National Quality Forum

Moderator: Shaconna Gorham
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OPERATOR: This is Conference #: 83573033.

Operator: Welcome everyone. The webcast is about to begin. Please note, today's call is being recorded. Please stand by.

Shaconna Gorham: Good afternoon everyone. This is Shaconna Gorham and I'm here with my colleagues Vy Luong and Reva Winkler and we welcome you to the Eye Care, Ear, Nose and Throat Conditions Standing Committee Workgroup Number 1 Call.

We have several workgroup members on the call. I'll just introduce your name and you can give a quick hello.

Matthew Carnahan?

Matthew Carnahan: Good morning.

Shaconna Gorham: Good afternoon. Vaishali?

Vaishali: Hi. Good morning from here to California.

Shaconna Gorham: Oh, good – Oh, I forget you all are in different time zones. And then we have a few developers on the line as well.

Flora?

Flora Lum: Good morning to you. I'm from California.

Shaconna Gorham: Good morning. And Flora's from the American Academy of Ophthalmology. Peter, are you on the line?

Peter Robertson: I am. Hi.

Bill Rich: Yes. And this is Bill Rich, Director of Health Policy for the American Academy. I just got on. Thank you.

Shaconna Gorham: Hello. (Rebecca), are you on the phone?

(Rebecca): I'm on the phone. Can you hear me?

Shaconna Gorham: We can. (Joshua Stein), from our workgroup, have you joined the call?

(Joshua Stein): Yes, I'm on.

Shaconna Gorham: Hi (Josh).

(Joshua Stein): Hi.

Shaconna Gorham: So, all of our workgroup members are on the call today. Vaishali is on the phone. She's listed as the discussant. However, she's had some medical issues. So, I'm not sure if my workgroup members – the standing committee members received my e-mail. But she is definitely going to participate. She just will not participate as a discussant today.

Female: OK.

Shaconna Gorham: OK. Is anyone on the line from AMA PCPI?

OK. Reva, you want to start our considerations of the candidate measures?

Reva Winkler: Sure. Hi everybody and welcome.

Today, the purpose of the workgroup is for the standing committee members to have an opportunity to share among a small group within the committee their initial thoughts about the evaluation of a group of – subgroup of the measures that the entire committee will be evaluating in June.

And so, the purpose is to give the – to share their initial thoughts, ask any questions about the information provided by the developers, ask any questions about the evaluation criteria and generally just become more comfortable with the evaluation process. All of this is in preparation for our in-person meeting in June.

So, really everyone should feel comfortable asking questions. I don't want anybody to feel like you're put on the spot. We really just want to help you understand the evaluation process better and the criteria. And be sure that you're able to find all the information and give a chance to share some of your initial thoughts with some of your colleagues.

So, the first measure we're going to be looking at is measure a 564, and this is complications within 30 days following cataract surgery that require additional surgical procedures. And so, this measure is an outcome measure and it comes from AMA PCPI – do we – not – anybody from PCPI on the phone? I'm surprised.

Female: Yes, we're on the phone. We're running…

Reva Winkler: OK.

Female: … large groups.

Reva Winkler: OK. Hi all. Welcome.

Female: (Hello).

Reva Winkler: So, this measure is the percentage of patients age 18 years and older with the diagnosis of uncomplicated cataract to a cataract surgery and had any of the specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications. Retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence. So, again, an outcome measure for a very commonly provided performed surgery.

So, I think our discussants are Matthew and (Joshua). So, perhaps just because you're listed first, Matt, why don't you give us your initial thoughts on this measure? We'll go through the criteria in order. We do want to try and get – to have an opportunity to talk about all four of the measures. So, you know, I'll try and watch the time so that we will get some discussion on all four.

So, Matthew, did you want to just begin and tell us your thoughts about the evidence and maybe opportunity for improvement on this measure?

Matthew Carnahan: So, it seems like something that most people are hopefully keeping a launch on. So, that's a – I think it sounds like it's a great idea that we have a more formalized process around that.

Based on what you're saying, it sounded like there were certain procedure diagnoses that would be a secondary identifier if they came up within 30 days of the initial cataract surgery, I wasn't clear on that, versus secondary diagnosis of those four; endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence. But I think the only concerns I had were around the exclusions.

Reva Winkler: OK.

Matthew Carnahan: It seemed like…

Reva Winkler: Why don't we wait for just a second until we get down to talking about the specifications? Let's just be sure there aren't any questions on the initial criteria around evidence. This is an outcome measure, so really the evidence is, you know, are there structures or processes that can influence the outcome? And so, the evidence criteria for an outcome measure is really very straightforward and then the opportunity for improvement. What current performance is it demonstrating and in terms of the overall importance for this measure? And then we'll go right to the specifications and talk about the exclusions.

Matthew Carnahan: OK. So, the question is, does it seem like it's a valid measure?

Reva Winkler: Not yet. We're talking about…

Matthew Carnahan: All right.

Reva Winkler: … the first parts of the criteria on evidence and then opportunity for improvement.

Matthew Carnahan: OK. So, the evidence is based on the one test side of the four doctors that were involved as well as looking at the PQRS outcomes from the…

Reva Winkler: Yes.

Matthew Carnahan: … what was it, 36 percent that's submitted?

Reva Winkler: Yes. Yes, that's – those were the testing results. And if you're looking at the information on the measure worksheet, we'll just follow right along, you know through the criteria.

Again, the evidence is really basic question for an outcome measure. And then the data provided from PQRS for the – for three years shows aggregate performance results that have been provided by the developer. So, just – any thoughts or questions?

Dr. (Stein)? Did you have any thoughts or questions on these two – on the initial subcriteria?

(Joshua Stein): You know, I think for the most part if that's (in) complications after cataract surgery is a good indicator of quality. Many of the potential complications that are being considered are reflective of a surgeon taking the proper time to carefully plan for the surgery and doing the surgery to his or her best ability.

A few of the complications may be attributable to factors that are beyond the controls of surgeon like retinal detachment, may be more related to the anatomy of the patient and that's something we can discuss. By link in complications to need for additional surgery that limits complications to those that are, you know, deemed important enough to require an additional procedure. So, I think we're capturing, you know, important complications.

And it also limits the burden of – in terms of the surgeon and the staff having to grab the data from the EHRs or the claims data since a need for additional surgery is something that should easily be capturable. So, I thought evidence is pretty good.

Reva Winkler: OK. In terms of opportunity for improvement, we see the aggregate performance results from PQRS. Any comment son that as you know over time there is a slight increase in the performance value?

Matthew Carnahan: That would suggest there's even more value to this measure, correct?

Reva Winkler: OK. Quite reasonable.

All right, so we do want to take a look – for the committee members, just to be sure you realize that we've inserted the preevaluation comments from the workgroup members in – to the worksheets for your reference. You can see what the thinking is among your workgroup members on these criteria. So, I just want you to be aware that we've tried to consolidate all this information.

OK. Let's move down to the (specific) acceptability of the measure, and we are talking initially on reliability about the specifications. And we do have multiple specifications for this measure for claims, for registry and also as an eMeasure. And with the HQMF specifications which are what – define any measure are included in your document set. And I hope you've all been able to find that.

So, I'd ask the members of the workgroup, were you able to locate the HQMF specifications in your document set?

Matthew Carnahan: I wasn't able to activate that link right there.

Reva Winkler: OK.

Matthew Carnahan: … password that I didn't have.

