Primary Care and Chronic Illness, Spring 2018 Cycle: CDP Report

TECHNICAL REPORT

January 11, 2019

This report is funded by the Department of Health and Human Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

NATIONAL QUALITY FORUM

Contents

Primary Care and Chronic Illness, Spring 2018 Cycle

TECHNICAL REPORT

Executive Summary

Primary care has a central role in improving the health of people and populations. Primary care practitioners manage the uniqueness and complexities of each patient. In this setting, the diagnosis and treatment of the patient focuses on the health of the entire patient and not a single disease. Chronic illnesses are long-lasting or persistent health conditions or diseases that patients and providers must manage on an ongoing basis. The incidence, impact, and cost of chronic disease is increasing in the United States. For example, at least 29 million Americans are living with diabetes, and 25 million are living with asthma.[1] In 2016, the U.S. spent $245 billion on diabetes care and $56 billion on asthma-related care, which are among the most expensive health conditions in the United States.[1]

In 2017, NQF consolidated several committees to form the Primary Care and Chronic Illness Standing Committee. This Committee oversees a measure portfolio that includes endocrine conditions; nonsurgical eyes, ears, nose, and throat conditions; infectious disease; musculoskeletal disorders; and pulmonary disease.

For this project, the Standing Committee evaluated seven measures undergoing maintenance review against NQF's standard evaluation criteria. The Consensus Standards Approval Committee (CSAC) upheld the Committee's recommendations. Six measures were endorsed, and one measure was not endorsed. The following six measures were endorsed:

- 0046 Screening for Osteoporosis for Women 65-85 Years of Age
- 0053 Osteoporosis Management in Women Who Had a Fracture
- 0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed
- 0056 Comprehensive Diabetes Care: Foot Exam
- 0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
- 0062 Comprehensive Diabetes Care: Medical Attention for Nephropathy

The Committee did not recommend the following measure:

- 0037 Osteoporosis Testing in Older Women (OTO)

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

Introduction

Over the last 15 years, NQF has endorsed more than 50 measures to help improve primary care and care for chronic illnesses. These measures are used in many national and state-level public reporting and accountability programs, as well as for quality improvement. In 2017, NQF consolidated several committees to form the Primary Care and Chronic Illness Standing Committee. This new, consolidated topical area will build on NQF's prior work by reviewing new and previously endorsed measures related to primary care and chronic illness. This measure portfolio includes endocrine conditions; nonsurgical eyes, ears, nose, and throat conditions; infectious disease; musculoskeletal disorders; and pulmonary disease.

Primary care has a central role in improving the health of people and populations. Primary care practitioners manage the uniqueness and complexities of each patient. In this setting, the diagnosis and treatment of the patient focuses on the health of the entire patient and not a single disease. Chronic illnesses are long-lasting or persistent health conditions or diseases that patients and providers must manage on an ongoing basis. The incidence, impact, and cost of chronic disease is increasing in the United States. At least 29 million Americans are living with diabetes, and 25 million are living with asthma.[1] In 2016, the U.S. spent $245 billion on diabetes care and $56 billion on asthma-related care, which are among the most expensive health conditions in the United States.[1]

High-quality performance measurement that captures the complexity of primary care and chronic illnesses is essential to improve diagnosis, treatment, and management of conditions. NQF will review measures in these important healthcare areas under a consolidated measure portfolio that reflects the importance of caring for chronic illness in primary care settings. Measures may focus on nonsurgical eyes or ears, nose, and throat conditions; diabetes care, osteoporosis; HIV; rheumatoid arthritis; gout; back pain; asthma; chronic obstructive pulmonary disease (COPD); and acute bronchitis.

NQF Portfolio of Performance Measures for Primary Care and Chronic Illness Conditions

The Primary Care and Chronic Illness Standing Committee (Appendix C) oversees NQF's portfolio of Primary Care and Chronic Illness measures that includes measures for seven subtopics. This portfolio contains 55 measures: 46 process measures, one intermediate clinical outcome measure, seven outcome measures, and one composite measure (see Table 1).

Table 1. NQF Primary Care and Chronic Illness Portfolio of Measures

	Process	Outcome	Intermediate Clinical Outcome	Composite
EENT	13	–	–	–
Endocrine	12	5	–	1
Health and Well-Being	–	–	1	–
Infectious Disease	8	2	–	–
Musculoskeletal	7	–	–	–

	Process	Outcome	Intermediate Clinical Outcome	Composite
Patient Safety	1	–	–	–
Pulmonary and Critical Care	5	–	–	–
Total	46	7	1	1

Some other measures related to primary care and chronic illness have been assigned to other portfolios. These include functional status measures (Patient Experience and Function), opioid use measures (Patient Safety), diabetes-related admission rate measures (Prevention and Population Health), and a variety of condition- or population-specific measures (Cardiovascular, Pediatric, Geriatric and Palliative Care, etc.).

