

# NATIONAL QUALITY FORUM

## Measure Evaluation 4.1 January 2010

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The sub-criteria and most of the footnotes from the [evaluation criteria](#) are provided in Word comments and will appear if your cursor is over the highlighted area (or in the margin if your Word program is set to show revisions in balloons). Hyperlinks to the evaluation criteria and ratings are provided in each section.

**TAP/Workgroup** (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each sub-criterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: If there is no TAP or workgroup, the SC also evaluates the sub-criteria (**yellow highlighted areas**).

**Steering Committee**: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the sub-criterion, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few sub-criteria as indicated)

(for NQF staff use) NQF Review #: OT2-012-09	NQF Project: Patient Outcomes Measures: Phases I and II
MEASURE DESCRIPTIVE INFORMATION	
<b>De.1 Measure Title:</b> <a href="#">Bariatric surgery and complications during the hospitalization or within 30 days of discharge.</a>	
<b>De.2 Brief description of measure:</b> <a href="#">This measure identifies patients 12 years and older with bariatric surgery who had a defined complication during hospitalization or within 30 days of discharge.</a>	
<b>1.1-2 Type of Measure:</b> <a href="#">outcome</a>	
<b>De.3</b> If included in a composite or paired with another measure, please identify composite or paired measure <a href="#">not applicable</a>	
<b>De.4 National Priority Partners Priority Area:</b> <a href="#">care coordination, safety</a>	
<b>De.5 IOM Quality Domain:</b> <a href="#">safety</a>	
<b>De.6 Consumer Care Need:</b> <a href="#">Getting Better</a>	

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	<b>NQF Staff</b>
<p><b>A.</b> The measure is in the public domain or an intellectual property (<a href="#">measure steward agreement</a>) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i></p> <p><b>A.1</b> Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? <a href="#">Yes</a></p> <p><b>A.2</b> Indicate if Proprietary Measure (as defined in measure steward agreement): <a href="#">proprietary measure</a></p> <p><b>A.3</b> Measure Steward Agreement: <a href="#">agreement signed and submitted</a></p> <p><b>A.4</b> Measure Steward Agreement attached:</p>	<p><b>A</b></p> <p>Y <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. <a href="#">Yes, information provided in contact section</a>	B Y <input type="checkbox"/> N <input type="checkbox"/>
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► <b>Purpose:</b> <a href="#">public reporting, quality improvement Accreditation, Payment Incentive, Accountability</a>	C Y <input type="checkbox"/> N <input type="checkbox"/>
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: <a href="#">Yes, fully developed and tested</a> D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? <a href="#">Yes</a>	D Y <input type="checkbox"/> N <input type="checkbox"/>
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (if submission returned):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (issues or questions regarding any criteria):	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
<b>1. IMPORTANCE TO MEASURE AND REPORT</b>	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. <i>Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)</i> 1a. High Impact	<a href="#">Eval Rating</a>
(for NQF staff use) <a href="#">Specific NPP goal</a> :	
1a.1 Demonstrated High Impact Aspect of Healthcare: <a href="#">high resource use, patient/societal consequences of poor quality, other</a> 1a.2 <a href="#">procedure that is increasing in use</a>  1a.3 Summary of Evidence of High Impact: <a href="#">A recent study by Thorpe et. al. showed that the obesity epidemic is responsible for over one-fourth of the spiraling growth in U.S. healthcare costs over the past 15 years (1,2). With the obesity epidemic, bariatric surgery is emerging as the leading method of weight loss among the morbidly obese. Bariatric surgery is one of the fastest growing hospital procedures, but with a 40% complication rate in 2001. Between 2001 and 2005 bariatric surgeries grew by 113% (3).  Despite the apparent long-term benefits of bariatric surgery, little is known about population-level patient rates of adverse outcomes and healthcare utilization immediately after bariatric surgery. Most of the literature has found a complication rate between 10% and 20% during the initial surgical stay; few studies have examined complication rates after the patient leaves the hospital.  Encinosa et.al. recently analyzed complications associated with bariatric surgery from 2001 to 2006 (3). While older and sicker patients underwent surgery during this time period, the 180-day risk-adjusted complication rate did decline from 41.7% to 32.8%. Most of the improvement was in the initial hospital stay, where the risk-adjusted inpatient complication rate declined from 23.6% to 14.8%. There was also a decline from 9.8% to 6.8% in risk-adjusted rates of readmissions with complications. Despite this improvement, complication rates remain unacceptably high. This data indicates the need to monitor and report</a>	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

