-C: Osteoporosis Therapies<br>Alendronate, Alendronate-cholecalciferol, Calcium carbonate-risedronate, Ibandronate, Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Teriparatide<br>The numerator for this measure can be identified using either administrative claims or review of medical records. The following criteria are used to identify the numerator criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.<br>For Medical Record Review Methodology (Physician Level)<br>When using the medical record as the data source, the numerator criteria is met by documentation that a Bone Mineral Density Test was performed or an osteoporosis therapy was prescribed. This may | | Hepatic Function Profile<br>All of the following:<br>Bilirubin<br>Alk. Phos<br>AST<br>ALT<br>Total Protein<br>Albumin<br>and<br>Serum Calcium<br>and<br>25(OH) Vitamin D level<br>Instructions to the patient must be specific for the laboratory test to be performed; general terms such as “labs” are unacceptable.<br>If some of the laboratory tests are performed while an inpatient and the patient is given a prescription for the remaining laboratory tests on discharge, select value 1, (Yes).<br>Allowable Values:<br>1 (Yes) There is an order for the specified laboratory tests.<br>2 (Yes) There are results for the specified laboratory tests in the record.<br>3 (Yes) A prescription for performance of the specified laboratory tests was given to the patient on discharge.<br>4 (Yes) Written discharge instructions given to the patient |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | include a prescription given to patient for treatment of osteoporosis at one or more encounters during the reporting period. This measure is also collected in the Physician Quality Reporting System using G-codes specific to the quality measure:<br>- 3095F Bone mineral density test performed<br>- 4005F Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed<br>For Administrative Methodology (Health Plan Level)<br>When using administrative claims as the data source, the numerator criteria is met by one or more codes in the following value sets:<br>Bone Mineral Density Tests Value Set<br>Osteoporosis Medications Value Set<br>A pharmacy claim for a medication listed in Table OMW-C<br>See S.2b. (Data Dictionary Code Table) | | include instructions to follow up with his or her physician for the specified laboratory tests.<br>5 (Partial) The only lab test not ordered or performed is the Vitamin D test, 25(OH)D.<br>6 (No) There is no order for all the specified laboratory tests, the specified laboratory test results are not in the record, there is no prescription given to the patient for the specified laboratory tests, and there are no written discharge instructions given to the patient to follow up with his or her physician for the specified laboratory tests.<br>7 (Refused) There is evidence in the record that the patient refused all laboratory testing for osteoporosis.<br>Oral Administration of Vitamin D - Administration of Vitamin D, alone or in combination with other components, by mouth. Vitamin D must be given by mouth at a dose to equal or exceed 800 IU daily. Examples of dosing regimens that are acceptable are:<br>1000 IU daily<br>400 IU. b.i.d.<br>10,000 IU weekly<br>50,000 IU weekly<br>Other dosing regimens that calculate to or are ordered at a level of 800 IU or greater per day |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | | | are also acceptable.<br>At least one dose needs to have been administered prior to discharge; orders alone are insufficient.<br>The Vitamin D can be administered as a single drug or in combination with another medication, such as Os-Cal Extra D3.<br>Allowable Values:<br>Y (Yes) There is documentation the patient received Vitamin D by mouth at a dose equal to or greater than 800 IU daily.<br>N (No) There is no documentation that Vitamin D by mouth at a dose equal to or greater than 800 IU. Daily was ordered.<br>U (Unable to determine)<br>R (Refused) Vitamin D was ordered in a dose equal to or greater than 800 IU daily, but the patient refused. |
| Denominator Statement | Women age 65-85. | Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure:<br>Women age 50-64<br>Women age 65-85<br>Women age 50-85 | Patients age 50 and over discharged from inpatient status with an ICD-9-CM Principal or Other Diagnosis Code of selected fractures as defined in Table 3.1 Vertebral Fracture, Table 4.1 Hip Fracture, or Table 5.1 Other Fracture, | Patients age 50 and over discharged from inpatient status with an ICD-9-CM Principal or Other Diagnosis Code of selected fractures as defined in Table 3.1 Vertebral Fracture, Table 4.1 Hip Fracture, or Table 5.1 Other Fracture |