Primary Care and Chronic Illness Measure Evaluation

On June 21, 2018 the Primary Care and Chronic Illness Standing Committee evaluated seven measures undergoing maintenance review against NQF's standard evaluation criteria.

Table 2. Primary Care and Chronic Illness Spring Cycle 2018 Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	7	0	7
Endorsed measures	6	0	6
Measures not endorsed	1	0	1
Measures withdrawn from consideration	6	0	6
Reasons for not endorsing	Importance – 0 Scientific Acceptability – 1 Use – 0 Overall Suitability – 0 Competing Measure – 0	Importance – 0 Scientific Acceptability – 0 Overall Suitability – 0 Competing Measure – 0	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 1, 2018 and closed on August 29, 2018. No comments were submitted for the Committee's consideration during their evaluation meetings as of June 12, 2018.

Comments Received After Committee Evaluation

Following the Committee's evaluation of the measures under consideration, NQF received 14 comments from three member organizations and individuals pertaining to the draft report and to the measures under consideration. Appendix A summarizes all comments for each measure under consideration.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Two NQF members provided their expression of support.

Overarching Issues

During the Standing Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Data Availability at the Clinician Level of Analysis

Clinical quality measures depend on the availability of data in order to facilitate achievement of high-quality, efficient healthcare for patients. Data are essential to performance measure testing (i.e., empirical validity testing) and analysis of the measure's data elements, as well as monitoring performance rates and/or identifying disparities. The Committee discussed the lack of data for quality measures at the clinician level of analysis. For example, developers frequently share the challenges to accessing data on potential disparities for clinical quality measures. In addition, developers, if they are not implementers of their measures, at times do not have access to the most current performance data due to the delay in these data becoming publicly available. These limitations in data availability can inhibit awareness of the strengths and weaknesses in clinical quality measures. For example, with a lack of infrastructure to collect data, compute performance results, and report those results, it is more challenging to improve and sustain performance. The Committee hopes that more robust clinician-level data will be readily available in the near future.

Unintended Consequences of Overuse of Clinical Tests/Exams

The Committee discussed potential unintended consequences of overuse of testing and/or exams in the osteoporosis and diabetes care measures. The performance of bone density testing is addressed in the osteoporosis maintenance measures under review in this cycle. The Committee noted that if a provider does not find documentation of a bone density test or the patient does not recall having a test, then the provider may order the test again unnecessarily. However, Committee members commented that the testing would not be overused if it has been over two years since the last bone density test was performed. In addition, the Committee member commented that the overuse of bone density exams is relatively low in women with fractures. The Committee also commented that the upper age limits and appropriate exclusions in the measures are helpful in reducing inappropriate overuse of the tests. Overall, the Committee believed that the benefit of a bone density test outweighed the unintended consequences, and the test is cost effective.

Similarly, the Committee discussed the potential overuse of performing a retinal eye exam for the diabetic population. The Committee noted that this is an exam that can be performed every two years. However, if the provider is not aware that the exam occurred or does not receive results, the exam could potentially be overused. It was noted that receiving eye exam results can be particularly challenging because they often occur in retail optometry centers that are less likely to have formal data sharing than healthcare systems. Committee members also mentioned that it can be difficult to get

patients to come in for eye exams, as they need to have someone drive them after a dilated eye examination. Overall, the Committee believed that the benefit of the retinal eye exam for diabetic patients outweighed this unintended consequence.

"Topped Out" Clinical Quality Measures

For re-evaluation of previously endorsed measures, there is increased emphasis on current performance and opportunity for improvement. One of the must-pass criteria of the NQF endorsement process is data demonstrating considerable variation, or overall less-than-optimal performance, in the quality of care across providers. Performance rates help determine if there is still an identified healthcare gap in quality care to the patient population.

The Committee discussed when to deem a clinical quality measure to be at its maximum performance level (i.e., "topped out"). Some Committee members noted that performance gap rates of 50 to 60 percent could represent the maximum performance results expected of certain clinical quality measures. The Committee also noted the additional challenge of measures that are voluntarily reported, especially at the clinician level. Some of these measures have performance gap rates of above 90 percent, but Committee members and developers note that the measures likely do not reflect that the healthcare quality problem no longer exists.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Appendix A includes the details of the Committee's discussion and ratings of the criteria for each measure.