<p>complications associated with this procedure, particularly given the presence of strategies that can further reduce complications (i.e., banding without bypass) (3).</p> <p><b>1a.4 Citations for Evidence of High Impact:</b> 1. Thorpe K, Florence C, Howard D, et al. The impact of obesity on rising medical spending. <i>Health Aff (Millwood)</i>. 2004;W4:480-486.                  2. Encinosa WE, Bernard DM, Chen CC, Steiner CA. Healthcare Utilization and Outcomes After Bariatric Surgery. <i>Med Care</i> 2006;44: 706-712.                  3. Encinosa WE, Bernard DM, Du D, Steiner CA. Recent improvements in bariatric surgery outcomes. <i>Med Care</i> 2009;47: 531-535.</p>	
<p><b>1b. Opportunity for Improvement</b></p> <p><b>1b.1 Benefits (improvements in quality) envisioned by use of this measure:</b></p> <p><b>1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:</b>                  Using a geographically diverse 1 million member test database (this database represents predominately a commercial population less than 65 year of age) the complication rate, as defined in this measure, was 12.1 percent. This indicates an opportunity for care improvement and the value of identifying patients who have experienced a complication after bariatric surgery. Also, this represents an overall complication rate; it does not take into account provider and regional variation that may be associated with higher complication rates.</p> <p><b>1b.3 Citations for data on performance gap:</b>                  Ingenix EBM Connect test results, October 2009</p> <p><b>1b.4 Summary of Data on disparities by population group:</b>                  not applicable</p> <p><b>1b.5 Citations for data on Disparities:</b>                  none</p>	<p><b>1b</b></p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p><b>1c. Outcome or Evidence to Support Measure Focus</b></p> <p><b>1c.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population):</b> This measure identifies patients with serious or life-threatening complications after bariatric surgery. It is essential to measure and understand complications from this treatment, particularly since there are strategies that can reduce many complications. This measure will identify surgeons or surgical centers that have higher than expected surgical complications. It will identify local and regional differences. It will identify high risk patients who could benefit from disease management services. This can result in the following: improved quality of care, reduction of 30-day complications, reduction of readmission rates, reduction of preventable ER visits, and facilitation of care coordination in high-risk situations.</p> <p><b>1c.2-3. Type of Evidence:</b> observational study</p> <p><b>1c.4 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome):</b>                  There is evidence that certain strategies can reduce bariatric surgery complications. For example, Encinosa et.al. found the declines in complication rates noted from 2001 and 2006 were due to the following: (1) increased use of laparoscopy; (2) increased use of banding without bypass; or (3) within-hospital increases in hospital volume (i.e., increased bariatric surgery experience). Although improvements were due to all three reasons, certain differences were also noted. First, the improvement in 180-day complications was due to laparoscopy and within-hospital increases in hospital volume. However, laparoscopy had no impact on readmissions and ER visits with complications. Both within-hospital increases in hospital volume and a move to banding reduced such postoperative visits. Laparoscopy reduced payments by 12% and banding reduced payments by 20%.</p>	<p><b>1c</b></p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

<p>Given these complexities and the opportunity for outcome improvements, it is critical to understand complication patterns in more detail including local and regional differences. This could result in fewer complications, better quality, and lower costs associated with bariatric surgery.</p> <p><b>1c.5 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom):</b> not applicable</p> <p><b>1c.6 Method for rating evidence:</b> none</p> <p><b>1c.7 Summary of Controversy/Contradictory Evidence:</b> none</p> <p><b>1c.8 Citations for Evidence (other than guidelines):</b> Encinosa WE, Bernard DM, Du D, Steiner CA. Recent improvements in bariatric surgery outcomes. Med Care 2009;47: 531-535.</p> <p><b>1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number):</b> not applicable</p> <p><b>1c.10 Clinical Practice Guideline Citation:</b> not applicable</p> <p><b>1c.11 National Guideline Clearinghouse or other URL:</b> not applicable</p> <p><b>1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom):</b> not applicable</p> <p><b>1c.13 Method for rating strength of recommendation (If different from <a href="#">USPSTF system</a>, also describe rating and how it relates to USPSTF):</b> not applicable</p> <p><b>1c.14 Rationale for using this guideline over others:</b> not applicable</p>	
<p><b>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Importance to Measure and Report</i>?</b></p>	<p>1</p>
<p><b>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met?</b> Rationale:</p>	<p>1 Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p><b>2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</b></p>	
<p>Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (<a href="#">evaluation criteria</a>)</p>	<p><a href="#">Eval Rating</a></p>
<p><b>2a. MEASURE SPECIFICATIONS</b></p>	
<p><b>S.1 Do you have a web page where current detailed measure specifications can be obtained?</b> <b>S.2 If yes, provide web page URL:</b></p> <p>2a. Precisely Specified</p>	
<p><b>2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome):</b> evidence of a complication during the bariatric surgery hospitalization or within 30 days of discharge</p> <p><b>2a.2 Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator):</b></p>	<p>2a-specs C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

date of bariatric surgery hospitalization through 30 days after hospital discharge