| Denominator | Women who had a documented | The denominator for this measure | Data Elements: (See definitions | Patients age 50 and over |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| Details | patient encounter (See Table 1 for encounter codes) during the reporting period.<br>Table 1: Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 | is identified by administrative codes which are specific to the level of reporting. When reporting this measure at the health plan level include all individuals with fractures enrolled in the health plan (i.e. all individuals with encounters for fractures in the health plan – inpatient and outpatient). When reporting this measure at the physician level include all individuals with fractures seen by the eligible provider (i.e., all individuals with encounters for fracture with the eligible provider).<br>Health Plan Level Denominator Details:<br>Women who had an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. This is the index fracture. If the patient had more than one fracture during the intake period, include only the first fracture. See | and allowable values in attached Excel file)<br>Admission date<br>Birthdate<br>ICD-9-CM Principal Diagnosis Code<br>ICD-9-CM Other Diagnosis Code<br>Comfort Measures Only<br>Clinical Trial<br>Bone Mineral Density Test Performed in the 12 Months Prior to the Fracture<br>On FDA-approved Pharmacotherapy for Treatment of Osteoporosis Prior to Fracture<br>Discharge Date<br>Discharge Disposition | discharged from inpatient status with an ICD-9-CM Principal or Other Diagnosis Code of selected fractures as defined in Table 3.1 Vertebral Fracture, Table 4.1 Hip Fracture, or Table 5.1 Other Fracture. (See codes in attached Excel file – Tables).<br>Data Elements: (See definitions provided in the attached Excel file – Data Elements)<br>Admission date<br>Birthdate<br>ICD-9-CM Principal Diagnosis Code<br>ICD-9-CM Other Diagnosis Codes<br>Comfort Measures Only<br>Clinical Trial<br>Laboratory Testing Performed in the Prior 12 Months<br>Discharge Date<br>Discharge Disposition |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | S.2b. (Data Dictionary Code Table) for all value sets.<br>Physician Level Denominator Details:<br>Women who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set).<br>Table 1: Patient encounter during the reporting period (CPT):<br>Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402<br>Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248 | | |
| Exclusions | Diagnosis of osteoporosis at the time of the encounter. | 1) Exclude women who had a fracture in the 60 days prior to the index fracture<br>2) Exclude women who had a bone mineral density test in the 2 years prior to the index fracture<br>3) Exclude women who had received osteoporosis therapy or medication in the 12 months prior to the index fracture | • Age less than 50 years<br>• "Comfort Measures Only" documented<br>• Enrollment in a clinical trial pertaining to osteoporosis<br>• On FDA-Approved pharmacotherapy for osteoporosis treatment as defined in Table 1.1 prior to the fracture date<br>• Bone Mineral density test documented in the 12 months prior to the fracture<br>• Expired | Exclusions are those patients with:<br>• Age less than 50 years<br>• "Comfort Measures Only" documented<br>• Enrollment in a clinical trial pertaining to osteoporosis<br>• Laboratory testing performed in the prior 12 months<br>• Expired |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | | See attached Excel file for definitions | |
| Exclusion Details | The denominator exclusion criteria is met by documentation in the medical record of a diagnosis of osteoporosis at the time of the encounter.<br>In the Physician Quality Reporting System (PQRS) this exclusion can be collected using G-codes specific to quality measurement:<br>3095F-1P: Documentation of medical reason(s) for not performing a central dual energy x-ray absorptiometry (DXA) measurement (i.e. diagnosis of osteoporosis). | 1) Exclude patients with a previous fracture: patients with an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 60 days (2 months) prior to the earliest date of service with a diagnosis of fracture. For index fractures requiring an inpatient stay, use the admission date as the earliest date of service with a diagnosis of fracture. For direct transfers, use the first admission date as the earliest date of service with a diagnosis of fracture.<br>2) Exclude patients who had a Bone Mineral Density test (see Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the earliest date of service with a diagnosis of fracture.<br>3) Exclude patients who had a claim/encounter for osteoporosis therapy (see Osteoporosis Medications Value Set) or received | See attached Excel file for definitions of exclusions as listed in S-10. | Age less than 50 years Admission date is subtracted from birth date to calculate age.<br>Comfort Measures Only Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as “comfort care” by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).<br>Clinical Trial Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e., fragility fracture).<br>Laboratory Testing Performed in the Prior 12 Months Documentation in the current medical record that all five required laboratory tests were performed in the 12 months prior |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | a dispensed prescription to treat osteoporosis (see Table OMW-C) during the 365 days (12 months) prior to the earliest date of service with a diagnosis of fracture.