# NATIONAL QUALITY FORUM

**Measure Submission and Evaluation Worksheet 5.0**

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 0397 NQF Project: Infectious Disease Project

(for Endorsement Maintenance Review)
Original Endorsement Date: Jul 31, 2008 Most Recent Endorsement Date: Jul 31, 2008 Last Updated Date: Jul 11, 2012

## BRIEF MEASURE INFORMATION

De.1 Measure Title: Hepatitis C: Antiviral Treatment Prescribed

Co.1.1 Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

De.2 Brief Description of Measure: Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who were prescribed at a minimum peginterferon and ribavirin therapy within the 12 month reporting period

2a1.1 Numerator Statement: Patients who were prescribed at a minimum peginterferon and ribavirin therapy within the 12 month reporting period

2a1.4 Denominator Statement: All patients aged 18 years and older with a diagnosis of chronic hepatitis C

2a1.8 Denominator Exclusions: Documentation of medical reason(s) why a patient was not prescribed at a minimum peginterferon and ribavirin therapy (eg, patient was not a candidate for therapy, could not tolerate)
Documentation of patient reason(s) why a patient was not prescribed at a minimum peginterferon and ribavirin therapy (eg, patient declined)
Documentation of system reason(s) why a patient was not prescribed at a minimum peginterferon and ribavirin therapy (eg, patient has no insurance coverage, therapy not covered)

1.1 Measure Type: Process
2a1. 25-26 Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry
2a1.33 Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

1.2-1.4 Is this measure paired with another measure? No

De.3 If included in a composite, please identify the composite measure (*title and NQF number if endorsed*):

## STAFF NOTES (*issues or questions regarding any criteria*)

Comments on Conditions for Consideration:

Is the measure untested? Yes☐ No☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:

1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*):
5. Similar/related endorsed or submitted measures (*check 5.1*):
Other Criteria:

Staff Reviewer Name(s):

## 1. IMPACT, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.
*Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria)

1a. High Impact: H☐ M☐ L☐ I ☐
(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 Subject/Topic Areas *(Check all the areas that apply)*: Infectious Diseases, Infectious Diseases : Hepatitis
De.5 Cross Cutting Areas (*Check all the areas that apply)*:

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact *(Provide epidemiologic or resource use data)*:
The hepatitis C virus (HCV) is a major public health problem and a leading cause of chronic liver disease.(1) An estimated 180 million people are infected worldwide.(2) HCV infection is the most common chronic bloodborne infection in the United States where the prevalence of HCV infection between the years 1999 and 2002 was 1.6%, equating to about 4.1 million persons positive for antibody to hepatitis C (anti-HCV), 80% of whom are estimated to be viremic.(3,4) Hepatitis C is the principal cause of death from liver disease and the leading indication for liver transplantation in the U.S.(5) Some calculations suggest that mortality related to HCV infection (death from liver failure or hepatocellular carcinoma) will continue to increase over the next two decades.(6)

According to the CDC (3), of every 100 HCV-infected individuals, approximately
- 75–85 will develop chronic infection
- 60–70 will develop chronic liver disease
- 5–20 will develop cirrhosis over a period of 20–30 years
- 1–5 will die from the consequences of chronic infection (liver cancer or cirrhosis)

1a.4 Citations for Evidence of High Impact cited in 1a.3: (1) Williams R. Global challenges in liver disease. HEPATOLOGY 2006;44: 521-526.
(2) www.who.int/immunization/topics/hepatitis_c/en/.
(3) Centers for Disease Control and Prevention. Hepatitis C Information for Health Care Professionals. http://www.cdc.gov/hepatitis/HCV/index.htm
(4) Armstrong GL, Wasley A, Simard EP, McQuillan GM, Kuhnert WL, Alter MJ. The prevalence of hepatitis C virus infection in the United States, 1999 through 2002. Ann Intern Med 2006;144:705-714.
(5) Kim WR. The burden of hepatitis C in the United States. HEPATOLOGY 2002;36(Suppl):S30-S34.
(6) Deuffic-Burban S, Poynard T, Sulkowski MS, Wong JB. Estimating the future health burden of chronic hepatitis C and human immunodeficiency virus infections in the United States. J Viral Hepat 2007;14:107-115.

1b. Opportunity for Improvement: H☐ M☐ L☐ I ☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
Assure that antiviral therapy is prescribed for all patients with confirmed Hepatitis C. Without treatment, Hepatitis C leads to liver disease, carcinoma, cancer, and death.

The standard of care (SOC) therapy for patients with chronic hepatitis C virus (HCV) infection has been the use of both peginterferon (PegIFN) and ribavirin (RBV). These drugs are administered for either 48 weeks (HCV genotypes 1, 4, 5, and 6) or for 24 weeks (HCV genotypes 2 and 3), inducing sustained virologic response (SVR) rates of 40%-50% in those with genotype 1 and of 80% or more in those with genotypes 2 and 3 infections. (AASLD 2011)

Two major advances have occurred since the last update of treatment guidelines for chronic hepatitis C (CHC) that have changed the optimal treatment regimen of genotype 1 chronic HCV infection: the development of direct-acting antiviral (DAA) agents and the identification of several single-nucleotide polymorphisms associated with spontaneous and treatment-induced clearance of HCV infection. Although PegIFN and RBV remain vital components of therapy, the emergence of DAAs has led to a substantial improvement in SVR rates and the option of abbreviated therapy in many patients with genotype 1 chronic HCV infection. A revision of the prior treatment guidelines is therefore necessary, but is based on data that are presently limited. Accordingly, there may be need to reconsider some of the recommendations as additional data become available. (AASLD 2011)

The issue of treatment of chronic HCV infection is in constant flux. There is highly active clinical research in this area, and new information appears with increasing frequency. (AASLD 2009)

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers)*: [*For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
CMS Physician Quality Reporting Initiative:

This measure was used in the 2008, 2009 and 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 63.25% is the aggregate perormance rate in the total patient population and 68.58% is the mean performance rate of TIN/NPI's.