**2a.3 Numerator Details** (All information required to collect/calculate the numerator, including all codes, logic, and definitions):

Was there evidence of any of the following complications during the following time period: date of bariatric surgery hospitalization through 30 days after hospital discharge

1. Readmission to the hospital with any diagnosis
2. One or more of the following services with a diagnosis of gastrointestinal perforation (code set DX0052), OR post-operative wound infection or dehiscence (code set DX0126), OR pulmonary embolism (code set DX0129), OR bacterial pneumonia (code set DX0298), OR anastomotic leak (code set DX0324), OR deep venous thrombosis (code set DX0326)?
  - Professional Encounter (code set PR0107, RV0107)
  - Facility Event - Confinement/Admission
  - Facility Event - Emergency Room
  - Facility Event - Outpatient Surgery
3. A procedure for wound dehiscence (code set PR0363)?
4. A stenosis and obstruction diagnosis (code set DX0325) and a claim on the same day with a stenosis and obstruction procedure (code set PR0362)?

DX0052 Gastrointestinal perforation  
569.83 PERFORATION OF INTESTINE

DX0126 Post-operative wound infection or dehiscence  
998.3 DISRUPTION OF WOUND\*  
998.31 DISRUPTION OF INTERNAL OPERATION SURGICAL WOUND  
998.32 DISRUPTION OF EXTERNAL OPERATION SURGICAL WOUND  
998.5 POSTOPERATIVE INFECTION NOT ELSEWHERE CLASSIFIED\*  
998.51 INFECTED POSTOPERATIVE SEROMA NEC  
998.59 OTHER POSTOPERATIVE INFECTION NEC

DX0129 Pulmonary embolism  
415.11 IATROGENIC PULMONARY EMBOLISM AND INFARCTION  
415.12 SEPTIC PULMONARY EMBOLISM  
415.19 OTHER PULMONARY EMBOLISM AND INFARCTION

DX0298 Bacterial Pneumonia  
481 PNEUMOCOCCAL PNEUMONIA  
482 OTHER BACTERIAL PNEUMONIA\*  
482.0 PNEUMONIA DUE TO KLEBSIELLA PNEUMONIAE  
482.1 PNEUMONIA DUE TO PSEUDOMONAS  
482.2 PNEUMONIA DUE TO HEMOPHILUS INFLUENZAE  
482.3 PNEUMONIA DUE TO STREPTOCOCCUS\*  
482.30 PNEUMONIA DUE TO UNSPECIFIED STREPTOCOCCUS  
482.31 PNEUMONIA DUE TO STREPTOCOCCUS GROUP A  
482.32 PNEUMONIA DUE TO STREPTOCOCCUS GROUP B  
482.39 PNEUMONIA DUE TO OTHER STREPTOCOCCUS  
482.4 PNEUMONIA DUE TO STAPHYLOCOCCUS\*  
482.40 PNEUMONIA DUE TO STAPHYLOCOCCUS UNSPECIFIED  
482.41 METHICILLIN SUSEPTIBLE PNEUMONIA STAPH AUREUS  
482.49 OTHER STAPHYLOCOCCUS PNEUMONIA  
482.8 PNEUMONIA DUE TO OTHER SPECIFIED BACTERIA\*  
482.81 PNEUMONIA DUE TO ANAEROBES  
482.82 PNEUMONIA DUE TO ESCHERICHIA COLI  
482.83 PNEUMONIA DUE TO OTHER GRAM-NEGATIVE BACTERIA  
482.84 LEGIONNAIRES+ DISEASE  
482.89 PNEUMONIA DUE TO OTHER SPECIFIED BACTERIA  
482.9 UNSPECIFIED BACTERIAL PNEUMONIA  
483 PNEUMONIA DUE TO OTHER SPECIFIED ORGANISM\*

483.0 PNEUMONIA DUE TO MYCOPLASMA PNEUMONIAE  
 483.1 PNEUMONIA DUE TO CHLAMYDIA  
 483.8 PNEUMONIA DUE TO OTHER SPECIFIED ORGANISM  
 485 BRONCHOPNEUMONIA ORGANISM UNSPECIFIED  
 486 PNEUMONIA, ORGANISM UNSPECIFIED  
 487.0 INFLUENZA WITH PNEUMONIA