Osteoporosis

0037 Osteoporosis Testing in Older Women (OTO) (National Committee for Quality Assurance [NCQA]): Not Endorsed

Description: The percentage of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Instrument-Based Data

This process measure was originally endorsed in 2009. It assesses the number of women age 65-85 who report ever having received a bone density test to check for osteoporosis. The measure collects data through a mailed survey (Medicare Health Outcome Survey) with telephone follow-up to beneficiaries with Medicare Advantage health plans. The goal of the measure is to reduce the incidence of fracture in women who are identified to be at risk of an osteoporotic fracture. Evidence supports that bone mineral density tests in women 65 years of age and older predict short-term risk for osteoporotic fractures.

The measure did not pass the validity criterion—a must-pass criterion. The Committee indicated its strong support of measures that address osteoporosis testing. However, Committee members had several concerns with the validity of this measure. For example, the Committee questioned how asking a question in a survey to the patient/proxy will lead to a better health outcome. The Committee agreed that evidence supports screening for osteoporosis with a bone density test; however, the evidence does

not support the intervention of patient self-reporting of a bone density test. In addition, a patient representative on the Committee expressed that patient self-reporting will not have a direct impact on the patient (i.e., how will the survey benefit the patient?). Finally, the Committee acknowledged that the measure captures a large patient population at the health plan level; however, several Committee members had concerns about whether the patient/proxy recall about having had a bone density test is accurate, since no tests have validated the patient response.

0046 Screening for Osteoporosis for Women 65-85 Years of Age (NCQA): Endorsed

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

This process measure has been endorsed since 2007. It assesses the number of women 65-85 who have ever received a dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis. The measure looks for documentation that a DXA test was performed at the clinician level of analysis. The goal of the measure is to reduce the incidence of fracture in women who are identified to be at risk of an osteoporotic fracture. Evidence supports that bone mineral density tests in women 65 years of age and older predict short-term risk for osteoporotic fractures.

The Standing Committee recommended the measure for continued endorsement. The Committee indicated its strong support of measures that address osteoporosis screening. The Committee agreed that there is moderate evidence supporting osteoporosis screening. The Committee did express a feasibility concern for this measure when there is a change in healthcare providers. In response, a Committee member recommended that the measure be made available as an eCQM in the future. In addition, the Committee discussed that a potential unintended consequence of the measure could be overuse of a dual-energy x-ray absorptiometry (DXA) test. However, the Committee believed that the benefit of a DXA test outweighed this unintended consequence.

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

Description: The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Clinician: Individual, Integrated Delivery System; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

This process measure has been endorsed since 2009. It focuses on secondary prevention of fractures through appropriate diagnosis and treatment of osteoporosis. The goal of the measure is to reduce the incidence of future fractures.

The Standing Committee recommended the measure for continued endorsement. The Committee indicated its strong support of measures that address osteoporosis testing and management and agreed that there is moderate evidence supporting the measure. While the Committee noted overuse of a bone mineral density test could be a a potential unintended consequence of the measure, the Committee

believed that the benefit of the test outweighed this unintended consequence. In future updates to this measure, the Committee recommended that the developer clearly specify the types of fractures (i.e., trauma/emergent fractures) and remove them from the value code set, where appropriate. In addition, the Committee recommended that the exclusions be re-visited. Finally, the Committee hopes to see more robust data available on the measure at the clinician level of analysis, which is currently in use in the CMS Quality Payment Program.

Diabetes

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed (NCQA): Endorsed

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Paper Medical Records

This process measure has been endorsed since 2009. It aims to promote regular eye examinations in diabetic adults. Diabetic retinopathy and vision loss are complications from diabetes, and adults with diabetes who do not receive regular retinal examinations are at a higher risk for developing these vision complications. The Committee indicated its strong support of this measure addressing retinal eye exams for the diabetic population.

The Committee agreed that moderate evidence supports the measure. The Committee noted that overuse of a retinal eye exam could be a potential unintended consequence of the measure; however, the Committee believed that the benefit of the eye exam outweighed this unintended consequence. The Committee also noted that it can be challenging for primary care practitioners to receive eye exam reports when performed by other clinicians and/or vision centers. The Committee also recommended that the developer continue to monitor the emerging technologies of computer imaging processing and artificial intelligence, which may offer an alternative method of evaluating retinal exams in the future. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

0056 Diabetes: Foot Exam (NCQA): Endorsed

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Electronic Health Data, Paper Medical Records

This process measure has been endorsed since 2009. It aims to promote the performance of foot exams, leading to identification of improper foot care, treatment to prevent further damage to the foot, and improvement in diabetes complications and quality of life.

