NQF-Endorsed Measures for Musculoskeletal Conditions

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

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Executive Summary

Musculoskeletal measures in the National Quality Forum's portfolio include injuries or disorders, including inflammatory and degenerative disorders affecting the muscles, nerves, tendons, joints, cartilage and supporting blood vessels, and supporting structures of the upper and lower limbs, neck, and lower back that are caused, precipitated or exacerbated by sudden exertion or prolonged exposure to physical factors such as repetition, force, vibration, or awkward posture. This definition specifically excludes those conditions such as contusions, abrasions, and lacerations resulting from sudden physical contact of the body with external objects.[1]

Currently, NQF's portfolio of musculoskeletal measures includes measures in the topic areas of arthritis and related conditions, and musculoskeletal injuries. Submitted measures address imaging for low back pain, rheumatoid arthritis, gout, and timely pain management for long bone fracture.

The Musculoskeletal Standing Committee evaluated 12 measures: 8 new measures and 4 measures undergoing maintenance review against NQF's standard evaluation criteria. Three measures were recommended for endorsement, 4 measures were recommended for trial measure approval (an optional pathway for eMeasures being piloted in this project), 2 measures were not recommended for trial measure approval, 1 measure was not recommended for endorsement, and 2 measures were deferred. The 3 measures that were recommended for endorsement by the Standing Committee are:

- 0054 Disease modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- 2524: Rheumatoid Arthritis: Functional Status Assessment
- 2523: Rheumatoid Arthritis: Assessment of Disease Activity

The Musculoskeletal project is the first to pilot test a new process for the optional pathway of trial measure approval, which is intended for eMeasures that are ready for implementation but have not yet been adequately tested to meet NQF endorsement criteria. The measures with trial measure approval are not recommended for use in accountability applications, however they have been judged to be ready for implementation in real-world settings in order to generate the data required to assess reliability and validity. They may be considered for endorsement after sufficient data to assess reliability and validity testing have been submitted to NQF, within three years of trial approval. Four measures are recommended by the Committee for trial measure approval:

- 2522: Rheumatoid Arthritis: Tuberculosis Screening
- 2525: Rheumatoid Arthritis: Disease modifying Anti-Rheumatic Drug (DMARD) Therapy
- 2549: Gout: Serum Urate Target
- 2550: Gout: ULT Therapy

Brief summaries of the measures currently under review are included in the body of this report; detailed summaries of the Committee's discussion and ratings of the criteria are included in Appendix A. Twenty-two (22) existing measures in the portfolio were retired and were not reviewed.

Introduction

Musculoskeletal conditions include injuries or disorders, including inflammatory and degenerative disorders affecting the muscles, nerves, tendons, joints, cartilage and supporting blood vessels, and supporting structures of the upper and lower limbs, neck, and lower back that are caused, precipitated or exacerbated by sudden exertion or prolonged exposure to physical factors such as repetition, force, vibration, or awkward posture. This definition specifically excludes those conditions such as contusions, abrasions, and lacerations resulting from sudden physical contact of the body with external objects.[2] Musculoskeletal disorders and diseases are a leading cause of disability in the United States, with increasing prevalence and cost associated with musculoskeletal diseases in an aging population.[3] In addition to the morbidity associated with musculoskeletal disorders, there has been a significant increase in the total costs associated with treatment of musculoskeletal disorders. Low back pain is among the most common reasons for visits to physicians and a major reason for work-related disability.

Due to the burden of these disorders, there is a critical need for nationally recognized musculoskeletal care measures. On average, the proportion of the US population with a musculoskeletal disease requiring medical care has increased annually by more than two percentage points over the past decade and now includes more than 30 percent of the population. An estimated 89.7 million persons cited a musculoskeletal disease as a primary health concern in response to the Medical Expenditures Panel Survey (MEPS) during the 2004 to 2006 time period, and in 2008 the number of adults reporting musculoskeletal diseases increased to 110.34 million in the National Health Interview (NHIS). There has been a more than 47 percent increase in total aggregate direct cost to treat persons with a musculoskeletal disease during this same time frame and estimates annual direct and indirect costs at $287 billion. Over the period 1996-2004, the proportion of persons with one or more of the major subgroups of musculoskeletal diseases, with the exception of injuries, has risen. Throughout the period under study, arthritis and joint pain has been the major condition subgroup with the highest prevalence rate, followed by spine conditions.

NQF has previously endorsed measures assessing quality of care for bone and joint conditions across several projects, including an outpatient imaging efficiency project aimed at endorsing measures that address the appropriate and efficient use of diagnostic imaging in the outpatient setting and endorsement of measures based on clinically enriched data. As of 2011, these projects yielded 26 NQF-endorsed measures, however twenty-two (22) existing measures in the portfolio have been retired and were not reviewed in this project; details are included in Appendix B.[4,5,6]

Currently, NQF's portfolio of musculoskeletal measures includes measures in the topic areas of gout, rheumatoid arthritis, low back pain and imaging, bone fracture and pain management, falls and surgical procedures. The measures address monitoring and therapies in the treatment of gout, screening, assessment and therapies for rheumatoid arthritis, imaging for low back pain, pain assessment,

management, and follow-up, screening and management of fall risk, and readmission rates following elective hip and/or knee replacement.

Imaging Musculoskeletal Disorders

Diagnosis of nonspecific musculoskeletal complaints is challenging and the use of imaging modalities, such as magnetic resonance imaging (MRI), plain x-rays or computerized tomography (CT) is often required to establish a diagnosis, determine treatment, or monitor disease progression.[7] MRI is a widely used medical technology, and is often employed as the preferred imaging tool for disorders of the musculoskeletal system (rheumatologic and orthopedic) and neurologic conditions, as it can better delineate soft tissue structures than x-rays or CT scans.[8] Relevant to low back pain measures within the NQF Musculoskeletal portfolio, an important study indicates that lumbar imaging for low back pain without indications of serious underlying conditions does not improve clinical outcomes and should be avoided without suggestion of a serious underlying condition.[9]

Rheumatoid Arthritis

Rheumatoid arthritis (RA) is a systemic inflammatory disease affecting the lining of the joints (synovial membrane), but can also affect other organs.[10] An estimated 1.5 million adults had rheumatoid arthritis in 2007.[11] Data from the National Vital Statistics System (NVSS) from 1979-1998 indicates the annual number of arthritis and other rheumatic conditions (AORC) deaths rose from 5,537 to 9,367. NCVSS data also show that three categories of AORC account for almost 80 percent of deaths: diffuse connective tissue diseases (34%), other specified rheumatic conditions (23%), and rheumatoid arthritis (22%).[12]

Gout

Gout is a painful condition that occurs when the bodily waste product uric acid is deposited as needle-like crystals in the joints and/or soft tissues. Scientists estimate that 6 million adults age 20 and older report having this condition. Men, particularly those between the ages of 40 and 50, are more likely to develop gout than women, whose incidence of gout increases after menopause. Gout is rare in children and young adults. According to the Centers for Disease Control and Prevention (CDC), gout affects approximately 3 million people in the United States each year, and the incidence and prevalence of gout appears to be increasing in frequency according to several studies.[13] According to researchers using National Health and Nutrition Examination Survey (NHANES) the prevalence of gout in the United States increased from 2.7 percent in 1988-1994, to 3.9 percent in 2007-2008 (8.3 million Americans). The prevalence of hyperuricemia also increased significantly during this time.[14]

Timely Pain Management: Long Bone Fracture

A long bone fracture is a fracture of the femur, humerus, tibia, fibula, radius, or ulna. Fractures of the tibial shaft are the most common long bone fractures; with an incidence greater than 75,000 per year in the US most of these fractures are found in young males. A second peak of incidence is noted among elderly patients, whose injuries likely resulted from a simple fall.[15][16] A recent study using the National Hospital Ambulatory Medical Care Survey from 1998–2003 indicates that there is little evidence that the pain management of long bone fractures in the emergency department has improved over time.[17]

National Quality Strategy

The National Quality Strategy (NQS) serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, State, and national) to improve the quality of health care in the U.S. The NQS establishes the "triple aim" of better care, affordable care, and healthy people/communities, focusing on six priorities to achieve those aims: *Safety, Person and Family Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living,* and *Affordable Care*.

Improvement efforts for musculoskeletal conditions including imaging for low back pain; screening, assessment and therapies for rheumatoid arthritis; assessment, monitoring and therapies in the treatment of gout, and timely pain management for long bone fracture are consistent with the NQS triple aim and align with several of the NQS priorities, including:

- Priority 1: Safer Care (reducing harm caused in the delivery of care)
- Priority 2: Person and Family Centered Care (timeliness), and
- Priority 4: Effective Prevention and Treatment.

Musculoskeletal Measure Evaluation: Refining the Evaluation Process

A change to the Consensus Development Process (CDP)—transitioning to Standing Steering Committees—has been incorporated into the ongoing maintenance activities for the Musculoskeletal portfolio. Trial measure approval, an optional pathway for eMeasures, is also being piloted in this phase of the Musculoskeletal project. These changes are described below.

Standing Committees

In an effort to remain responsive to its stakeholders' needs, NQF is constantly working to improve the CDP. Volunteer, multi-stakeholder steering committees are the central component to the endorsement process, and the success of the CDP projects is due in large part to the participation of its Steering Committee members. In the past, NQF initiated the Steering Committee nominations process and seated new project-specific committees only when funding for a particular project had been secured. Seating new committees with each project not only lengthened the project timeline, but also resulted in a loss of process continuity and consistency because committee membership changed—often quite substantially—over time.

To address these issues in the CDP, NQF is beginning to transition to the use of Standing Committees for various topic areas. These Standing Committees will oversee the various measure portfolios; this oversight function will include evaluating both newly-submitted and previously-endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing feedback on how the portfolio should evolve, and serving on any ad hoc or expedited projects in their designated topic areas.

The Musculoskeletal Standing Committee currently includes 21 members (see Appendix D). Each member has been randomly appointed to serve an initial two- or three- year term, after which he/she may serve a subsequent three-year term if desired.

Trial Measure Approval

NQF has developed and is piloting in this project an optional path of trial measure approval for eMeasures. This path is intended for eMeasures that meet technical eligibility requirements and are ready for implementation, but have not yet been adequately tested to meet NQF endorsement criteria. For such eMeasures, NQF is piloting use of the multi-stakeholder consensus process to evaluate and approve eMeasures that address important areas for performance measurement and quality improvement, even though they may not have the requisite testing needed for NQF endorsement.

Trial measure approval by a Committee indicates eMeasures are ready for testing purposes only, and is not endorsement of the measure for accountability applications. Approved measures are judged by the Committee to meet the other NQF criteria of importance to measure and report, feasibility, and usability and planned use, and are evaluated relative to any related and competing measures. For approved measures, measure developers are expected to provide full field testing and submit them for full endorsement within 3 years after approval. The trial measure designation automatically expires 3 years after initial Committee approval if the measure is not submitted for full endorsement prior to that time.

The Musculoskeletal Standing Committee has recommended four eMeasures for this optional pathway; those measures are discussed in the Musculoskeletal Measure Evaluation section of this report. Additional information regarding the trial measure approval pathway is available on the NQF webpage.

NQF Portfolio of Performance Measures for Musculoskeletal Conditions

Currently, NQF's portfolio of musculoskeletal measures includes measures for gout, rheumatoid arthritis, pain management and imaging. This portfolio contains 29 measures: 18 process measures, 9 outcome measures and 1 resource use measure (see table below). Twelve of these measures were evaluated by the Musculoskeletal Standing Committee.

NQF Musculoskeletal Portfolio of Measures

	Process	Outcome/Resource Use	Composite
Pain Management and Bone Fracture	2	1	
Low Back Pain: Imaging	2		
Rheumatoid Arthritis	5		
Gout	4		
Safety	2		
Surgery	0	2	
Functional Status	2	6	
Rehabilitation	1	1	
Total	**18**	**10**	

The remaining 18 measures have been assigned, for various reasons, to other projects. These include various pain management measures, functional status measures, surgery measures and rehabilitation measures.

Endorsement of measures by NQF is valued not only because the evaluation process itself is both rigorous and transparent, but also because evaluations are conducted by multi-stakeholder committees comprised of clinicians and other experts from hospitals and other healthcare providers, employers, health plans, public agencies, community coalitions, consumers and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, legislative mandate requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

Over time, and for various reasons, some previously-endorsed measures related to musculoskeletal disorders have been dropped from the full NQF portfolio. In some cases, the measure steward may not want to continue maintain the measure for endorsement (e.g., update specifications as new drugs/tests become available or as diagnosis/procedure codes evolve or go through NQF's measure maintenance process). In other cases, measures may lose endorsement upon maintenance review. Loss of endorsement can occur for many different reasons including—but not limited to—a change in evidence without an associated change in specifications, high performance on a measure signifying no further opportunity for improvement, and endorsement of a superior measure. In the case of several measures related to back pain the measure steward, the National Committee for Quality Assurance (NCQA), withdrew measures that were included in NCQA's Back Pain Recognition Program (BPRP) as the BPRP program was retired in August 2012 and the measures are no longer in use.

Use of Measures in the Portfolio

Five measures in the musculoskeletal portfolio that are under review in this project are currently used in the Physician Reporting Quality System. See Appendix C for details of federal program use for the measures, all of which pertain to rheumatoid arthritis.

Improving NQF's Musculoskeletal Portfolio

Committee input on gaps in the portfolio

During their discussions the Committee identified numerous areas where additional measure development is needed, including:

- management of chronic pain;
- use of MRI for management of chronic knee pain;
- tendinopathy: evaluation, treatment, and management;
- outcomes: spinal fusion, knee and hip replacement;
- overutilization of procedures; and

- secondary fracture prevention.

Measures in the "pipeline"

NQF recently launched a *Measure Inventory Pipeline*—a virtual space for developers to share information on measure development activities. Developers can use the Pipeline to display data on current and planned measure development and to share successes and challenges. Information shared via the Pipeline is available in real time and can be revised at any time. NQF expects that developers will use the Pipeline as a tool to connect to, and collaborate with, their peers on measurement development ideas. Currently, no measures related to musculoskeletal conditions have been submitted to the Pipeline.

Musculoskeletal Measure Evaluation

On May 7-8, 2014, the Musculoskeletal Standing Committee evaluated 12 measures: 8 new measures and 4 measures undergoing maintenance review against NQF's standard evaluation criteria. Six of the 8 new measures were reviewed against NQF's trial measure approval criteria. To facilitate the evaluation, the committee and candidate standards were divided into 3 workgroups for preliminary review of the measures against the evaluation sub-criteria prior to consideration by the entire Standing Committee. The Committee's discussion and ratings of the criteria are summarized in the evaluation tables in Appendix A.

Musculoskeletal Summary

	Maintenance	New	Total
Measures under consideration	4	8	12
Measures recommended for Endorsement	1	2	3
Measures recommended for Trial Measure Approval	0	4	4
Measures where consensus is not yet reached	0	0	0
Measures not recommended for Endorsement	1	2	3
Measures deferred	2	0	2
Reasons for not recommending	Importance – 1 Scientific Acceptability – NA Overall – NA Competing Measure – NA	Importance – 2 Scientific Acceptability – NA Overall – 2 Competing Measure – NA	Importance – 3 Scientific Acceptability – 2 Overall – NA Competing Measure – NA

Comments Received

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF has begun soliciting comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from March 25-April 7, 2014 for the measures under review. All submitted comments were provided to the Committee prior to their initial deliberations held during the workgroups calls. A total of 3 pre-evaluation comments were received and pertained to the specifications for measure NQF# 0514: MRI Lumbar Spine for Low Back Pain and NQF# 0052: Use of Imaging Studies for Low Back Pain and were considered by the Committee in its deliberations. The 30-day post-evaluation comment was open from July 2, 2014 to July 31, 2014. During this commenting period, NQF received ninety-eight comments from seven member organizations. The Committee discussed these comments and took action on measure-specific comments as needed, during the Committee's post-comment call, which was held on August 21, 2014.

Overarching Issue

Insufficient Evidence

During the Standing Committee's discussion of the measures, the overarching issue of insufficient evidence emerged that was factored into the Committee's ratings and recommendations for multiple measures. The Committee acknowledged that NQF criteria have become more rigorous following the 2010 Task Force recommendations regarding evaluating evidence. In their review of measures related to use of anti-inflammatory prophylaxis for gout, timely pain management in the emergency department for long bone fractures and imaging for low back pain, the Committee concluded that the evidence presented did not sufficiently support the claim that the measured processes would improve health outcomes.

Summary of Measure Evaluation

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

Gout

Four new measures addressing assessment, monitoring and therapies in the treatment of gout were reviewed. The four measures met eligibility requirements to be included in the pilot trial measure approval pathway, which allows measures to be evaluated without complete testing and approved to be implemented in real-world settings in order to generate the data required to assess reliability and validity. Two measures were recommended for trial measure approval.

NQF #2550: Gout ULT Therapy (American College of Rheumatology): Recommended for Trial Measure Approval

Description: *Percentage of patients aged 18 and older with a diagnosis of gout and either tophus/tophi or at least two gout flares (attacks) in the past year who have a serum urate level > 6.0 mg/dL, who are prescribed urate lowering therapy (ULT)****; Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician: Individual;*

Setting of Care: *Ambulatory Care : Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry*

This new eMeasure was recommended for trial measure approval. The developer, American College of Rheumatology (ACR) will implement these measures into its national registry. This measure is based on evidence-based clinical guidelines and focuses on the use of uric acid lowering therapies in patients with more severe gout. The Committee agreed that although a summary of the systematic review of the evidence wasn't presented, they were familiar with the evidence and the evidence criterion should be rated as moderate. The Committee found the data submitted sufficiently demonstrated that there was opportunity for improvement and agreed that this measure addresses a high-priority aspect of healthcare, as gout flares in this high risk population are a significant cause of morbidity and cost.