DX0324 Anastomotic leak  
 537.89 OTHER SPECIFIED DISORDER OF STOMACH AND DUODENUM  
 997.4 DIGESTIVE SYSTEM COMPLICATION NEC  
 E878.2 ABNORM REACT D/T ANASTOMOSIS-BYPASS/GRAFT SURG

DX0326 Deep venous thrombosis  
 451.11 PHLEBITIS AND THROMBOPHLEBITIS OF FEMORAL VEIN  
 451.19 PHLEBITIS&THROMBOPHLEB OTH DEEP VES LOWER EXTREM  
 451.2 PHLEBITIS&THROMBOPHLEBITIS LOWER EXTREM UNSPEC  
 451.81 PHLEBITIS AND THROMBOPHLEBITIS OF ILIAC VEIN  
 451.9 PHLEBITIS&THROMBOPHLEBITIS OF UNSPECIFIED SITE  
 453.8 EMBOLISM AND THROMBOSIS OF OTHER SPECIFIED VEINS  
 453.9 EMBOLISM AND THROMBOSIS OF UNSPECIFIED SITE  
 997.2 PERIPHERAL VASCULAR COMPLICATIONS NEC

DX0325 Stenosis and obstruction  
 536.8 DYSPEPSIA&OTHER SPEC DISORDERS FUNCTION STOMACH  
 537.0 ACQUIRED HYPERTROPHIC PYLORIC STENOSIS  
 537.2 CHRONIC DUODENAL ILEUS  
 537.3 OTHER OBSTRUCTION OF DUODENUM  
 537.6 HOURGLASS STRICTURE OR STENOSIS OF STOMACH  
 537.9 UNSPECIFIED DISORDER OF STOMACH AND DUODENUM  
 560.81 INTESTINAL OR PERITONEAL ADHESIONS W/OBSTRUCTION  
 560.89 OTHER SPECIFIED INTESTINAL OBSTRUCTION  
 560.9 UNSPECIFIED INTESTINAL OBSTRUCTION

PR0362 Stenosis and obstruction  
 44.21 Dilation of pylorus by incision  
 44.22 Endoscopic dilation of pylorus  
 43220 Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)  
 43226 Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire  
 43241 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement  
 43245 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie)  
 44615 Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction

PR0363 Wound dehiscence  
 54.0 Incision of abdominal wall  
 54.11 Exploratory laparotomy  
 54.12 Reopening of recent laparotomy site  
 54.19 Other laparotomy  
 54.61 Reclosure of postoperative disruption of abdominal wall  
 12020 Treatment of superficial wound dehiscence; simple closure  
 12021 Treatment of superficial wound dehiscence; with packing  
 13160 Secondary closure of surgical wound or dehiscence, extensive or complicated  
 49002 Reopening of recent laparotomy

Code Set/Code Set Description/Procedure Code  
 PR0107 Professional encounter 99201

PR0107 Professional encounter 99202  
 PR0107 Professional encounter 99203  
 PR0107 Professional encounter 99204  
 PR0107 Professional encounter 99205  
 PR0107 Professional encounter 99211  
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 PR0107 Professional encounter S0272  
 PR0107 Professional encounter S0273

Code Set/Code Set Description/Revenue Code

RV0107 Professional encounter 0510  
 RV0107 Professional encounter 0511  
 RV0107 Professional encounter 0512  
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 RV0107 Professional encounter 0526



RV0107 Professional encounter 0528  
 RV0107 Professional encounter 0529  
 RV0107 Professional encounter 0981  
 RV0107 Professional encounter 0983

**2a.4 Denominator Statement** (*Brief, text description of the denominator - target population being measured*):

Patients 12 years and older hospitalized for bariatric surgery

**2a.5 Target population gender:** Male, Female

**2a.6 Target population age range:** 12 years or older at the end of the report period

**2a.7 Denominator Time Window** (*The time period in which cases are eligible for inclusion in the denominator*):

24 months before the end of the report period through 30 days before the end of the report period (need 30 day period to look for complications)

**2a.8 Denominator Details** (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions*):

The following criteria must be met for denominator inclusion:

1. Age 12 years or older at the end of the report period
2. Patient must be continuously enrolled in medical benefits throughout the 24 months prior to the end of the report period (note: our standard enrollment break logic allows unlimited breaks of no more than 45 days and no breaks greater than 45 days)
3. Define the start date as the the earliest date of one of the following services, where there is a procedure for bariatric surgery (code set PR0004):
  - Facility Event - Confinement/Admission
  - Facility Event - Outpatient Surgery

PR0004 Bariatric surgery

43644 Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

43645 Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption

43770 Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)