The Committee agreed that moderate evidence supports the measure. In addition, the performance gap continues to exist. Similar to the prior review in 2014, the Committee recommended that the developer

remove the upper age limit on the measure, as those over age 75 are at highest risk for lower limb complications. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (NCQA): Endorsed

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Paper Medical Records

This process measure has been endorsed since 2009. It aims to promote regular hemoglobin A1c (HbA1c) testing in diabetic adults. The testing of HbA1c levels is an important component of diabetes treatment and care. The results of testing aid clinicians in providing patients with optimal treatment and can lead to the prevention of diabetes compilations that would impact quality of life.

The Committee agreed that moderate evidence supports the measure. While performance rates are relatively high, the Committee believed the benefits that result from using the measure are much greater than the unintended consequences that would result from its retirement. The Committee agreed that lower impact process measures may pose an issue in the future. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

0062 Comprehensive Diabetes Care: Medical Attention for Nephropathy (NCQA): Endorsed

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or monitoring test or had evidence of nephropathy during the measurement year; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Other, Paper Medical Records

This process measure has been endorsed since 2009. It aims to promote regular screening and monitoring of nephropathy in diabetic adults. Kidney disease is a major complication of diabetes, and early screenings for people at risk of developing chronic kidney disease can help delay its onset. The Committee agreed that moderate evidence supports the measure.

The Committee expressed concerns regarding the numerator's inclusions. There was intitally concern about the numerator's inclusion of patients on angiotensin converting enzyme inhibitors (ACEI) or angiotensin-receptor blockers (ARB) being noted as sufficient screening for nephropathy. A patient could be on these medications for a condition other than nephropathy, such as hypertension. The Committee concluded that most practitioners would be monitoring nephropathy for individuals on these medications and agreed that the measure meets the reliablity and validity criteria. The Committeee did note that depending on the electronic health record, the information required to collect the data for this measure may not exist in defined data fields. The Committee agreed that the measure is moderately feasible to implement. Overall, the Committee agreed that this is an important measure and voted to recommend it for continued endorsement.

Measures Withdrawn from Consideration

Six measures previously endorsed by NQF were not re-submitted for maintenance of endorsement and have been withdrawn during the endorsement evaluation process. Endorsement for these measures has been removed.

Table 3. Measures Withdrawn from Consideration

Measure	Reason for withdrawal
0045 Communication with the Physician or Other Clinician Managing on-Going Care Post Fracture for Men and Women Aged 50 Years and Older	The measure developer withdrew this measure from endorsement consideration because it is no longer in use. NQF removed endorsement.
0519 Diabetic Foot Care and Patient Education Implemented	The measure developer withdrew this measure from endorsement consideration because it is no longer in use and is determined to no longer be reliable and/or valid by the developer. NQF removed endorsement.
2416 Laboratory Investigation for Secondary Causes of Fracture	The measure developer withdrew this measure from endorsement consideration because it is no longer in use. NQF removed endorsement.
2417 Risk Assessment/Treatment After Fracture	The measure developer withdrew this measure from endorsement consideration because it is no longer in use. NQF removed endorsement.
2467 Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus	The measure developer withdrew this measure from endorsement consideration because it is no longer in use. NQF removed endorsement.
2468 Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus	The measure developer withdrew this measure from endorsement consideration because it is no longer in use. NQF removed endorsement.

References

1 HealthPayerIntelligence. Top 10 most expensive chronic diseases for healthcare payers. https://healthpayerintelligence.com/news/top-10-most-expensive-chronic-diseases-for-healthcare-payers. Published July 19, 2017. Last accessed July 2018.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Endorsed Measures

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

Submission | **Specifications**

Description: Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis.

Numerator Statement: The number of women who have documentation in their medical record of having received a DXA test of the hip or spine.

Denominator Statement: Women age 65-85.

Exclusions: Diagnosis of osteoporosis at the time of the encounter.

Patient receiving hospice services anytime during the measurement period.