10th percentile: 0.00%
25th percentile: 25.00%
50th percentile: 100.00%
75th percentile: 100.00%
90th percentile: 100.00%

1b.3 Citations for Data on Performance Gap: [*For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
Confidential CMS PQRI 2010 Performance Information by Measure. Jan 2010-February 2011 TAP file

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]
Although the continued prevalence of HCV is problematic in communities across America, inequalities in disease prevalence, treatment, and outcomes make it a particularly important minority health issue.(1) First, there are disparities in the prevalence of HCV infection, with African Americans being twice as likely to have ever been infected with HCV, and having a higher prevalence of chronic HCV infection compared with non-Hispanic white Americans.(2) Additionally, there are significant disparities in access to HCV care for racial and ethnic minorities.(3) Finally, African American and Hispanic patients with HCV infection, even once properly diagnosed, have less desirable treatment outcomes compared to white patients.(4) These trends are indicative of a growing healthcare crisis with regards to HCV that threatens minority communities for decades to come.(1)

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
(1) Bryant Cameron Webb. The "Secret" epidemic: Disparities in Hepatitis C Incidence, Treatment, and Outcomes. Prepared for the Joint Center for Political and Economic Studies. October 2010.

(2) Alter MJ, Kruszon-Moran D, Nainan OV, et al. The prevalence of hepatitis C virus infection in the United States, 1988 through 1994. New England Journal of Medicine. 1999:341(8): 556-562.

(3) Trooskin SB, Navarro VJ, Winn RJ, et al. Hepatitis C risk assessment, testing and referral for treatment in urban primary care: Role of race and ethnicity. World J Gastro 2007:13:1074.

(4) Conjeevaram HS, Fried MW, Jeffers LJ, et al. Virahep-C study group. Peginterferon and ribavirin treatment in African American and Caucasian American patients with hepatitis C genotype 1. Gastroenterology. 2006 Aug; 131(2):470-7.

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐ If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I ☐ Quality: H☐ M☐ L☐ I ☐ Consistency: H☐ M☐ L☐ I ☐

| Quantity | Quality | Consistency | Does the measure pass subcriterion1c? |
|---|---|---|---|
| M-H | M-H | M-H | Yes☐ |
| L | M-H | M | Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No☐ |
| M-H | L | M-H | Yes☐ IF potential benefits to patients clearly outweigh potential harms: otherwise No☐ |
| L-M-H | L-M-H | L | No ☐ |

| Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service | Does the measure pass subcriterion1c? Yes☐ IF rationale supports relationship |
|---|---|

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)*:
The goal of therapy is to prevent complications and death from HCV infection. Prescribing the latest antiviral treatment may lead to better outcomes for patients with Hepatitis C and a reduced incidence of virus transmission, liver disease, cancer and mortality. (AASLD 2011)

The standard of care (SOC) therapy for patients with chronic hepatitis C virus (HCV) infection has been the use of both peginterferon (PegIFN) and ribavirin (RBV). These drugs are administered for either 48 weeks (HCV genotypes 1, 4, 5, and 6) or for 24 weeks (HCV genotypes 2 and 3), inducing sustained virologic response (SVR) rates of 40%-50% in those with genotype 1 and of 80% or more in those with genotypes 2 and 3 infections. (AASLD 2011)

1c.2-3 Type of Evidence *(Check all that apply)*:
Clinical Practice Guideline

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)*:
According to the guidelines, specific recommendations are based on relevant published information. The evidence cited in this guideline is directly related to the prescribing of specific types of antiviral therapy for the treatment of chronic hepatitis C.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: The guideline developer did not state the quantity of studies used.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): While the quality of the body of evidence is not addressed, the guideline developer stated: These recommendations provide a data-supported approach to establishing guidelines. They are based on the following: (1) a formal review and analysis of the recently published world literature on the topic (Medline search up to June 2011); (2) the American College of Physicians' Manual for Assessing Health Practices and Designing Practice Guidelines; (3) guideline policies, including the American Association for the Study of Liver Diseases' (AASLD) Policy on the Development and Use of Practice Guidelines and the American Gastroenterological Association's Policy Statement on the Use of Medical Practice Guidelines; and (4) the experience of the authors in regard to hepatitis C. (AASLD 2011)

In addition, Class IA recommendations reflect Class I-Conditions for which there is evidence and/or general agreement that a given diagnostic evaluation procedure or treatment is beneficial, useful, and effective; and Level A-Data derived from multiple randomized clinical trials or meta-analyses. (AASLD 2011)

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* The consistency of results across studies was not addressed by the guideline.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:
The benefit over harms across studies was not addressed by the guideline.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? No

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: n/a

1c.11 System Used for Grading the Body of Evidence: Other

1c.12 If other, identify and describe the grading scale with definitions: n/a

1c.13 Grade Assigned to the Body of Evidence: n/a

1c.14 Summary of Controversy/Contradictory Evidence: A summary of controversy/contradictory evidence was not provided.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:
n/a

1c.16 Quote verbatim, the specific guideline recommendation *(Including guideline # and/or page #)*:
The optimal therapy for genotype 1, chronic HCV infection is the use of boceprevir or telaprevir in combination with peginterferon alfa and ribavirin. (Class I, Level A) (AASLD 2011-Recommendation 1)

The optimal therapy for chronic HCV infection is the combination of peginterferon alfa and ribavirin. (Class I, Level A) (AASLD 2009-Recommendation 11)

1c.17 Clinical Practice Guideline Citation: Marc G. Ghany, David R. Nelson, Doris B. Strader, David L. Thomas, and Leonard B. Seeff. An Update on Treatment of Genotype 1 Chronic Hepatitis C Virus Infection: 2011 Practice Guideline by the American Association for the Study of Liver Diseases (AASLD). Hepatology, October 2011: 1433-1444.

1c.18 National Guideline Clearinghouse or other URL: http://guidelines.gov/content.aspx?id=14708

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? Yes

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: The Practice Guidelines Committee of the AASLD. Potential conflict of interest: Dr. Nelson receives research support from Vertex, Merck, Phamassett, Genentech/Roche, Gilead, Bristol-Myers Squibb, Tibotec, Bayer/Onyx and serves on advisory boards of Merck, Pharmassett, Genentech/Roche, Gilead, Tibotec, and Bayer/Onyx, and is a consultant for Vertex. Dr. Thomas receives research support from Merck, Gilead and serves on a Merck advisory board. Dr. Ghany, Dr. Seeff, and Dr. Strader have nothing to report.

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: Classification Description

Class I Conditions for which there is evidence and/or general agreement that a given diagnostic evaluation procedure or treatment is beneficial, useful, and effective.
Class II Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a diagnostic evaluation, procedure or treatment.
Class IIa Weight of evidence/opinion is in favor of usefulness/efficacy.
Class IIb Usefulness/efficacy is less well established by evidence/opinion.
Class III Conditions for which there is evidence and/or general agreement that a diagnostic evaluation, procedure/treatment is not useful/effective and in some cases may be harmful.