43771 Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only

43772 Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only

43773 Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only

43774 Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components

43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty

43843 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty

43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)

43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy

43847 Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption

43848 Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric

<p>restrictive device (separate procedure)            43886 Gastric restrictive procedure, open; revision of subcutaneous port component only            43887 Gastric restrictive procedure, open; removal of subcutaneous port component only            43888 Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only            S2082 Laparoscopy, surgical; gastric restrictive proc,</p>
<p><b>2a.9 Denominator Exclusions</b> (<i>Brief text description of exclusions from the target population</i>): none</p>
<p><b>2a.10 Denominator Exclusion Details</b> (<i>All information required to collect exclusions to the denominator, including all codes, logic, and definitions</i>):          not applicable</p>
<p><b>2a.11 Stratification Details/Variables</b> (<i>All information required to stratify the measure including the stratification variables, all codes, logic, and definitions</i>):          not applicable</p>
<p><b>2a.12-13 Risk Adjustment Type</b>: no risk adjustment necessary</p>
<p><b>2a.14 Risk Adjustment Methodology/Variables</b> (<i>List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method</i>):          not applicable</p>
<p><b>2a.15-17 Detailed risk model available</b> Web page URL or attachment:</p>
<p><b>2a.18-19 Type of Score</b>: rate/proportion  <b>2a.20 Interpretation of Score</b>: better quality = lower score  <b>2a.21 Calculation Algorithm</b> (<i>Describe the calculation of the measure as a flowchart or series of steps</i>):          1. Assign a YES or NO result to member based on numerator response (i.e., was there a complication)          2. Rate = YES/[YES+NO]</p>
<p><b>2a.22 Describe the method for discriminating performance</b> (<i>e.g., significance testing</i>):          Performance results can be compared to results from our geographically diverse 1 million member test database.</p>
<p><b>2a.23 Sampling (Survey) Methodology</b> <i>If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)</i>:</p>
<p><b>2a.24 Data Source</b> (<i>Check the source(s) for which the measure is specified and tested</i>)          Electronic administrative data/claims</p>
<p><b>2a.25 Data source/data collection instrument</b> (<i>Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.</i>):          ICD-9 codes, CPT codes, revenue codes</p>
<p><b>2a.26-28 Data source/data collection instrument reference</b> web page URL or attachment:</p>
<p><b>2a.29-31 Data dictionary/code table</b> web page URL or attachment:</p>
<p><b>2a.32-35 Level of Measurement/Analysis</b> (<i>Check the level(s) for which the measure is specified and tested</i>)          Population: national, Population: regional/network, Population: states, Population: counties or cities,          Clinicians: Individual, Clinicians: Group, Program: Disease management, Program: QIO, Can be measured at all levels</p>
<p><b>2a.36-37 Care Settings</b> (<i>Check the setting(s) for which the measure is specified and tested</i>)          Ambulatory Care: Office, Ambulatory Care: Clinic, Ambulatory Care: Hospital Outpatient, Long term acute care hospital, Hospital</p>