<br>Table OMW-C: Osteoporosis Therapies<br>Alendronate, Alendronate-cholecalciferol, Calcium carbonate-risedronate, Ibandronate, Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Teriparatide<br>The denominator exclusions for this measure can be identified using either administrative claims or review of medical record. The following criteria are used to identify the denominator exclusion criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.<br>For Medical Record Review Methodology (Physician Level)<br>When using the medical record as the data source, the denominator exclusion criteria can be met by documentation that a previous fracture occurred, a bone mineral density test was performed or an osteoporosis therapy was | | to the admission date. The five required laboratory tests are:<br>Complete blood cell count (CBC)<br>Kidney function test<br>Liver function test<br>Serum calcium<br>Vitamin D level (25(OH)D) |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | prescribed during the specified timeframe prior to the fracture. In the Physician Quality Reporting System (PQRS) this exclusion is collected using G-codes specific to quality measurement:<br>- 3095F or 4005F with 1P: Documentation of medical reason(s) for not performing a bone mineral density test or not prescribing pharmacologic therapy for osteoporosis (i.e. history of fracture in 60 days prior to index fracture, bone mineral density test in 24 months prior to index fracture, or pharmacologic treatment for osteoporosis in 12 months prior to index fracture).<br>For Administrative Methodology (Health Plan Level)<br>When using administrative claims as the data source, the denominator exclusion criteria is met using the following value sets referenced above during the specified time frame prior to the fracture.<br>Outpatient Value Set<br>ED Value Set<br>Nonacute Inpatient Value Set<br>Acute Inpatient Value Set<br>Fractures Value Set<br>Bone Mineral Density Tests Value Set | | |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | Osteoporosis Medications Value Set<br>See S.2b. (Data Dictionary Code Table) for all value sets. | | |
| Risk Adjustment | No risk adjustment or risk stratification<br>N/A | No risk adjustment or risk stratification<br>N/A | No risk adjustment or risk stratification<br>N/A | No risk adjustment or risk stratification<br>N/A |
| Stratification | N/A | N/A | This measure is not stratified. | This measure is not stratified. |
| Type Score | Rate/proportion better quality = higher score | Rate/proportion better quality = higher score | Rate/proportion better quality = higher score | Rate/proportion better quality = higher score |
| Algorithm | Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.<br>-Sex: Females<br>-Age: 65-85 years of age<br>-Patient encounter during the reporting period (12 months)<br>Step 2: Exclude from the eligible population in step 1 patients who have a diagnosis of osteoporosis at time of encounter.<br>Step 3: Identify the number of patients with a central dual-energy x-ray absorptiometry test documented.<br>Step 4: Calculate the rate (number of patients who had a central dual-energy x-ray absorptiometry test documented divided by the eligible population). No diagram provided | Health Plan Level:<br>Step 1: Determine the eligible population.<br>Step 1A: Identify all female patients in each age strata who had any of the following visits with a diagnosis of fracture during the intake period: outpatient, observation or ED, nonacute inpatient encounter or an acute inpatient encounter. If the patient had more than one fracture, include only the first fracture. This is the index fracture.<br>Step 1B: Test for Negative Diagnosis History. Do not include patients with an outpatient visit, an observation visit, an ED visit, a nonacute inpatient encounter or an acute inpatient encounter for a fracture during the 60 days (2 months) prior to the index fracture.<br>Step 1C: Exclude patients who had | 1. Target population is identified by principal or other diagnosis code<br>2. Admission and appropriate age identified; those not admitted and under age 50 are excluded<br>3. Expired patients are excluded<br>4. Patients who had comfort measures only or who participated in a clinical trial for osteoporosis are excluded<br>5. Patients who had a bone mineral density test in the prior 12 months or who were on FDA=approved pharmacotherapy for osteoporosis immediately prior to the fracture are excluded<br>6. Those who had a DXA scan ordered or performed are in the numerator<br>7. For those remaining patients without a DXA scan if | 1. Target population identified as inpatients age 50 and over<br>2. Target population of fragility fracture patients identified by Diagnosis Code<br>3. Patients to be excluded by virtue of discharge status expired, comfort measures only, and clinical trial are excluded<br>4. Patients for whom the physician has documented that they are known to have osteoporosis, or for whom there is documentation of a known cause of osteoporosis, are excluded from the measure to avoid testing for information that is known.<br>5. Patients who had all the laboratory testing in the prior 12 months are excluded from the measure.<br>6. Remaining patients who had all the laboratory testing done |