Level of Evidence Description
Level A Data derived from multiple randomized clinical trials or meta-analyses.
Level B Data derived from a single randomized trial, or nonrandomized studies.
Level C Only consensus opinion of experts, case studies, or standard-of-care.

NOTE: To more fully characterize the quality of evidence supporting recommendations, the Practice Guidelines Committee of the AASLD requires a Class (reflecting benefit versus risk) and Level (assessing strength or certainty) of Evidence to be assigned and reported with each recommendation (Table 1, adapted from the American College of Cardiology and the American Heart association Practice Guidelines).

1c.23 Grade Assigned to the Recommendation: Class I, Level A

1c.24 Rationale for Using this Guideline Over Others: It is the PCPI policy to use guidelines, which are evidence-based, applicable to physicians and other health-care providers, and developed by a national specialty organization or government agency. In addition, the PCPI has now expanded what is acceptable as the evidence base for measures to include documented quality improvement (QI) initiatives or implementation projects that have demonstrated improvement in quality of care.

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: Moderate 1c.26 Quality: Moderate1c.27 Consistency: Moderate
1c.28 Attach evidence submission form:
1c.29 Attach appendix for supplemental materials:

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

## 2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? Yes

S.2 If yes, provide web page URL: www.physicianconsortium.org

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I ☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)*:
Patients who were prescribed at a minimum peginterferon and ribavirin therapy within the 12 month reporting period

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
Once during the measurement period

2a1.3 Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses*:
Definition:
Prescribed – May include prescription given to the patient for at a minimum peginterferon and ribavirin therapy at one or more visits in the 12-month period OR patient already taking at a minimum peginterferon and ribavirin therapy as documented in current medication list (ie, may include additional antiviral therapy, as appropriate).

Numerator Note: The language of "at a minimum" in this measure is an acknowledgement that the recommended treatment for Hepatitis C genotype 1 has changed to include directly-acting antiviral medications, in addition to peginterferon and ribavirin. However, the recommended treatment for genotypes 2-6 remains the same: only peginterferon and ribavirin. Further treatment changes are anticipated in the near future; therefore, in an effort to keep this measure feasible and to accommodate changing treatments, the base requirement for this measure is to prescribe peginterferon and ribavirin. Further measure modifications are expected in the coming years.

EHR Specifications:
eMeasure developed – see attached

Claims Specifications:
CPT Category II code: 4153F – Combination peginterferon and ribavirin therapy prescribed

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*: Adult/Elderly Care

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
12 consecutive months

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
EHR Specifications:
eMeasure developed – see attached

Claims Specifications:
ICD-9-CM diagnosis codes: 070.54
AND
CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Documentation of medical reason(s) why a patient was not prescribed at a minimum peginterferon and ribavirin therapy (eg, patient was not a candidate for therapy, could not tolerate)
Documentation of patient reason(s) why a patient was not prescribed at a minimum peginterferon and ribavirin therapy (eg, patient

declined)
Documentation of system reason(s) why a patient was not prescribed at a minimum peginterferon and ribavirin therapy (eg, patient has no insurance coverage, therapy not covered)

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, patient was not a candidate for therapy, could not tolerate) patient reason(s) (eg, patient declined) or system reason(s) for why a patient was not prescribed at a minimum peginterferon and ribavirin therapy (eg, patient has no insurance coverage, therapy not covered). Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Additional details by data source are as follows:

EHR Specifications:
eMeasure developed – see attached

Claims Specifications:
4135F with 1P: Documentation of medical reason(s) for not prescribing at a minimum peginterferon and ribavirin therapy (eg, patient was not a candidate for therapy, could not tolerate)
4135F with 2P: Documentation of patient reason(s) for not prescribing at a minimum peginterferon and ribavirin therapy (eg, patient declined)
4135F with 3P: Documentation of system reason(s) for not prescribing at a minimum peginterferon and ribavirin therapy (eg, patient has no insurance coverage, therapy not covered)

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses )*:
We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification 2a1.12 If "Other," please describe:

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:
None

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*: Better quality = Higher score

2a1.20 Calculation Algorithm/Measure Logic*(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*:
To calculate performance rates:
1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).
2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator when exceptions have been specified [for this measure: medical reason(s) (eg, patient was not a candidate for therapy, could not tolerate), patient reason(s) (eg, patient declined), or system reason(s) (eg, patient has no insurance coverage, therapy not covered)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

Calculation algorithm is included in the e-measure which has been emailed to NQF staff.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):
Not applicable. The measure does not require sampling or a survey.

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe:
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): Not applicable.

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)*: Clinician : Group/Practice,

Clinician : Individual, Clinician : Team

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)*: Ambulatory Care : Clinician Office/Clinic, Ambulatory Care : Urgent Care, Other:Hospital Outpatient Clinic

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability*.)

2a2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
Refer to the validity section for a description of the data sample for our EHR testing project.

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)*:
Refer to the validity section for a description of the analytic methods for our EHR testing project.

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
Refer to the validity section for a description of the testing results for our EHR testing project.

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H☐ M☐ L☐ I ☐

2b1.1 Describe how the measure specifications *(measure focus, target population, and exclusions)* are consistent with the evidence cited in support of the measure focus (*criterion 1c)* and identify any differences from the evidence:
The measure specifications are consistent with the evidence from the guideline.

The language of "at a minimum" in this measure is an acknowledgement that the recommended treatment for Hepatitis C genotype 1 has changed to include directly-acting antiviral medications, in addition to peginterferon and ribavirin. However, the recommended treatment for genotypes 2-6 remains the same: only peginterferon and ribavirin. Further treatment changes are anticipated in the near future; therefore, in an effort to keep this measure feasible and to accommodate changing treatments, the base requirement for this measure is to prescribe peginterferon and ribavirin. Further measure modifications are expected in the coming years.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

2b2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
EHR Measure Validity
The measure performance was calculated from data collected using two different methods of collection:

- Automated EHR report
- Visual inspection of the medical record by professional data abstractors to capture the data elements to manually construct the performance

The data source was electronic health records in the ambulatory care setting.
The data sample came from 2 sites representing a community health center and a large independent specialty practice, both in the midwest region
The sample consisted of 1144 patient encounters.
Visual inspection of the medical record was performed in 2010.

Face Validity
An expert panel was used to assess face validity of the measure. This panel consists of 22 members, with representation from the following specialties: infectious diseases, gastroenterology, methodology, hepatology, family medicine, OB/GYN, internal medicine, nursing, health plan representation and patient advocacy.