<p><b>2a.38-41 Clinical Services</b> (<i>Healthcare services being measured, check all that apply</i>)                  Clinicians: Physicians (MD/DO)</p>	
TESTING/ANALYSIS	
<p><b>2b. Reliability testing</b></p> <p><b>2b.1 Data/sample</b> (<i>description of data/sample and size</i>): Our primary data sample included a geographically diverse 12 million member benchmark database. The database represents predominately a commercial population less than 65 year of age.</p> <p><b>2b.2 Analytic Method</b> (<i>type of reliability &amp; rationale, method for testing</i>):                  Quality assurance of each measure is accomplished through the testing using multiple methods. Types of testing, data samples and volume vary to ensure the integrity of the measure. Rigorous development, analysis and testing processes are deployed for creating measure specifications. Software testing ensures the software is working as designed. Reliability and validity testing of measures is based on differing data samples and volume of members. National benchmarks are created on a large volume set of data representing members throughout the United States. All quality checks for all measure results must have consistent results and meet expected outcomes based on industry knowledge and experience.</p> <p>Customer Acceptance Testing (CAT) is another important quality process. CAT ensures that the clinical measures are functioning as intended and that they generate accurate results for typical billing patterns. Using actual claims data, a team of business analysts, nurses, and health services researchers conduct a detailed analysis of the output. For each clinical condition in the product (e.g., Diabetes Mellitus, Coronary Artery Disease, etc.) there is a set of CAT data with at least 4000 members who satisfy the condition confirmation criteria. This data is extracted from a large (50+ million member) multi-payer benchmark database and contains inpatient, outpatient, pharmacy, and laboratory data. The testing team analyzes claims from individual members and compares the creation of denominators (target population), numerators, and exclusions from this manual review process to output results from the quality measure.</p> <p>Regression testing is the part of CAT that verifies the reliability of the product across software releases. For a new release the testing team confirms that every unchanged measure produces the same results as in previous releases, accounting for systematic changes to the software (e.g., code updates, logic changes, etc). Regression testing is conducted at multiple points throughout the software development cycle.</p> <p><b>2b.3 Testing Results</b> (<i>reliability statistics, assessment of adequacy in the context of norms for the test conducted</i>):                  Within our data sample, we identified 5412 members that had bariatric surgery during the measurement period. When using a more limited list of complications (readmission, gastrointestinal perforation, post-operative wound infection or dehiscence, or pulmonary embolism), the 30-day complication rate was 5.64 percent. We then added other complications identified in articles published by Encinosa et.al. (2006, 2009) and analyzed our modified measure using a smaller database - the subsequent 30-day complication rate was 13.0 percent. [Note: We will retest this modified measure using our standard 12 million member benchmark database with results available June 2010.]</p>	2b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
<p><b>2c. Validity testing</b></p> <p><b>2c.1 Data/sample</b> (<i>description of data/sample and size</i>): as above</p> <p><b>2c.2 Analytic Method</b> (<i>type of validity &amp; rationale, method for testing</i>):                  Face Validity Testing (FVT) is the final testing step in the software release cycle. One million members are randomly selected from the large multi-payer benchmark database and their claims data is processed through the software. The Medical Director reviews the results to verify that:</p> <ol style="list-style-type: none"> <li>1. Prevalence rates for a condition are comparable to nationally published rates</li> <li>2. Compliance rates for a measure are comparable to the rates reported in the published literature or by other national sources (e.g. HEDIS). If no comparable sources are available, the rates are judged based on what is clinically reasonable.</li> </ol> <p>In addition, all results are reviewed for face validity by members of an external physician clinical</p>	2c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

<p>consultant panel.</p> <p>Our claims-based measures have been validated using a chart review comparison process. This validation project is summarized below:          Goal: evaluate the reliability of claims-based measure results using chart review as the gold standard          Methods:          The charts of 100 members from two clinics in one city were reviewed. Results from our claims-based measures were compared to information present in the chart. During this process, 726 measures were evaluated.          Results:          The overall error rate was less than 5%. The error rate varied depending on the type of claim required for numerator compliance and is summarized as follows:          o The error rate was highest with medications, with an 11 percent error rate (2/18). From chart review, it was difficult to tell if this represented a real error, a medication sample was provided, or the prescription was never filled).          o The error rate was 4 percent (14/318) for measures that required labs for numerator compliance. It was noted that a claims-based measure approach sometimes identified labs that were missing in chart review.          o The error rate for office visit and specialty appointments was 2 percent (8/390). Of note, administrative claims was more likely than chart review to identify relevant office and specialty visits, particularly for appointments that occurred outside the clinic or network.          o Errors were found related to coding in claims data, not due to the claims-based measures or methodology. These errors were not quantified.</p> <p><b>2c.3 Testing Results</b> (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>):          as above</p>	
<p><b>2d. Exclusions Justified</b></p> <p><b>2d.1 Summary of Evidence supporting exclusion(s):</b>          not applicable</p> <p><b>2d.2 Citations for Evidence:</b></p> <p><b>2d.3 Data/sample</b> (<i>description of data/sample and size</i>):</p> <p><b>2d.4 Analytic Method</b> (<i>type analysis &amp; rationale</i>):</p> <p><b>2d.5 Testing Results</b> (<i>e.g., frequency, variability, sensitivity analyses</i>):</p>	<p>2d          C <input type="checkbox"/>          P <input type="checkbox"/>          M <input type="checkbox"/>          N <input type="checkbox"/>          NA <input type="checkbox"/></p>
<p><b>2e. Risk Adjustment for Outcomes/ Resource Use Measures</b></p> <p><b>2e.1 Data/sample</b> (<i>description of data/sample and size</i>): not applicable</p> <p><b>2e.2 Analytic Method</b> (<i>type of risk adjustment, analysis, &amp; rationale</i>):</p> <p><b>2e.3 Testing Results</b> (<i>risk model performance metrics</i>):</p> <p><b>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:</b> The purpose of this measure is to identify all patients who have evidence of specific complications within 30 days of bariatric surgery.</p>	<p>2e          C <input type="checkbox"/>          P <input type="checkbox"/>          M <input type="checkbox"/>          N <input type="checkbox"/>          NA <input type="checkbox"/></p>
<p><b>2f. Identification of Meaningful Differences in Performance</b></p>	<p>2f          C <input type="checkbox"/></p>