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| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | a Bone Mineral Density test during the 730 days (24 months) prior to the fracture or a claim/encounter for osteoporosis therapy or received a dispensed prescription to treat osteoporosis during the 360 days (12 months) prior to the fracture.<br>Step 2: Identify Numerator: To do so, identify all patients who were given an appropriate Bone Mineral Density test or received the appropriate treatment to treat osteoporosis during the first 180 days (6 months) after the fracture.<br>Step 3: To calculate the rate, take the number of patients who received the appropriate screening or treatment within the 6-month period following a fracture divided by the number of people calculated to be in the eligible population (those remaining after Step 1C is complete).<br>Physician Level:<br>Step 1: Determine the eligible population.<br>Step1A: Identify all female patients in each age strata who had a documented patient encounter with the eligible provider with a diagnosis of fracture.<br>Step 1B: Exclude patients who had | some other risk assessment method was performed, they are placed in the numerator.<br>8. For those remaining patients without a scan or fracture risk assessment method performed, if they were seen by or linked to a fracture liaison service or placed on FDA-approved pharmacotherapy for osteoporosis, they are placed in the numerator.<br>9. For those remaining patients without a scan or fracture risk assessment method or pharmacotherapy, if there is a documented reason for no pharmacotherapy they are placed in the numerator; if the patient refused pharmacotherapy they are excluded from the measure<br>10. For those patients remaining who have had no DXA scan ordered or performed, no other fracture risk assessment method, and no pharmacotherapy administered and there is no reason for no pharmacotherapy documented and they have not refused pharmacotherapy, if they were contacted by, seen by or linked to a fracture liaison service they are placed in the numerator.<br>11. All remaining patients are part of the denominator | during the current inpatient stay are placed in the numerator<br>7. Remaining patients whose only missing laboratory test is a 25(OH)D are identified; if they received at least one oral dose of Vitamin D equal to or greater than 800IU daily they are placed in the numerator<br>8. All remaining patients are in the denominator. Available at measure-specific web page URL identified in S.1 |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | | a fracture in the 60 days prior to the index fracture, a Bone Mineral Density test during the 24 months prior to the fracture or received a medication to treat osteoporosis during the 12 months prior to the fracture.<br>Step 2: Identify all patients who had a documented bone mineral density test or pharmacologic therapy after a fracture.<br>Step 3: To calculate the rate, take the number of patients who received screening or pharmacologic therapy and divide by the number of people in the eligible population (those remaining after Step 1B is complete). No diagram provided | population. Available at measure-specific web page URL identified in S.1 | |
| Submission items | 5.1 Identified measures: 0037 : Osteoporosis Testing in Older Women<br>0045 : Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older<br>0053 : Osteoporosis Management in Women Who Had a Fracture<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, | 5.1 Identified measures: 0037 : Osteoporosis Testing in Older Women<br>0046 : Screening for Osteoporosis for Women 65-85 Years of Age<br>0045 : Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, | 5.1 Identified measures: 0048 : Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older<br>0053 : Osteoporosis Management in Women Who Had a Fracture<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: Differences: 1. NQF#0048 is intended for use in Care Settings of Ambulatory | 5.1 Identified measures: 0045 : Osteoporosis: Communication with the Physician Managing On-going Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older<br><br>5a.1 Are specs completely harmonized? No<br><br>5a.2 If not completely harmonized, identify difference, rationale, impact: Differences : 1. Target population of #0045 is the ambulatory care/clinic or physician office |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | rationale, impact: There are multiple NQF-endorsed measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0046) and the most closely related measure, 0037. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. ---------- Measure 0037 assesses the percentage of women who report having received a bone mineral density test to screen for osteoporosis., is collected using a survey and is only specified for health plan level reporting. Measure 0037 has the same focus and target population as measure 0046 and therefore could be considered competing. The two measures are completed harmonized on all data elements with the exception of the following which could not be harmonized due to difference in data source: TYPE OF TEST: | rationale, impact: There are multiple measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0053) and the most closely related measures, 0037, 0046, 0045, 2416, 2417. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. NCQA OWNED RELATED MEASURES: 0037: Osteoporosis Testing in Older Women & 0046: Screening for Osteoporosis for Women 65-85 Years of Age. Measures 0037 and 0046 assess the number of women 65-85 who report ever having received a bone density test to check for osteoporosis. These measures focus on screening for osteoporosis in the general population, whereas measure 0053 is focused on secondary prevention in a population of women who have experienced a fracture. Therefore, | Care: Clinician Office/Clinic, Ambulatory Care: Urgent Care; OAF-02 is intended for use in acute care hospitals. 2. Denominator of #0045 is patients with hip, spine or distal radial fracture; denominator of OAF-02 includes those sites of fracture plus additional sites of fracture. 3. NQF#0048 allows only central DXA to be performed and does not allow for any other fracture risk assessment method. 4. NQF #0048 does not address the use of a fracture liaison service. 5. NQF #0048 does not state a time frame for performance of the testing 6. The data source for NQF#0048 is administrative claims, while the data source for OAF-02 is the medical record. 7. NQF#0053 excludes men, excludes women under the age of 67, and excludes patients with an acute care hospitalization. 8. NQF#0053 allows 6 months to elapse from the date of the fracture. 9. The level of analysis of NCQA measures is either health-plan or physician-specific; OAF-02 level of analysis is the inpatient facility. Rationale: 1. The acute care hospital setting assures more timely care and increases the likelihood of | patient; target population of this measure (OAF-01) is hospital inpatient. 2. Numerator of #0045 is notification of physician following the patient that patient should be tested or treated for osteoporosis; numerator of OAF-01 is ordering of laboratory testing for underlying causes of osteoporosis/osteopenia or administration of Vitamin D. 3. Denominator of #0045 is patients with hip, spine or distal radial fracture; denominator of OAF-01 includes those sites of fracture plus additional sites of fracture known to be sites of fragility fracture such as humerus, ankle, and pelvis. 4. The level of analysis for OAF-01 is facility=specific; the level of analysis for #0045 is the individual physician. Rationale: 1. Communication to a following physician does not ensure that testing will be ordered; reviewing hospital inpatients encourages appropriate testing during hospitalization or ordering post discharge. 2. If the patient does not follow up with a physician, or a different physician than the one who was communicated to (partners, etc.), then the communication is lost in terms of |


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| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | Because measure 0037 is a survey measure, the term "bone mineral density test" is used to refer to "dual energy x-ray absorptiometry test." This term is used because cognitive testing indicated the term was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however, 0046 is able to capture more specific about the type of test done due to the data source used for measure collection. EXCLUSIONS: Measure 004 includes an exclusion for diagnosis of osteoporosis at the time of encounter. An exclusion for diagnosis of osteoporosis is not feasible in the survey measure (0046) due to the timing of data collection. ---------- Given the two different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however the two measures address the same quality gap for different levels of accountability. -Measure 0037 addresses whether a health plan is addressing the risk for osteoporosis in the patient population by determining the percent of the population that had a bone mineral density test | we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures. 0045 : Osteoporosis: Communication with the Physician or other Clinician Managing On-going Care Post Fracture for Men and Women Aged 50 Years and Older. Measure 0045 looks at the percentage of women and men age 50 and older who are treated for a fracture and have documentation of communication from the physician who treated the fracture to the physician or other clinician managing the patient's on-going care. The intent of measure 0045 is to measure whether communication took place between the physician who treated the fracture and the provider who is responsible for managing the patient's care post-fracture. The focus of the measure is on communication and care coordination, whereas the focus of 0053 is on treatment and/or screening in the same population. Therefore, we consider these measures to be related but not | diagnosis and treatment of osteoporosis, particularly in a timely manner that will curtail intervening fragility fractures that will occur with a delay in diagnosis and treatment. 