NQF#2521: Gout: Serum Urate Monitoring (American College of Rheumatology): Not Recommended

Description: *Percentage of patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period, and who had their serum urate level measured within 6 months;* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician: Individual;* ***Setting of Care****: Ambulatory Care; Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry*

This new eMeasure was submitted but not recommended for trial measure approval. The Committee noted that no randomized controlled trials were cited in the evidence that establish a linkage between monitoring serum urate levels, treating uric acid level targets and improved patient outcomes. Although the Committee agreed that there was an opportunity for improvement in the management of gout, the Committee agreed the measure would have a low impact and the measure did not pass Importance to Measure and Report.

NQF #2526: Gout: Anti-inflammatory Prophylaxis with ULT Therapy (American College of Rheumatology): Not Recommended

Description: *Percentage of patients with gout who are initiated on ULT who are receiving concomitant anti-inflammatory prophylaxis (low dose colchicine, NSAID, or glucocorticoid) to reduce flares****; Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician : Individual;* ***Setting of Care:*** *Ambulatory Care : Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry*

This new eMeasure was submitted for the Trial Measure Pathway but not recommended for approval as the Committee determined it did not meet the importance criterion. The Committee noted that most of the evidence provided supported the use of colchicine as an anti-inflammatory prophylaxis, while there was less evidence presented to support the use of NSAIDs and/or glucocorticoids indicated in the measure. The Committee noted a significant performance gap as demonstrated by a 2009 study of 297 Veterans receiving allopurinol, of which only 10 percent received colchicine prophylaxis. When discussing the impact of the measure, however, the Committee questioned the costliness of gout flares versus prophylaxis, with Committee members noting the recent increase in the cost of colchicine. As a

result, the Committee found the measure would have a low impact and the measure did not pass the importance criterion.

NQF#2549: Gout: Serum Urate Target(American College of Rheumatology): Recommended for Trial Measure Approval

Description: *Percentage of patients aged 18 and older with a diagnosis of gout treated with urate-lowering therapy (ULT) for at least 12 months, whose most recent serum urate result is less than 6.8 mg/dL.;* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician: Individual;* ***Setting of Care:*** *Ambulatory Care: Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data: Electronic Clinical Data : Electronic Health Record: Electronic Clinical Data : Registry.*

This new eMeasure was submitted for the Trial Measure pathway. During evaluation of the measure at the in-person meeting, the Committee did not reach consensus on a recommendation for trial measure approval. The Committee questioned whether the measure specifications met the Scientific Acceptability criterion, noting that urate levels may not be a reliable method of monitoring a patient with a diagnosis of gout. Committee members suggested the measure might be more meaningful if patients with a serum urate level of less than 6.8, and on uric acid lowering therapy with no gout attacks, tophi or erosions were excluded from the measure. After review of comments received during the public and NQF member commenting period, the Committee re-voted on the measure during the Post-Comment Call, and recommended the measure for Trial Measure Approval. As suggested by the Committee, the developer agreed to change the measure specifications to include an exclusion for existing patients with documentation that no gout flares have occurred within the last year.

Rheumatoid Arthritis

A previously NQF-endorsed measure and 4 newly submitted measures addressing rheumatoid arthritis were reviewed. Two of the new measures met eligibility requirements to be included in the pilot trial measure approval pathway, which allows measures to be evaluated without complete testing and approved to be implemented in real-world settings in order to generate the data required to assess reliability and validity. Three of the 5 measures were recommended for endorsement, and 2 of the 5 measures were recommended for trial measure approval.

NQF #2524: Rheumatoid Arthritis: Functional Status Assessment (American College of Rheumatology): Recommended for Endorsement

Description: *Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis for whom a functional status assessment was performed at least once during the measurement period;* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician: Individual;* ***Setting of Care:*** *Ambulatory Care: Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data: Electronic Health Record*

This new eMeasure is anticipated to be incorporated in to the American College of Rheumatology (ACR) national registry, and is a refinement of the functional status rheumatoid arthritis measure currently being used in the Physician Quality Reporting System (PQRS). The Committee noted there is little direct evidence available related to assessment of functional status for patients with rheumatoid arthritis. The Committee agreed that functional status as an outcome is important, as it is a predictor of future disability and mortality, and provides feedback to both the patient and the provider. Ultimately, the

Committee agreed that the measure is important to measure and report. The Committee noted there are some feasibility concerns regarding potential technical and workflow changes for providers to collect the data elements, but agreed the measure is moderately feasible and recommended the measure for endorsement.

NQF #2523: Rheumatoid Arthritis: Assessment of Disease Activity (American College of Rheumatology): Recommended for Endorsement

Description: *Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis and >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure;* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician: Individual;* ***Setting of Care:*** *Ambulatory Care: Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data: Electronic Health Record*

This new eMeasure has been reviewed and recommended by Measure Applications Partnership for use in 2015 CMS programs. It is also programmed into the ACR national registry, and the developer expects the measure to be included in stage three of the CMS Meaningful Use program. The Committee agreed that using validated assessments to set treatment goals and target therapy results in improved patient outcomes, including better functional and radiographic outcomes. Overall, the Committee agreed that the measure is important to measure and report. Although some Committee members noted that feasibility might be dependent on the current workflow of providers, with potential technical challenges related to adding the data element fields required for the measure; the Committee recommended the measure for endorsement.

NQF #2522: Rheumatoid Arthritis: Tuberculosis Screening (American College of Rheumatology): Recommended for Trial Measure Approval

Description: *Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who have documentation of a tuberculosis (TB) screening performed within 12 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD);* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician: Individual;* ***Setting of Care:*** *Ambulatory Care: Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data: Electronic Health Record*

This new eMeasure was recommended for trial measure approval. The measure has been recommended by the Measures Application Partnership for use in 2015 CMS programs. The Committee noted that this is a key patient safety measure, as patients initiating disease-modifying anti-rheumatic drugs have an increased risk of tuberculosis. Overall, the Committee agreed that the measure is important to measure and report.

0054 Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (National Council on Quality Assurance): Recommended for Continued Endorsement

Description: *The percentage of patients 18 years and older by the end of the measurement period, diagnosed with rheumatoid arthritis and who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD);* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Health Plan, Integrated Delivery System;* ***Setting of Care:*** *Ambulatory Care : Clinician Office/Clinic;* ***Data Source:*** *: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy*

This measure was originally endorsed in 2009 and is specified at the health plan level. The measure is currently used for public reporting, health plan ranking, federal payment programs, HEDIS accreditation, and quality improvement programs. The Committee agreed strong evidence is presented linking the use of disease-modifying anti-rheumatic drugs in patients with rheumatoid arthritis to better outcomes, such as slowing the progression of rheumatoid arthritis and preventing further damage to joints. The Committee questioned the opportunity for improvement on the measure, as 90 percent of commercial plans are meeting the measure, although performance was lower for Medicaid and Medicare plans. The developer noted that although the average performance rate is high across commercial health plans, there is still considerable variation among the different types of health plans, including variation by region. Ultimately, the Committee agreed the measure is important to measure and report. As such, the Committee voted to recommend the measure for continued endorsement.

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy (American College of Rheumatology): Recommended for Trial Measure Approval

Description: *Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months;* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Clinician : Individual;* ***Setting of Care:*** *Ambulatory Care : Clinician Office/Clinic;* ***Data Source:*** *Electronic Clinical Data, Electronic Health Record*

This new measure is recommended for trial measure approval and is planned for use in the ACR registry. An important clarification noted by the developer is that the description should read, "percentage of patients greater than 18 years with a diagnosis of rheumatoid arthritis who are prescribed, administered, or ordered a disease-modifying anti-rheumatic drug in a measurement year" as opposed to "newly prescribed DMARD therapy". This measure is related to measure #0054 however, while the two measures have a similar focus they address different levels of accountability and require data from different data sources. The developers of the measures, the National Committee for Quality Assurance (NCQA) (#0054) and ACR (#2525) have held an initial meeting to review the similarities and differences between the two measures' logic and value sets and will continue this harmonization effort. The Committee agreed the measure is important to measure and report and recommended the trial measure pathway due to the small number of sites tested thus far.

Imaging Musculoskeletal Disorders

Two previously NQF-endorsed measures addressing imaging were reviewed, however both measures have been deferred and will be brought back for review in a future project.

NQF #0052: Use of Imaging Studies for Low Back Pain (National Committee for Quality Assurance): Deferred

Description: *The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.;* ***Measure Type:*** *Process;* ***Level of Analysis:*** *Health Plan: Integrated Delivery System;* ***Setting of Care:*** *Ambulatory Care: Clinician Office/Clinic: Ambulatory Care: Urgent Care: Hospital/Acute Care Facility;* ***Data Source:*** *Administrative claims: Electronic Clinical Data: Electronic Clinical Data : Imaging/Diagnostic Study;*

This measure was originally endorsed in 2009 and is used for public reporting, health plan ranking, federal payment programs, HEDIS accreditation, and quality improvement programs. The Committee agreed that imaging studies including computed tomography (CT), magnetic resonance imaging (MRI) and x-ray are often overused in the diagnosis and treatment of non-specific lower back pain and as a result, total spending is quite high for the diagnosis and treatment of low back pain. The Committee noted that the face validity testing for the measure and raised concerns regarding the lack of "red flag" exclusions for conditions that potentially indicate a serious health condition. The Committee agreed the measure did not meet the validity criterion and the measure did not pass scientific acceptability.

The Consensus Standards Advisory Committee (CSAC) noted that while determination of the validity of a measure does include consideration of potential threats to validity, they were concerned about the Committee's interpretation of NQF criteria related to measure exclusions. The CSAC also noted that the developer stated that the frequency of occurrence of the exclusions suggested by the Committee was very low. As a result, not including those suggested exclusions would not distort the measure. CSAC requested that NCQA be given time to address the Committee's concerns and that the measure evaluation be deferred until the revised measure can be presented to the Committee for reconsideration.

NQF #0514 MRI Lumbar Spine for Low Back Pain (Centers for Medicare & Medicaid Services): Deferred

Description: *This measure calculates the percentage of MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim, and for which the patient did not have prior claims-based evidence of antecedent conservative therapy.* ***Measure Type:*** *Efficiency;* ***Level of Analysis:*** *Facility, Population : National, Population : State;* ***Setting of Care:*** *Ambulatory Care : Clinician Office/Clinic: Hospital/Acute Care Facility: Imaging Facility;* ***Data Source:*** *Administrative Claims*

This measure was originally endorsed in 2008 and is used for public reporting and quality improvement programs. Although the Committee agreed the measure met the importance criterion, they questioned the lack of improvement in performance reported on the measure between 2007 and 2011. The Committee also noted concerns with the measure's scientific acceptability. These concerns included insufficient exclusions for a history of previous back surgery, exclusions in conflict with guidelines provided in the evidence and dependence on the accuracy of claims to assess if antecedent conservative therapies were pursued. The Committee gave the validity criterion a low rating and the measure did not pass scientific acceptability.

The Consensus Standards Advisory Committee (CSAC) noted that while determination of the validity of a measure does include consideration of potential threats to validity, they were concerned about the Committee's interpretation of NQF criteria related to measure exclusions. CSAC also noted that the developer is in the process of revising the measure to address the Committee's concerns, but were unable to complete the changes within the current project timeline. As a result, CSAC requested time be given to address the Committee's concerns and that the measure evaluation be deferred until the revised measures can be presented to the Committee for reconsideration.

Timely Pain Management

One previously NQF-endorsed measure addressing timely pain management in the emergency department for long bone fractures was reviewed. The measure was not recommended for endorsement.

NQF#0662: Median Time to Pain Management for Long Bone Fracture (Centers for Medicare & Medicaid) Not Recommended

Description: *Median time from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF);* ***Measure Type:*** *Efficiency;* ***Level of Analysis:*** *Facility, Population : National;* ***Setting of Care:*** *Hospital/Acute Care Facility;* ***Data Source:*** *Administrative claims: Electronic Clinical Data: Electronic Clinical Data: Electronic Health Record: Paper Medical Records.*

This measure was originally endorsed in 2011 and is in use in public reporting, payment, regulatory and accreditation programs and quality improvement programs. The Committee questioned if the evidence provided by the developer directly supported the measure focus, which is to improve the median time of pain medication administration from emergency department arrival for emergency department patients with a principal diagnosis of long bone fracture. The Committee agreed that the evidence presented was insufficient to meet the evidence criterion. The Committee gave the evidence criterion a low rating and the measure did not pass importance to measure and report.

Measures withdrawn by the developer from further consideration of endorsement

The following measures were withdrawn during the measure evaluation period

Measure	Measure Steward	Reason for withdrawal
0305: Back Pain: Surgical Timing	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0306: Back Pain: Patient Reassessment	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0309: Back Pain: Appropriate Use of Epidural Steroid Injections	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0310: Back Pain: Shared Decision Making	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0312: Back Pain: Repeat Imaging Studies	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0314: Back Pain: Advice Against Bed Rest	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.

Measure	Measure Steward	Reason for withdrawal
0315: Back Pain: Advice for Normal Activities	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0316: Back Pain: Appropriate Imaging for Acute Back Pain	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
Back Pain: Mental Health Assessment	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0317: Back Pain: Recommendation for Exercise	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0319: Back Pain: Physical Exam	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0322: Back Pain: Initial Visit	National Committee for Quality Assurance	This measure was included in NCQA's Back Pain Recognition Program that was retired in August 2012.
0050: Osteoarthritis: Function and Pain Assessment	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	The developer was unable to complete necessary testing.
0051: Osteoarthritis (OA): Assessment for use of anti-inflammatory or analgesic over-the-counter (OTC) medications	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	The developer was unable to complete necessary testing.
0589: Rheumatoid Arthritis New DMARD Baseline Serum Creatinine	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.
0590: Rheumatoid Arthritis New DMARD Baseline Liver Function Test	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.
0591: Rheumatoid Arthritis New DMARD Baseline CBC	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.
0592: Rheumatoid Arthritis Annual ESR or CRP	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.

Measure	Measure Steward	Reason for withdrawal
0597: Methotrexate: LFT within 12 weeks	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.
0598: Methotrexate: CBC within 12 weeks	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.
0599: Methotrexate: Creatinine within 12 weeks	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.
0601: New Rheumatoid Arthritis Baseline ESR or CRP within Three Months	Resolution Health, Inc.	The developer has not submitted the measure for reendorsement.

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Appendix A: Details of Measure Evaluation

Endorsed Measures

Measures Endorsed for Trial Measure Approval

Measures not recommended

Measures not recommended for Trial Measure Approval

Measures Deferred

Endorsed Measures

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

0054 Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Submission | Specifications

Description: The percentage of patients 18 years and older by the end of the measurement period, diagnosed with rheumatoid arthritis and who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Numerator Statement: Patients diagnosed with rheumatoid arthritis who were dispensed at least one ambulatory prescription for a disease- modifying anti-rheumatic drug (DMARD) during the measurement year.

Denominator Statement: All patients, ages 18 years and older by December 31 of the measurement year, who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year:

- Outpatient visit, with any diagnosis of rheumatoid arthritis

- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis

Visit type need not be the same for the two visits.

Exclusions: Exclude patients who have a diagnosis of HIV. Look for evidence of HIV diagnosis as far back as possible in the patient's history through the end of the measurement year.

Exclude patients who have a diagnosis of pregnancy any time during the measurement year.

Adjustment/Stratification:

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [5/8/2014]

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

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

1a. Evidence: **H-13**; **M-8**; **L-1**; **I-0; IE-0**; 1b. Performance Gap: **H-6**; **M-13**; **L-3**; **I-0;** 1c. Impact: **H-16**; **M-3**; **L-2**; **I-1**

Rationale:

- The developer presented clinical practice guidelines from the National Institute for Clinical Excellence (NICE) and the American College of Rheumatology (ACR) and a systematic review of empirical evidence to support the need for disease-modifying anti-rheumatic drugs (DMARDs) in patients with rheumatoid arthritis (RA) and linking treatment to better outcomes, such as slowing the progression of RA and preventing further damage to joints. The Committee agreed strong evidence is presented to support the measure is sufficient.

- Committee members questioned whether there is a continued opportunity for improvement on the measure, with 90 percent of commercial plans meeting the measure, although performance was lower for Medicaid and Medicare plans. The developer noted that although the average performance rate is high across commercial health plans, there is still considerable variation among the different types of health plans, including variation by region. Given this consideration, the Committee agreed that there is room for improvement.
- The Committee agreed the measure will have a high impact, as RA is considered one of the leading causes of the morbidity, mortality in the country. Rheumatoid arthritis has also been established as a top 20 impact condition by the Centers for Medicare and Medicaid Services.

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

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

2a. Reliability: **H-11**; **M-11**; **L-0**; **I-0** 2b. Validity: **H-0**; **M-16**; **L-4**; **I-2**

<u>Rationale</u>:

- The Committee agreed that the reliability testing provided, with scores showing agreement ranging from 0.87-0.93, indicates the measure is highly reliable and the scores can distinguish differences in performance among the health plans.
- Committee members were concerned about factors that might influence getting a prescription or not, such as a variance in copay fees from plan to plan, or lack of rheumatologists in various regions. The Committee asked for clarification regarding whether plans, or whether providers should be accountable in the measure. The developer acknowledged that this is a broader issue not necessarily specific to this measure, and clarified that ultimately the plan is held accountable for this measure.
- Committee members also raised concerns regarding whether inactive RA should be captured in the measure, as prescribing DMARDs for this population would not be appropriate. The developer explained that this element would be difficult to capture via claims for this claims based measure.
- The Committee agreed that for data element validity, there was good agreement on denominator identification, as administrative data and medical record data agreed for over 73 percent of patients. There was some discussion about the variation, that some prescriptions were missed, perhaps due to the issues mentioned above such as high copays. The developer explained that while some patients might be missed, the assumption is the distribution of these types patients would be equal across the plans and not skew results.