Reva Winkler: OK. But you've been able to access the SharePoint site, correct?

Matthew Carnahan: Yes, everything else I've been able to access.

Reva Winkler: OK. When you open up the – click on the link for this measure, you'll see that there are multiple documents underneath it. And one of them is a folder and that folder has several documents in it. One of which is the HTML document that is the human readable specifications for the eMeasure.

Female: Yes. So, I'm screen sharing it right now, Reva. As you can see I opened up the document folder for this measure and I clicked on the ZIP file. If you open up the ZIP file you can see the HTML formatted document right here. If you click on it, it's more of a readable format for the HQMF. Can you all see this?

Male: Yes.

Male: Yes.

Female: OK.

Reva Winkler: All right.

Female: Great.

Female: Yes.

Reva Winkler: We just want to be sure you're aware that it's there and that's how you look at the specifications.

And if you scroll down to the bottom, you'll actually see the kind of the measured logic and how the data elements are put together for the eMeasure. And in this, they list out the various exclusions as well.

So, Matthew…

Vaishali: This is Vaishali. I was actually having trouble getting on the SharePoint website itself. And so, I can just call afterwards and have someone walk me.

Reva Winkler: OK. We'll do that.

Female: That will be great.

Vaishali: Great, thank you.

Reva Winkler: Sure. OK. So, Matthew, you want to talk about the specifications?

Matthew Carnahan: If you're seeing right there there's a large – I guess two parts to it. One is that there's a large number of exclusions. It sounded like they felt it over two-thirds of cases would still be included, which is great. And then on the reporting piece, maybe that's a separate area.

But if looking at the PQRS data, there's only a certain proportion of people who are submitting and maybe there is a submitter bias as to – and perhaps it's even a more valid measure should there be some sort of requirement that people submit, meaning that those who aren't submitting may have higher complication rates than even the…

Reva Winkler: OK.

Matthew Carnahan: … percent it did submit.

Reva Winkler: All right. Dr. (Stein), any thoughts on the specifications for this measure? There is a rather extensive list of exclusions.

(Joshua Stein): Yes. I didn't go through all the ICD-9 codes for exclusions. I figure that's something we might do in person.

Reva Winkler: OK.

(Joshua Stein): It did seem like there was a lot and I think it's something that the group and or the developer would need to look carefully at since there are a lot of people who are – patients who are being excluded. Obviously, surgeons will need to properly code patients with the co-morbidities that are exclusions for them to get excluded and how well providers are doing that is something that may need to be looked into. You know, if one surgeon is not that great at documenting the number of ocular comorbidity the patient has then there may be patients that other providers are excluding that that provider may not be excluded.

Let me just see my other comments.

Yes, I had some questions about, you know, whether the – how well the data captures if surgeries – if subsequent procedures are being done on the contralateral eye, whether the different, you know, registry in EHR and claims data are capturing which eye had the subsequent surgery. You know, if someone had a cataract surgery and then they had a vitrectomy on their contralateral eye, whether they could get dinged for that and I know with claims data that's an issue. But I think with some of the other data sources it should be better captured…

Reva Winkler: Yes. Did you want to check with the developers to see if they had any response to that question?

Somebody from PCPI? Yes. OK.

(Jamie): Yes. This is (Jamie). (Jamie Dwyer) at (inaudible). Currently, the eCQM has (drive in) that – is that laterality is not something that's capturable and all of the terminologies that are used. So that is a challenge that we are aware of and that we've encountered.

Excuse me. Sorry. But it is something that as we begin to phase out some of these other transitional vocabularies we might be able to include that a little bit more. But we have provided guidance that we hoped that there were would be documentation about the laterality and the patient's medical record, but that's something that's for the purposes of the measure. We are unable to capture it at this point in time.

Reva Winkler: OK.

Matthew Carnahan: And I also had a question about if someone had multiple complications in the same patient, how that's handled?

(Jamie): So…

Matthew Carnahan: Is there something you can comment on?

(Jamie): I think that it would just be counted once. Because they think we were looking at from every single cataract surgery. So every cataract surgery is the – that's the trigger point. And then from there, we'll look to see if within 30 days if there was anyone, there could be more but we just need to make sure if there was one that was documented then that is efficient and that counts for the measure.

Matthew Carnahan: And then one other point, and you can cut me off if I'm going to too many details...

(Jamie): Yes.

Matthew Carnahan: … I don't know if this is the forum to…

(Jamie): That's fine.

Matthew Carnahan: … this level of detail. It might, you know, there are all these exclusion criteria for the various ICD-9 ocular condition, but it may be worthwhile for the developer to consider excluding those with more complex cataract surgery, the 66982 code, or at least doing risk adjustment for those cases and if they're more complex. It looks like right now they're all being lumped together.

(Jamie): So I think that we would probably need to take a look at that and work with specialty societies to determine if that might be something that's appropriate for a future iteration of the measure. But at this point we've just completed the annual update, so that would not be something that would be added in the immediate future. Or who knows in the immediate future.

Reva Winkler: OK. All right, from either – anybody in the workgroup, any other questions or comments about the specifications of the measure?

OK. Then in terms of reliability, this measure has been tested. We do have data from the registry in reporting on 390 physicians reporting, the reliability was evaluated at the level of a measure score for the registry. The eMeasure or the data element validity testing was performed, which would count for a

data element validity, so that – the reliability will get the same score for the eMeasures in – as it would for validity.

But are there any questions or discussion of the results of the reliability testing for this measure for either the registry measure or the eMeasure? From either – from the committee? Matthew or (Joshua), do you have any thoughts?

(Joshua Stein): I thought the reliability was pretty good. 0.87 to a 0.97.

Reva Winkler: OK. So no concerns about that or questions. You're following things along.

OK. In terms of the validity, again, one of the – there are multiple questions around validity and one is, does the specification – are the specifications consistent with the evidence? And this is an outcome measure, so that's pretty straightforward.

Again, validity testing for the claims registry measure was done with a systematic assessment of phase validity. For the eMeasure, there was an evaluation of the data element validity by testing the measure data elements automated through the EHR versus a manual abstraction. And so these two you can see are the relatively high percentage identified there.

Any questions on the actual testing for validity? There are some aspects of validity that – potential threats to validity that we'll talk about in a second. Any concerns or thoughts there from the workgroup?

OK. Questions?

(Joshua Stein): This is (Josh). I would've liked to have seen more than just one site that the data reviewed from just one site. You know, if that site…

Reva Winkler: Sure.

(Joshua Stein): … happens to have a practice office where they capture information better or worse than other sites, I'm not sure, it's a good reflection of, you know, eye care in general. And I know with the IRIS Registry and with some of the other sources that are going to be available soon, hopefully this won't be an issue.

Reva Winkler: All right. Yes. Pardon me. As you can see, the note that we've written, NQFs criteria is evolving and many people have voiced that exact sentiment about needing to see how well the measure works in multiple systems.

And so – but at this point, we're kind of transitioning and evolving with more and more eMeasures coming in and so we don't require it because it was tested before this current timeframe. But new measures coming in, we are going to expect to see testing in more than one system. So, your sentiment is shared by many folks.

Anything else on the validity testing?

Let's talk about the threats to validity, because I think this is where you were bringing up some of your questions around the exclusions and the number of exclusions. And we updated some data that was provided by the developer just last week and – where they did a frequency analysis of the exclusions in the Medicare of 5 percent beneficiary claims data file. And so they were able to look at the claims around 46,000 plus patients undergoing cataract surgery and with over 70,000 procedures. And so they found 52 percent of the procedures had a cataract measure exclusions associated with it. So, I'd be interested in hearing what the workgroup members think about that data.