Oluwatoyin Adeyemi, MD (infectious diseases) Cook County Hospital, Rush University Medical Center, Chicago, IL
Maureen L. Borkowski, RN, BSN Information Specialist, American Liver Foundation, Cedar Grove, NJ
Joel V. Brill, MD (gastroenterology) American Gastroenterological Association, Phoenix, AZ

Betty Jo Edwards, MD (OB/GYN) Texas Medical Arts Tower, Houston, TX
Debra Esser, MD, MMM (family medicine) Omaha, NE
Gregory T. Everson, MD (gastroenterology) University of Colorado Denver, Section of Hepatology, Aurora, CO
Troy Fiesinger, MD, FAAFP (family medicine) Memorial Family Medicine Residency, Physicians at Sugar Creek, Sugar Land, TX
Michael W. Fried, MD (gastroenterology, hepatology) Professor of Medicine, Director, UNC Liver Center, University of North Carolina @ Chapel Hill, Chapel Hill, NC
Stephen A. Harrison, MD (gastroenterology) Assistant Professor, Division of Gastroenterology, Brooke Army Medical Center, Fort Sam Houston, TX
Ira Jacobson, MD (gastroenterology, hepatology) Chief, Division of GI & Hepatology, Weill Medical College of Cornell, New York, NY
Catherine MacLean, MD, PhD (health plan representative) Medical Director, Programs for Clinical Excellence WellPoint, Inc., Westlake Village, CA
Lynn McElroy American Liver Foundation, Cedar Grove, NJ
Paola Ricci, MD (gastroenterology) VA Medical Center-Gastroenterology, Minneapolis, MN
Sam J. W. Romeo, MD, MBA (family medicine) General Partner, Tower Health & Wellness Center, LP, Turlock, CA
John F. Schneider, MD, PhD (internal medicine) Past President, Illinois State Medical Society, Flossmoor, IL
Leonard B. Seeff, MD (hepatology) Food and Drug Administration, Silver Spring, MD
Kenneth E. Sherman, MD, PhD (hepatology, gastroenterology) Director, Division of Digestive Disease, University of Cincinnati School of Medicine, Cincinnati, OH
Alan D. Tice, MD, FACP (infectious diseases) Infections Limited Hawaii, Honolulu, HI
Monte Troutman, DO, FACOI (gastroenterology) Chairman, Department of Medicine, Chief, Division of Gastroenterology, University of North Texas Health Science Center/ Texas College of Osteopathic Medicine, Fort Worth, TX
John Ward, MD (internal medicine) Director, Division of Viral Hepatitis, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (proposed), Centers for Disease Control and Prevention, Atlanta, GA
Josie R. Williams, MD, MMM (gastroenterology/methodology) Director, Rural & Community Health Institute: QPSI, Asst. Professor of Internal & Family Medicine, Texas A&M University System, College Station, TX
John B. Wong, MD (gastroenterology, hepatology) Tufts New England Medical Center, Clinical Decision Making, Boston, MA

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
EHR Measure Validity
Data from a performance report for the measure automatically-generated from the EHR (designed to collect the necessary data elements to identify eligible cases and calculate the performance score) were compared to data elements found and scores calculated manually on visual inspection of the medical record by trained abstractors.

Data analysis included:
• Percent agreement at the denominator, numerator
• Kappa statistic to ensure that agreement rates are not a phenomenon of chance

Face Validity
Face validity of the measure score as an indicator of quality was systematically assessed as follows.
After the measure was fully specified, the expert panel (workgroup membership) was asked to rate their agreement with the following statement:
The scores obtained from the measure as specified will provide an accurate reflection of quality and can be used to distinguish good and poor quality.
Scale 1-5, where 1= Strongly Disagree; 3=Neither Agree nor Disagree; 5= Strongly Agree

2b2.3 Testing Results *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment)*:
EHR Measure Validity
This measure demonstrates moderate agreement when comparing EHR automated report to visual inspection of the medical record.

Reliability: N, Kappa (95% CI)
Overall: 71, 0.49 (0.017- 0.514)

Face Validity
The results of the expert panel rating of the validity statement were as follows: N = 13; Mean rating = 4.77 and 100.00% of respondents either agree or strongly agree that this measure can accurately distinguish good and poor quality

The results of the expert panel rating of the validity statement were as follows:
Frequency Distribution of Ratings
1 - 0 (Strongly Disagree)
2 - 0
3 - 0 (Neither Disagree nor Agree)
4 - 3
5 - 10 (Strongly Agree

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
EHR Measure Validity
The measure performance was calculated from data collected using two different methods of collection:
- Automated EHR report
- Visual inspection of the medical record by professional data abstractors to capture the data elements to manually construct the performance

The data source was electronic health records in the ambulatory care setting.
The data sample came from 2 sites representing a community health center and a large independent specialty practice, both in the midwest region
The sample consisted of 1144 patient encounters.
Visual inspection of the medical record was performed in 2010.

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)*:
EHR Measure Validity
- An automated report of performance was created.
- Manual abstractors reviewed each patient who did not meet the measure according to the automated report.
- Exceptions were documented even for performance measures that did not allow for exceptions in the specifications in an attempt to see whether some measures should include denominator exceptions to more accurately reflect quality.

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
EHR Measure Validity
The automated report was unable to capture exceptions for this measure, as there was no discrete field for allowable exception. The percentage of false negatives due to exception (the number of patients who appeared to fail the measure on automated calculation but were found to not meet the numerator and have a valid exception on the manual review) was 45.7% (16/35 patients) for the measure.

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:

This measure is not risk adjusted.

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)*:
This measure is not risk adjusted.

2b4.3 Testing Results *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)*:
This measure is not risk adjusted.

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: As a process measure, no risk adjustment is necessary.

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
CMS Physician Quality Reporting Initiative:
2,215 cases were reported on for the 2010 program, the most recent year for which data is available.

The following information is for the 2010 program, the only year for which such data is available.
Clinical Condition and Measure: Hepatitis C: Consideration for Antiviral Therapy
# Eligible Professionals: 36,071
# Professionals Reporting >=1 Valid QDC: 203
% Professionals Reporting >=1 Valid QDC: 0.56%
# Professionals Satisfactorily Reporting: 98
% Professionals Satisfactorily Reporting: 48.28%

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:
CMS Physician Quality Reporting Initiative:
The inter-quartile range (IQR) was calculated to determine the variability of performance on the measure.