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3. Feasibility: H-13; M-8; L-0; I-0

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

<u>Rationale</u>:

- Overall, the Committee agreed the measure if feasible to implement. The data elements are being already captured and generated in the EHR during the provision of care.

4. Use and Usability: H-12; M-19; L-1; I-0

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

Rationale:

- The Committee agreed the measure meets the use and usability criterion, noting that the measure is already widely used by a number of plans and rating systems for healthcare quality.

5. Related and Competing Measures

- This measure is related to: NQF #2525: Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug Therapy for RA. Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months. The two measures have a similar focus but address different levels of accountability and collect data from different data sources. The developers, NCQA and ACR have held an initial meeting to review the commonalities and differences in measure logic and value sets between the two measures. The stewards will continue this harmonization effort.

Standing Committee Recommendation for Endorsement: **Y-21**; **N-1**

6. Public and Member Comment

- Four comments were submitted for this measure. Although one commenter noted that there is likely a minimal gap in care for this measure, all four comments were supportive of the Committee's decision to recommend the measure for continued endorsement.

7. Consensus Standards Approval Committee (CSAC) Review (October 23, 2014): Y-16; N-0; A-0

- **Decision: Approved for continued endorsement**

8. Board of Directors Vote: Yes (November 19, 2014)

- **Decision: Ratified for continued endorsement**

2523 Rheumatoid Arthritis: Assessment of Disease Activity

Submission | Specifications

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis and >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

Numerator Statement: # of patients with >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

Denominator Statement: Patients 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

Exclusions: N/A

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record

Measure Steward: American College of Rheumatology

STANDING COMMITTEE MEETING [5/7/2014]

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

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

1a. Evidence: **H-2**; **M-13**; **L-0**; **I-0; IE-6**; 1b. Performance Gap: **H-9**; **M-11**; **L-1**; **I-0;** 1c. Impact: **H-10**; **M-10**; **L-1**; **I-0**

Rationale:

- The developer presented American College of Rheumatology clinical guidelines that recommend routine disease activity measurement to target low disease activity. These tools were developed to aid in measuring responses in clinical trials, and are based on expert opinion with Category C evidence. The Committee noted that there are not data from randomized controlled trials related to measuring disease activity to improve outcomes, and the Committee agreed that using validated assessments to set treatment goals and target therapy can result in improved patient outcomes, including better functional and radiographic outcomes.
- Performance gap data from 3 testing sites showed that 35-61 percent of patients met the criteria of an assessment in at least 50 percent of patient encounters with a mean rate of 50 percent. The Committee agreed this demonstrated there was room for improvement.
- The Committee agreed that this measure addresses a national health priority and will have a high impact, as rheumatoid arthritis has been established as a top 20 impact condition by the Centers for Medicare and Medicaid Services.

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

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

2a. Reliability: **H-1**; **M-20**; **L-0**; **I-0** 2b. Validity: **H-1**; **M-19**; **L-0**; **I-1**

Rationale:

- The Committee agreed moderate reliability testing is presented, as testing was performed at the data element level, rather than the performance score.
- The Committee agreed the validity of the measure is moderate, as face validity testing is presented.

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3. Feasibility: H-1; M-18; L-2; I-0

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

Rationale:

- The Developer provided a sufficient eMeasure feasibility assessment for this eMeasure.
- The Committee agreed the measure is moderately feasible, as some Committee members noted that the feasibility might be dependent on kind of the current workflow of implementers of the measure, and there could be potential technical challenges with adding the data element fields required for the measure.

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4. Use and Usability: H-3; M-17; L-1; I-0

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

Rationale:

- This measure has been reviewed and recommended by MAP for use in 2015 CMS programs. The developer indicated that the measure is expected to be included in stage three of the CMS Meaningful Use program. As a result, the Committee agreed the measure meets the criterion.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-20**; **N-1**

6. Public and Member Comment

Comments included:

- Ten comments were submitted for this measure. Although nine commenters were supportive of the Committee's decision to recommend the measure, several expressed feasibility concerns. One commenter noted that technical challenges may exist relative to collecting data for this measure from an EHR due to variations in physician office workflow and adding the necessary data element fields into the EHR. Commenters agreed that the measure is conceptually important, but were concerned about the reliability of data extractions on the assessments from EHRs.

Developer response:

- "As supported by growing evidence and established practice guidelines, we believe that the assessment of disease activity is a foundational concept in quality measurement and improvement. A tight control treatment strategy aiming for remission in early rheumatoid arthritis is more effective than usual care treatment in daily clinical practice. We initially also had concerns that collecting data for this measure could present implementations challenges. However, our measures testing sites have evidenced that it is feasible to support successful workflow and data extraction from an EHR to reliably collect and report data on this measure. We tested this measure in multiple sites with multiple different EHR systems and were able to successfully and reliably test this measure. In addition, the ACR also has experience with collecting this data through our RISE registry, which pulls data directly from practice's EHR systems to calculate performance. We have been able to successfully implement this measure in our RISE registry practices. Furthermore, this is a critically important clinical concept for rheumatologists and lays the foundation for future outcomes measures in the field."
- "To address the commenter's second concern, the measure does in fact list specific tools for measuring disease activity, which can be found in the measure specification guide, including:

- Simplified Disease Activity Index (SDAI)
- Clinical Disease Activity Index (CDAI)
- Patient Activity Score (PAS)
- Patient Activity Score II (PASII)
- Routine Assessment of Patient Index Data (RAPID3)
- Modified disease activity scores with twenty-eight-joint counts (DAS 28 CRP/DAS 28 ESR)

The ACR recently undertook an extensive multi-year project, involving systematic literature reviews, expert consensus ratings, and national surveys to reach consensus on which RA disease activity measures are valid, reliable, and responsive, and feasible to implement in routine clinical practice."

- "The ACR-endorsed 6 RA disease activity measurement tools, which include overlapping core elements. All include a patient-reported component (PRO). No measure is currently a gold standard; there is good scientific evidence supporting each endorsed measure. Therefore, clinicians can select from a range of valid options appropriate to their practice settings and available resources. This novel approach to measurement has been extensively validated in RA over a period of several decades."

Committee response:

- The Committee accepted the developer's response and made no changes to their decision to recommend the measure for endorsement.

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7. Consensus Standards Approval Committee (CSAC) Review (October 23, 2014): Y-16; N-0; A-0

- **Decision: Approved for endorsement**

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8. Board of Directors Vote: Yes (November 19, 2014)

- **Decision: Ratified for endorsement**

2524 Rheumatoid Arthritis: Functional Status Assessment

Submission | Specifications

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis for whom a functional status assessment was performed at least once during the measurement period.

Numerator Statement: Number of patients with functional status assessment documented once during the measurement period. Functional status can be assessed using one of a number of valid and reliable instruments available from the medical literature.

Denominator Statement: Patients age 18 and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

Exclusions: N/A

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record

Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY

STANDING COMMITTEE MEETING [5/7/2014]

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

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

1a. Evidence: **H-0**; **M-3**; **L-0**; **I-0; IE-19**; 1b. Performance Gap: **H-12**; **M-9**; **L-0**; **I-1;** 1c. Impact: **H-16**; **M-6**; **L-0**; **I-0**

Rationale:

- The Committee acknowledged that functional status as an outcome is important, as it is a predictor of future disability and mortality, and provides feedback to both the patient and the provider. The Committee noted that although there direct evidence was not provided about the relationship to health outcomes, there is indirect evidence for the relationship. The Committee agreed the developer provided sufficient evidence to meet the criterion.
- The developers presented results from three test sites that showed a 44 to 87 percent variation in performance on the measure. The Committee agreed that this data sufficiently demonstrates a performance gap.
- The Committee agreed this measure addresses a national health priority and the measure will have a high impact, as rheumatoid arthritis has been established as a top 20 impact condition by the Centers for Medicare and Medicaid Services.

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

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

2a. Reliability: **H-3**; **M-19**; **L-0**; **I-0** 2b. Validity: **H-5**; **M-15**; **L-1**; **I-1**

Rationale:

- The Committee noted that testing was performed at the data element level, not the performance score, and as a result agreed the measure demonstrates moderate reliability.
- The Committee agreed the validity of the measure is moderate, noting face validity testing is presented for the measure.

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3. Feasibility: H-2; M-13; L-5; I-2

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

Rationale:

- The developers provided a feasibility assessment of the critical data elements and all of these elements scored high (2 out of 3 or 3 out of 3) based on a survey of four EHR vendors. The surveyed EHR vendors also assessed the feasibility of the measure logic and determined that the submitted measure is feasible. Some Committee members raised concern over potential technical and workflow changes for providers, as 2 of 3 sites suggested that technical implementation would take several weeks and workflow implementation training would take several months. The developer responded that if this measure is recommended for NQF

endorsement and becomes a part of CMS programs, there will be a strong incentive for EHR vendors to reduce the burden associated with implementation of the measure.

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4. Use and Usability: H-6; M-12; L-3; I-1

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

Rationale:

- Committee noted that the developer anticipates this e-measure will be incorporated into the ACR registry and is a refinement of the current PQRS functional status rheumatoid arthritis measure.
- Some Committee members expressed concern that this measure would set the bar of performance too low and result in providers opting to select the "other" option rather than one the four recommended and validated functional assessment tools. The developer noted that all four recommended tools are nonproprietary and are available online, and that providers are strongly encouraged to use them rather than the "other" option.
- The Committee agreed the measure meets the use and usability criterion.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-19**; **N-3**

6. Public and Member Comment Comments included:

- Nine comments were received for this measure. Commenters were generally supportive of the measure, however there were several concerns noted.
- One commenter noted that feasibility may be challenging for implementation for family physicians, due to the fact that different functional status assessments are available for use.
- One commenter expressed concern over the accuracy of functional assessments and their use in a quality measure. Another commenter agreed that while assessing pain and functional status with a validated tool is important, concerned was expressed that this measure may not lead to improvement in functional status as an outcome.

Developer response:

- "We appreciate this feedback, but maintain that functional status assessment is foundational to patient care and has been noted to be a primary concern for patients. There is strong agreement among national and international guidelines that measuring functional status is important to judge response to therapy and also to assess prognosis. We agree with the commenter that functional status does not always reflect RA disease activity; Disease activity and functional status are related, but distinct and not perfectly correlated concepts. Therefore, this measures provides an essential complement to the disease activity measure (2523: rheumatoid arthritis: assessment of disease activity) in order to capture the full spectrum of the patient's experience and provide the clinician with complete information to make evidence-based clinical care decisions."

Committee response:

- The Committee requested that the developer explicitly state that the measure only applies to rheumatologists and the developer agreed to make that clear in the specifications. The Committee accepted the developer's response and made no changes to their decision to recommend the measure for endorsement.

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7. Consensus Standards Approval Committee (CSAC) Review (October 23, 2014): Y-16; N-0; A-0

- **Decision: Approved for endorsement**

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8. Board of Directors Vote: Yes (November 19, 2014)

- **Decision: Ratified for endorsement**

Measures Endorsed for Trial Measure Approval

2522 Rheumatoid Arthritis: Tuberculosis Screening

Submission | Specifications

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who have documentation of a tuberculosis (TB) screening performed within 12 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).

Numerator Statement: Any record of TB testing documented or performed (PPD, IFN-gamma release assays, or other appropriate method) in the medical record in the 12 months preceding the biologic DMARD prescription.

Denominator Statement: Patients 18 years and older with a diagnosis of rheumatoid arthritis who are seen for at least one face-to-face encounter for RA who are newly started on biologic therapy during the measurement period.

Exclusions: N/A

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record

Measure Steward: American College of Rheumtology

STANDING COMMITTEE MEETING [5/7/2014)

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

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

1a. Evidence: **H-2**; **M-7**; **L-0**; **I-0; IE-13**; 1b. Performance Gap: **H-8**; **M-14**; **L-0**; **I-0;** 1c. Impact: **H-15**; **M-7**; **L-0**; **I-0**

Rationale:

- The Committee noted that direct evidence was not provided linking the process of tuberculosis screening on patients who start a first course of biologic disease-modifying anti-rheumatic drugs (DMARDs) to improved outcome, but there is evidence showing that this population has an increased risk of tuberculosis. The Committee also noted that this is a key patient safety measure and a randomized control study would be unethical. The Committee unanimously passed the measure on the evidence criterion.
- The developer presented performance gap data using ACR's Rheumatology Clinical Registry that demonstrated there was a performance rate of 73.6 percent and 92.9 percent in 2011 and 2012, respectively. The Committee agreed that the data sufficiently demonstrated a performance gap.
- The Committee agreed this measure addresses a national health priority and the measure will have a high impact, as rheumatoid arthritis has been established as a top 20 impact condition by the Centers for Medicare and Medicaid Services.

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2. Scientific Acceptability of Measure Properties: <u>As this e-measure is a candidate for the trial implementation pathway, testing for the measure will be submitted at a later time.</u>

Trial Measure Specifications: H-3; M-17; L-1; I-1

The measure may be considered for endorsement after sufficient data to assess reliability and validity testing have been submitted to NQF, within three years of trial approval.

<u>Rationale:</u>

- Committee members raised concern regarding multiple methods of testing and the accuracy for tuberculosis screening; specifically how providers are interpreting the results. The Committee agreed that was a broader issue not specific to this measure. Overall however, the Committee found the trial measure specifications to be consistent with the evidence.

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3. Feasibility: H-5; M-15; L-0; I-2

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

<u>Rationale</u>:

- The developer provided an eMeasure feasibility assessment of the critical data elements and all of these elements scored high (2 out of 3 or 3 out of 3) based on a survey of four EHR vendors. The Committee agreed the measure is moderately feasible.
- Some Committee members raised concerns over tuberculosis testing accuracy. False positive test results could lead to tuberculosis treatment with potential harmful side effects. Although this could be unintended consequence, the Committee noted this is more of an issue problem with tuberculosis testing in general and not specific to this measure.

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4. Use and Usability: H-4; M-16; L-2; I-0

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

<u>Rationale</u>:

- This developer noted that this measure has been reviewed by the Measures Application Partnership for use in 2015 CMS programs. The Committee agreed that the measure meets the usability and use criterion.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Trial Measure Approval : **Y-21**; **N-1**

6. Public and Member Comment

Comments included:

- Eleven comments were submitted for this measure, all in support of the Committee's decision to recommend the measure for trial measure approval.

7. Consensus Standards Approval Committee (CSAC) Review (October 23, 2014): Y-16; N-0; A-0

- **Decision: Approved Trial Measure Approval**

8. Board of Directors Vote: Yes (November 19, 2014)

- **Decision: Ratified for Trial Measure Approval**

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Submission | Specifications

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months.

Numerator Statement: Patient received a DMARD

Denominator Statement: Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period

Exclusions: Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record

Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY

STANDING COMMITTEE MEETING [5/08/2014]

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

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

1a. Evidence: **H-9**; **M-10**; **L-0**; **I-2; IE-0**; 1b. Performance Gap: **H-4**; **M-16**; **L-2**; **I-0;** 1c. Impact: **H-12**; **M-10**; **L-0**; **I-0**

Rationale:

- The developer provided an overview of the measure and clarified that the description should read "percentage of patients greater than 18 years with a diagnosis of rheumatoid arthritis who are prescribed, administered, or ordered a DMARD in a measurement year" as opposed to "newly prescribed DMARD therapy".
- The Committee noted that the evidence presented was primarily based on clinical guidelines with level C evidence. Members agreed that DMARD treatment is critical and noted that it would be very difficult to try to conduct a randomized controlled trial on this aspect of care. The Committee agreed that the evidence presented was sufficient to meet the evidence criterion.
- The developer also noted observational data that support DMARDs usage leading to decreased health care costs. Although this may not be the case with biologics due to cost, the developer noted, DMARDs have been shown to be cost effective and improve outcomes in both observational and randomized control trials.
- The Committee noted the high performance rate on the measure for participants in the ACR clinical registry and questioned the opportunity for improvement on the measure. The developer noted that a limited group of rheumatologists report through the registry, and the performance by registry participants might not be reflective of broader performance, which is likely lower. The Committee agreed that the data was sufficient enough to demonstrate a performance gap.
- The Committee agreed this measure addresses a national health priority and the measure will have a high impact, as rheumatoid arthritis has been established as a top 20 impact condition by the Centers for Medicare and Medicaid Services.

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2. Scientific Acceptability of Measure Properties: As this e-measure is a candidate for the trial implementation pathway, testing for the measure will be submitted at a later time.

Trial Measure Specifications: H-3; M-17; L-0; I-2

The measure may be considered for endorsement after sufficient data to assess reliability and validity testing have been submitted to NQF, within three years of trial approval.

Rationale:

- The developer has completed testing at two sites and will submit additional data at a later time. Overall, the Committee agreed the specifications were clearly specified.

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3. Feasibility: H-6; M-15; L-1; I-0

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

Rationale:

- The developer provided an eMeasure feasibility assessment of the critical data elements and all of these elements scored high (2 out of 3 or 3 out of 3) based on a survey of four EHR vendors The Committee agreed that the eMeasure is moderately feasible, noting that the required data elements are routinely generated and readily available.

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4. Use and Usability: H-4; M-17; L-0; I-1

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

Rationale:

- The Committee noted that the measure is in use in the ACR registry and will be important to begin to address gaps in care. The Committee agreed that the measure meets the use and usability criterion.