Matthew Carnahan: I think it goes back to what (Joshua) was saying, maybe we should look at reducing the number of exclusion criteria. I mean things like (we've seen how) cataract, it was quite – there's a few in here that you would think that have the potential to become really routine cases if proper care is taken. And so it should, right, put the patient at higher risk of having a return or it is the complications within 30 days.

Reva Winkler: OK. So that sounds like that's a discussion point for the entire committee at the in-person meeting, because it is an important aspect of this measure.

It'll probably be good for the workgroup members to take a closer look at the list of exclusions and it is fairly lengthy and perhaps be able to discuss that in a little more detail with the rest of the group at the in-person meeting.

OK. Another potential threat to validity is case-mix adjustment and that was mentioned a little bit earlier. This measure is not risk adjusted. And, I guess, I'd want the workgroup to know what your thoughts on that is, particularly for an outcome measure.

Matthew or (Josh)?

(Joshua Stein): Yes, I think that risk adjustment is important. You know, I think we're – that it's a little challenging because we're just getting – we don't have – we don't know exactly what to risk adjust for. And, I guess, the assumption is that if you, you know, if you exclude people with all these ocular comorbidities there's no need to risk adjust. And, you know, ocular comorbidities are certainly a reason why someone might have complications but, you know, maybe things like overall patient health, socio demographic, characteristics, health literacy, you know, there are various other things that could impact, you know, risk of complications.

I think the challenge is, you know, how easy it is to capture those variables in the different data sources that are being used and how to properly risk adjust. And I can understand why the developers, you know, recommending not to risk adjust. I would just say that that should be something that the developers should look to do down the line because it would make the measure a lot better.

Reva Winkler: OK. Thoughts, if any, the workgroup members? OK. So that's another thought.

Meaningful differences. There was some updated information that in terms of the range of performance, not a lot of detail. We didn't have any information specific to the eMeasure in terms of data results.

And then the other question, I think, I'd like to hear your thoughts on is the comparability of the data sources. This measure is specified for claims registry in an eMeasure and we know these measures can be used for multiple data sources in various programs. How do you – What are your thoughts on, you know, the various – different data sources and comparability of the results?

(Jamie): Excuse me, Reva. Really quick. This is (Jamie) from the PCPI again. I just want to be very clear that this measure is only specified for registry in EHR. It is not…

Reva Winkler: OK, sorry.

(Jamie): … measure. Yes, that's OK. (Inaudible) in the next cataract (but it's ours), are both registry EHR only.

Reva Winkler: OK. I guess I'm confused because the data that you provided for the exclusions clearly claims – came from a claims data file.

(Jamie): This measure is – since it came from PQRS information this measure is only reportable via registry for the PQRS program. While typically measures are claims registry reportable, this one is only registry and I'm sure that they collect their data in a somewhat similar fashion. But, again, CMS collected that they provided to us so I'm not sure that we have followed the information about how that's collected.

Reva Winkler: OK.

Sam Tierney: Reva, this is Sam Tierney. And just to add to that, I, you know, we have pointed the good one. I can see the source of the confusion with the information we've provided from the Medicare file.

That was really to enhance the testing data, because we hadn't had good information from the other data sources related to exclusion. But we knew certainly with the point of interest and discussion among the steering committee members…

Reva Winkler: Right.

Sam Tierney: … wanting to understand the impact of those exclusions on the measure. So that was part of an additional analysis that we did. But it's not reflective of the data source of the measure.

Reva Winkler: OK.

(Joshua Stein): I think that, you know, looking at results from different sources in general, not just for the specific measure, but for all the ones that are being considered today, you know. If you're seeing that one data source is picking up either complications or better outcomes a lot better than other source, you know, whether the data should be weighted or risk adjusted or something. But you don't want a provider to have an advantage or disadvantage because their data is coming from one source versus another, so I think it's an important thing that needs to be looked at down the line.

Reva Winkler: OK. All right.

Vaishali: So this is Vaishali. And, you know, we will provide our written comments by the end of the week as I had mentioned. And we haven't reviewed, you know, things yet because I had a medical situation come up last week. But my first thought regarding, you know, this – so with that disclaimer, thought, you know, regarding the – this measure being an EHR versus some of the testing being in the claims is that if they intended to implement this measure in EHR then I would, you know, suggest doing additional testing in EHR data set.

(Crosstalk)

Male: It's registry reported.

Female: OK. So then do additional testing in registry because, you know, and having work both with claims data and extensively with electronic medical records data, you know, it's not – we (shouldn't have think) that they're both the same and we also shouldn't assume that it's always, you know, that EHR data or registry data is as – that we're going to be able to get what we want out of it very cleanly for reporting purposes on the registry. So that's why I think testing – additional testing would be a good idea.

Reva Winkler: OK. All right. So those were the various things to consider, it's potential threats to validity when you're doing the assessment or the rating on validity and using the algorithm. Again, we've included the comments.

So, if there are no further comments on validity we'll go then to feasibility, which is focused mainly on the data source and the burden of data collection analysis and reporting, the degree to which the data elements are defined in electronic data sources. And there was a feasibility assessment provided for the eMeasure.

Any questions about the feasibility criteria, the information provided from anybody on the workgroup?

Dr. Carnahan, Dr. (Stein)? Do you feel comfortable with this one?

OK.

Matthew Carnahan: Yes, I think we've already addressed…

Reva Winkler: Yes, a lot of those. I agree. OK, how about – the usability and use criterion as this is, you know, how is the measure being used? It's being used in the PQRS program. It's also being used – eMeasure is being used in the Meaningful Use program. It's also used in the IRIS Registry. So, in terms of public reporting, PQRS has indicated that many of those measures will be publicly reported soon, as well as used in the value-based payment modifier for CMS. So, it is being used for high stakes purposes.

Do either of you or anybody on the workgroup are you using this measure at all?

Male: No.

Reva Winkler: In your practice? OK. OK. So, any questions or thoughts around usability and use, in terms of the criteria or the information provided?

OK. Well then we've gone through the criteria for the first measure around the complications. So we can go on – unless there are any further questions from the workgroup members. We can go on to the next measure which is 565, which is another outcome measure for cataracts which is the 20, 40 or better visual acuity within 90 days following cataract surgery, sort of a basic question of how well can you see after you've had your cataract surgery.

So, again, on this one, (Joshua) and Matthew I think you're the same discussants for this measure. In terms of, you know, it is an outcome measure so evidence is pretty straightforward. In terms of opportunity for improvement and or the specifications, what are your thoughts?

(Joshua Stein): You want us to start with the evidence or…

Reva Winkler: Yes. You know, the evidence again for the outcome measure is really – is there – are there process or structures or something actionable that can influence the outcome? So, it's a very straightforward criteria for an outcome measure.

(Joshua Stein): Yes. So, I think that visual acuity after cataract surgery is an important outcome since it's the primary reason for doing the surgery and…

Reva Winkler: Right.

(Joshua Stein): … it's tied to improvements and quality of life, maintaining independence, operating motor vehicle, et cetera. So, I think it's pretty straightforward to me.

Reva Winkler: OK. So, again, evidence for outcome measures are pretty straightforward.