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:
Scores on this measure: N =808; 63.25% is the aggregate perormance rate in the total patient population and 65.58% is the mean performance rate of TIN/NPI's

10th percentile: 0.00%
25th percentile: 25.00%
50th percentile: 100.00%
75th percentile: 100.00%
90th percentile: 100.00%

The inter-quartile range (IQR) provides a measure of the dispersion of performance. The IQR is 75.00, and indicates that 50% of physicians have performance on this measure ranging from 25.00% and 100.00%. A quarter of reporting physicians have performance of 25.00% or less.

Source: Confidential CMS PQRI 2010 Performance Information by Measure. Jan 2010-February 2011 TAP file

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches*

*result in comparable scores.*)

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
Please refer to the EHR Measure Validity section of this form.

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)*:
Please refer to the EHR Measure Validity section of this form.

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)*:
Please refer to the EHR Measure Validity section of this form.

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts)*: We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:
The PCPI advocates that performance measure data should, where possible, be stratified by race, ethnicity, and primary language to assess disparities and initiate subsequent quality improvement activities addressing identified disparities, consistent with recent national efforts to standardize the collection of race and ethnicity data. A 2008 NQF report endorsed 45 practices including stratification by the aforementioned variables.(1) A 2009 IOM report "recommends collection of the existing Office of Management and Budget (OMB) race and Hispanic ethnicity categories as well as more fine-grained categories of ethnicity(referred to as granular ethnicity and based on one's ancestry) and language need (a rating of spoken English language proficiency of less than very well and one's preferred language for health-related encounters)."(2)

References:
(1)National Quality Forum Issue Brief (No.10). Closing the Disparities Gap in Healthcare Quality with Performance Measurement and Public Reporting. Washington, DC: NQF, August 2008.

(2)Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. March 2010. AHRQ Publication No. 10-0058-EF. Agency for Healthcare Research and Quality, Rockville, MD. Available at: http://www.ahrq.gov/research/iomracereport. Accessed May 25, 2010.

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

## 3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)

C.1 Intended Actual/Planned Use *(Check all the planned uses for which the measure is intended)*: Public Reporting, Quality

Improvement (Internal to the specific organization)

3.1 Current Use *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [*For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.*]
This measure is currently in use in PQRS and has been since 2008.

The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has been validated. Continued NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

3a.2.Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has been validated. Continued NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): This measure may be used in a Maintenance of Certification program.

3b. Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[*For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement*].
All PCPI measures are suitable for use in quality improvement initiatives and are made freely available on the PCPI website and through the implementation efforts of medical specialty societies and other PCPI members. The PCPI strongly encourages the use of its measures in QI initiatives and seeks to provide information on such initiatives to PCPI members.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
The PCPI believes that the use of PCPI measures in quality improvement initiatives is a beneficial way to gather scientific data with which to improve physician performance. This is appropriate since the measure has been tested and the reliability of the performance data has been validated. NQF endorsement will facilitate our ongoing progress toward this quality improvement objective.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

## 4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are:
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

4b. Electronic Sources: H☐ M☐ L☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)*: ALL data elements in electronic health records (EHRs)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H☐ M☐ L☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:
We are not aware of any unintended consequences related to this measurement.

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I ☐

A.2 Please check if either of the following apply (*regarding proprietary measures*):
4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues *(e.g., fees for use of proprietary measures)*:
This measure was found to be reliable and feasible for implementation.

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

## OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐
Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

## 5. COMPARISON TO RELATED AND COMPETING MEASURES

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

5.1 If there are related measures *(either same measure focus or target population)* or competing measures *(both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?

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

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures *(e.g., a more valid or efficient way to measure quality);* OR provide a rationale for the additive value of endorsing an additional measure. *(Provide analyses when possible)*:

## CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), 515 N. State St., Chicago, Illinois, 60654

Co.2 Point of Contact: Mark S., Antman, DDS, MBA, Director, Measure Development Operations Performance Improvement, mark.antman@ama-assn.org, 312-464-5056-

Co.3 Measure Developer if different from Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), 515 N. State St., Chicago, Illinois, 60654

Co.4 Point of Contact: Mark S., Antman, DDS, MBA, Director, Measure Development Operations Performance Improvement, mark.antman@ama-assn.org, 312-464-5056-

Co.5 Submitter: Katherine, Ast, MSW, LCSW, katherine.ast@ama-assn.org, 312-464-4920-, American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Co.6 Additional organizations that sponsored/participated in measure development:
American Association for the Study of Liver Diseases, American Gastroenterological Association Institute

Co.7 Public Contact: Mark S., Antman, DDS, MBA, Director, Measure Development Operations Performance Improvement, mark.antman@ama-assn.org, 312-464-5056-, American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

## ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
Co-Chairs:
John B. Wong, MD (gastroenterology, hepatology, methodology)
John W. Ward, MD (internal medicine)
Work Group Members:
Joel V. Brill, MD (gastroenterology)
Roger Chou, MD (internal medicine, guideline experience)
Richard H. Davis, Jr., PA-C (physician assistant)
Yngve Falck-Ytter, MD, AGAF (gastroenterology/liver/hepatologist)
Troy Fiesinger, MD, FAAFP (family medicine)
Marc G. Ghany, MD, MHSc (guideline experience/hepatology)
Arthur Yu-shin Kim, MD (HIV and HCV co-infection)
Barbara H. McGovern, MD (HIV and HCV co-infection)
Daniel B. Raymond (consumer/patient advocacy group)
Paola Ricci, MD (hepatology/gastroenterology)
Saverio Sava, MD (CHC representative/hepatologist)
Lynn Gardiner Seim, MSN, RN (patient advocacy)
Jessica A. Shepherd, MD, MBA (OB/GYN)
Margaret C. Shuhart, MD, MS (hepatology/gastroenterology)
Amy Hirsch Shumaker, PharmD, BCPS (pharmacy, hepatology, infectious disease)

Chris Taylor (patient advocacy/public health)
Glenn Treisman, MD, PhD (HIV and HCV psychiatrist)
Weifeng Weng, PhD (health services researcher/ABIM PIM development)
John Yao, MD, MPH, MBA, MPA, FACP (health plan representative)

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward: n/a

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 Year the measure was first released: 2006
Ad.4 Month and Year of most recent revision: 06, 2012
Ad.5 What is your frequency for review/update of this measure? See Ad.9.
Ad.6 When is the next scheduled review/update for this measure? 06, 2012

Ad.7 Copyright statement: Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI™).

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND



Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.