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5. Related and Competing Measures

- This measure is related to: NQF #0054: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis. Description: The percentage of patients 18 years and older by the end of the measurement period, diagnosed with rheumatoid arthritis and who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD). The two measures have a similar focus but address different levels of accountability and collect data from different data sources. The developers, NCQA and ACR have held an initial meeting to review the commonalities and differences in measure logic and value sets between the two measures. The stewards will continue this harmonization effort

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Standing Committee Recommendation for Trial Measure Approval: **Y-21**; **N-1**

6. Public and Member Comment

Comments included:

- Six comments were submitted for this measure. Five comments were in support of the Committee's decision to recommend the measure for trial measure approval.
- One commenter suggested that the measure only include patients who accept therapy and that the provider should not fail the measure when he/she has documented the recommendations for a DMARD and patient elects to forego it. The commenter also noted concerns about exclusions, specifically patients with comorbidities that DMARDs are contraindicated or deemed excessively risky.

Developer response:

- "We appreciate this comment and have discussed the topic throughout our measure development and also with NQF staff. The NQF discourages using patient preference as an exclusion or exception to measures. "Merely indicating that a patient declined a service or intervention does not indicate the quality of the exchange that occurred between the healthcare provider and patient. Exclusions for patient preference (refusal) could be related to quality problems" from NQF Measure Evaluation Criteria. National Quality Forum. "CSAC Guidance on Quality Performance Measure Construction." May 2011.We do not anticipate a 100% performance rate with this measure and plan to work with entities implementing this measure to clarify appropriate performance targets."

Committee response:

- The Committee discussed the whether or not adding the patient preference exclusion would be appropriate, and ultimately agreed that patients who refuse therapy should still be included. The Committee accepted the developer's response and made no changes to their decision to recommend the measure for Trial Measure Approval.

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7. Consensus Standards Approval Committee (CSAC) Review (October 23, 2014): Y-16; N-0; A-0

- **Decision: Approved for Trial Measure Approval**

8. Board of Directors Vote: Yes (November 19, 2014)

- **Decision:, Ratified for Trial Measure Approval**

2549 Gout: Serum Urate Target

Submission | Specifications

Description: Percentage of patients aged 18 and older with a diagnosis of gout treated with urate-lowering therapy (ULT) for at least 12 months, whose most recent serum urate result is less than 6.8 mg/dL.

Numerator Statement: Patients whose most recent serum urate level is less than 6.8 mg/dL

Denominator Statement: Adult patients aged 18 and older with a diagnosis of gout treated with urate lowering therapy (ULT) for at least 12 months

Exclusions: Patients with a history of solid organ transplant

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY

STANDING COMMITTEE MEETING [5/7/2014]

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

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

1a. Evidence: **H-0**; **M-9**; **L-4**; **I-4; IE-4**; 1b. Performance Gap: **H-1**; **M-11**; **L-3**; **I-6;** 1c. Impact: **H-1**; **M-9**; **L-5**; **I-6**

Rationale:

- The developer presented evidence that included the 2012 American College of Rheumatology Guidelines for Management of Gout: Systematic Nonpharmacologic and Pharmacologic Therapeutic Approaches to Hyperuricemia. The evidence was based on a systematic review of the literature on pharmacologic and non-pharmacologic urate lowering therapies, which focused on published meta-analyses and randomized clinical trials. The Committee agreed that the evidence supported a relationship between uric acid levels and gout, but no direct evidence was presented to support a target serum urate level of 6.8 mg/dl versus other targets. The developer responded that while there is no direct evidence to support the target serum urate level of 6.8 mg/dl, evidence does indicate that lowering serum urate levels leads to improved outcomes in the form of decreased gouty attacks in individuals with a diagnosis of gout. The developer also noted that the literature indicates that 6.8 mg/dl is the solubility level for serum urate. The Committee noted that clear empirical evidence is needed for set serum urate targets and these targets should be specified in the measure.

- The Committee noted that evidence indicates serum urate levels are not consistently monitored in all patients diagnosed with chronic gout and receiving urate lowering therapy. However, the Committee questioned the need for regular monitoring of serum urate levels for all patients who are on urate lowering therapy and are stable over time, versus individuals in the acute phase of disease management. The Committee also questioned if a patient centered approach might be preferred based on the observation of symptoms indicating gouty attacks, or tophaceous gout and erosions, rather than targeting treatment towards a particular serum urate level. The developer responded that safety monitoring recommendations in patients with a diagnosis of gout include tests for liver function, renal function and a complete blood count. Serum urate levels could easily be included in those monitoring tests. Serum urate levels, the presence of tophus, tophus progression and the recurrence of attacks are all well correlated in patients receiving urate lowering therapy in chronic gout management.

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2. Scientific Acceptability of Measure Properties: <u>As this e-measure is a candidate for the trial implementation pathway, testing for the measure will be submitted at a later time.</u>

Trial Measure Specifications: H-1; M-11; L-5; I-4 The measure may be considered for endorsement after sufficient data to assess reliability and validity testing have been submitted to NQF, within three years of trial approval.

<u>Rationale</u>:

- The Committee questioned whether having a snapshot of serum urate levels is a reliable method of monitoring a patient. The Committee also noted that clarification is needed regarding the clinical methods by gout is diagnosed, and a definition of what constitutes a gouty attack should be included in the measure specifications. The developer response was that a patient placed on urate-lowering therapy is sufficient indication that the physician has diagnosed gout.
- The Committee questioned if the measure numerator could be specified more accurately. The numerator in the measure specifications consists of all patients whose most recent serum urate level is less than 6.8 mg/dl. The Committee noted that the measure might be more meaningful if patients with a serum urate level of less than 6.8 mg/dl, on uric acid lowering therapy and experiencing no gouty attacks, tophi or erosions were excluded from the numerator.

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3. Feasibility: H-5; M-11; L-2; I-3

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

<u>Rationale</u>:

- The developer provided an eMeasure feasibility assessment of the critical data elements and all of these elements scored high (2 out of 3 or 3 out of 3) based on a survey of four EHR vendors. The Committee agreed that the submitted eMeasure specification follows industry standards to represent the measure electronically which should enable automated data extraction and measure score calculation. The Committee agreed that the measure is moderately feasible.

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4. Use and Usability: H-1; M-11; L-4; I-5

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

Rationale:

- The Committee noted that unnecessary testing and/or treatment could have unintended consequences including increased cost of care. The developer responded that if the patient was already undergoing urate lowering therapy, benefit could be found in adjusting the dosage and that the cost burden of additional testing was not prohibitive. The Committee agreed that the measure meets the use and usability criterion.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Trial Measure Approval: **Y-13**; **N-4 (8/21/14)**:

6. Public and Member Comment

Comments included:

- Eight comments were submitted for the measure. Seven of these comments were in support of the measure and one was not in support of the measure.
- One commenter again expressed concern over urate levels being a reliable method of monitoring a patient with gout, stating that the evidence does not strongly suggest that serum urate levels correlate with the disease state. The commenter also questioned whether the 6.8 mg/dL level most is appropriate, noting that the other measures use 6.0 mg/dL.

Developer response:

- "We would like to restate the evidence demonstrating strong association between serum urate levels and patient outcomes (gout attacks and tophi resolution). The ACR recognizes a huge variation in understanding the mechanisms of gout, best practices and available evidence between rheumatologists and other specialties. This discrepancy and gap of understanding confirms the importance of this measure, as our evidence shows a strong correlation between urate levels and patient outcomes. We further document that there are large gaps in quality looking at current practices.
- "We realize that the guidelines recommend 6.0 mg/dl, however, quality measures make allowances for less stringent standards to allow for patients at the margins. The concentration for urate crystal solubility is 6.8 mg/dl. This higher level (than guidelines recommend) avoids penalizing physicians with patients who are improving, but with scores slightly above 6.0 mg/dl. We recognize that this level is a process indicator, rather than an outcome, so we allowed flexibility."

Committee response:

During evaluation of the measure at the in-person meeting, the Committee did not reach consensus on a recommendation for trial measure approval. After additional discussion the Committee re-voted on the measure during the Post-Comment Call, and recommended the measure for Trial Measure Approval. As suggested by the Committee, the developer agreed to change the measure specifications to include an exclusion for existing patients with documentation that no gout flares have occurred within the last year.

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7. Consensus Standards Approval Committee (CSAC) Review (October 23, 2014): Y-16; N-0; A-0

- **Decision: Approved for Trial Measure Approval**

8. Board of Directors Vote: Yes (November 19, 2014)

- **Decision: Ratified for Trial Measure Approval**

2550 Gout: ULT Therapy

Submission | Specifications

Description: Percentage of patients aged 18 and older with a diagnosis of gout and either tophus/tophi or at least two gout flares (attacks) in the past year who have a serum urate level > 6.0 mg/dL, who are prescribed urate lowering therapy (ULT)

Numerator Statement: Patients who are prescribed urate lowering therapy (ULT)

Denominator Statement: Adult patients aged 18 and older with a diagnosis of gout and a serum urate level > 6.0 mg/dL who have at least one of the following: presence of tophus/tophi or two or more gout flares (attacks) in the past year

Exclusions: None

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY

STANDING COMMITTEE MEETING [5/7/2014]

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

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

1a. Evidence: **H-0**; **M-14**; **L-2**; **I-1; IE-4**; 1b. Performance Gap: **H-4**; **M-15**; **L-0**; **I-2;** 1c. Impact: **H-1**; **M-14**; **L-2**; **I-4**

Rationale:

- Committee members noted that the initial evidence presented did not directly support the use of uric acid lowering therapies in patients with more severe gout. In response to workgroup calls, the developer presented additional evidence, including two randomized controlled trials demonstrating that Febuxostat lowered serum uric acid and reduce the frequency of gout attacks. Articles were also presented that describe the effects of allopurinol on lowering both uric acid and frequency of attack and tophus reduction.
- One Committee member noted that the studies presented focused on patients with high uric acid levels, and that evidence was not presented focusing on patients with minor or less severe attacks of gout. The developer clarified that this measure captures patients who have more severe disease by including those who have had at least two or more gout flares in the past year in the denominator. The Committee questioned whether a patient who has just one attack per year would need to be included in this measure.

- The majority of the Committee agreed that although a summary of the systematic review wasn't presented, the measure is based on evidence-based clinical guidelines, leading to a moderate rating of the evidence.
- The Committee found the data submitted sufficiently demonstrated that there was opportunity for improvement.
- The Committee agreed that this measure addressed a high-priority (high-impact) aspect of healthcare, as gout flares in this high risk population represent a significant cause of morbidity and cost.

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2. Scientific Acceptability of Measure Properties: <u>As this e-measure is a candidate for the trial implementation pathway, testing for the measure will be submitted at a later time.</u>

The measure may be considered for endorsement after sufficient data to assess reliability and validity testing have been submitted to NQF, within three years of trial approval.

<u>Rationale</u>:

- The Committee agreed that the specifications are precise. There was a suggestion that the denominator specification be reviewed; the developer indicated that they would perform further analyses using data obtained through testing. Recommendations from the Committee included analyzing patients with recurring attacks separately; considering the contraindications in terms of exclusions; considering whether non-drug therapy trial could be incorporated – at least in the patients without tophaceous gout and erosions, and reviewing the 6 mg/dl threshold.
- Committee members raised concern about the reliability of the diagnosis particularly in primary care settings that could result in potential overtreatment. There was also concern about increase in gout flares when initiating urate lowering therapy without receiving other education or prophylactic pieces, as exclusive focus on medication management could potentially result in less patient education that is an important part of gout care.

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3. Feasibility: H-0; M-14; L-5; I-2

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

<u>Rationale</u>:

- The developer provided an eMeasure feasibility assessment of the critical data elements and all of these elements scored high (2 out of 3 or 3 out of 3) based on a survey of four EHR vendors. The Committee agreed that the submitted eMeasure specification follows industry standards to represent the measure electronically which should enable automated data extraction and measure score calculation. The Committee agreed that the measure is moderately feasible.

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

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

<u>Rationale</u>:

- The developer stated that the specifications for this measure will be finalized and full field testing will be completed in the next 12 months, at which time the ACR will seek full NQF endorsement. In addition, the ACR will implement these measures into its EHR-enabled registry

this year, at which time they will be part of the registry´s plan for public reporting. The Committee agreed that the measure met the use and usability criterion.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-14**; **N-7** - **<u>The Committee recommended this measure for trial measure approval.</u>**

6. Public and Member Comment

Comments included:

- Six comments were submitted for this measure. Five of the comments were in support of the Committee's recommendation to recommend the measure for trial measure approval. One commenter expressed concern that "this type of measure may over-emphasize pharmacologic management when dietary or education may be more effective at certain levels of serum urate".

Developer response:

- "In addition to the 2012 ACR Gout Guidelines, the threshold of 2 or more attacks per year was previously endorsed in the 2006 EULAR gout guidelines and 2007 British Society for Rheumatologists gout guidelines. These recommendations have been consistent across 3 separate agencies for the last decade, and we feel the threshold of 2 attacks per year should be retained. Severe/recalcitrant and polyarticular patients are unlikely to have fewer than 2 attacks per year and therefore would already be included in the denominator population. Nephrolithiasis in a gout patient is an ACR gout guideline indication; however, this is relatively small group of patients and ascertaining whether a stone is urate based is likely difficult to abstract from the chart."

Committee response:

- The Committee accepted the developer's response and made no changes to their decision to recommend the measures for Trial Measure Approval.

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7. Consensus Standards Approval Committee (CSAC) Review (October 23, 2014): Y-16; N-0; A-0

- **Decision: Approved for endorsement**

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8. Board of Directors Vote: Yes (November 19, 2014)

- **Decision: Ratified for endorsement**

Measure Not Recommended

0662 Median Time to Pain Management for Long Bone Fracture

Submission | Specifications

Description: Median time from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).

Numerator Statement: Time (in minutes) from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a diagnosis of a (long bone) fracture.

Denominator Statement: N/A Measure is a continuous variable.

Exclusions: N/A Measure is a continuous variable. See numerator details.

Adjustment/Stratification:

Level of Analysis: Facility, Population : National

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Efficiency

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

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [5/8/2014]

1. Importance to Measure and Report: **The measure did not meet the Importance criteria and failed at evidence**

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

1a. Evidence: **H-0**; **M-3**; **L-7**; **I-9; IE-2**; 1b. Performance Gap: **H-NA**; **M-NA**; **L-NA**; **I-NA;** 1c. Impact: **H-NA**; **M-NA**; **L-NA**; **I-NA**

Rationale:

- Evidence provided by the developer included studies that evaluated pain management practices for long bone fractures in the hospital emergency room. The Committee questioned if the evidence provided by the developer directly supported the measure focus, which is to improve the median time of pain medication administration from emergency department arrival for emergency department patients with a principal diagnosis of long bone fracture. Committee members noted that the studies presented didn't sufficiently link the process of measuring and reporting the time gap between arrival and administration of pain medication for long bone fractures to improved clinical outcomes. Committee members agreed that less time to administration is likely better, but the evidence was also lacking to support a particular timeframe for treating pain in long bone fractures. Members acknowledged that there are no clinical guidelines that support or give a particular timeframe for treatment. Subsequently, the Committee agreed that the evidence presented was insufficient for meeting the evidence criterion.

2. Scientific Acceptability of Measure Properties:

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

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

4. Feasibility: H-NA; M-NA; L-NA; I-NA

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

3. Use and Usability: H-NA; M-NA; L-NA; I-NA

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

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-NA**; **N-NA**

6. Public and Member Comment

Comment:

- One commenter, the American College of Emergency Physicians (ACEP) submitted a letter requesting reconsideration of this measure for endorsement. The letter included comments that:
    - the evidence and performance gap for the measure were previously established, including by an NQF Committee in 2011
    - there is inadequate pain management among patients with long bone fracture (LBF) presenting to the ED, and that certain populations may not be receiving appropriate pain management in the ED, and
    - the measure is in use in the Hospital Outpatient Quality Reporting (HOQR) program and has been approved by the NQF Measures Application Partnership for use in the PQRS program and was approved in 2014 for use in the American Board of Emergency Medicine Maintenance of Certification Part IV activities.

The letter is available at this link.

Developer response: The developer submitted a letter requesting reconsideration of this measure for endorsement. The developer expressed concern that this measure, which is focused on timely pain management for ED patients with long bone fractures, was considered in the Musculoskeletal portfolio. The developer notes that the measure "focuses on the coordination and timely delivery of care to ED patients" and should have been evaluated within the Care Coordination portfolio with other ED timeliness measures. The developer also noted that:

- the Committee cited a lack of evidence linking the process of care to defined patient outcomes, and responds that numerous studies demonstrated that pain is often inadequately managed in the ED

- the Committee highlighted a lack of exclusion tin the measure for patients for whom pain medication is contraindicated, and responds that these patients would not be included in the measure, and
- the measure was developed as part of a group of measures targeting efficiency of care in the ED and time to long bone fracture pain management was identified as measurement area for which a denominator population could be clearly defined with few unintended consequences, and the denominator population would consist of patients for whom pain management is almost always warranted.

The letter is available at this link.

Committee response: The Committee agreed the measure addresses efficiency, and recognized that care in the ED should be timely and efficient and noted that the evidence presented indicates that disparities in adequate pain management exist based on age and race. However, members were concerned that the measuring median time to pain administration is an indirect way to measure the adequacy of pain management in the ED, and were concerned about unintended consequences for complex patients. Members also observed that there is a spectrum of patients with fractures included in the measure, and that the metric may be more or less meaningful depending on the type of fracture presented. The Committee again raised concerns that there is little evidence linking the measurement of the median time to pain management for long bone fractures to improved clinical outcomes, questioned whether there could be a more direct way of measuring adequacy of pain management, and questioned how success on the measure would be defined. As a result, the Committee declined to reconsider the measure.