Adjustment/Stratification: No risk adjustment or risk stratification

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

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Data, Electronic Health Records, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/21/2018

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-14; M-6; L-0; I-0**; 1b. Performance Gap: **H-0; M-18; L-1; I-1**

Rationale:

- Overall, the Committee agreed that the draft US Preventative Services Task Force Recommendation (2018) supported screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women age 65 years and older.
- Performance data extracted from Physician Quality Reporting System (PQRS) suggest a persistent performance gap. The mean performance rates for the years 2009-2012 ranged from 55.1% to 61.2%. In 2012, 505,070 eligible providers (6.1%) chose to report on this measure.
- The Committee expressed concern that this measure's last performance data are from 2012 and they would prefer to see more current data.
- The Committee did not express any major concerns with the disparities data on osteoporosis screening in women.

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

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

2a. Reliability: **H-0; M-20; L-0; I-0**; 2b. Validity: **H-N/A; M-20; L-0; I-0**

<u>Rationale</u>:

- A Committee member was concerned that the measure is excluding the long-term, institutionalized population.
- Another Committee member recommended that exclusions, such as the palliative care population, could potentially be added in the future.
- The Committee determined that the measure specifications were precise, and the specifications were consistent with the evidence presented.
- The measure was tested prior to the 2014 maintenance review for reliability of the critical data elements using the inter-abstractor method. The developer did not submit updated reliability testing. The Committee concluded the measure was reliable with a numerator kappa score of 0.77, indicating there is substantial agreement.
- The measure is not tested for empirical validity. The developer provided face validity testing and justification for no empirical validity testing, noting that the only available data for this measure are from reporting in the CMS Quality Payment Program (QPP), however these data are not constructed in a way that allowed the developer to test empirical validity of the measure.
- The Committee accepted the developer's justification for lack of empirical validity testing and agreed with the face validity methodology and results for the measure. Face validity was assessed with several panels of experts from diverse backgrounds. The panel of experts concluded with good agreement that the measure as specified is measuring what it intends to measure and that the results of the measurement allow users to make the correct conclusions about the quality of care that is provided and will accurately differentiate quality across providers.

3. Feasibility: H-0; M-20; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee noted a potential challenge to measurement at the clinician level when a patient changes healthcare providers or health plan. In response, a Committee member recommended that the measure should be made available as an electronic clinical quality measure (eCQM) in the future.
- Overall, the Committee agreed that the data elements are routinely generated, used during care delivery and the measure is moderately feasible to implement.

4. Use and Usability: <u>The measure meets the Use and Usability criteria</u>

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-20; No Pass-0;** 4b. Usability: **H-1; M-18; L-0; I-1**

<u>Rationale</u>:

- The measure is used in the QPP, which is a public reporting/accountability program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).
- Overall, the Committee agreed with a moderate rating for usability of the measure. The measure has demonstrated a slight improvement in performance rates by 2.6% from 2009-2012, and there is still opportunity for more improvement.
- Committee members expressed usability concerns, noting that the measure specifications could lead to a potential unintended consequence of overuse of a DXA test. However, the Committee concluded that the benefits from having the test outweighed the consequences of potential extra screenings.

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5. Related and Competing Measures

- This measure is related to 0053: Osteoporosis Management in Women Who Had a Fracture.
- Measure 0053 was identified as related to measure 0046, as both involve bone density testing. However, following the review of the specifications for measures 0046 and 0053, the Committee believed that the two measures have significant differences in the measure focus and target population. Measure 0053 addresses women who have experienced a fracture and are focused on secondary prevention of future fractures as opposed to measure 0046, which addresses screening for osteoporosis. The Committee also discussed the denominator age range for the two measures and agreed that both appropriately address different age ranges and cannot be aligned. As a result, the Committee agreed the two measures are already harmonized to the extent possible.

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6. Standing Committee Recommendation for Endorsement: **Yes-20; No-0**

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7. Public and Member Comment

- NQF received two post-evaluation comments supporting the Committee's decision to recommend the measure. One comment simply supported the measure. While the other commenter supported the measure, they shared several recommendations concerning the measure specifications. The commenter expressed concern that implementation of the measure could promote the overuse of screening. In addition, the commenter made recommendations to improve the denominator, including incorporating additional ICD 10 codes and expanding the denominator exclusions to include patients who have already been assessed with the FRAX tool and patient refusal.