2. OAF-02 includes additional sites of fracture known to be sites of fragility fracture such as humerus, clavicle, ankle, tibia, and pelvis 3. OAF-02 recognizes that there are instances in which a DXA cannot be performed due to lack of equipment, scheduling, or other patient issues (such as inability to position the patient in a DXA scanner or patient access issues) and allows for the use of valid alternative risk assessment methods. 4. The physician following the patient may not be skilled or specialized in the diagnosis or treatment of osteoporosis, so that QAF-02 provides that patients are seen by or referred to entities skilled in diagnosis and management of osteoporosis, such as fracture liaison services or specialty physicians, if the diagnostic testing is not actually done while an inpatient. 5. Rapid assessment and management reduce the re-fracture rate that can occur while the patient is waiting to be assessed or | benefit to the patient. 3. OAF-01 indicates specifically which laboratory tests should be done, while 0045 does not. Often, patients are not assessed for Vitamin D deficiency/insufficiency. Given that Vitamin D insufficiency is at epidemic levels in the United States and is a substance necessary to enhance the absorption of calcium and increase the efficacy of osteoporosis medications and calcium, treatment success is enhanced by assessment of 25(OH)D levels. 4. OAF-01 avoids the costs of additional phlebotomy and repeat testing. 5. OAF-01 avoids delay in diagnosis and treatment of underlying causes of osteoporosis/osteopenia. 6. #0045 does not recognize the efforts of the orthopedic community to "Own the Bone" and perpetuates the fragmentary care for osteoporosis that has resulted in inadequate diagnosis and treatment thus far. Impact on interpretability: #0045 results give no information as to whether the testing was ordered, only that the doctor was notified, and therefore the relationship to improved patient care and outcome is unknown. OAF-01 is clear in that it indicates if all required lab tests |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | regardless who their provider is. This test may have been done outside of the context of their primary care provider. Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction.---------- Measures 0045, 0053, 2416, and 2417 address a different population than 0046. These measures address women who have experienced a fracture, and are focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Therefore we consider these measures to be related but not competing. The differences between these measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence we have aligned the measures.<br><br>5b.1 If competing, why superior or rationale for additive value: | competing. The differences between these two measures are reflective of the different measure intents. Where it is appropriate to the measure focus and evidence, we have aligned the measures. OTHER RELATED MEASURES: The other osteoporosis management related measures are more narrowly focused than the NCQA measures. These measures (2416, 2417) are hospital-level accountability measures and focus solely on women who were hospitalized for fractures. 2416: Laboratory Investigation for Secondary Causes of Fracture. Measure 2416 assesses the percentage of patients age 50 and over who were hospitalized for a fragility fracture and had the appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from an inpatient hospitalization. This measure has a different focus from measure 0053 (identifying cause of fracture as opposed to screening/treatment for osteoporosis). While the target population of this measure overlaps with the target population of 0053, measure 2416 is restricted to fractures that require hospitalization whereas | managed in NQF#0048. 6. NQF#0048 indicates that documented patient, system or medical reasons exclude the patient from the measure. How is that determined on an administrative claim? While the same considerations are active in OAF-02, that information is only documented in a medical record, not an administrative claim. 7. OAF-02 includes men and women 50 and over because any fragility fracture in that age group, irrespective of gender, needs to be assessed and treated for osteopenia/osteoporosis; the disease is not limited to women 67 and over. This measure is for acute care inpatients, where care can be rendered efficiently. 8. Patients with a fragility fracture have a high rate of re-fracture, that can occur in the 6 months that are allowed in NQF#0053; there is no point in delay of diagnosis and treatment. 9. Early diagnosis and treatment is often a facility-based initiative; OAF-02 allows facilities to evaluate the effectiveness of any such program they initiate or have in place. 