NQF response: Throughout the various iterations of the NQF measure evaluation criteria, it is true that the basic criteria and concepts have remained largely unchanged. However, the measure evaluation guidance—which focuses on the specificity and rigor with which the criteria are applied—has become more comprehensive and more specific over time.

Assignment of measures is based on the focus of the measure and the relevant Committee expertise required in reviewing measures. While there were concerns expressed regarding assignment of this measure to this portfolio, the measure evaluation guidance is also intended to promote consistency in evaluation across measures against the NQF criteria, regardless of the project.

Measures Not Recommended for Trial Measure Approval

2521 Gout: Serum Urate Monitoring

Submission | Specifications

Description: Percentage of patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period, and who had their serum urate level measured within 6 months

Numerator Statement: Patients whose serum urate level was measured within six months after initiating ULT or after changing the dose of ULT

Denominator Statement: Adult patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period

Exclusions: None

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY

STANDING COMMITTEE MEETING [5/7/2014] The measure did not pass Importance to Measure and Report criteria and failed at High Priority.

1. Importance to Measure and Report: **(1a. Evidence, 1b. Performance Gap, 1c. High Impact)**

1a. Evidence: **H-0**; **M-5**; **L-5**; **I-5; IE-6**; 1b. Performance Gap: **H-2**; **M-11**; **L-2**; **I-6;** 1c. Impact: **H-0**; **M-8**; **L-6**; **I-7**

Rationale:

- Evidence presented by the developer included the 2012 American College of Rheumatology Guidelines for Management of Gout: Systematic Nonpharmacologic and Pharmacologic Therapeutic Approaches to Hyperuricemia. The evidence was based on a systematic review of the literature on pharmacologic and non-pharmacologic urate lowering therapies, which focused on published meta-analyses and randomized clinical trials. Adherence to urate lowering therapy has been identified as a major gap in quality of care. Problems with adherence prevent achievement of other critical goals of management specifically achieving treatment target of serum urate < 6 mg/dl in patients with indications for urate lowering therapy. The Guidelines recommend frequent monitoring of serum urate during ULT titration (every 2-5 weeks) and once target is achieved every 6 months.
- The Committee noted that there were no trials cited in the evidence that establish a linkage between monitoring serum urate levels, treating to uric acid level targets and improved patient

outcomes. The developer acknowledged that while there were no trials linking the monitoring serum urate levels to treatment, observational data of international studies indicated that patients that are not monitored experience more gouty attacks than those that are monitored. Although consensus was not reached when rating the evidence criterion, the Committee proceeded to review the performance gap data.
- The Committee found the data submitted demonstrated that there was opportunity for improvement.
- The Committee did not agree that this measure addresses a high-priority (high-impact) aspect of healthcare and the measure did not pass the impact criterion.

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2. Scientific Acceptability of Measure Properties:

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

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

---

4. Feasibility: H-NA; M-NA; L-NA; I-NA

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

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3. Use and Usability: H-NA; M-NA; L-NA; I-NA

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

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Trial Measure Approval: **Y-NA**; **N-NA**

6. Public and Member Comment

Comments included:

- Twelve comments were submitted for this measure. Two commenters agreed with the Committee's decision not to recommend the measure for Trial Measure Approval.
- Commenters against the Committee's decision argued that "there is good evidence that achieving a serum urate level <6 mg/dl is associated with a marked reduction in gout flares and disappearance of tophi. Commenters noted that "serum urate monitoring will detect intentional and unintentional medication non-adherence by patients, giving clinicians the opportunity to reinforce education about gout treatment, and will give clinicians important goals for treatment that will improve outcomes for people with gout". Other comments included "the vast majority of gout patients started on ULT do not have a repeat serum urate assessed and without titrating ULT to the dose necessary to achieve the therapeutic target, patients will be left suboptimally treated, with ongoing complications from gout".

Committee response:

- The Committee discussed the Comments received and again noted that there were no trials cited in the evidence that establish a linkage between monitoring serum urate levels, treating to

uric acid level targets and improved patient outcomes. The Committee agreed not to make any changes to their decision to not recommend the measure for Trial Measure Approval.

2526 Gout: Anti-inflammatory Prophylaxis with ULT Therapy

Submission | Specifications

Description: Percentage of patients aged 18 and older with a diagnosis of gout initiated on urate-lowering therapy (ULT), who are receiving concomitant anti-inflammatory prophylaxis (defined as low dose colchicine, non-steroid anti-inflammatory drug (NSAID) or glucocorticoid)

Numerator Statement: Patients prescribed anti-inflammatory prophylaxis (including low-dose colchicine, non-steroidal anti-inflammatory (NSAID) or glucocorticoid)

Denominator Statement: Patients aged 18 and older with an established gout diagnosis initiating urate lowering (ULT) therapy

Exclusions: None

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY

STANDING COMMITTEE MEETING [5/7/2014]

1. Importance to Measure and Report: The measure did not pass Importance to Measure and Report criteria and failed at High Priority.

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

1a. Evidence: **H-1**; **M-3**; **L-8**; **I-2; IE-7**; 1b. Performance Gap: **H-1**; **M-8**; **L-9**; **I-3;** 1c. Impact: **H-2**; **M-5**; **L-12**; **I-2**

Rationale:

- The Committee discussed how the evidence presented was based on a small study and was not directly related to the measure as specified, as most of the data was on colchicine and there was less data presented to support NSAIDS and/or corticosteroids. The Committee noted that starting urate lowering therapy can lead to an increased rate of acute gout flares for several months, and anti-inflammatory prophylaxis leads to a reduction of flares. Although consensus was not reached, the measure moved forward, as 52 percent of the Committee rated the evidence as high, moderate, or insufficient evidence with exception.
- The developers presented a VA study demonstrating a performance gap of 10 percent. Although consensus not reached, the measure moved forward as 43 percent of the Committee rated performance gap as high or moderate.
- Committee members questioned the costliness of gout flares versus prophylaxis for a broader group of patients. There was also concern expressed regarding the cost of colchicine

prophylaxis. The majority of the Committee gave the impact criterion a low rating and the measure did not pass Importance to Measure and Report.

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2. Scientific Acceptability of Measure Properties:

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

2a. Reliability: **NA** 2b. Validity: **NA**

---

4. Feasibility: NA

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

---

3. Use and Usability: NA

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

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5. Related and Competing Measures

No related or competing measures noted.

Standing Committee Recommendation for Trial Measure Approval: **NA**

6. Public and Member Comment

Comments included:

- Eleven comments were submitted for this measure. Two commenters agreed with the Committee's decision not to recommend the measure for Trial Measure Approval.
- One commenter noted that "there are a large number of anti inflammatories that would serve to prophylaxis against gout attack while starting or increasing urate lowering therapy. There are a number of different glucocorticoid preparations, large number of NSAIDS not to mention colchicine. Would need to be very broad in the number medications acceptable to meet the measure."
- One commenter stated that "this is an appropriate measure since flare risk is higher when initiating ULT; provision of anti-inflammatory prophylaxis will reduce that risk (i.e., prevent flares), thereby improving patient adherence to ULT. Duration of prophylaxis upon initiation of ULT is dependent upon disease activity (flares, tophi), but should be for at least 6 months in the uncomplicated case with appropriate disease control."
- One commenter stated that "this is a reasonable quality measure but need to include some sense of a timeframe around initiation of ULT - it says this is for patients "initiated on ULT" but after a period of time (e.g. 6 months), the patient may no longer need prophylaxis, so it might be good to qualify this as pertaining to patients "during the first 3-6 months of ULT" or something to that effect."

Developer response:

- "We appreciate the feedback and agree that there needs to be a variety of medications that meet the measure. As a result, we have provided an expansive list of medications in the

measure specifications. We chose not to dictate the durations of prophylaxis as, although there are data supporting the use of prophylaxis when initiating urate lowering therapy, there are fewer data guiding the specific duration of the prophylaxis. Therefore, we propose this measure as an important first step in increasing evidence-based practice through the use of prophylaxis and will refine the measure as evidence becomes available to define best practice regarding the duration of prophylaxis.

- "We appreciate your feedback and have timing specifications for the initiation of ULT. After initiating urate lowering therapy, there is an increased rate of acute gout flares for several months. From recent randomized control trials, where prophylaxis was continued for only 8 weeks, 40% of patients flared upon cessation of prophylaxis, whereas if prophylaxis was continued for 6 months, only 5% of patients flared. In a small randomized control trial using colchicine vs. placebo, patients assigned to colchicine had fewer flares at 0-3 and 3-6 months (0.57 and 0 flares) vs. patients assigned to placebo (1.91, 1.05 flares), both differences statistically different."

Committee response:

- The Committee discussed the Comments received and agreed not to make any changes to their decision to not recommend the measure for Trial Measure Approval.

Measures Deferred

0052 Use of Imaging Studies for Low Back Pain

Submission | Specifications

Description: The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.

Numerator Statement: Patients who received an imaging study with a diagnosis of low back pain on the Episode Date (i.e. the earliest date of service for an outpatient or ED encounter during the Intake Period (January 1-December 3 of the measurement year) with a principal diagnosis of low back pain) or in the 28 days following the Episode Date. The measure is reported as an inverted rate (i.e. 1 – numerator/denominator). A higher score indicates appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur).

Denominator Statement: All patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year with a claim/encounter for an outpatient or emergency department visit code with a principal diagnosis of low back pain during the Intake Period (January 1-December 3 of the measurement year).

Exclusions: No Exclusions

Adjustment/Stratification:

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Ambulatory Care : Urgent Care

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Imaging/Diagnostic Study

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [05/8/2014]

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

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

1a. Evidence: **H-5**; **M-15**; **L-1**; **I-0; IE-1**; 1b. Performance Gap: **H-10**; **M-12**; **L-0**; **I-0;** 1c. Impact: **H-19**; **M-3**; **L-0**; **I-0**

Rationale:

- Evidence provided by the developer included the Clinical Practice Guideline for the treatment of Adult Acute and Subacute Low Back Pain from the Institute for Clinical Systems Improvement (ICSI), updated November 2012. The ICSI guideline, states “Clinicians should not recommend imaging (including computed tomography [CT], magnetic resonance imaging [MRI] and x-ray) for patients with non-specific low back pain.” The Committee questioned the value of the ICSI guideline, noting that only six small randomized controlled trials (RCTs) were used to develop the guideline, and if the limited study populations were representative of all patients especially

considering the exclusion of other guidelines and numerous systematic reviews on this topic. The Committee agreed that the evidence presented was sufficient for meeting the evidence criterion.

- Data presented by the developer indicated significant variation in the rate of appropriate imaging for patients with low back pain across health plans. In 2012, there was a 15.5-point difference between plans in the 10th percentile and plans in the 90th percentile for commercial plans and 13.9 points for Medicaid plans. While the Committee agreed that this variation indicates a gap in quality care, the lack of change in performance since the measure was initially endorsed in 2009, indicates that practice variation has not changed.
- The Committee noted that total spending is quite high for the diagnosis and treatment of low back pain. A member of the Committee cited Martin's 2008 study, "Expenditures and Health Status among adults with spine problems," published in The Journal of the American Medical Association to provide some context. The Martin study estimates spending on low back pain between twenty to thirty billion dollars a year, with total spending on care for all spinal disorders estimated between sixty and one hundred billion dollars a year. The Committee agreed that the measure is high impact, as overutilization of imaging services is a significant factor in spending on services for low back pain.

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2. Scientific Acceptability of Measure Properties: <u>The measure did not meet the Scientific Acceptability criteria and failed at validity</u>

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

2a. Reliability: **H-8**; **M-14**; **L-0**; **I-0** 2b. Validity: **H-1**; **M-7**; **L-4**; **I-4**

<u>Rationale</u>:

- The Committee questioned the practitioner's ability to accurately determine whether a patient has a negative diagnosis for low back pain in the 6 months prior, as specified in the denominator statement. The developer clarified the measure was a claims based measure.
- The developer presented the results of the measure score reliability testing, noting that the measure had a high reliability score in a comparison of signal to noise in commercial health plans and Medicaid plans. Beta-binomial analysis indicates that commercial HMO and PPO plans have an average reported reliability score of .99, and Medicaid plans have an average reliability score of .94. The Committee was satisfied with the measure specifications and the developer's interpretation of the measure score reliability testing.
- The Committee noted that scientific acceptability of the measure is highly dependent on validity. The Committee questioned why certain "red flag" conditions are not excluded from the measure. These "red flag" conditions include unexplained weight loss, insidious onset; unexplained fever; history of urinary or other infection; immunosuppression; diabetes mellitus; prolonged use of corticosteroids; osteoporosis; prior lumbar spine surgery. Some Committee members found the lack of exclusion of these conditions a significant threat to validity. Subsequently, the Committee agreed the measure did not meet the validity criterion.
- A member of the Committee noted that the American College of Radiology (2011) guideline includes appropriate criteria for the imaging of low back pain and encouraged the developer to strengthen the measure by incorporating this guideline.

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4. Feasibility: H-NA; M-X-NA L-NA; I-NA

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

---

3. Use and Usability: H-NA; M-NA; L-NA; I-NA

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

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-NA**; **N-NA**

6. Public and Member Comment

Comments included:

- Four comments were submitted for this measure; three were in support of the Committee's decision to not recommend the measure for continued endorsement.

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

The Consensus Standards Advisory Committee (CSAC) noted that while determination of the validity of a measure does include consideration of potential threats to validity, they were concerned about the Committee's interpretation of NQF criteria related to measure exclusions. CSAC also noted that the developer is in the process of revising the measure to address the Committee's concerns, but were unable to complete the changes within the current project timeline. As a result, CSAC requested time be given to address the Committee's concerns and that the measures be deferred until the revised measures can be presented to the Committee for reconsideration.

0514 MRI Lumbar Spine for Low Back Pain

Submission | Specifications

Description: This measure calculates the percentage of MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim, and for which the patient did not have prior claims-based evidence of antecedent conservative therapy.

Antecedent conservative therapy may include (see subsequent details for codes):

1)Claim(s) for physical therapy in the 60 days preceding the lumbar spine MRI;

2)Claim(s) for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI; and,

3)Claim(s) for evaluation and management in the period >28 days and <60 days preceding the lumbar spine MRI.

Numerator Statement: Of MRI of the lumbar spine studies (with a diagnosis of low back pain) in the denominator, number of studies without evidence of claims-based, prior antecedent conservative therapy.

The numerator measurement of prior conservative therapy is based on the claim date of the MRI of the lumbar spine from the denominator, with the prior conservative therapy within the defined time periods relative to each MRI lumbar spine claim (i.e., a patient can be included in the numerator count more than once, if the patient had more than one MRI lumbar spine procedure in the measurement period, and the MRI lumbar spine procedure occurred on different days).

Denominator Statement: MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim.

The diagnosis of low back pain must be on the MRI lumbar spine claim (i.e., the lumbar spine MRI must be billed with a low back pain diagnosis in one of the diagnosis fields on the claim). MRI lumbar spine studies without a diagnosis of low back pain on the claim are not included in the denominator count. If a patient had more than one MRI lumbar spine study for a diagnosis of low back pain on the same day, only one study would be counted; but, if a patient had multiple MRI lumbar spine studies with a diagnosis of low back pain on the claim during the measurement period, each study would be counted (i.e., a patient can be included in the denominator count more than once).

Exclusions: Indications excluded from the measure's denominator include any patients with the following procedures or diagnosis codes:

- Patients with lumbar spine surgery in the 90 days prior to MRI;
- Cancer;
- Trauma;
- Intravenous drug abuse;
- Neurologic impairment;
- Human immunodeficiency virus (HIV);
- Unspecified immune deficiencies; and,
- Intraspinal abscess.

Additional details about those procedures and diagnoses excluded from the measure's denominator, including look-back periods (where applicable) and code lists, can be found in the "Denominator Exclusion Details" section.

Adjustment/Stratification:

Level of Analysis: Facility, Population : National, Population : State

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Imaging Facility

Type of Measure: Efficiency

Data Source: Administrative claims

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [5/14/2014]

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

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

1a. Evidence: **H-2**; **M-12**; **L-4**; **I-1; IE-2**; 1b. Performance Gap: **H-7**; **M-13**; **L-0**; **I-2;** 1c. Impact: **H-19**; **M-3**; **L-0**; **I-0**

Rationale:

- Evidence provided by the developer included a 2007 American College of Radiology (ACR) Appropriateness Criteria® low back pain (LBP) which recommends that uncomplicated acute LBP is a benign, self-limited condition that warrants no imaging studies. The 2007 ACR Appropriateness Criteria® is included in the total measure evidence, and is based on a systematic review of forty-eight studies. Forty of the studies were rated category three and four, with four being the lowest quality. None the studies were rated as category one. In addition to the 2007 ACR Appropriateness Criteria, the total measure evidence includes fourteen additional guidelines. The Committee also noted only minimal evidence was included for Medicare beneficiaries, who are included in the population defined by the measure.
- The Committee noted a performance gap between 14 percent and 16 percent when comparing facility scores at the 10^{th} and 90^{th} percentiles, indicating a continued opportunity for improvement and that the measure showed minimal improvement between 2007 and 2011. The developer explained that measure data was collected from paid claims and subject to a two- year delay, resulting in 2011 data reflecting 2009 performance. The developer also suggested that future improvement would be seen as a result of the 2010 initiation of public reporting, allowing all facilities to compare performance. The Committee also questioned the variance in performance between facilities in utilization of imaging services. The developer responded that facility size, type, caseload and access to the latest information on care guidelines could account for performance differences between facilities. The Committee agreed that the data sufficiently demonstrated a gap in care.
- The Committee agreed that this measure addresses a high-priority (high-impact) aspect of healthcare, as MRI lumbar spine studies without antecedent conservative therapy can contribute to poor patient outcomes and a higher cost of care.