In terms of opportunity for improvement, you can see the mean – the aggregate mean performance from the data from PQRS shows that the results generally are above 90 percent, thoughts on the improvability by this measure.

(Joshua Stein): You know, it's interesting that if you don't exclude patients with comorbidities, the (ask risk) data that the developer presented and showed it to be 85.5 percent whereas the U.K. data set reports 94.7 percent when you do exclude all the patients with comorbidities.

I guess the, you know, the question is, is it better to have a more inclusive measure that doesn't restrict it to people just, you know, who don't have a bunch of comorbidity and come up with a rate that's around 86 percent versus have a more limited group of patients who are eligible and with the aim of trying to get it at 100 percent.

You know, it might be that, you know, instead of having a measure where, you know, the – you'd expect everyone to have 100 percent, you could have a measure where you expect everyone to have, you know, 85 to 90 percent and then those with lower rates or those with higher rates, you know, might be better or worse.

Reva Winkler: All right.

Matthew Carnahan: Along those lines, (inaudible) was a voluntary reporting program and maybe we're getting a bias on that and we would get a lower rate. Possibly they are…

Reva Winkler: Sure.

Matthew Carnahan: … reporting and we're doing it as well.

Reva Winkler: All right. You know, the other thing to consider is what the range and the variation among those with – underneath that data because we just have the single data point.

OK. So we can move on to the scientific acceptability and the specifications. So, what – any thoughts on the specifications for this measure?

(Joshua Stein): Yes, you know, I have a few things for the developer to consider. You know, sometimes patients undergo cataract surgery with best corrected visual acuity of 40 or 20/40 or better before the surgery. And, you know, should those patients be excluded from the denominator? Because, you know, I can see that providers could gain the system by, you know, operating on patients with better vision to begin with since – if the goal is to end up with 20/40 or worse – or better vision afterwards?

The other concern is how the 20/40 is being measured. You know, there are different ways that's documented in the chart. And maybe – and I didn't see this in all the details but, you know, is it by a manifest refraction, best corrected, uncorrected, pinhole acuity, any of those.

And then the other question is at what time point is it being assessed? You know, so if someone sees a surgeon eight times in the first 90 days, if any of those eight that get – they record a vision of 20/40 or better, does that count, or does it need to be greater than X amount of time? Those are the kind of details that wasn't really fully clear about.

(Elvia): This is (Elvia) with the AMA PCPI staff. And I just wanted to point out that this is best corrected visual acuity measure. So it studies the focus.

Matthew Carnahan: It is near or far, correct?

(Elvia): Yes.

(Joshua Stein): At any time point in the first 90 days?

Female: Our specification especially for the eCQM is any point in time within the 90 days. So that's a subsequent – it would be like a subsequent (business) from the cataract surgery. So depending on when that would be. That would be when the visual acuity would be assessed. It includes 90 days after the surgery, but also less than.

Reva Winkler: Other questions or thoughts on specification?

(Joshua Stein): So if a surgeon operates on someone and they're coming back and seeing him and they're getting 20/50, 20/50, are there incentives to bring the patient back more time until they finally get a 20/40 number or does that not concern you guys?

Sam Tierney: Hi. This is Sam Tierney. So I think that's a good question. It's not something that's come up during implementation or an unintended consequence that we've discussed. We could certainly confer with our AAO colleagues and kind of discuss the issue further and see if they've learned anything from their implementation on the IRIS Registry.

Matthew Carnahan: Were these registries, do the ophthalmetry people co-managing these patient to input that data?

Sam Tierney: So, this is Sam. I guess – is Dr. Flora Lum on the line? I wonder if Dr. Lum, I'm sorry to have put you on the spot or Peter Robertson, if you could speak to the registry since you all manage the implementation…

Flora Lum: Good morning. Yes. (Mester) is the operating surgeon, so the data inputted by the surgeon or the surgeon's practice. If it's co-managed then the ophthalmologist still may track the patient and track the visual acuity. If they don't have the visual acuity then they wouldn't get credit for the measure. That's how our registry works.

Matthew Carnahan: We don't have any idea what percent of fallout we might get based on co-managed patients who might not be seen beyond the first post-operative made by the operating ophthalmologist.

Bill Rich: Yes, this is Bill Rich. The potential is 15 percent of the three million cataracts. Of those, probably – I think it's about 70 percent are done by ophthalmetry. I don't know the initial, you know, the final percentage in the two years of claims data, so small number.

Reva Winkler: OK. Any other questions or thoughts about the specification from the workgroup members?

Vaishali: This is Vaishali. I – Wasn't the question, if a patient has more than one visual acuity assessment in that post 90-day period then which one to use for the measure? I thought that was the question from (Josh Stein)?

(Jamie): So, this is (Jamie). With respect to that, we don't have it currently specified using the most recent or anything like that. It's basically looking to see if at any point within those 90 days did you meet one of these criteria. Did you meet the 20/40 better?

So, you could have multiple. As long as it met at once then it would be counted. If it's in (inaudible) all then obviously been (inaudible) it all. But the number of times that the visual acuity could be assessed is, I guess, however many frequent – however frequently that patient is seen. But, again, you only need to meet that criteria once in order for it to be counted towards the measure.

(Joshua Stein): Yes. So, clearly patients who are coming back more often and getting their vision tested more often have a greater opportunity to meet the measure, you know, whether that's good or bad, something we can think about.

And then I think the point that Matthew brought up about co – patients who are being co-managed, if the numbers that the ophthalmetrists are recoding in their office, you know, limits the number of time points that are being considered by that position because those other time points that the ophthalmetrists are measuring are not being captured in whatever data source then that could impact how well one does on the measure.

Bill Rich: Yes, and just for clarification, this is Bill Rich again. The reason why it's (inaudible) people feel at different times and it's the best correct division in the patient's discharge, you know, and I've seen it. So that's why it says up to 90 days, so people (inaudible) in three weeks, some six weeks. The fact that they're coming back doesn't mean they're gaining, it means that the retraction is still changing and they're not going to – so that's why the variability of – from three weeks to 90 days is acceptable because people heal with different rates.

Female: Yes. So, I agree with that too. And so the reason why I was asking the question is to also make a point that, you know, in light of the registry and electronic medical records I've researched that we've done – we do fine. That patients have, you know, multiple visual acuities in a short period of time after surgery.

And so what we've done in the past is taken – when we have multiple recordings of visual acuities we would take the best measure during that period. So I'm in agreement with that approach.

Reva Winkler: OK. All righty, anything else on specifications? If not we can go down and take a look at the testing to reliability. Again, we do have testing in the performance measure score from the registry data and that is presented to you. They did a nice job of providing the reliability at the minimum level of quality reporting events to recapture the measure which is 10 versus those that have

many – more data points. And then, again, the eMeasure is a similar data validity testing as we talked about in the last measure.

So, any thoughts or comments from the workgroup on the criteria for reliability or the information provided?

Dr. (Stein), anything from you?

(Joshua Stein): Just that it goes up as there are more cases. So, you know, whether the minimum number should be 10 or should be 30 or 50 is something that, you know, obviously by increasing the minimum number than you are – there are a bunch of surgeons that are not going to be included but the reliability also goes up quite a bit. So I think this is a trade-off.

Reva Winkler: OK.

Matthew Carnahan: Is there going to be a way to identify that when it's reported? Where there's a percentage of perhaps the (N) involved to get that point?

Reva Winkler: We have folks from the registry to talk about how they might report that data. No?

Male: Sorry. What was your question again?