Ad.8 Disclaimers:

Ad.9 Additional Information/Comments: Coding/Specifications updates occur annually. The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.

Date of Submission (*MM/DD/YY*): 07/02/2012

# Hepatitis C: Antiviral Treatment Prescribed (NQF 0397)

| | | | |
|---|---|---|---|
| **eMeasure Name** | Hepatitis C: Antiviral Treatment Prescribed | **eMeasure Id** | 2270EEC6-61C3-452F-89FC-BB78B6F5A6C1 |
| **Version number** | 1 | **eMeasure Set Id** | A2EC09A7-1797-46A2-A4B5-A5EC4C87D484 |
| **Available Date** | No information | **Measurement Period** | January 1, 20xx through December 31, 20xx |
| **Measure Steward** | American Medical Association - Physician Consortium for Performance Improvement | | |
| **Endorsed by** | National Quality Forum | | |
| **Description** | Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who were prescribed peginterferon and ribavirin therapy within the 12 month reporting period | | |
| **Copyright** |  | | |
| **Measure scoring** | Proportion | | |
| **Measure type** | Process | | |
| **Stratification** | None | | |
| **Risk Adjustment** | None | | |
| **Data Aggregation** | | | |
| **Rationale** | Assure that antiviral therapy is prescribed. The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is combination pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment. (AGA, 2006). Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, active substance abuse in the absence of concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions.(AGA, 2006). Data elements required for the measure can be captured and the measure is actionable by the physician. | | |
| **Clinical Recommendation Statement** | The treatment of choice is peginterferon plus ribavirin (Grade I). (AASLD, 3004). The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is combination pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment (Category I). (AGA) Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, | | |

| | |
|---|---|
| | active substance abuse in the absence on concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions (Category I). (AGA, 2006). Combination therapy results in better treatment responses than monotherapy, but the highest response rates have been achieved with pegylated interferon in combination with ribavirin. (NIH, 2002). |
| **Improvement notation** | Higher score indicates better quality |
| **Measurement duration** | 12 month(s) |
| **Reference** | American Gastroenterological Association (AGA) technical review on the management of hepatitis C. Gastroenterology. 2006 Jan; 130(1): 231-264. |
| **Reference** | Dienstag JL, McHutchinson JG. American Gastroenterological Association (AGA) medical position statement on the management of hepatitis C. Gastroenterology. 2006 Jan; 130 (1): 225-30. |
| **Reference** | Stradler DB, Wright T, Thomas DL, Seeff LB. American Association for the Study of Liver Diseases (AASLD) practice guidelines: Diagnosis, management and treatment of hepatitis C. Hepatology. 2004 April: 1147-1171. |
| **Reference** | National Institutes of Health (NIH). Management of hepatitis C: 2002. Rockville (MD): National Institutes of Health (NIH); 2002 Aug 26. |
| **Definition** | Initial Patient Population(s): Patient Age: Patients aged 18 years and older at the beginning of the measurement period. Diagnosis Active: Patient has a documented diagnosis of chronic Hepatitis C.<br>Encounter: At least 2 visits with the physician, physician s assistant, or nurse practitioner during the measurement period. |
| **Definition** | Denominator(s): All patients aged 18 years and older with a diagnosis of chronic Hepatitis C |
| **Definition** | Denominator Exclusion(s): N/A |
| **Definition** | Numerator(s): Patients who were prescribed peginterferon and ribavirin therapy within the 12 month reporting period. |
| **Definition** | Denominator Exception(s): Documentation of medical reason(s) for not prescribing peginterferon and ribavirin therapy (eg, patient was not a candidate for therapy, could not tolerate). Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy (eg, patient declined) Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy (eg, patient has no insurance coverage, therapy not covered). |
| **Guidance** | |
| **Supplemental Data Elements** | Report "Patient Characteristic: Gender" using "Gender HL7 Value Set (2.16.840.1.113883.1.11.1)"; Report "Patient Characteristic: Race" using "Race CDC Value Set (2.16.840.1.114222.4.11.836)"; Report "Patient Characteristic: |

| | |
|---|---|
| | Ethnicity" using "Ethnicity CDC Value Set (2.16.840.1.114222.4.11.837)"; Report "Patient Characteristic: Payer" using "Payer Source of Payment Typology Value Set (2.16.840.1.113883.3.221.5)". |

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## Population criteria

- **Initial Patient Population =**
  - AND: "Patient Characteristic: birth date" >= 18 year(s) starts before start of "Measurement period"
  - AND: "Diagnosis, Active: Chronic Hepatitis C" starts before or during ("Encounter: Encounter Office & Outpatient Consult" during "Measurement period")
  - AND: Count >= 2 of:"Encounter: Encounter Office & Outpatient Consult" during "Measurement period"
- **Denominator =**
  - AND: "Initial Patient Population"
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND:
    - AND:
      - OR: "Medication, Administered: Peginterferon"
      - OR: "Medication, Order: Peginterferon"
      - OR: "Medication, Active: Peginterferon"
    - AND:
      - OR: "Medication, Order: Ribavirin"
      - OR: "Medication, Active: Ribavirin"
    - during "Measurement period"
- **Denominator Exceptions =**
  - AND:
    - OR:
      - OR:
        - OR:
          - OR: "Medication, Administered not done: Medical reason" for "Peginterferon RxNorm Value Set"
          - OR: "Medication, Administered not done: Patient reason" for "Peginterferon RxNorm Value Set"
          - OR: "Medication, Administered not done: System reason" for "Peginterferon RxNorm Value Set"
          - during "Measurement period"
        - OR:
          - OR: "Medication, Order not done: Medical reason" for "Peginterferon RxNorm Value Set"
          - OR: "Medication, Order not done: Patient reason" for "Peginterferon RxNorm Value Set"
          - OR: "Medication, Order not done: System reason" for "Peginterferon RxNorm Value Set"
          - during "Measurement period"
        - OR:

        - OR: "Medication, Active not done: Medical reason" for "Peginterferon RxNorm Value Set"
        - OR: "Medication, Active not done: Patient reason" for "Peginterferon RxNorm Value Set"
        - OR: "Medication, Active not done: System reason" for "Peginterferon RxNorm Value Set"
        - during "Measurement period"
    - OR:
        - OR: "Medication, Order not done: Medical reason" for "Ribavirin RxNorm Value Set"
        - OR: "Medication, Order not done: Patient reason" for "Ribavirin RxNorm Value Set"
        - OR: "Medication, Order not done: System reason" for "Ribavirin RxNorm Value Set"
        - during "Measurement period"
    - OR:
        - OR: "Medication, Active not done: Medical reason" for "Ribavirin RxNorm Value Set"
        - OR: "Medication, Active not done: Patient reason" for "Ribavirin RxNorm Value Set"
        - OR: "Medication, Active not done: System reason" for "Ribavirin RxNorm Value Set"
        - during "Measurement period"
- OR:
    - OR:
        - OR: "Medication, Intolerance: Peginterferon"
        - OR: "Medication, Allergy: Peginterferon"
        - OR: "Medication, Adverse Effects: Peginterferon"
        - starts before or during ("Encounter: Encounter Office & Outpatient Consult" during "Measurement period")
    - OR:
        - OR: "Medication, Intolerance: Ribavirin"
        - OR: "Medication, Allergy: Ribavirin"
        - OR: "Medication, Adverse Effects: Ribavirin"
        - starts before or during ("Encounter: Encounter Office & Outpatient Consult" during "Measurement period")

## Data criteria (QDM Data Elements)

- "Diagnosis, Active: Chronic Hepatitis C" using "Chronic Hepatitis C Value Set GROUPING (2.16.840.1.113883.3.526.03.624)"
- "Encounter: Encounter Office & Outpatient Consult" using "Encounter Office & Outpatient Consult CPT Value Set (2.16.840.1.113883.3.526.02.99)"
- "Medication, Active: Peginterferon" using "Peginterferon RxNorm Value Set (2.16.840.1.113883.3.526.02.628)"
- "Medication, Active: Ribavirin" using "Ribavirin RxNorm Value Set (2.16.840.1.113883.3.526.02.629)"
- "Medication, Active not done: Medical reason" using "Medical reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.313)"
- "Medication, Active not done: Patient reason" using "Patient reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.311)"
- "Medication, Active not done: System reason" using "System reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.310)"
- "Medication, Administered: Peginterferon" using "Peginterferon RxNorm Value Set (2.16.840.1.113883.3.526.02.628)"
- "Medication, Administered not done: Medical reason" using "Medical reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.313)"
- "Medication, Administered not done: Patient reason" using "Patient reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.311)"

- "Medication, Administered not done: System reason" using "System reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.310)"
- "Medication, Adverse Effects: Peginterferon" using "Peginterferon RxNorm Value Set (2.16.840.1.113883.3.526.02.628)"
- "Medication, Adverse Effects: Ribavirin" using "Ribavirin RxNorm Value Set (2.16.840.1.113883.3.526.02.629)"
- "Medication, Allergy: Peginterferon" using "Peginterferon RxNorm Value Set (2.16.840.1.113883.3.526.02.628)"
- "Medication, Allergy: Ribavirin" using "Ribavirin RxNorm Value Set (2.16.840.1.113883.3.526.02.629)"
- "Medication, Intolerance: Peginterferon" using "Peginterferon RxNorm Value Set (2.16.840.1.113883.3.526.02.628)"
- "Medication, Intolerance: Ribavirin" using "Ribavirin RxNorm Value Set (2.16.840.1.113883.3.526.02.629)"
- "Medication, Order: Peginterferon" using "Peginterferon RxNorm Value Set (2.16.840.1.113883.3.526.02.628)"
- "Medication, Order: Ribavirin" using "Ribavirin RxNorm Value Set (2.16.840.1.113883.3.526.02.629)"
- "Medication, Order not done: Medical reason" using "Medical reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.313)"
- "Medication, Order not done: Patient reason" using "Patient reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.311)"
- "Medication, Order not done: System reason" using "System reason SNOMED-CT Value Set (2.16.840.1.113883.3.526.02.310)"
- "Patient Characteristic: birth date" using "birth date LOINC Value Set (2.16.840.1.113883.3.560.100.4)"

## Supplemental Data Elements

- "Patient Characteristic: Gender" using "Gender HL7 Value Set (2.16.840.1.113883.1.11.1)"
- "Patient Characteristic: Race" using "Race CDC Value Set (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic: Ethnicity" using "Ethnicity CDC Value Set (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic: Payer" using "Payer Source of Payment Typology Value Set (2.16.840.1.113883.3.221.5)"

| Measure set | CLINICAL QUALITY MEASURE SET 2011-2012 |
|---|---|

Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA) convened Physician Consortium for Performance Improvement® (PCPI ™) and /or the National Committee for Quality Assurance (NCQA).

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| Value Set Developer | Value Set OID | Value Set Name | QDM Category | Code System | Code System Version | Code | Descriptor |
|---|---|---|---|---|---|---|---|
| National Quality Forum | 2.16.840.1.113883.3.560.100.4 | birth date | Individual Characteristic | LOINC | 2.36 | 21112-8 | Birth date |

| Value Set Developer | Value Set OID | Value Set Name | QDM Category | Code System | Code System Version | Code | Descriptor |
|---|---|---|---|---|---|---|---|
| HL7 | 2.16.840.1.113883.1.11.1 | Gender | Individual Characteristic | HL7 Administrative Gender (2.16.840.1.113883.5.1) | 2011 | F | Female |
| HL7 | 2.16.840.1.113883.1.11.1 | Gender | Individual Characteristic | HL7 Administrative Gender (2.16.840.1.113883.5.1) | 2011 | M | Male |
| HL7 | 2.16.840.1.113883.1.11.1 | Gender | Individual Characteristic | HL7 Administrative Gender (2.16.840.1.113883.5.1) | 2011 | UN | Undifferentiated |
| CDC NCHS | 2.16.840.1.114222.4.11.836 | Race | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 1002-5 | American Indian or Alaska Native |
| CDC NCHS | 2.16.840.1.114222.4.11.836 | Race | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 2028-9 | Asian |
| CDC NCHS | 2.16.840.1.114222.4.11.836 | Race | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 2054-5 | Black or African American |
| CDC NCHS | 2.16.840.1.114222.4.11.836 | Race | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 2076-8 | Native Hawaiian or Other Pacific Islander |
| CDC NCHS | 2.16.840.1.114222.4.11.836 | Race | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 2106-3 | White |
| CDC NCHS | 2.16.840.1.114222.4.11.836 | Race | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 2131-1 | Other Race |
| CDC NCHS | 2.16.840.1.114222.4.11.837 | Ethnicity | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 2135-2 | Hispanic or Latino |
| CDC NCHS | 2.16.840.1.114222.4.11.837 | Ethnicity | Individual Characteristic | CDC Race and Ethnicity Code | 3/30/2007 | 2186-5 | Not Hispanic or Latino |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 1 | MEDICARE |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 11 | Medicare (Managed Care) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 111 | Medicare HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 112 | Medicare PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 113 | Medicare POS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 119 | Medicare Managed Care Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 12 | Medicare (Non-managed Care) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 121 | Medicare FFS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 122 | Drug Benefit |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 123 | Medicare Medical Savings Account (MSA) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 129 | Medicare Non-managed Care Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 19 | Medicare Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 2 | MEDICAID |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 21 | Medicaid (Managed Care) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 211 | Medicaid HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 212 | Medicaid PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 213 | Medicaid PCCM (Primary Care Case Management) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 219 | Medicaid Managed Care Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 22 | Medicaid (Non-managed Care Plan) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 23 | Medicaid/SCHIP |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 24 | Medicaid Applicant |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 25 | Medicaid - Out of State |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 29 | Medicaid Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3 | OTHER GOVERNMENT (Federal/State/Local) (excluding Department of Corrections) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 31 | Department of Defense |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 311 | TRICARE (CHAMPUS) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3111 | TRICARE Prime--HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3112 | TRICARE Extra--PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3113 | TRICARE Standard - Fee For Service |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3114 | TRICARE For Life--Medicare Supplement |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3115 | TRICARE Reserve Select |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3116 | Uniformed Services Family Health Plan (USFHP) -- HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3119 | Department of Defense - (other) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 312 | Military Treatment Facility |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3121 | Enrolled Prime--HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3122 | Non-enrolled Space Available |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3123 | TRICARE For Life (TFL) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 313 | Dental --Stand Alone |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 32 | Department of Veterans Affairs |