10. OAF-02 can increase compliance with #0053 and #0048. | were done or undone. Data Collection Burden: It is quicker to find laboratory and medication reports than it is to find a specific letter or communication in a medical record, particularly as the measure is converted to eSpecifications.<br><br>5b.1 If competing, why superior or rationale for additive value: No NQF-endorsed competing measures were found. |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | Although 0037 and 0046 have the same measure focus and same target population, they are specified for different levels of analysis and use different data sources. The recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk. Therefore both measures 0046 and 0037 define the numerator as "ever" having a bone mineral density test. It is not feasible for a health plan to have access to enough historical claims data or medical record data to determine if its entire member population has ever had a bone mineral density test. Therefore, a survey method is the recommended data source for collecting this type of historical data for health plans. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, measure 0046 looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on past care.<br>We have described above the rationale for where the measures | 0053 focuses on a broader population. Therefore we consider these measures to be related but not competing. Measure 2416 captures some of the same quality focus as 0053 but is designed to be appropriate for hospital level accountability and is therefore restricted to hospitalized individuals. The differences between this measure and 0053 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment we have summarized where data elements in these two measures are aligned. 2417: Risk Assessment/Treatment After Fracture. Measure 2417 assesses the number of patients age 50+ who were hospitalized for a fragility fracture and have either a dual-energy x-ray absorptiometry (DXA) scan ordered or performed, a prescription for FDA-approved pharmacotherapy, or are linked to a fracture liaison service prior to discharge from an inpatient hospitalization. If DXA is not available and documented, then any other specified fracture risk assessment method may be ordered or performed. This measure has a similar focus to 0053 and an overlapping target | 5b.1 If competing, why superior or rationale for additive value: No NQF-endorsed competing measures were found. | |

| | 0046 Screening for Osteoporosis for Women 65-85 Years of Age | 0053 Osteoporosis Management in Women Who Had a Fracture | 2417 Risk Assessment/Treatment After Fracture | 2416 Laboratory Investigation for Secondary Causes of Fracture |
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| | cannot be further harmonized in their technical specifications due to the level of analysis and data source. | population (individuals hospitalized for a fragility fracture). Therefore this measure could be considered competing with 0053; however, 2417 is designed to focus on hospital level accountability and therefore is only inclusive of populations and services provided within the hospital setting. Measure 0053 is designed to be broader and capture both outpatient and inpatient populations and services. In the attached memo on measure alignment we outline the specific data elements where these two measures are aligned.<br><br>5b.1 If competing, why superior or rationale for additive value: Measure 0053 is designed to be as broad as possible to include the largest possible population (all women age 50+ with a fracture other than face, finger, toe, and skull) and include the broadest possible settings of care (inpatient and outpatient). The measure is designed for both health plan and outpatient physician level accountability. It is focused on guideline recommended care for osteoporosis management after a fracture. A companion measure in development focuses on screening and treatment in men age 50+ | | |

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| | | (guideline recommendations for when men should receive treatment and screening for osteoporosis and the recommended treatment differ between men and women therefore a separate measure is necessary). Measure 2417 (under review for NQF endorsement) is designed to be appropriate for hospital level accountability and therefore focuses on a smaller population (all patients 50+ hospitalized for a fragility fracture) and includes a single setting of care (inpatient). While some post-fracture care occurs in the inpatient setting, much of the responsibility for providing follow-up care for osteoporosis management in women rests with the outpatient care system and providers. Additionally, many patients who suffer a fracture may not be treated with an inpatient hospitalization. Therefore it is important to have a measure that captures a broader population and settings of care for osteoporosis management following a fracture. | | |

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