Male: Yes, the question isn't clear. Is it the minimum number of cataracts that performed in a year? Is that the question?

Matthew Carnahan: The number of cases that were reported (related) to the percentage that was given?

Female: Right. Because at registry – well, for the cataract measures group they do have to report a minimum of 20, 20 cases.

Reva Winkler: OK.

Male: But in general, the registry we capture all cases regardless of the number of procedures performed by the physician either it's one or 100 (inaudible).

(Crosstalk)

Matthew Carnahan: If we're seeing a higher percentage success with those with the higher volume submitted, but we don't that to be true. But if that was the case, would it identify that volume in relation to the percentage success? (In many) cases it had a 100 percent success, but someone else had made it 1,000 cases and had a lower success, just do an increased variability of the cases that they were doing surgery and are chose to submit all versus cherry-picking the patients. Would that be identifiable in the reporting?

Female: So, I think there's a little bit of confusion when we talk about registry because the traditional registry, which is a manual entry, that's the cataracts measures group for which they can use this measure. And that is 20 cases across. Every provider has to report those cases. Now, the IRIS Registry as Peter had said, we collect cases if they can't cherry-pick on the cases that are selected for that measure, for the eMeasure.

Male: Even if they – there is where I (inaudible) the co-management cases that they would have to selectively answer because they were an offsite location with an ophthalmetrist, the 15 percent.

Female: Well, I say those would count. As I said the – so if you have this measure, it's the responsibility of the operating ophthalmologist, if they don't have the visual acuity and the visual acuity is not at best correct to 20/40 then they would not receive credit for the measure. Because even if it was co-managed, we feel that the operating ophthalmologist should actually be responsible for the outcome and should track that outcome. And it's easy to get that back in to the record if they're getting reports from and I think probably that's the proper management is that the co-managing ophthalmetrist will report back on the outcome – official outcome of the patient. So, they could still receive credit at co-managing but they have – they would have to track that visual acuity outcome.

Male: Otherwise, the patient will sit in the denominator but they will not get credit no matter what (position it can) if the post-op co-managing vision is not tracked, recorded and submitted.

Reva Winkler: OK. All right. Any other questions on the reliability testing that's provided or the criteria from the workgroup members?

OK, then we'll move down to validity. Again, the validity testing is similar phase validity for the registry, the eMeasure was again a comparison of manual abstraction versus automated with fairly high agreement. Again, I think consideration of threats to validity, so there was some updated information again provided based on claims data which we heard the explanation previously. So, 25 percent of the procedures had a exclusion for this measure. And this is another outcome measure that's not risk adjusted.

Any comments from the workgroup members, any questions to the developer about any of these things?

(Joshua Stein): Just similar to my comment before that I'd like to see more than one practice assessed.

Reva Winkler: OK. Anything from anybody else from the workgroup? All right, you're feeling comfortable that you understand the information and it's – you'll be able to discuss it with the entire committee at the meeting in June.

OK. We've sort of have a similar situation in terms of the meaningful differences and the comparability that we did with the last measure. Probably isn't a lot new to say. And so, please consult the algorithm for evaluating the information to determine your ratings. And you can see that we've inputted the committee's pre-evaluation comments here which you've raised a lot of these issues. So these are reminder of the kinds of things you want to share with the entire committee as you have the discussion and final ratings.

Again, similarly we have the same issues around feasibility and use and usability. Is there – Are there any questions from the committee around the criteria or the information provided?

OK. And again, I'll ask – are any of you using this measure at all yourself, in your own personal practice?

Male: No.

Male: No.

Reva Winkler: No? OK. All righty. So…

Bill Rich: No.

Reva Winkler: I'm sorry? I wasn't sure…

Bill Rich: That question…

Reva Winkler: Yes, who's…

Bill Rich: This is Bill Rich. I should've – Was that question addressed to any members?

Reva Winkler: Yes. I was asking the workgroup members.

Bill Rich: OK.

Reva Winkler: Yes, if they had any personal experience.

OK, any other comments or questions about the – that measure before we move on to the next one? If not, the next one is again another outcome measure, in this case for primary open-angle glaucoma, reduction of intraocular pressure by 15 percent or a documentation of a plan of care.

And Dr. (Stein), you and Vaishali were assigned for this and we know that Vaishali hasn't had a chance to really look at the information quite yet. So, could you kind of give us your initial thoughts on this measure?

(Joshua Stein): Sure. So, in terms of evidence to support the measure, you know, there are several large randomized control trials that have shown that lowering intraocular pressure reduces glaucoma progression for patients with ocular hypertension, all severities of glaucoma. (In the) academy, it has a preferred practice pattern that recommends lower – initial lowering of 25 percent and the studies will report lowering of pressure, the trials 18 percent to 42 percent.

You know, I think the developers provide information to justify the 15 percent threshold. You know, this is not a direct outcomes measure. You know, the

outcome would be damage to the nerve or loss of visual field on a pyrometry but it's pretty well established the entire intraocular pressure affects those outcomes. So, I think it's kind of a good surrogate for that outcome.

Reva Winkler: OK. Thoughts from any of the other workgroup members on evidence? This measure also that was provided – I'm sorry. Yes.

Vaishali: This is Vaishali. So, I mean without having, you know, review this measure itself, I can comment on the evidence and my comment is that I agree with Dr. (Stein) that there is, you know, several large randomized control trial that would support lowering of intraocular pressure and its affect on improving or rather reducing progression of glaucoma. And so with that, you know, this – I would be supportive of this measure.

Reva Winkler: OK.

Matthew Carnahan: You know what? I agree with that, but I actually have a question. I guess, I'm just going to encourage (all) medication of patients for those who perhaps don't have any signs of progression using all the other measures of progression. And we're just now encouraging someone's getting a 10 percent, a 12 percent reduction having (inaudible) just get merits and so forth. And so they still are getting treated to 15 percent to be successful.

Bill Rich: This is Bill Rich. I'll comment on that. And, you know, if you look at this, I would actually point out that this is not a process, this is what we call an intermediate outcome measure. The same as hypertension, the same as hemoglobin A1c. So in effect, it is an outcome measure because the – just like hypertension, the end organ damage is of course way, way downstream. So, it's actually not material or practical to look at end organ damage itself, we're actually developing measures to do that.

You can't legislate morality, I mean, you know, our people that are over treat (and make them) dizzy somewhat with hypertension when they – who's an 80-year-old that they have maybe two points, where it's appropriate not to aggressively treat them, we know that compliance would be hypertension guidelines can lead to some problems in the elderly.

So, I think that you could do that with any measure. And could someone do it? Yes. Would someone do that and potentially create harm, economic and damage from – irritation from the (topical jobs)? Sure they could, but there's no way to have a pure measure that if someone wants to be a bad physician that they can do it and it could – it applies to every single measure at the NQF or any registry uses.

Reva Winkler: Right. Thoughts from anybody on the data provided for the opportunity for improvement? Again, we've got four years of PQRS data that was provided, the number of eligible professionals reporting the aggregate mean performance is in the 93 percent to 95 percent range, creeping up slowly over time.

(Joshua Stein): Yes, I think that the reason why it's as high as it is is the plan of care clause that's sort of an out if one doesn't achieve a 15 percent lowering of intraocular pressure. I'd love to see what the percentages would be if that – if it, you know, if the plan of care clause was dropped from the measure and I think that's something that, you know, when we meet in person we should talk about. To me, it seems like the plan of care clause pretty much gives the provider an opportunity to do almost anything and they'd still get counted. I don't know if others interpret it that way.