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2. Scientific Acceptability of Measure Properties: The measure did not meet the Scientific Acceptability criteria and failed at validity.

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

2a. Reliability: **H-1**; **M-19**; **L-1**; **I-1** 2b. Validity: **H-0**; **M-4**; **L-15**; **I-3**

Rationale:

- The Committee noted the calculation of measure performance was based on exclusion of claims in the measure numerator for antecedent conservative therapy taking place in the period ranging from 28 days prior to 60 days prior to an MRI study. The Committee questioned if claims for evaluation and management (E/M) were reliable to establish that antecedent conservative therapy had taken place. The Committee also noted that delays in the scheduling of an MRI study might affect the measure calculation.
  The developer responded that with the restriction to the use of claims data in the measure, E/M codes were the only suitable proxy to determine if conservative therapy had taken place.
- The developer provided an overview of the measure score reliability testing, explaining that while the 53.1 percent median value for the signal to noise analysis was slightly lower than the target value, the measure is used to establish a median benchmark value of facility performance rather than categorize performance.
- The Committee questioned the exclusions including a history of prior back surgery and previous trauma. The Committee noted that history of surgery should be an absolute exclusion, rather

than a 90-day exclusion, as post-op back surgery patients cannot be categorized as uncomplicated back pain patients.
- The Committee questioned the potential effect on measure validity by the inclusion of different sources and types of claims data from a variety of facilities. The developer responded that the inclusion of these additional data would allow for better future benchmarking in all facilities, that facilities would be able to compare performance.
- The Committee also questioned the interpretation of guidelines used in establishing exclusions for patients over 70 years of age, finding that in some cases, the guidelines cited are in direct conflict with the measure exclusions. Conflicts noted included suspected lumbar disc herniation, sciatica, acute radicular pain, spinal cord infarction or degenerative conditions. The developer responded that there are plans to update the measure by including codes for these conditions in the measure exclusions.

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3. Feasibility: H-NA; M-NA; L-NA; I-NA

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

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4. Use and Usability: H-NA; M-NA; L-NA; I-NA

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

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-NA**; **N-NA**

6. Public and Member Comment

Comments included:

- Three comments were submitted for this measure. Two comments were in support of the Committee's recommendation not to recommend the measure for continued endorsement.
- One commenter requested that the Committee reconsider the measure for endorsement, and the developer has requested reconsideration of the measure.

Developer included:

- The developer noted that the measure exclusions have been modified to address concerns raised during the pre-meeting work group call. However, there are still additional concerns noted about the specifications during the in-person meeting that are currently being addressed and are not yet ready to be reviewed at this time.

Committee response:

- Committee members were concerned that the next opportunity to review the revised measure could be as long as three years, however members agreed not to make any changes to their decision to not recommend the measure for continued endorsement at this time.

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

The Consensus Standards Advisory Committee (CSAC) noted that while determination of the validity of a measure does include consideration of potential threats to validity, they were concerned about the Committee's interpretation of NQF criteria related to measure exclusions. The CSAC also noted that the developer stated that the frequency of occurrence of the exclusions suggested by the Committee was very low. As a result, not including those suggested exclusions would not distort the measure. CSAC requested that NCQA be given time to address the Committee's concerns and that the measure be deferred until the revised measure can be presented to the Committee for reconsideration.

Appendix B: NQF Musculoskeletal Portfolio and related measures

Gout

Measure Number	Measure Title
2549	Gout: Serum Urate Target [ACR] *(Recommended for Trial Measure Approval)*
2550	Gout: ULT Therapy [ACR] *(Recommended for Trial Measure Approval)*

Rheumatoid Arthritis

Measure Number	Measure Title
2522	Rheumatoid Arthritis: Tuberculosis Screening [ACR] *(Recommended for Trial Measure Approval)*
2523	Rheumatoid Arthritis: Assessment of Disease Activity [ACR]
0054	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis [ACR] *(Recommended for Trial Measure Approval)*
2524	Rheumatoid Arthritis: Functional Status Assessment [ACR]
2525	Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Imaging

Measure Number	Measure Title
0052	Use of Imaging Studies for Low Back Pain [CMS]
0514	MRI Lumbar Spine for Low Back Pain [NCQA]

Bone Fracture

Measure Number	Measure Title
0354	Hip Fracture Mortality Rate [AHRQ]

Pain Management

Measure Number	Measure Title
0662	Median Time to Pain Management for Long Bone Fracture [CMS]
0209	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment [National Hospice and Palliative Care Organization]
0420	Pain Assessment and Follow-Up [CMS]

Falls

Measure Number	Measure Title
0035	Fall Risk Management [NCQA]

Measure Number	Measure Title
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls [NCQA]

Surgery

Measure Number	Measure Title
1551	Hospital-level 30-day, all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) [CMS]
1609	ETG Based Hip/Knee Replacement Cost of Care Measure [Optum]

Functional Status

Measure Number	Measure Title
0423	functional Status Change For Patients With Hip Impairments [Focus On Therapeutic Outcomes, Inc]
0425	functional Status Change For Patients With Lumbar Spine Impairments[Focus On Therapeutic Outcomes, Inc]
0426	functional Status Change For Patients With Shoulder Impairments [Focus On Therapeutic Outcomes, Inc]
0427	functional Status Change For Patients With Elbow, Wrist Or Hand Impairments [Focus On Therapeutic Outcomes, Inc]
0422	functional Status Change For Patients With Knee Impairments [Focus On Therapeutic Outcomes, Inc]
0424	functional Status Change For Patients With Foot/Ankle Impairments[Focus On Therapeutic Outcomes, Inc]
0428	functional Status Change For Patients With General Orthopedic Impairments [Focus On Therapeutic Outcomes, Inc]
0429	change In Basic Mobility As Measured By The Am-Pac [Crecare]
0430	change In Daily Activity Function As Measured By The Am-Pac [Crecare]

Rehabilitation

Measure Number	Measure Title
0673	Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem [Rand Corporation]
0688	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay) [CMS]

Appendix C: Musculoskeletal Portfolio—Use In Federal Programs

NQF #	Title	Federal Programs: Finalized as of February 2014
0054	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	Measure is finalized in PQRS
2523	Rheumatoid Arthritis: Assessment of Disease Activity	Measure is finalized in PQRS
2524	Rheumatoid Arthritis: Functional Status Assessment	Measure is finalized in PQRS
2525	Rheumatoid Arthritis: Functional Status Assessment	Measure is finalized in PQRS

Appendix D: Project Standing Committee and NQF Staff

STANDING COMMITTEE

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Appendix E: Measure Specifications

0514 MRI Lumbar Spine for Low Back Pain

STATUS

Steering Committee Review

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

This measure calculates the percentage of MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim, and for which the patient did not have prior claims-based evidence of antecedent conservative therapy.

Antecedent conservative therapy may include (see subsequent details for codes):

1)Claim(s) for physical therapy in the 60 days preceding the lumbar spine MRI;

2)Claim(s) for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI; and,

3)Claim(s) for evaluation and management in the period >28 days and <60 days preceding the lumbar spine MRI.

TYPE

Efficiency

DATA SOURCE

Administrative claims This measure is not a PRO-PM measure.

No data collection instrument provided No data dictionary

LEVEL

Facility, Population : National, Population : State

SETTING

Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Imaging Facility

TIME WINDOW

As noted in the numerator statement, the numerator measurement of prior conservative therapy is based on the claim date of the lumbar spine MRI from the denominator, with the prior conservative therapy identified within the defined time periods relative to each MRI lumbar spine claim (i.e., a patient can be included in the numerator count more than once, if the patient had more than one MRI lumbar spine procedure in the measurement period, and the MRI lumbar spine procedure occurred on different days).

Special attention should be paid to the exclusion criterion, "[c]laim(s) >28 days and <60 days preceding the lumbar spine MRI for low back pain evaluation and management." The measure contractor's technical expert panel (TEP), which assisted with the development of this measure, was most concerned with the time window specification for this exclusion, because its members wanted to have evidence of prior evaluation and management service consistent with a period

of prior conservative therapy, without considering the visit that involved the ordering of the imaging study as part of the conservative therapy.

Since its endorsement, this specification has been interpreted in two ways:

1) Low back pain is related to the lumbar spine MRI, and the patient had a claim(s) for evaluation and management (E&M) service(s) in the specified time window preceding the MRI of the spine; or,

2) E&M service claim also has to include a diagnosis for low back pain.

Analyses of Medicare claims data found there is a significant difference in the calculated percentages depending upon whether the E&M claim contains a diagnosis of low back pain in order for the patient to be considered as having had prior conservative therapy, and, thus, excluded from the numerator. The 2008 publicly reported data were calculated without application of low back pain diagnoses on the E&M claims, and the national average rate was 32.7 percent. Application of a requirement that the E&M claim have a low back pain diagnosis yielded a national average rate of 65.9 percent based on an analysis of 2009 data.

In reviewing this issue, the TEP recognized that patients may have an E&M visit that involves multiple presenting complaints, some of which may not consistently be captured in the diagnostic coding for the E&M claim. Thus, requiring that the low back pain diagnosis be applied to E&M claims in the specified time window may be too restrictive a definition for prior antecedent conservative therapy.

Following this discussion, the specification for the MRI lumbar spine measure was revised to reflect how the measure was calculated using 2008 data (i.e., that no diagnosis code(s) restrictions were applied to the prior E&M visits). Similarly, low back pain diagnostic coding is not required on claims for the other two numerator exclusions (physical therapy and chiropractic treatment). The 2009 claims data, which were publicly reported in summer 2011, were calculated in the same manner.

Starting in July 2012, certain denominator exclusions were modified to include a look-back period. Prior to July 2012, these diagnostic exclusions were only considered if they appeared on the MRI claim. Moving forward, CMS wanted to identify exclusion diagnoses as reported in one of the diagnosis fields for any inpatient, outpatient, or carrier claim.

Diagnostic exclusions, and the relevant look-back periods, for which a look-back period was deemed appropriate include:

- Cancer: within 12 months prior to the MRI procedure;
- Trauma: within 45 days prior to the MRI procedure;
- Intravenous Drug Abuse: within 12 months prior to MRI procedure;
- Neurologic Impairment: within 12 months prior to MRI procedure;
- HIV: within 12 months prior to the MRI procedure; and,
- Unspecified Immune Deficiencies: within 12 months prior to MRI procedure.

NUMERATOR STATEMENT

Of MRI of the lumbar spine studies (with a diagnosis of low back pain) in the denominator, number of studies without evidence of claims-based, prior antecedent conservative therapy.

The numerator measurement of prior conservative therapy is based on the claim date of the MRI of the lumbar spine from the denominator, with the prior conservative therapy within the defined time periods relative to each MRI lumbar spine claim (i.e., a patient can be included in

the numerator count more than once, if the patient had more than one MRI lumbar spine procedure in the measurement period, and the MRI lumbar spine procedure occurred on different days).

NUMERATOR DETAILS

MRI lumbar spine studies can be billed separately for the technical and professional components, or billed globally to include both the professional and technical components. The number of professional component claims will exceed the number of technical component claims due to over-reads.

To capture all volumes in both the outpatient and office settings, both office (typically paid under Medicare Physician Fee Schedule) and facility (typically paid under the OPPS/APC methodology) claims should be considered. In the absence of a TC or 26-modifier code, outpatient facility claims should be considered technical components and included in utilization. A technical unit can be identified by the use of modifier code, "TC." A global unit can be identified by the absence of a "TC" or "26" modifier.

The following CPT codes are used in the numerator:

• 72148 (MRI lumbar spine without contrast)

• 72149 (MRI lumbar spine with contrast)

• 72158 (MRI lumbar spine with and without contrast)

Indications of claims-based, antecedent conservative therapy include a procedure code(s) from any of the following domains:

1) Claim(s) for physical therapy, which use at least one of the following CPT codes in the 60 days preceding the lumbar spine MRI:

• 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility)

• 97112 (Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities)

• 97113 (Aquatic therapy with therapeutic exercises)

• 97124 (Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion))

• 97140 (Manual therapy technical (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes)

2) Claim(s) for chiropractic evaluation and manipulative treatment, which use at least one of the following CPT codes in the 60 days preceding the lumbar spine MRI:

• 98940 (Chiropractic manipulative treatment (CMT); spinal, one to two regions)

• 98941 (Spinal, three to four regions)

• 98942 (Spinal, five regions)

• 98943 (Extraspinal, one or more regions)

3) Claim(s) for evaluation and management, which use at least one of the following CPT codes >28 days and <60 days preceding the lumbar spine MRI:

• 99201 through 99205

• 99211 through 99215

• 99241 through 99245

- 99341 through 99345
- 99347 through 99350
- 99354 through 99357
- 99385 through 99387
- 99395 through 99397
- 99401 through 99404
- 99455 through 99456
- 99499

Draft ICD-10 specifications for the measure are included in the attached document: 0514_Draft_ICD10_Specifications_2_28_14.

DENOMINATOR STATEMENT

MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim.

The diagnosis of low back pain must be on the MRI lumbar spine claim (i.e., the lumbar spine MRI must be billed with a low back pain diagnosis in one of the diagnosis fields on the claim). MRI lumbar spine studies without a diagnosis of low back pain on the claim are not included in the denominator count. If a patient had more than one MRI lumbar spine study for a diagnosis of low back pain on the same day, only one study would be counted; but, if a patient had multiple MRI lumbar spine studies with a diagnosis of low back pain on the claim during the measurement period, each study would be counted (i.e., a patient can be included in the denominator count more than once).

DENOMINATOR DETAILS

The following CPT codes are included in the denominator:

- 72148 (MRI lumbar spine without contrast)
- 72149 (MRI lumbar spine with contrast)
- 72158 (MRI lumbar spine with and without contrast)

The above-listed CPT codes must be concurrently billed with at least one the following ICD-9 codes, indicating a diagnosis of low back pain. Specific ICD-9 codes used to define the denominator include:

- 721.3 (Lumbosacral spondylosis without myelopathy)
- 721.90 (Spondylosis of unspecified site without mention of myelopathy)
- 722.10 (Displacement of lumbar intervertebral disc without myelopathy)
- 722.52 (Degeneration of lumbar or lumbosacral intervertebral disc)
- 722.6 (Degeneration of intervertebral disc, site unspecified)
- 722.93 (Other unspecified disc disorder of lumbar region)
- 724.02 (Spinal stenosis of lumbar region)
- 724.2 (Lumbago)
- 724.3 (Sciatica)
- 724.5 (Unspecified backache)
- 724.6 (Disorders of sacrum)
- 724.70 (Unspecified disorder of coccyx)

- 724.71 (Hypermobility of coccyx)
- 724.79 (Other disorder of the coccyx)
- 738.5 (Other acquired deformity of back or spine)
- 739.3 (Nonallopathic lesion of lumbar region, not elsewhere classified)
- 739.4 (Nonallopathic lesion of sacral regions, not elsewhere classified)
- 846.0 (Sprain and strain of lumbosacral (joint) (ligament))
- 846.1 (Sprain and strain of sacroiliac (ligament))
- 846.2 (Sprain and strain of sacrospinatus (ligament))
- 846.3 (Sprain and strain of sacrotuberous (ligament))
- 846.8 (Other specified sites of sacroiliac region sprain and strain)
- 846.9 (Unspecified site of sacroiliac region sprain and strain)
- 847.2 (Lumbar sprain and strain)

If the diagnosis code is a three-digit ICD-9 code, then all codes starting with the 3 digits are used in the measure calculation (i.e., using an "all inclusive" approach). If the diagnosis code is specified as a four-digit ICD-9 code, then only the specific four-digit diagnosis code is used. If the diagnosis code is a five-digit code, the code used is either the specific five-digit diagnosis code, if all five numeric digits are shown, or, if the fifth digit is designated with an "X," then this is designating an "all inclusive" range to the fifth digit.

Draft ICD-10 specifications for the measure are included in the attached document: 0514_Draft_ICD10_Specifications_2_28_14.

EXCLUSIONS

Indications excluded from the measure's denominator include any patients with the following procedures or diagnosis codes:

- Patients with lumbar spine surgery in the 90 days prior to MRI;
- Cancer;
- Trauma;
- Intravenous drug abuse;
- Neurologic impairment;
- Human immunodeficiency virus (HIV);
- Unspecified immune deficiencies; and,
- Intraspinal abscess.

Additional details about those procedures and diagnoses excluded from the measure's denominator, including look-back periods (where applicable) and code lists, can be found in the "Denominator Exclusion Details" section.