<p><b>2f.1</b> Data/sample from Testing or Current Use (<i>description of data/sample and size</i>): <a href="#">as above</a></p> <p><b>2f.2</b> Methods to identify statistically significant and practically/meaningfully differences in performance (<i>type of analysis &amp; rationale</i>):</p> <p><b>2f.3</b> Provide Measure Scores from Testing or Current Use (<i>description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance</i>):</p>	<p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p><b>2g. Comparability of Multiple Data Sources/Methods</b></p> <p><b>2g.1</b> Data/sample (<i>description of data/sample and size</i>): <a href="#">as above</a></p> <p><b>2g.2</b> Analytic Method (<i>type of analysis &amp; rationale</i>):</p> <p><b>2g.3</b> Testing Results (<i>e.g., correlation statistics, comparison of rankings</i>):</p>	<p>2g</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p><b>2h. Disparities in Care</b></p> <p><b>2h.1</b> If measure is stratified, provide stratified results (<i>scores by stratified categories/cohorts</i>): <a href="#">not applicable</a></p> <p><b>2h.2</b> If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:</p>	<p>2h</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p><b>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Scientific Acceptability of Measure Properties</i>?</b></p>	<p>2</p>
<p><b>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met?</b> Rationale:</p>	<p>2</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p><b>3. USABILITY</b></p>	
<p>Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (<a href="#">evaluation criteria</a>)</p>	<p><a href="#">Eval</a> <a href="#">Rating</a></p>
<p><b>3a. Meaningful, Understandable, and Useful Information</b></p> <p><b>3a.1</b> Current Use: <a href="#">in use</a></p> <p><b>3a.2</b> Use in a public reporting initiative (disclosure of performance results to the public at large) (<i>If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). <u>If not publicly reported</u>, state the plans to achieve public reporting within 3 years</i>):</p> <p><b>3a.3</b> If used in other programs/initiatives (<i>If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). <u>If not used for QI</u>, state the plans to achieve use for QI within 3 years</i>): <a href="#">Health plans, physicians (individuals and groups), care management, and other vendors/customers are using this on a national level. Some are using this data in public reporting initiatives.</a></p> <p><b>Testing of Interpretability</b> (<i>Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement</i>)</p> <p><b>3a.4</b> Data/sample (<i>description of data/sample and size</i>): <a href="#">Results are summarized and reported by</a></p>	<p>3a</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

users/customers depending on their business need. Therefore, this is no single public reporting format.  3a.5 Methods (e.g., focus group, survey, QI project):  3a.6 Results (qualitative and/or quantitative results and conclusions):	
3b/3c. Relation to other NQF-endorsed measures  3b.1 NQF # and Title of similar or related measures:	
(for NQF staff use) Notes on similar/related <u>endorsed</u> or submitted measures:	
3b. Harmonization If this measure is related to measure(s) already <u>endorsed by NQF</u> (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population): 3b.2 Are the measure specifications harmonized? If not, why?	3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
3c. Distinctive or Additive Value 3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:  5.1 <b>Competing Measures</b> If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), describe why it is a more valid or efficient way to measure quality:	3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Usability</i> ?	3
Steering Committee: Overall, to what extent was the criterion, <i>Usability</i> , met? Rationale:	3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
<b>4. FEASIBILITY</b>	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. ( <u>evaluation criteria</u> )	<u>Eval Rating</u>
4a. Data Generated as a Byproduct of Care Processes  4a.1-2 How are the data elements that are needed to compute measure scores generated? data generated as byproduct of care processes during delivery, coding/abstraction performed by someone other than person obtaining original information,	4a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
4b. Electronic Sources  4b.1 Are all the data elements available electronically? (elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims) Yes  4b.2 If not, specify the near-term path to achieve electronic capture by most providers.	4b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
4c. Exclusions	4c C <input type="checkbox"/>