Bill Rich: This Bill Rich again. I would refer you to the hypertension measures where there are stipulations that the patient come back, referred to another practitioner where you can still get credit.

So, again, for consistency that's absolutely true, (Josh), but it's also – this measure is consistent with other intermediate outcome measure site. They don't call it a plan of care, but if you look very carefully at the detail of that measure it does give you steps to do and I think we'll be glad to supply that to you.

Reva Winkler: All right. Well, we've moved in to specifications. So, do the workgroup members have any other comments or questions about the specifications for the measure?

(Joshua Stein): You know, I think I have a similar question as the last measure, if someone has multiple visits. At what visit is the 15 percent going to be applied, you know? If someone's visiting an eye care provider 10 times in a year their chances of – at one point in time, you know, being 15 percent reduce is a lot better than someone who only sees an eye doctor once or twice a year. That's one concern I have.

Reva Winkler: OK.

Peter Robertson: This is Peter from the American Academy of Ophthalmology. So, the way the measure is currently specified, so just based on the current visit. Each of the dominator is the patient obviously coming in for an office visit and being (tried) to the diagnosis of glaucoma. So it would be the pressure on that visit. If it was obviously reduced by 15 percent they'd meet that criteria, the numerator, and if not, you know, they documented the plan of care in some fashion and they should meet the measure that way.

The way the measure is reported directly through PQRS is you can report it once the patient reporting here or you can report it on every visit. So, it's really up to the provider.

(Joshua Stein): Are those being aggregated together, meaning are some of the providers reporting it once per year and the others reporting it the other way, or are they being considered separately?

Peter Robertson: No. All that data would be considered together. There's no way we can't control how – why the report were measured to PQRS per se. We can set the parameters and that's the way the measure is being set up. It would be reported a minimum of once per patient, but it could obviously be reported (for it). And that's up to the provider in how they report a measure.

Reva Winkler: OK. All right.

Matthew Carnahan: And this would be…

Reva Winkler: Any other questions. Yes.

Matthew Carnahan: I'm sorry. This is – it's 15 percent of reduction from the (TMEX), is that part average of three pretreatment measures or preintervention level of measures?

Peter Robertson: It's specified as pre-intervention.

Matthew Carnahan: So, it could be any – the highest preintervention measure, or the measure just prior to change in therapy?

(Joshua Stein): I think that's a good point, Matthew. A lot of times we don't know, you know, when a patient gets referred to us we don't – a lot of times they come in on treatment and, you know, identifying what that number is sometimes can be a challenge. That why it's a separate issue.

Peter Robertson: True. And I think that's one of the reasons why (inaudible) component is a possible numerator option and, you know, because you could well get patients being referred to you who or at least currently well managed and they already have an IOP reduced by 15 percent from prior treatment or, you know, the opposite they, you know, they could be sort of not well managed and it could take some time for you to get their IOP under control. And rather than penalize the provider on those circumstances, they can still, you know, receive for the measure, you know, providing (frequent) to the patient.

Reva Winkler: OK, any other questions about the specifications, comments from any of the workgroup members?

Bill Rich: Hi, this is Bill. I think Peter broke up a little bit, but I like to clarify that it's the time of treatment recognition, the pressure is high and the decision to treat is there. So it could be someone treated some place else. And so in the real world it's either someone comes into your practice treated or untreated, with the pressure that's deemed not appropriate pressure for their optic nerve function at the visual field or it's a new patient that you see.

That's the initial (inaudible) where you assign your target pressure to lower. So, you don't have control over someone that's been someone else – somewhere else that Dr. (Stein) is. But you do make the value judgment that

pressure even though the person's on (dropsies) and appropriate have to be lowered and that's where you start measuring.

Matthew Carnahan: So, a question along those lines, if a patient is – you're seeing that patient for the first time or even it's in an established patient and you're changing therapy based on – (and to ours), to medication but you have an adequate intraocular pressure, are you now held accountable for 15 percent reduction, or do you – can you (somehow ask this)?

(Crosstalk)

Matthew Carnahan: Go ahead, Peter.

Peter Robertson: Yes, this is Peter: So, yes, so in that circumstance saying you were getting a new course of therapy. That's also been the category of documentation of care fund. So it's not held against you. I mean you would receive credit for the measure from the documentation of the care fund aspect. And then obviously on subsequent visit you could review the IOP again, see if it's now within (inaudible) range and you would meet the measure for that criteria.

Reva Winkler: OK. Workgroup members are you – any other questions. Do you feel clear on the discussion on specs that you've just had?

OK, so let just briefly take a look at the testing for reliability that was done. In this case there was a testing provided for measure score reliability using data from the IRIS Registry. With the reliability rate ranging from 0.35 up to one, and then they also did a data element reliability testing in a single practice of comparing the PQRS claims against chart review as well as the H.R. chart abstraction versus the chart review. So, several different types of reliability testing for this measure.

Questions about the criteria or questions about the information provided by the – from the workgroup?

Matthew Carnahan: What was that reasoning for the 33 percent agreement with the numerator of the PQRS versus the chart review? Was there some – a deep dive into that, or speculation?

Peter Robertson: I don't have a – I have to go and look back and look in the details of the study (inaudible) right now. But I did find more so – the difference was they found more evidence when reviewing the charts. That the measure was met and actually recorded by the practice, so I can't really give you a conclusion as to why that was. But that's what the – what was found during the testing.

Reva Winkler: OK.

(Joshua Stein): But clearly the data source that the information is coming from is going to impact the reliability at least until it gets further investigated. So, that's something that needs to be thought about if one is aggregating this information from, you know, comparing different providers who are inputting this information through different sources, because you'd hate for a provider to look bad because of the way they chose to enter this information in versus another one who did a different mechanism. So, I think those sort of issues need to be investigated.

Reva Winkler: OK. Thoughts from any on the workgroup on reliability? OK.

We can go down to validity and this is just a question again about the specifications versus the evidence provided around the reductions in intraocular pressure. And just be sure there aren't any comments from the workgroup on the explanation from the developers.

(Joshua Stein): You know, that the developers did an expert panel of 16 and to look for phase validity in 15 of the 16 members either agreed or strongly agreed. But I don't think anyone questioned that lowering IOP is an important parameter.

Reva Winkler: OK. On this particular measure, there are no exclusions. It's an intermediate outcome measure. It is not risk adjusted. They did provide some updated data from the IRIS Registry showing the current results of those participants giving you means, medians, IQRs and a lot more sort of data on how on the variation and results in the dispersion.

Does – Do you believe this measure provides meaningful differences in performance among providers?

(Joshua Stein): You know, just going back to my earlier comment about the documented pair – plan of care clause. I think that kind of skews everything up towards the – toward the 100 percent. And, you know, the question I have is whether, you know, whether one should aim, create a measure where the goal is to – if it's for, you know, high quality to be 100 percent versus as I described earlier one where say it's 90 percent and that way you wouldn't be dealing with the issue that Matthew brought up about over treating patients who don't need to be treated or trying to get this information on documented plan of care. I understand that other measures are using that, but I just find that a little problematic in that clause.

Reva Winkler: OK. So, anything, the other workgroup members.

Matthew Carnahan: To take that one step further, unfortunately, coming into similarity with this measure. If you found you did not meet your target pressure you could then go ahead and do the plan to reach that and have it not be counted, correct? And maybe those billing implications as to why that wouldn't happen, but it seems like if there was a reportable measure associated with it that it could become a practice evolution towards ensuring success.