  Measure Steward/Developer Response

  Thank you for this comment. With regard to concerns about overuse of screening due to poor record continuity, the numerator allows for documentation in the medical record of the patient ever having received a DXA test of the hip or spine. Providers should get a patient's test history (and any associated reports with results) before ordering a DXA test. Documenting such results from prior tests counts for meeting the numerator, and the provider would not need to perform another DXA. While some women are at lower risk of developing osteoporosis due to identifiable patient factors, the USPSTF recommends all women over the age of 65 (regardless of individual patient factors) be

screened for osteoporosis, and the measure aligns with this recommendation statement. NCQA will explore appropriateness and feasibility of counting a FRAX tool assessment as meeting the numerator for this measure. Member refusals of screening are not valid exclusions. Therefore, these members should remain in the measure denominator if they meet criteria. It is anticipated that the impact of these members is relatively low and would not result in bias when comparing results across providers. NCQA will review and consider including G0438 and G0439 as eligible encounters for the measure. If recommended by our measurement advisory panels we will update the specifications to include these codes during the measure's annual NQF update.

- The Committee reviewed the comments and developer's response during the September 25, 2018 Post-Comment Web Meeting. The Committee agreed with the developer that patient refusal can be an issue but also acknowledged the challenge of excluding patients from measures due to refusal. The Committee discussed the overuse issue and agreed it is a valid concern but believed that the benefit of dual-energy x-ray absorptiometry (DXA) scan outweighs potential overuse issues. They also suggested inclusion of additional tests (quantitative CT). The developer stated they will specifically look at the feedback received from the Committee and commenters during their currently on-going re-evaluation of the measure, and the Committee agreed this is an acceptable response. The Committee maintained the decision to recommend re-endorsement.

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8. Consensus Standards Approval Committee (CSAC) Vote (October 23, 2018): Yes-17; No-0

Decision: Approved for continued endorsement.

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9. Appeals

No appeals were received.

0053 Osteoporosis Management in Women Who Had a Fracture

Submission | **Specifications**

Description: The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.

Numerator Statement: Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis after a fracture occurs.

Denominator Statement: Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure:

Women age 50-64

Women age 65-85

Women age 50-85

Exclusions: - Exclude women who had a bone mineral density test during the 24 months prior to the index fracture.

- Exclude women who had a claim/encounter for osteoporosis treatment during 12 months prior to the index fracture.

- Exclude women who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the index fracture.

- Exclude women who are enrolled in a Medicare Institutional Special Needs Plan (I-SNP) or living long-term in an institution any time during the measurement year.

- Exclude women receiving hospice care during the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/21/2018

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-3; M-16; L-0; I-0**; 1b. Performance Gap: **H-7; M-12; L-0; I-1**

Rationale:

- Overall, the Committee agreed that the American Association of Clinical Endocrinologists guidelines (2016) supported the measure intent for bone density testing for women aged 65 and older and younger postmenopausal women at increased risk for bone loss and fracture.
- One Committee member noted that the evidence of the draft US Preventive Services Task Force Recommendation (2018) is focused on primary prevention whereas this measure intent is secondary prevention.
- Performance data extracted from Healthcare Effectiveness Data and Information Set (HEDIS) data suggest a persistent performance gap. The mean performance rates for the years 2014-2016 for Medicare Advantage Health Plans ranged from 35.9% to 40%.
- Performance data extracted from Physician Quality Reporting System (PQRS) data suggest a persistent performance gap. The mean performance rates for the years 2009-2012 ranged from 56.5% to 70.6%. In 2012, 204,369 eligible providers (0.8%) chose to report on this measure. The Committee noted the low reporting by eligible providers on this measure in PQRS, however, the Committee is aware that it is a voluntary reporting program.
- The Committee did not express any major concerns with the disparities evidence on osteoporosis screening and treatment.

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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-0; M-19; L-0; I-0**; 2b. Validity: **H-N/A; M-16; L-2; I-1**

Rationale:

- The Committee determined that the measure specifications were precise, and the specifications were consistent with the evidence presented.
- One Committee member noted that fracture types are not clearly specified (i.e. trauma/ emergent fractures). The developer noted this recommendation and will review it and remove from the value code set in future updates, where appropriate.
- The measure was tested for reliability at the measure score level using the beta binomial method (ratio of signal to noise) at for health plan analysis. The developer did not submit updated reliability testing. Generally, a minimum reliability score of 0.7 is used to indicate sufficient signal strength to discriminate performance between accountable entities. This measure had an overall reliability score of 0.92 from 2012 HEDIS data.
- The measure was also tested prior to the 2014 maintenance review for reliability of the critical data elements using the inter-abstractor method for the clinician level of analysis. The Committee concluded the measure was reliable with a numerator kappa score of 0.47, indicating there is moderate agreement.
- The measure is not tested for empirical validity at the clinician level of analysis. The developer provided face validity testing and a justification for no empirical validity testing, noting that the only available data for this measure are from reporting in the CMS Quality Payment Program (QPP) and these data are not constructed in a way that allowed the developer to test empirical validity of the measure. Face validity was assessed with several panels of experts from diverse backgrounds. The panel of experts concluded that the measure as specified is measuring what it intends to measure and that the results of the measurement allow users to make the correct conclusions about the quality of care that is provided and will accurately differentiate quality across providers.
- The measure was tested prior to the 2014 maintenance review for empirical validity at the health plan level of analysis. The developer tested validity by exploring whether performance for the measure correlated with a similar measure, using the Pearson correlation test. The results indicate a p-value less than 0.05, confirming a correlation (although weak) with the similar measure.
- The Committee expressed concern that the measure currently excludes long-term, institutionalized populations. The Committee believed that the developer should revisit exclusions in future updates to the measure. Specifically, the Committee discussed the addition of the palliative care population as an exclusion in future updates to the measure.
- The Committee agreed with the NQF staff preliminary ratings of moderate for reliability and validity. The Committee accepted the developer's justification for lack of empirical validity testing and agreed with the face validity methodology and results for the measure at the clinician level of analysis.

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3. Feasibility: H-0; M-15; L-4; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Overall, the Committee agreed that the data elements are routinely generated, used during care delivery and the measure is moderately feasible to implement.

4. Use and Usability: <u>The measure meets the Use and Usability criteria</u>

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-19; No Pass-0;** 4b. Usability: **H-0; M-17; L-1; I-1**

<u>Rationale</u>:

- The measure is used for both public reporting and in accountability programs. The developer described seven current accountability uses of the measure. The Committee had no concerns about the use of the measure.
- Committee members expressed concern with usability that the measure specifications could lead to a potential unintended consequence of overuse of a DXA test. However, the Committee concluded that the benefits from having the test outweighed the consequences of potential extra screenings.
- The Committee was supportive of the developer expanding the current exclusions (such as the addition of a palliative care population) in a future iteration of the measure.
- The Committee hopes the measure will be updated with more robust clinician level data, which is currently in use in the QPP.
- Overall, the Committee agreed with a moderate rating for usability of the measure. The measure has demonstrated a slight improvement in performance rates at both the health plan and clinician level, and there is still opportunity for more improvement.

5. Related and Competing Measures

- This measure is related to 0046: Screening for Osteoporosis for Women 65-85 Years of Age.
- Measure 0046 was identified as related to measure 0053, as both involve bone density testing. However, following the review of the specifications for measures 0046 and 0053, the Committee believed that both measures have significant differences in the measure focus and target population. Measure 0053 addresses women who have experienced a fracture and are focused on secondary prevention of future fractures as opposed to measure 0046, which addresses screening for osteoporosis. The Committee also discussed the denominator age range for the two measures and agreed that the two measures appropriately address different age ranges and cannot be aligned. As a result, the Committee agreed the two measures are already harmonized to the extent possible.

6. Standing Committee Recommendation for Endorsement: **Yes-19; No-0**

7. Public and Member Comment

- NQF received two post-evaluation comments supporting the Committee's decision to recommend the measure. One comment simply supported the measure. While the other commenter supported the measure, they expressed concern that implementation of the measure could promote the overuse of bone mineral density testing. The commenter recommended that the developer expand the denominator exclusion to include women with fracture related to traumatic injury and consider revising the fracture definition to only include women with vertebral and hip fractures.

Measure Steward/Developer Response
Thank you for this comment and suggestion. The intent of this measure is secondary prevention of future fragility fractures. The measure does not include fractures that are likely due to trauma (such as fractures of the finger, toe, face or skull). Further, the measure does not require a bone mineral density (BMD) test be performed after the fragility fracture as the measure also allows the provider to go directly to treatment if they do not think a BMD test will alter the diagnosis/course of treatment. To help address the concern about overuse of BMD testing, the measure has an exclusion which removes patients who received a BMD test in the 2 years prior to the fracture. NCQA is currently taking this measure through our HEDIS reevaluation process. We are reviewing the fracture codes included in this measure and will consider if further limiting the facture codes would help address the concern about overuse. Any proposed changes to the measure will be brought to our measurement advisory panels for feedback. If changes are recommended by the panels and approved by NCQA's Committee on Performance Measurement, the specification will be updated during the measure's annual NQF review.