<p><b>4c.1</b> Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No</p> <p><b>4c.2</b> If yes, provide justification.</p>	<p>P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p><b>4d.</b> Susceptibility to Inaccuracies, Errors, or Unintended Consequences</p> <p><b>4d.1</b> Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. no significant errors are anticipated</p>	<p>4d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p><b>4e.</b> Data Collection Strategy/Implementation</p> <p><b>4e.1</b> Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: As noted earlier, our original measure developed approximately three years ago used a more limited list of complications (readmission, gastrointestinal perforation, post-operative wound infection or dehiscence, or pulmonary embolism); the 30-day complication rate was 5.64 percent. More recently, we modified this measure to include additional complications identified in the articles published by Encinosa et.al. (2006, 2009). Dr. Encinosa kindly provided his ICD-9 and CPT complication code list for our use. We have analyzed our modified measure using a smaller database; the subsequent 30-day complication rate was 13.0 percent. This rate is more consistent with the rates reported by Encinosa. We will retest this modified measure using our standard 12 million member benchmark database with results available June 2010.</p> <p>We have not experienced any problems with the measure related to data collection, data integrity, or overall feasibility.</p> <p><b>4e.2</b> Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>):</p> <p><b>4e.3</b> Evidence for costs:</p> <p><b>4e.4</b> Business case documentation:</p>	<p>4e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p><b>TAP/Workgroup:</b> What are the strengths and weaknesses in relation to the sub-criteria for <i>Feasibility</i>?</p>	<p>4</p>
<p><b>Steering Committee:</b> Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:</p>	<p>4 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<b>RECOMMENDATION</b>	
<p><b>(for NQF staff use)</b> Check if measure is untested and only eligible for time-limited endorsement.</p>	<p>Time-limited <input type="checkbox"/></p>
<p><b>Steering Committee:</b> Do you recommend for endorsement? Comments:</p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/></p>
<b>CONTACT INFORMATION</b>	
<p><b>Co.1</b> Measure Steward (Intellectual Property Owner) <b>Co.1</b> <u>Organization</u></p>	

Ingenix   12125 Technology Drive, MN002-0135   Eden Prairie   Minnesota   55344
<b>Co.2 Point of Contact</b> Kay   Schwebke   kay.schwebke@ingenix.com   952-833-7154
<b>Measure Developer If different from Measure Steward</b> <b>Co.3 Organization</b> Ingenix   12125 Technology Drive, MN002-0135   Eden Prairie   Minnesota   55344
<b>Co.4 Point of Contact</b> Kay   Schwebke   kay.schwebke@ingenix.com   952-833-7154
<b>Co.5 Submitter If different from Measure Steward POC</b> Kay   Schwebke   kay.schwebke@ingenix.com   952-833-7154
<b>Co.6 Additional organizations that sponsored/participated in measure development</b>
<b>ADDITIONAL INFORMATION</b>
<b>Workgroup/Expert Panel involved in measure development</b> <b>Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.</b> Alexander, Beth Pharm D, BCPS Assistant Professor, Augsburg College Ayenew, Woubeshet, MD Hennepin Faculty Associates; Hennepin County Medical Center Becker, Keith, MD Fairview Medical Center Betcher, Susan, MD Allina Medical Clinic Bruer, Paul, MD Comprehensive Ophthalmology, LLC Capecchi, Joseph, MD Allina Medical Clinic Giesler, Janell, MD Allina Medical Clinic Grabowski, Carol, MD Allina Medical Clinic Hansen, Calvin, MD Iowa Health Physicians Hargrove, Jody, MD Arthritis and Rheumatology Consultants Hermann, Richard, MD Tufts - New England Medical Center Jemming, Brian, Pharm D CentraCare Health System Kohen, Jeffrey, MD Veterans Affairs Medical Center McCarthy, Teresa, MD University of Minnesota, Department of Family Medicine & Community Health McEvoy, Charlene, MD, MPH HealthPartners & HealthPartners Research Foundation; Assistant Professor of Medicine, University of Minnesota McGee, Deanna, Pharm D, BCPS Retail Pharmacy Ogle, Kathleen, MD Hennepin Faculty Associates; Hennepin County Medical Center: Assistant Professor of Medicine, University of Minnesota Medical School Peter, Kathleen, MD Park Nicollet Medical Center Pieper-Bigelow, Christina, MD Allina Medical Clinic Redmon, Bruce, MD University of Minnesota Physicians Scharpf, Steven, MD Mountain Valleys Health Centers Weitz, Carol, MD Independent  This external consultant panel is responsible for assisting with the literature review, developing and maintaining measures, developing and maintaining code sets, and reviewing test results.
<b>Ad.2 If adapted, provide name of original measure:</b> <b>Ad.3-5 If adapted, provide original specifications URL or attachment</b>
<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.6 Year the measure was first released:</b> 2006 <b>Ad.7 Month and Year of most recent revision:</b> 2009-09



**Ad.8 What is your frequency for review/update of this measure?** every three years at minimum - this measure will be updated in 2011

**Ad.9 When is the next scheduled review/update for this measure?** 2011-08

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**Ad.11 -13 Additional Information web page URL or attachment:**

**Date of Submission (MM/DD/YY):** 10/27/2009