Reva Winkler: All right, any comment from the developer?

Female: I just want to go back to probably the rationale for the measure. And I think the rationale is Dr. (Stein) and Dr. Carnahan know well is that patients with increased IOP are not the same as drops and intraocular pressure. And so, the plan of care was to address different options that really did call attention on the part of the physician that they really need to address the IOP reduction if it didn't meet the 15 percent and considering all the other factors.

So, I would just say, yes, definitely, you know, there's all – as Dr. Rich said there are options that people are gaining you know, with maybe not do the appropriate things but we are kind of thinking the assumption that doctors want to take care of the patients. They want to do the best care and with quality measure reminds them to pay a lot of attention to the intraocular pressure with the progression of glaucoma. As we said, we can't legislate morality and behavior, we're just trying to put in an extensive that people

should pay attention to the right things and pay attention to the treatment outcome.

Matthew Carnahan: For a question for the developers. With the picking of a 15 percent being below the 18 to 25 percent, could you share a part of the discussion that evolve, that would lead to choosing a lower as oppose to a preferred practice pattern percentage target?

Flora Lum: Well, if you know – yes, the randomized control trial showed that percentage. But we all know that the randomized control populations are not the same as average populations with a lot of comorbidities and socioeconomic and, you know, we're thinking of patients who may not adhere to their glaucoma medication. So there's a lot of factors and I think we thought for the real world setting at 15 percent reduction was really more realistic than a higher percentage in a very preselected population that were tested in randomized control trial.

Reva Winkler: OK.

Matthew Carnahan: But that's not coming with any evidence, correct, around this percentage being acceptable for the non-randomized control trial grouping?

Flora Lum: I will go back and look at the rationale. They don't have the original measure rationales right in front of me. But we did put together some, you know, it was based on looking at those randomized control trials and trying to fit a figure that was a little more reasonable.

Matthew Carnahan: Thank you.

Reva Winkler: OK, any more thoughts from the workgroup on reliability and validity of the measure?

OK. So, in terms of feasibility and use and usability, I think again this is a registry measure and the define fields, you know, are electronic when it gets submitted to registry. Any thoughts or concerns, questions about feasibility of this measure from anybody on the workgroup? How about use and usability?

Again, I'd ask the individual measure, the workgroup, is this a measure that you've used or been measured on? If there's any personal experience.

Matthew Carnahan: No.

Reva Winkler: It doesn't sound like it. OK. This measure is used in the PQRS program and also obviously in the IRIS Registry. I guess I would ask the folks Bill and Flora, is there any intention to public reporting any information from the registry?

Flora Lum: Well, yes, as you know in 2015 everything will be publicly reported. The only things that won't be publicly reported for the first year are new measures. Because these are established measures, they would be reported as of this year.

Reva Winkler: So you're saying the registry data as – it's submitted to PQRS?

Flora Lum: Correct.

Reva Winkler: OK, good. OK. All righty, any other thoughts, comments, questions from the workgroup before we move on to the last measure?

OK. So the last measure is measure 86 and this is (all single) glaucoma. And this is a process measure about optic nerve evaluation. And so, Dr. Carnahan, could you kind of take the lead on discussing this measure?

Matthew Carnahan: Sure. So, based on some previous studies it seemed like there had been a suboptimal frequency of optic nerve and evaluation amongst ophthalmologist. And yet that's an expectation for managing these patients. And so, this measure it appears to be looking at if there's an optic nerve of that evaluation both clinically and it seems like an and or nerve fiber layer analysis within a 12-month period. And again, there are certain exceptions and, I guess, that's a later conversation.

Reva Winkler: OK. This is a process measure. And so, the first sub-criterias on evidence, and so we are looking for evidence that there's been an evaluation of the

evidence that the evaluation of the optic nerve does impact the patient outcomes and what is the empiric evidence to support that relationship?

Matthew Carnahan: Anything to get people to do the right thing which is – with this measure seems to be directing.

Reva Winkler: Would you say this is an evidence-based process of care?

Matthew Carnahan: Yes.

Reva Winkler: OK. Questions or comments?

Matthew Carnahan: … in the European study for the evidence right there but, yes.

Reva Winkler: OK. Comments or questions on evidence from anybody else on the workgroup?

OK, so you feel – you guys feel comfortable about evidence, all right. So, again this measure is used – has been used in PQRS for several years. The aggregate data is presented under 1B for opportunity for improvement, any comments there?

(Joshua Stein): I just have a comment about the disparities, you know, the developer...

Reva Winkler: OK.

(Joshua Stein): ... developer pointed out disparities and prevalence of glaucoma by race. But the real question is whether there are disparities in use of testing in this case evaluation of the optic nerve. And our group published some data shown that there are some racial disparities especially Latinos get less fundus photography ocular imaging compared to Non-Hispanic white. There are some racial disparities.

Reva Winkler: OK, good. So, well the overall aggregate performance might be high if it were stratified by racial and – or ethnic groups. You might see different results for some populations.

(Joshua Stein): And or that may be something important to risk adjust for.

Reva Winkler: OK. All right, any other comments or questions on opportunity for improvement?

All right. So, we'll go down and look at reliability. Again, we start with the specifications. So, Dr. Carnahan, what are your thoughts on the specifications for this measure?

Matthew Carnahan: Can the developers clarify for me if the code is done properly. It's only – that's the trigger, the CPT Category II code, 2027F. But if that was just a nerve fiber or analysis with an OCT, does that allow appropriate triggering as oppose to an actual visualization by the provider of the nerve using a lens and a slit lamp?

Reva Winkler: Can somebody from PCPI respond to Dr. Carnahan's question?

Sam Tierney: Yes. So, this is Sam Tierney again. So, I think, you're getting to the question of sort of the use of the CPT II code. And I think that we would express that anyone using the CPT II code would use it consistent with the description and it describes the evaluation of the optic nerve test. So, I hope that sort of addresses your question. You added a lot of extra detail that I'm not quite sure I can address but I do think there's an expectation that the – anyone reporting a CPT II code would have done the evaluation consistent with the descriptor of the CPT II code which requires an optic nerve test evaluation.

(Joshua Stein): So, I think, Matthew's question is if we were to – if a provider were to use other CPT codes that indicate the – in assessment of the optic nerve or retinal nerve fiber layer have been done. For example, the CPT code for ocular imaging like OCT, the CPT code for fundus photography are those included or should those be included?

(Jamie): So, this is (Jamie), with the PCPI. So, I think what you are calling attention to is an actual procedure code that is attributed to the performance of that optic nerve head evaluation.

So, the CPT II – Category II code, the 2027F, that is for the claims purposes. And so, that's reported on all claims if one – if an optic nerve head evaluation

was performed. That's how with that type of reporting modality is to capture that the numerator of – the numerator was met.

Excuse me. With the other procedures for doing – for actually performing the optic nerve head evaluation CPT as you had just mentioned, that would be included in a value set within the numerator for the eCQM which could also be implemented into a registry. We find that registry in EHR classifications are more similar than registry and claim but it kind of depends on how that registry is built and how the vendor chooses to represent that within their implementation. Does that help?

(Joshua Stein): So, are there circumstances where someone where a doc can bill for say fundus photography or OCT but not check off the CPT II code? And if that not get credit or the completing – completing those other CPT is automatically to the CPT II code getting checked off?