EXCLUSION DETAILS

Indications excluded from the measure's denominator include any patients with the following procedures or diagnosis codes:

- Patients with lumbar spine surgery in the 90 days prior to MRI (CPT codes 22010 through 22865 and 22899)

• Cancer, within 12 months prior to MRI procedure. A cancer exclusion diagnosis must be found in one of the diagnosis fields of any inpatient, outpatient or carrier claim during the look-back period (ICD-9 codes 140 through 208, 230 through 234, and 235 through 239)

• Trauma, within 45 days prior to MRI procedure. A trauma exclusion diagnosis must be found in one of the diagnosis fields of any inpatient, outpatient or carrier claim during the look-back period (ICD-9 codes 800 through 839, 850 through 854, 860 through 869, 905 through 909, 926.11, 926.12, 929, 952, and 958 through 959)

• Intravenous drug abuse, within 12 months prior to MRI procedure. An IV drug abuse exclusion diagnosis must be found in one of the diagnosis fields of any inpatient, outpatient or carrier claim during the look-back period (ICD-9 codes 304.0X, 304.1X, 304.2X, 304.4X, 305.4X, 305.5X, 305.6X, and 305.7X)

• Neurologic impairment, within 12 months prior to MRI procedure. A neurologic impairment exclusion diagnosis must be found in one of the diagnosis fields of any inpatient, outpatient or carrier claim during the look-back period (ICD-9 codes 344.60, 344.61, and 729.2)

• Human immunodeficiency virus (HIV), within 12 months prior to MRI procedure. An HIV exclusion diagnosis must be found in one of the diagnosis fields of any inpatient, outpatient or carrier claim during the look-back period (ICD-9 codes 042 through 044)

• Unspecified immune deficiencies, within 12 months prior to MRI procedure. An unspecified immune deficiency exclusion diagnosis must be found in one of the diagnosis fields of any inpatient, outpatient or carrier claim during the look-back period (ICD-9 code 279.3)

• Intraspinal abscess. An intraspinal exclusion diagnosis must be found in one of the diagnoses fields on the MRI lumbar spine claim (ICD-9 codes 324.9 or 324.1)

If the diagnosis code is a three-digit ICD-9 code, then all codes starting with the 3 digits are used in the measure calculation (i.e., using an “all inclusive” approach). If the diagnosis code is specified as a four-digit ICD-9 code, then only the specific four-digit diagnosis code is used. If the diagnosis code is a five-digit code, the code used is either the specific five-digit diagnosis code, if all five numeric digits are shown, or, if the fifth digit is designated with an “X,” then this is designating an “all inclusive” range to the fifth digit.

RISK ADJUSTMENT

No risk adjustment or risk stratification

This measure does not use risk adjustment or risk stratification.

Provided in response box S.15a

STRATIFICATION

This measure does not use risk adjustment or risk stratification.

TYPE SCORE

Other (specify): Percentage better quality = lower score

ALGORITHM

1) Identify all patients in the Medicare FFS SAF file with a claim for an MRI lumbar spine study during the measurement period.

2) Of patients identified in Step 1, select those patients for whom the MRI claim includes a diagnosis of low back pain.

3) Of claims identified in Step 2, review the relevant look-back periods for claims-based evidence of any of the procedures or diagnoses excluded from the measure; remove claims for which an exclusion has been identified.

4) The resulting number of claims is the denominator.

5) Of claims in the denominator, identify those patients for whom there is no evidence of prior antecedent conservative therapy, which is specified as any of the following:

A) Claim(s) for physical therapy in the 60 days preceding the lumbar spine MRI;

B) Claim(s) for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI; or,

C) Claim(s) for evaluation and management in the period >28 days and <60 days preceding the lumbar spine MRI.

6) The resulting number of claims for which there is no evidence of antecedent conservative therapy is the numerator.

7) The measure score is the value of the numerator divided by the denominator, recorded as a percentage. No diagram provided

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5.1 Identified measures: 0052 : Use of Imaging Studies for Low Back Pain

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The CMS measure (NQF #0514) is similar in construct to NQF measure #0052, Use of Imaging Studies for Low Back Pain (developed by the National Committee on Quality Assurance). Both measures consider the overuse of imaging for patients with a diagnosis of low back pain. However, the measures have key differences in intent and patient population that limit the desirability of complete harmonization: the CMS measure looks specifically at lumbar MRI studies, whereas the NCQA measure considers all imaging. The measures also evaluate the use of lumbar imaging for different patient populations: the CMS measure is focused specifically on senior care, whereas the NCQA measure is limited to patients aged 18-50 years old. Finally, the unit of analysis differs between the two measures: the CMS measure evaluates performance at the facility level, while the NCQA measure assesses performance at a variety of levels.

5b.1 If competing, why superior or rationale for additive value: This measure addresses a different target population than does the NCQA measure, and, consequently, the measures are not viewed as competing measures.

0662 Median Time to Pain Management for Long Bone Fracture

STATUS

Steering Committee Review

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

Median time from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).

TYPE

Efficiency

DATA SOURCE

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records The CMS Abstraction & Reporting Tool or other electronic tool supplied by the facility's vendor.

Available at measure-specific web page URL identified in S.1 Attachment http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FSpecsManualTemplate&cid=1228771828064

LEVEL

Facility, Population : National

SETTING

Hospital/Acute Care Facility

TIME WINDOW

Facilities report data quarterly

NUMERATOR STATEMENT

Time (in minutes) from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a diagnosis of a (long bone) fracture.

NUMERATOR DETAILS

Included Populations:

- Patients with a patient age on Outpatient Encounter Date (Outpatient Encounter Date – Birthdate) >= 2 years, and
- An ICD-9-CM Principal Diagnosis Code for a (long bone) fracture as defined in Appendix A, OP Table 9.0, and
- Patients with Pain Medication, and
- An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0

Excluded Populations:

- Patients less than 2 years of age
- Patients who expired
- Patients who left the emergency department against medical advice or discontinued care

Data Elements:

- Birthdate
- Discharge Status
- E/M Code
- Arrival Time
- ICD-9-CM Principal Diagnosis Code
- Outpatient Encounter Date
- Pain Medication
- Pain Medication Date
- Pain Medication Time

DENOMINATOR STATEMENT

N/A Measure is a continuous variable.

DENOMINATOR DETAILS

N/A Measure is a continuous variable. See numerator details.

EXCLUSIONS

N/A Measure is a continuous variable. See numerator details.

EXCLUSION DETAILS

N/A Measure is a continuous variable. See numerator details.

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

At this time, this measure is not stratified.

TYPE SCORE

Continuous variable better quality = lower score

ALGORITHM

Algorithm Narrative for OP-21:

Median Time to Pain Management for Long Bone Fracture

Continuous Variable Statement: Time (in minutes) from emergency department arrival to time of initial oral, intransal or parenteral pain medication administration for emergency department patients with a diagnosis of a (long bone) fracture.

1. Start processing. Run cases that are included in the Pain Management Hospital Outpatient Population and pass the edits defined in the Data Processing Flow through this measure.

2. Check Discharge Code. a. If Discharge Code is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b. If Discharge Code equals 6, 7, or 8, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. c. If Discharge Code equals 1, 2, 3, 4a, 4b, 4c, 4d, or 5, continue processing and proceed to Pain Medication.

3. Check Pain Medication.

a. If Pain Medication is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Pain Medication equals No, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If Pain Medication equals Yes, continue processing and proceed to Arrival Time.

4. Check Arrival Time.

a. If the Arrival Time equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Stop processing.

b. If Arrival Time equals a Non-Unable To Determine Value, continue processing and proceed to Pain Medication Date.

5. Check Pain Medication Date.

a. If Pain Medication Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Pain Medication Date equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Stop processing.

c. If Pain Medication Date equals a Non Unable To Determine Value, continue processing and proceed to Pain Medication Time.

6. Check Pain Medication Time.

a. If Pain Medication Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Pain Medication Time equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Stop processing.

c. If Pain Medication Time equals a Non Unable To Determine Value, continue processing and proceed to Measurement Value Calculation.

7. Calculate Measurement Value. Measurement Value, in minutes, is equal to the Pain Medication Date and Pain Medication Time minus Outpatient Encounter Date and Arrival Time.

8. Check Measurement Value.

a. If Measurement Value is less than zero minutes, the case will proceed to a Measurement Category Assignment of X and will be rejected. Stop processing.

b. If Measurement Value is greater than or equal to zero minutes, the case will proceed to a Measurement Category Assignment of D and will be in the Measure Population. Stop processing. Available at measure-specific web page URL identified in S.1

5.1 Identified measures:

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: There are no competing measures.

5b.1 If competing, why superior or rationale for additive value: A search on the NQF website and the NQMC website revealed no competing measures.

One related measure was identified, in use in Australia.

Pain management: percentage of paediatric patients who presented to the ED with a primary diagnosis of limb fracture and received analgesic therapy within 30 minutes of presentation, during the 6 month time period. 2012 Jan. NQMC:007678

Australian Council on Healthcare Standards - Nonprofit Organization

0052 Use of Imaging Studies for Low Back Pain

STATUS

Steering Committee Review

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Imaging/Diagnostic Study This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0052_Use_of_Imaging_Studies_for_Low_Back_Pain_Value_Sets.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Ambulatory Care : Urgent Care

TIME WINDOW

12 months

NUMERATOR STATEMENT

Patients who received an imaging study with a diagnosis of low back pain on the Episode Date (i.e. the earliest date of service for an outpatient or ED encounter during the Intake Period (January 1-December 3 of the measurement year) with a principal diagnosis of low back pain) or in the 28 days following the Episode Date. The measure is reported as an inverted rate (i.e. 1 – numerator/denominator). A higher score indicates appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur).

NUMERATOR DETAILS

Patients who received an imaging study (see Imaging Study Value Set) with a diagnosis of low back pain (see Low Back Pain Value Set) on the Episode Date (i.e. the earliest date of service for an outpatient or ED encounter during the Intake Period (January 1-December 3 of the measurement year) with a principal diagnosis of low back pain) or in the 28 days following the Episode Date. The measure is reported as an inverted rate (i.e. 1 – numerator/denominator). A higher score indicates appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur).

DENOMINATOR STATEMENT

All patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year with a claim/encounter for an outpatient or emergency department visit code with a principal diagnosis of low back pain during the Intake Period (January 1-December 3 of the measurement year).

DENOMINATOR DETAILS

All patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year with a claim/encounter for an outpatient or emergency department visit code (see Outpatient Value Set, Observation Value Set, ED Value Set, Osteopathic Manipulative Treatment Value Set) with a principal diagnosis of low back pain (see Low Back Pain Value Set) during the Intake Period (January 1-December 3 of the measurement year). Do not include any ED visit that results in an inpatient admission.

Patients must have all of the following:

(1) A negative diagnosis history for low back pain (see Low Back Pain Value Set) during the 180 days (6 months) prior to the Episode Date (i.e. the earliest date of service for an outpatient or ED encounter during the Intake Period with a principal diagnosis of low back pain). The patient must not have a diagnosis of low back pain during the 180 days prior to the Episode Date.

(2) A negative diagnosis history for any of the following:

- Cancer (see Malignant Neoplasms Value Set, Other Neoplasms Value Set, and History of Malignant Neoplasm Value Set) at any time during the patient's history through 28 days after the Episode Date.
- Recent Trauma (see Trauma Value Set) any time during the 12 months (1 year) prior to the Episode Date through 28 days after the Episode Date.
- Intravenous drug abuse (see IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the Episode Date through 28 days after the Episode Date.
- Neurologic impairment (see Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the Episode Date through 28 days after the Episode Date.

EXCLUSIONS

No Exclusions

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Identify all patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year who had any of the following visits during the Intake Period (i.e. January 1 – December 3) with a principal diagnosis of low back pain (Low Back Pain Value Set): outpatient visit (Outpatient Value Set), observation visit (Observation Value Set), emergency department visit (ED Value Set), or osteopathic manipulative treatment (Osteopathic Manipulative Treatment Value Set). Do not include emergency department visits that result in an inpatient admission.

Step 2: Determine the Episode Date. For each patient identified in Step 1, determine the earliest episode of low back pain. If the patient had more than one encounter, include only the first encounter.

Step 3: Test for Negative Diagnosis History. Exclude patients with a diagnosis of low back pain (Low Back Pain Value Set) during the 180 days (6 months) prior to the Episode Date.

Step 4: Exclude any patient who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- Cancer (Malignant Neoplasms Value Set, Other Neoplasms Value Set, or History of Malignant Neoplasm Value Set) any time during the patient's history through 28 days after the Episode Date.
- Recent Trauma (Trauma Value Set) any time during the 12 months (1 year) prior to the Episode Date through 28 days after the Episode Date.
- Intravenous drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the Episode Date through 28 days after the Episode Date.
- Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the Episode Date through 28 days after the Episode Date.

Step 5: Calculate a rate (number of patients receiving an imaging study (i.e. plain x-ray, MRI, CT scan).

Step 6: Subtract the rate calculated in Step 5 from one to invert the measure result to represent appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur). The measure is reported as an inverted rate (i.e. 1- numerator/denominator) to reflect the number of people who did not receive an imaging study. No diagram provided

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5.1 Identified measures: 0514 : MRI Lumbar Spine for Low Back Pain

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The NCQA Measure (NQF #0052 - Use of Imaging Studies for Low Back Pain) is similar in construct to the CMS measure (NQF #0514 - MRI Lumbar Spine for Low Back Pain). Both measures consider the overuse of imaging for patients with a diagnosis of low back pain. However, the measures have key differences in intent and patient population that limit the desirability of complete harmonization. The NCQA measure considers all imaging, whereas the CMS measure looks specifically at lumbar MRI studies. The measures also evaluate the use of lumbar imaging for different patient populations. The NCQA measure is limited to patients aged 18-50 years old, whereas the CMS measure is focused specifically on senior care. Finally, the unit of analysis differs between the two measures: the NCQA measure assesses performance at the health plan level, while the CMS measure evaluates performance at the facility level.

5b.1 If competing, why superior or rationale for additive value: The NCQA measure (NQF #0052) addresses a different target population than the CMS measure (NQF #0514), and as such the measures are not competing measures.

0054 Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

STATUS

Steering Committee Review

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18 years and older by the end of the measurement period, diagnosed with rheumatoid arthritis and who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0054_DMARD_Therapy_for_Rheumatoid_Arthritis_Value_Sets.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

The measurement year (12 month period).

NUMERATOR STATEMENT

Patients diagnosed with rheumatoid arthritis who were dispensed at least one ambulatory prescription for a disease- modifying anti-rheumatic drug (DMARD) during the measurement year.

NUMERATOR DETAILS

Target population is those who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (see DMARD Value Set to identify a DMARD prescription using claims data, see Table ART-C to identify a DMARD prescription using pharmacy data) during the measurement year.

Table ART-C: DMARDs

5-Aminosalicylates:

Sulfasalazine

Alkylating agents:

Cyclophosphamide

Aminoquinolines:

Hydroxychloroquine

Anti-rheumatics:

Auranofin, Gold sodium thiomalate, Leflunomide, Methotrexate, Penicillamine

Immunomodulators:

Abatacept, Adalimumab, Anakinra, Certolizumab, Certolizumab pegol, Etanercept, Golimumab, Infliximab, Rituximab, Tocilizumab

Immunosuppressive agents:

Azathioprine, Cyclosporine, Mycophenolate

Janus kinase (JAK) inhibitor:

Tofacitinib

Tetracyclines:

Minocycline

DENOMINATOR STATEMENT

All patients, ages 18 years and older by December 31 of the measurement year, who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year:

- Outpatient visit, with any diagnosis of rheumatoid arthritis

- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis

Visit type need not be the same for the two visits.

DENOMINATOR DETAILS

All patients, ages 18 years and older by December 31 of the measurement year, who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year:

- Outpatient visit (see Outpatient Value Set), with any diagnosis of rheumatoid arthritis (see Rheumatoid Arthritis Value Set)

- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis (see Rheumatoid Arthritis Value Set)

Visit type need not be the same for the two visits.

EXCLUSIONS

Exclude patients who have a diagnosis of HIV. Look for evidence of HIV diagnosis as far back as possible in the patient's history through the end of the measurement year.

Exclude patients who have a diagnosis of pregnancy any time during the measurement year.

EXCLUSION DETAILS

Exclude patients who have a diagnosis of HIV (see HIV Value Set). Look for evidence of HIV diagnosis as far back as possible in the patient's history through the end of the measurement year.

Exclude patients who have a diagnosis of pregnancy (see Pregnancy Value Set) any time during the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Determine the eligible population. To do so, identify all patients ages 18 years and older by December 31 of the measurement year who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year:

- Outpatient visit (see Outpatient Value Set), with any diagnosis of rheumatoid arthritis (see Rheumatoid Arthritis Value Set)

- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis (see Rheumatoid Arthritis Value Set)

Step 2: Determine the number of patients who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (see DMARD Value Set to identify a DMARD prescription using claims data, see Table ART-C to identify a DMARD prescription using pharmacy data) during the measurement year.

Step 3: Exclude patients from the eligible population who had a diagnosis of HIV or pregnancy. For HIV, look for evidence of a diagnosis (use HIV Value Set) as far back as possible in the patient's history through the end of the measurement year. For pregnancy, exclude patients who have a diagnosis (use Pregnancy Value Set) any time during the measurement year.

Step 4: Calculate the rate (the number of patients receiving a prescription for disease-modifying anti-rheumatic drugs out of the number of patients in the eligible population after excluded patients have been removed). No diagram provided

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5.1 Identified measures: 0585 : Hydroxychloroquine annual eye exam

0598 : Methotrexate: CBC within 12 weeks

0599 : Methotrexate: Creatinine within 12 weeks

0597 : Methotrexate: LFT within 12 weeks

0592 : Rheumatoid Arthritis Annual ESR or CRP

0591 : Rheumatoid Arthritis New DMARD Baseline CBC

0590 : Rheumatoid Arthritis New DMARD Baseline Liver Function Test

0589 : Rheumatoid Arthritis New DMARD Baseline Serum Creatinine

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NCQA will follow-up with the measure steward to discuss harmonizing relevant data elements.

5b.1 If competing, why superior or rationale for additive value: N/A

2521 Gout: Serum Urate Monitoring

STATUS

Steering Committee Review

STEWARD

AMERICAN COLLEGE OF RHEUMATOLOGY

DESCRIPTION

Percentage of patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period, and who had their serum urate level measured within 6 months

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry The ACR plan for measure testing includes testing data from at least 3 different types of EHRs, from at least 3 different sites, using a standardized data collection form.

No data collection instrument provided Attachment 2521_SerumUrateMonitoring_Mon_Apr_21_11.14.50_CDT_2014.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

A 12-month reporting period is anticipated for this measure.