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|---|---|---|---|---|---|---|---|
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 321 | Veteran care--Care provided to Veterans |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3211 | Direct Care--Care provided in VA facilities |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3212 | Indirect Care--Care provided outside VA facilities |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 32121 | Fee Basis |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 32122 | Foreign Fee/Foreign Medical Program(FMP) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 32123 | Contract Nursing Home/Community Nursing Home |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 32124 | State Veterans Home |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 32125 | Sharing Agreements |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 32126 | Other Federal Agency |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 322 | Non-veteran care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3221 | Civilian Health and Medical Program for the VA (CHAMPVA) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3222 | Spina Bifida Health Care Program (SB) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3223 | Children of Women Vietnam Veterans (CWVV) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3229 | Other non-veteran care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 33 | Indian Health Service or Tribe |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 331 | Indian Health Service - Regular |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 332 | Indian Health Service - Contract |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 333 | Indian Health Service - Managed Care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 334 | Indian Tribe - Sponsored Coverage |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 34 | HRSA Program |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 341 | Title V (MCH Block Grant) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 342 | Migrant Health Program |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 343 | Ryan White Act |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 349 | Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 35 | Black Lung |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 36 | State Government |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 361 | State SCHIP program (codes for individual states) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 362 | Specific state programs (list/ local code) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 369 | State, not otherwise specified (other state) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 37 | Local Government |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 371 | Local - Managed care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3711 | HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3712 | PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3713 | POS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 372 | FFS/Indemnity |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 379 | Local, not otherwise specified (other local, county) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 38 | Other Government (Federal, State, Local not specified) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 381 | Federal, State, Local not specified managed care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3811 | Federal, State, Local not specified - HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3812 | Federal, State, Local not specified - PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3813 | Federal, State, Local not specified - POS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 3819 | Federal, State, Local not specified - not specified managed care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 382 | Federal, State, Local not specified - FFS |

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|---|---|---|---|---|---|---|---|
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 389 | Federal, State, Local not specified - Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 39 | Other Federal |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 4 | DEPARTMENTS OF CORRECTIONS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 41 | Corrections Federal |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 42 | Corrections State |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 43 | Corrections Local |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 44 | Corrections Unknown Level |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 5 | PRIVATE HEALTH INSURANCE |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 51 | Managed Care (Private) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 511 | Commercial Managed Care - HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 512 | Commercial Managed Care - PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 513 | Commercial Managed Care - POS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 514 | Exclusive Provider Organization |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 515 | Gatekeeper PPO (GPPO) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 519 | Managed Care, Other (non HMO) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 52 | Private Health Insurance - Indemnity |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 521 | Commercial Indemnity |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 522 | Self-insured (ERISA) Administrative Services Only (ASO) plan |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 523 | Medicare supplemental policy (as second payer) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 529 | Private health insurance—other commercial Indemnity |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 53 | Managed Care (private) or private health insurance (indemnity), not otherwise specified |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 54 | Organized Delivery System |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 55 | Small Employer Purchasing Group |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 59 | Other Private Insurance |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 6 | BLUE CROSS/BLUE SHIELD |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 61 | BC Managed Care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 611 | BC Managed Care - HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 612 | BC Managed Care - PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 613 | BC Managed Care - POS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 619 | BC Managed Care - Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 62 | BC Indemnity |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 63 | BC (Indemnity or Managed Care) - Out of State |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 64 | BC (Indemnity or Managed Care) - Unspecified |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 69 | BC (Indemnity or Managed Care) - Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 7 | MANAGED CARE, UNSPECIFIED (to be used only if one can't distinguish public from private) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 71 | HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 72 | PPO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 73 | POS |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 79 | Other Managed Care, Unknown if public or private |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 8 | NO PAYMENT from an Organization/Agency/Program/Private Payer Listed |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 81 | Self-pay |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 82 | No Charge |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 821 | Charity |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 822 | Professional Courtesy |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 823 | Research/Clinical Trial |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 83 | Refusal to Pay/Bad Debt |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 84 | Hill Burton Free Care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 85 | Research/Donor |

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| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 89 | No Payment, Other |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 9 | MISCELLANEOUS/OTHER |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 91 | Foreign National |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 92 | Other (Non-government) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 93 | Disability Insurance |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 94 | Long-term Care Insurance |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 95 | Worker's Compensation |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 951 | Worker's Comp HMO |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 953 | Worker's Comp Fee-for-Service |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 954 | Worker’s Comp Other Managed Care |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 959 | Worker's Comp, Other unspecified |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 96 | Auto Insurance (no fault) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 98 | Other specified (includes Hospice - Unspecified plan) |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 99 | No Typology Code available for payment source |
| PHDSC | 2.16.840.1.113883.3.221.5 | Payer | Individual Characteristic | Source of Payment Typology | October 2010 | 9999 | Unavailable / Unknown |