(Jamie): Again, I think, it depends on what reporting modality you're talking about. So, if you're providing claims information like for instance for the PQRS program, you have to report that CPT Category II code. Otherwise, it is not valid. It's a performance not met.

If you are using a registry, registry could, I believe, they could include the CPT Category II codes as an option. They can do some mapping on the backend of their codes to report that way. But, again, I think that anyone for AAO, you can please feel free to the jump in on IRIS information if you feel that's necessary or helpful. But it depends on how it was built out, but in the instances of registry in EHR, the 2027F is not required.

Matthew Carnahan: A question on clarification around the exceptions. Those in exception code using the – well, the one documented, does that extend the time period of the 12 months? Or is that just validating why you didn't check the optic nerve, why you're examining the patient during that 12 months? Does that question make sense?

(Jamie): I think so. I think you're asking if that medical (reason) will need to be documented at the time of the performance of the evaluation. Well, (I examine and) that would be true.

Matthew Carnahan: Would it extend the time period?

Sam Tierney: So, this is Sam. I think it applies to that visit only. So, it doesn't necessarily apply to the full 12 months reporting period or measurement period. The expectation is if you didn't do the optic nerve head evaluation in that visit, you would – and you had a good medical reason for not doing so, you would report that CPT II code if it was a claims reporting or one of the codes within the value set if you were reporting on the eMeasure.

(Jamie): Yes. And this is (Jamie) again, and so, if you are to look at the HTML, the human readable document for the e-measure, (looking at the) denominator exceptions within the actual logic down below kind of the header, those (green old) boxes. You would find that the timing for the medical reason exception has to start during that actual visit that brought a patient into that measure. Does that help answer the question?

Matthew Carnahan: So, it sounds like the 12 months is pretty solid and the exception code is really just justifying why you didn't check, but the patient would still be in the denominator because they have the primary open-angle glaucoma. Sorry, I'm just not sure why the exception code would – is there still – they're not in the denominator, is that what you're stating?

(Jamie): So they would need the denominator and basically, the way it – the way that measures and calculated, when you look at the initial population and the denominator and you bring in your patients, then you look to see if there are any exclusions for this measure, there are not. Then you look to see if there was a numerator and if that numerator action was performed and if that numerator action was not performed, then you look to see if there is a valid exception.

We distinguish and you'll note that every single eCQM, every eMeasure has a differentiation between an inclusion and an exception even though we are kind of unable to break those out in the NQF form. But – So – That's where – That's the distinction, that's when the calculation gets – that's when it gets pulled out. Does that help clarify?

Matthew Carnahan: When it gets pulled out of the denominator.

Sam Tierney: You know, they pull out the denominator but only after you check to see if the numerator action were performed.

Matthew Carnahan: Very good. That makes perfect sense. Thank you.

(Jamie): OK. Glad to help.

Reva Winkler: OK. Any other questions from the committee around the specifications? Be sure we understand how the measure is calculated. OK.

Now, again, reliability testing, there was a little bit of updated data provided. So, on the reliability – performance measure score testing based on the PQRS administrative claims database, we also had performance measure score testing using the PQRS GPRO database which is essentially a registry. And then, again, we've got the eMeasure, a data element validity in the place of reliability.

So, is there any – are there any questions from the workgroup on the information provided or the criteria for evaluating the reliability criteria?

(Joshua Stein): No, just – I guess my only same concern was the performance gap with 36 percent of the eligible physicians providing data for the volunteer PQRS being to the 95 percent. And so I just don't know how valid that is, but I guess we'll find out now that it's required in 2015.

Reva Winkler: Right. OK. All right, thoughts from anybody else on the workgroup on the reliability testing data? Any questions for the developer? Be sure you understand the data that's provided.

OK, then we can move down to validity. Similarly, you know, do the specifications, reflect the evidence that was presented and discussed. And then again we did have phase validity assessment for the claims registry version and for the eMeasure, a similar data element validity testing against – of the automated versus – and abstracted measure with high levels of agreement for the data elements.

Any questions about the validity testing? And then there is data provided on the frequency of exclusions for all three – I'm sorry, for the claims and registry, we don't have the information for the eMeasure.

Again any – any concerns? The overall exception rate for claims was 1.8 and for registry was 3.0, so relatively low exception rates.

Questions or comments from the workgroup?

OK, so this is not a – this is a process measure which typically are not risk adjusted. Again, in terms of meaningful differences they claim sample with over 9,000 clinicians and mean performance rate at 70 – 0.77. So you see sort of the range and statistics around that data. Similarly for registry we don't have a similar data for eMeasure. But does this measure provide enough dispersion or variation in the measure results so that comparisons among providers can be made?

Matthew Carnahan: Well, that brings us the same issues that (Joshua) talked about with the socioeconomic…

Reva Winkler: Right.

Matthew Carnahan: … effects. In fact, we don't…

Reva Winkler: OK.

Matthew Carnahan: … really have stratified.

Reva Winkler: Right. OK that's good. It's an important aspect of it because a measure may be relatively high for aggregate, but still have value in specific sub-populations.

All right, so that's really all the information we have on validity. So again – so I think with our same discussion around feasibility and usability and use for this measure, again this is a measure from the PQRS programs and meaningful use program also used in the IRIS Registry. So there is getting more and more experience with this measure everyday.

So, this is – any other questions from the workgroup about the criteria, the information provided for this measure, measure 86?

OK. All right, the – so we've looked through the criteria for all the four measures for this workgroup, and so before we finish up I just want to be sure if the workgroup members have any questions about anything specific to the measures or anything about the criteria or about the process – the evaluation process we're going through and where we go from here. We're going to take the notes from your discussion today and include them in the worksheet so that that will be available for all the committee members at your in-person meeting in June.

So, as you can see this is an iterative process to help you become more familiar with the criteria and the information provided. The workgroup – this session was – I think they're useful in clarifying some of the information being able to ask question to the developers so that you have a clear understanding of the measure and the information provided.

So, is there anything left – a minute from anybody questions, comments, concerns. Workgroup members, you feeling comfortable and OK with the process and where you go from here?

Matthew Carnahan: Yes, it was very, very helpful. I appreciate the developer's participation.

Reva Winkler: Right.

(Joshua Stein): I agree.

Reva Winkler: OK, very good. OK. And, yes, thanks to everybody from AAO and PCPI. We really do appreciate the time you took to come and respond to the questions from the workgroup members. And certainly we look forward to seeing you at the in-person meeting in June.

Shaconna or Vy, are there anything more from you before we finish up?

Vy Luong: Sure. I think the only thing is I know some committee members as well as developers has been asked – have been asking about our agenda for the June

in-person meeting, we are finalizing that and should get that out to you all shortly. So, that's my note, as well as, Reva, if you can – if we can open up member and public comments right now?

Reva Winkler: Sure, yes. Operator?

Operator: At this time if you have a comment, please press star then the number one on your telephone keypad.

And there are no public comments at this time.

Shaconna Gorham: OK.

Reva Winkler: OK.

Shaconna Gorham: Thank you.

Reva Winkler: All right, if there are no further questions I thank everybody for your time and participation on today's call. I look forward with – to working with everybody as we continue through this evaluation process. Thanks all everybody and have a good day.

(Joshua Stein): Bye.

Female: Bye-bye.

Female: Bye-bye.

Female: Thank you.

Operator: Ladies and gentlemen this does conclude today's conference call. You may now disconnect.

END