NUMERATOR STATEMENT

Patients whose serum urate level was measured within six months after initiating ULT or after changing the dose of ULT

NUMERATOR DETAILS

Patients whose serum urate level was measured within six months after initiating ULT or after changing the dose of ULT

DENOMINATOR STATEMENT

Adult patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period

DENOMINATOR DETAILS

Adult patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period

EXCLUSIONS

None

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

STRATIFICATION

TYPE SCORE

ALGORITHM

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

2522 Rheumatoid Arthritis: Tuberculosis Screening

STATUS

Steering Committee Review

STEWARD

American College of Rheumtology

DESCRIPTION

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who have documentation of a tuberculosis (TB) screening performed within 12 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record Data source: electronic health records

Instrument: RA Measure Testing Data Collection Form

Available in attached appendix at A.1 Attachment TB_Screen_Value_Sets_Updated.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

12 months prior to the encounter during the measurement period (12 months) where the patient was newly prescribed biologic DMARD therapy.

NUMERATOR STATEMENT

Any record of TB testing documented or performed (PPD, IFN-gamma release assays, or other appropriate method) in the medical record in the 12 months preceding the biologic DMARD prescription.

NUMERATOR DETAILS

See attachment S2B

DENOMINATOR STATEMENT

Patients 18 years and older with a diagnosis of rheumatoid arthritis who are seen for at least one face-to-face encounter for RA who are newly started on biologic therapy during the measurement period.

DENOMINATOR DETAILS

For the purposes of this measure, patients who are 'newly started on biologic therapy' are those who have been prescribed DMARD biologic therapy during the measurement period and who

were not prescribed DMARD biologic therapy in the 12 months preceding the encounter where DMARD biologic therapy was newly started.

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Cases meeting target process/Target population No diagram provided

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

2523 Rheumatoid Arthritis: Assessment of Disease Activity

STATUS

Steering Committee Review

STEWARD

American College of Rheumatology

DESCRIPTION

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis and >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record Data source: electronic health records

Instrument:RA Measure Testing Data Collection Form

Available in attached appendix at A.1 Attachment Disease_Activity_Updated_Value_Sets.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

12 months

NUMERATOR STATEMENT

# of patients with >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

NUMERATOR DETAILS

For purposes of this measure, “Rheumatoid Arthritis Disease Activity Measurement Tools” include the following instruments:

-Clinical Disease Activity Index (CDAI)

-Disease Activity Score with 28-joint counts (erythrocyte sedimentation rate or C-reactive protein) (DAS-28)

-Patient Activity Scale (PAS)

-Patient Activity Score-II (PAS-II)

-Routine Assessment of Patient Index Data with 3 measures (RAPID 3)

-Simplified Disease Activity Index (SDAI)

A result of any kind qualifies for meeting numerator performance.

DENOMINATOR STATEMENT

Patients 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

DENOMINATOR DETAILS

One of the requirements for a patient to be included in the Initial Patient Population is that the patient has a minimum of 2 RA encounters with the same provider, all occurring during the measurement period.

If the patient qualifies for the Initial Patient Population, then every encounter for RA should be evaluated to determine whether disease activity using a standardized measurement tool was assessed. The logic represented in this measure will determine if the patient had a disease activity assessment performed at each visit during the measurement period (ie, Occurrence A of Encounter, Performed). The measure requires all of the eligible encounters to be analyzed in order to determine if the patient’s disease activity was assessed at >=50% of encounters for RA. Once it has been determined if the patient meets >=50% threshold, all patient data across a single physician should be aggregated to determine the performance rate.

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Cases Meeting the Target Process / Target Population No diagram provided

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

2524 Rheumatoid Arthritis: Functional Status Assessment

STATUS

Steering Committee Review

STEWARD

AMERICAN COLLEGE OF RHEUMATOLOGY

DESCRIPTION

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis for whom a functional status assessment was performed at least once during the measurement period.

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record Data source: electronic health records

Instrument: RA MEASURE TESTING DATA COLLECTION FORM

Available in attached appendix at A.1 Attachment Functional_Status_Assessment_Updated_Value_Sets.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

12 months

NUMERATOR STATEMENT

Number of patients with functional status assessment documented once during the measurement period. Functional status can be assessed using one of a number of valid and reliable instruments available from the medical literature.

NUMERATOR DETAILS

Functional status can be assessed by using one of a number of instruments, including several instruments originally developed and validated for screening purposes. Examples include, but are not limited to:

-Health Assessment Questionnaire-II (HAQ-II)

-Multi-Dimensional Health Assessment Questionnaire (MDHAQ)

-PROMIS Physical Function 10-item (PROPF10)

-PROMIS Physical Function 20-item (PROPF20)

-PROMIS Physical Function Computerized Adaptive Tests (PROPFCAT)

Use of a standardized tool or instrument to assess functional status other than those listed will meet numerator performance.

DENOMINATOR STATEMENT

Patients age 18 and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

DENOMINATOR DETAILS

SEE ATTACHMENT IN S2B

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

CASES MEETING TARGET PROCESS / TARGET POPULATION No diagram provided

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

STATUS

Steering Committee Review

STEWARD

AMERICAN COLLEGE OF RHEUMATOLOGY

DESCRIPTION

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months.

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record Source: Electronic Health Records

Instrument: RA MEASURE TESTING DATA COLLECTION FORM

Available in attached appendix at A.1 Attachment DMARD_Value_Sets_Updated.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

12 months

NUMERATOR STATEMENT

Patient received a DMARD

NUMERATOR DETAILS

DMARD therapy includes:

Biologic Agents-

abatacept

adalimumab

anakinra

certolizumab

etanercept

golimumab

infliximab

rituximab

tocilizumab

Non-Biologic Agents-

azathioprine

cyclophosphamide

cyclosporine

gold

hydroxychloroquine

leflunomide

methotrexate

minocycline

penicillamine

sulfasalazine

Anti-inflammatory medications, including glucocorticoids do not meet the measure.

DENOMINATOR STATEMENT

Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period

DENOMINATOR DETAILS

Patients 18 years and older with a diagnosis of Rheumatoid Arthritis seen for two or more encounters for Rheumatoid Arthritis during the measurement period.

EXCLUSIONS

Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.

EXCLUSION DETAILS

Please see attached file DMARD_Value_Sets_Updated.xls

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

CASES MEETING TARGET PROCESS/TARGET POPULATION No diagram provided

COPYRIGHT / DISCLAIMER

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The current NQF-endorsed DMARD measure is specified for claims-based reporting. Our proposed measure is e-specifed and intended for use in electronic reporting options. Also, the NCQA's DMARD measure does not include Rheumatoid Arthritis, Inactive as an exclusion. This exclusion has been incorporated into this submission. The ACR would be happy to work with NCQA to harmonize the measures.

5b.1 If competing, why superior or rationale for additive value: The current NQF-endorsed DMARD measure is specified for claims-based reporting. Our proposed measure is e-specifed and intended for use in electronic reporting options. Also, the NCQA's DMARD measure does not include Rheumatoid Arthritis, Inactive as an exclusion. This exclusion has been incorporated into this submission.

2526 Gout: Anti-inflammatory Prophylaxis with ULT Therapy

STATUS

Steering Committee Review

STEWARD

AMERICAN COLLEGE OF RHEUMATOLOGY

DESCRIPTION

Percentage of patients aged 18 and older with a diagnosis of gout initiated on urate- lowering therapy (ULT), who are receiving concomitant anti-inflammatory prophylaxis (defined as low dose colchicine, non-steroid anti-inflammatory drug (NSAID) or glucocorticoid)

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry The ACR plan for measure testing includes testing data from at least 3 different types of EHRs, from at least 3 different sites, using a standardized data collection form.

No data collection instrument provided Attachment 2526_AntiInflammatory_Mon_Apr_21_11.12.51_CDT_2014-1-.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

A 12-month reporting period is anticipated for this measure.

NUMERATOR STATEMENT

Patients prescribed anti-inflammatory prophylaxis (including low-dose colchicine, non-steroidal anti-inflammatory (NSAID) or glucocorticoid)

NUMERATOR DETAILS

Patients prescribed anti-inflammatory prophylaxis (including low-dose colchicine, non-steroidal anti-inflammatory (NSAID) or glucocorticoid)

DENOMINATOR STATEMENT

Patients aged 18 and older with an established gout diagnosis initiating urate lowering (ULT) therapy

DENOMINATOR DETAILS

Patients aged 18 and older with an established gout diagnosis initiating urate lowering (ULT) therapy

EXCLUSIONS

None

EXCLUSION DETAILS

None

RISK ADJUSTMENT

STRATIFICATION

TYPE SCORE

ALGORITHM

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

2549 Gout: Serum Urate Target

STATUS

Steering Committee Review

STEWARD

AMERICAN COLLEGE OF RHEUMATOLOGY

DESCRIPTION

Percentage of patients aged 18 and older with a diagnosis of gout treated with urate-lowering therapy (ULT) for at least 12 months, whose most recent serum urate result is less than 6.8 mg/dL.

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry The ACR plan for measure testing includes testing data from at least 3 different types of EHRs, from at least 3 different sites, using a standardized data collection form.

No data collection instrument provided Attachment 2549_GOUTSerumUrateTarget_Mon_Apr_21_11.08.11_CDT_2014.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

12 months

NUMERATOR STATEMENT

Patients whose most recent serum urate level is less than 6.8 mg/dL

NUMERATOR DETAILS

Patients whose most recent serum urate level is less than 6.8 mg/dL

DENOMINATOR STATEMENT

Adult patients aged 18 and older with a diagnosis of gout treated with urate lowering therapy (ULT) for at least 12 months

DENOMINATOR DETAILS

Adult patients aged 18 and older with a diagnosis of gout treated with urate lowering therapy (ULT) for at least 12 months

EXCLUSIONS

Patients with a history of solid organ transplant

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

STRATIFICATION

TYPE SCORE

ALGORITHM

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

2550 Gout: ULT Therapy

STATUS

Steering Committee Review

STEWARD

AMERICAN COLLEGE OF RHEUMATOLOGY

DESCRIPTION

Percentage of patients aged 18 and older with a diagnosis of gout and either tophus/tophi or at least two gout flares (attacks) in the past year who have a serum urate level > 6.0 mg/dL, who are prescribed urate lowering therapy (ULT)

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry The ACR plan for measure testing includes testing data from at least 3 different types of EHRs, from at least 3 different sites, using a standardized data collection form.

No data collection instrument provided Attachment 2550_GOUTUrateLoweringTherapy_Mon_Apr_21_11.20.30_CDT_2014.xls

LEVEL

Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

A 12-month reporting period is anticipated for this measure.

NUMERATOR STATEMENT

Patients who are prescribed urate lowering therapy (ULT)

NUMERATOR DETAILS

Patients who are prescribed urate lowering therapy (ULT)

DENOMINATOR STATEMENT

Adult patients aged 18 and older with a diagnosis of gout and a serum urate level > 6.0 mg/dL who have at least one of the following: presence of tophus/tophi or two or more gout flares (attacks) in the past year

DENOMINATOR DETAILS

Adult patients aged 18 and older with a diagnosis of gout and a serum urate level > 6.0 mg/dL who have at least one of the following: presence of tophus/tophi or two or more gout flares (attacks) in the past year

EXCLUSIONS

None

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

STRATIFICATION

TYPE SCORE

ALGORITHM

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

Appendix F1: Related and Competing Measures (tabular format)

Comparison of NQF #2525 and NQF #0054

	2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
Steward	AMERICAN COLLEGE OF RHEUMATOLOGY	National Committee for Quality Assurance
Description	Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months.	The percentage of patients 18 years and older by the end of the measurement period, diagnosed with rheumatoid arthritis and who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).
Type	Process	Process
Data Source	Electronic Clinical Data : Electronic Health Record	Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry
Level	Clinician : Individual	Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinician Office/Clinic	Ambulatory Care : Clinician Office/Clinic
Time Window	12 months	The measurement year (12 month period).
Numerator Statement	Patient received a DMARD	Patients who had at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) during the measurement year.
Numerator Details	DMARD therapy includes: Biologic Agents- abatacept adalimumab anakinra certolizumab etanercept golimumab infliximab rituximab tocilizumab Non-Biologic Agents- azathioprine cyclophosphamide cyclosporine gold hydroxychloroquine	DMARD PRESCRIPTIONS (Table ART-C) 5-Aminosalicylates: Sulfasalazine Alkylating agents: Cyclophosphamide Aminoquinolines: Hydroxychloroquine Anti-rheumatics: Auranofin, Gold sodium thiomalate, Leflunomide, Methotrexate, Penicillamine Jcodes for Anti-rheumatics: J16000, J9250, J9260 Immunomodulators: Abatacept, Adalimumab, Anakinra, Certolizumab, Certolizumab pegol, Etanercept, Golimumab, Infliximab, Rituximab, Rocilizumab Jcodes for Immunomodulators: J0129, J0135, J0718, J1438, J1745, J3262, J9310

	2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
	leflunomide methotrexate minocycline penicillamine sulfasalazine Anti-inflammatory medications, including glucocorticoids do not meet the measure.	Immunosuppressive agents: Azathioprine, Cyclosporine, Mycophenolate Jcodes for Immunosuppressive agents: J7502, J7515, J7516, J7516, J7517, J7518 Tetracyclines: Minocycline
Denominator Statement	Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period	All patients, ages 18 years and older by the end of the measurement year who had either of the two of the following with different dates of service on or between the beginning of the measurement year and the end of the 11th month of the measurement year: - Outpatient visit, with any diagnosis of rheumatoid arthritis - Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis
Denominator Details	Patients 18 years and older with a diagnosis of Rheumatoid Arthritis seen for two or more encounters for Rheumatoid Arthritis during the measurement period.	CODES TO IDENTIFY RHEUMATOID ARTHRITIS (Table ART-A) ICD-9-CM Diagnosis: 714.0, 714.1, 714.2, 714.81 --- CODES TO IDENTIFY VISIT TYPE (Table ART-B) Outpatient - CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 - UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983
Exclusions	Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.	Exclude patients who have a diagnosis of HIV. Look for evidence of HIV diagnosis as far back as possible in the member's history through the end of the measurement year. Exclude patients who have a diagnosis of pregnancy during the measurement year.
Exclusion Details	Please see attached file DMARD_Value_Sets_Updated.xls	CODES TO IDENTIFY EXCLUSIONS (Table ART-D) ICD-9-CM Diagnosis: Pregnancy: 630-679, V22, V23, V28 HIV: 042, V08

Appendix F2: Related and Competing Measures (narrative format)

Comparison of NQF #2525 and NQF #0054

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Steward

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

AMERICAN COLLEGE OF RHEUMATOLOGY

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

National Committee for Quality Assurance

Description

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months.

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

The percentage of patients 18 years and older by the end of the measurement period, diagnosed with rheumatoid arthritis and who had at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Type

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Process

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Process

Data Source

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Electronic Clinical Data : Electronic Health Record

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry

Level

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Clinician : Individual

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Population : National, Population : Regional, Population : State

Setting

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Ambulatory Care : Clinician Office/Clinic

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Ambulatory Care : Clinician Office/Clinic

Time Window

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

12 months

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

The measurement year (12 month period).

Numerator Statement

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Patient received a DMARD

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Patients who had at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) during the measurement year.

Numerator Details

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

DMARD therapy includes:

Biologic Agents-

abatacept

adalimumab

anakinra

certolizumab

etanercept

golimumab

infliximab

rituximab

tocilizumab

Non-Biologic Agents-

azathioprine

cyclophosphamide

cyclosporine

gold

hydroxychloroquine

leflunomide

methotrexate

minocycline

penicillamine

sulfasalazine

Anti-inflammatory medications, including glucocorticoids do not meet the measure.

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

DMARD PRESCRIPTIONS (Table ART-C)

5-Aminosalicylates:

Sulfasalazine

Alkylating agents:

Cyclophosphamide

Aminoquinolines:

Hydroxychloroquine

Anti-rheumatics:

Auranofin, Gold sodium thiomalate, Leflunomide, Methotrexate, Penicillamine

Jcodes for Anti-rheumatics: J16000, J9250, J9260

Immunomodulators:

Abatacept, Adalimumab, Anakinra, Certolizumab, Certolizumab pegol, Etanercept, Golimumab, Infliximab, Rituximab, Rocilizumab

Jcodes for Immunomodulators: J0129, J0135, J0718, J1438, J1745, J3262, J9310

Immunosuppressive agents:

Azathioprine, Cyclosporine, Mycophenolate

Jcodes for Immunosuppressive agents: J7502, J7515, J7516, J7516, J7517, J7518

Tetracyclines:

Minocycline

Denominator Statement

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

All patients, ages 18 years and older by the end of the measurement year who had either of the two of the following with different dates of service on or between the beginning of the measurement year and the end of the 11th month of the measurement year:

- Outpatient visit, with any diagnosis of rheumatoid arthritis

- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis

Denominator Details

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Patients 18 years and older with a diagnosis of Rheumatoid Arthritis seen for two or more encounters for Rheumatoid Arthritis during the measurement period.

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

CODES TO IDENTIFY RHEUMATOID ARTHRITIS (Table ART-A)

ICD-9-CM Diagnosis: 714.0, 714.1, 714.2, 714.81

CODES TO IDENTIFY VISIT TYPE (Table ART-B)

Outpatient

- CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

- UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983

Exclusions

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Exclude patients who have a diagnosis of HIV. Look for evidence of HIV diagnosis as far back as possible in the member's history through the end of the measurement year.

Exclude patients who have a diagnosis of pregnancy during the measurement year.

Exclusion Details

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Please see attached file DMARD_Value_Sets_Updated.xls

0054 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

CODES TO IDENTIFY EXCLUSIONS (Table ART-D)

ICD-9-CM Diagnosis:

Pregnancy: 630-679, V22, V23, V28

HIV: 042, V08

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