- The Committee reviewed the comments and developer's response during the September 25, 2018 Post-Comment Web Meeting. Committee members recommended not to expand the denominator exclusions to the measure due to concerns over losing a large cohort of women if the definition of fractures was limited to vertebral and hip fractures. The Committee maintained the decision to recommend re-endorsement.

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8. Consensus Standards Approval Committee (CSAC) Vote (October 23, 2018): Yes-17; No-0

Decision: Approved for continued endorsement.

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9. Appeals

No appeals were received.

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Submission | **Specifications**

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

Numerator Statement: Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following:

-a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year

–a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

-Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

For exams performed in the year prior to the measurement year, a result must be available.

Denominator Statement: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):

-Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year

-Exclude patients 65 and older with an advanced illness condition and frailty

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Health Plan, Clinician : Individual

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/21/2018

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-4; M-16; L-0; I-0**; 1b. Performance Gap: **H-8; M-12; L-0; I-0**

Rationale:

- The Committee agreed that the updated evidence presented from clinical practice guidelines from the American Diabetes Association (2018), the American Academy of Ophthalmology (2017), and the American Geriatrics Society (2013) supported the measure intervention, as the performance of retinal exams leads to identification and/or maintenance of diabetic retinopathy and improvement in quality of life.
- Performance data extracted from Healthcare Effectiveness Data and Information Set (HEDIS) data suggest that a majority of adults with diabetes do not receive annual eye exams and performance levels for this measure are low. Performance rates for the years 2014-2016 are as follows: commercial mean rate: 50.5%-52.6%; Medicare mean rate: 68.5%-70.2%; Medicaid mean rate: 54.4%-54.9%. Additional performance data provided by the developer included NCQA's Diabetes Recognition Program (DRP) from 2015-2017: 61.4%-62.8%; and 2015 Physician Quality Reporting System (PQRS) reporting year: 78.1%.
- To support evidence of disparities, Committee members noted that many studies have demonstrated that underserved and poorer populations have less good control of their diabetes mellitus and that control is a key driver of retinopathy progression and severity.

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

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

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

<u>Rationale</u>:

- The Committee determined that the measure specifications were precise and the specifications were consistent with the evidence presented. One committee member recommended expanding the denominator population to include those less than 65 years old in the future.
- The measure was tested for reliability at the level of the measure score using the beta binomial method. The Committee concluded the measure was reliable, as the majority of reliability ratings for the different health plans and physicians were greater than 0.8.
- The Committee agreed with the NQF staff preliminary ratings of moderate for both the reliability and validity criteria and did not pursue further discussion.

3. Feasibility: H-1; M-19; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee noted a potential challenge to measurement at the provider level because data may not be readily available as a result of patients visiting different providers for the eye exam or using vision benefits instead of their regular health insurance for the exam.
- Overall, the Committee agreed that the data elements are routinely generated, used during care delivery and the measure is moderately feasible to implement.

4. Use and Usability: <u>The measure meets the Use and Usability criteria</u>

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-20; No Pass-0;** 4b. Usability: **H-0; M-19; L-0; I-1**

<u>Rationale</u>:

- The measure is used for both public reporting and in accountability programs. The developer described seven current accountability uses of the measure. The Committee had no concerns about the use of the measure.
- Committee members expressed concern that the measure specifications require the exam to be performed too frequently, leading to overuse of a retinal eye exam. However, the Committee concluded that the benefits from having the exam outweighed the consequences of potential extra screenings.
- Overall, the Committee agreed with a moderate rating for usability of the measure. Committee members noted that although the measure has demonstrated a slight improvement in performance for Medicare plans, a slight decline for commercial plans, and no change for Medicaid plans over the past three years, there is still opportunity for more improvement.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-20; No-0**

7. Public and Member Comment

- NQF received two post-evaluation comments supporting the Committee's decision to recommend the measure. One comment simply supported the measure. While the other commenter also supported the measure, they expressed concern that implementation of the measure could promote overuse of retinal eye exams, if a physician cannot obtain confirmation of a previous eye exam during the calendar year. The commenter also raised concerns that the use of the measure will increase physician burden and suggested claims evidence be accepted for documentation requirements. The commenter noted that CMS has proposed the removal of this measure from Medicare Shared Savings Program. In addition, the commenter made recommendations to expand the denominator population to include all patients over the age of 18 years.

  Measure Steward/Developer Response
  Thank you for this comment. This measure is intended for the broad population of patients with diabetes and aligns with current clinical guideline recommendation from the American Diabetes Association. The measure as specified assesses annual eye exams unless a negative result was found in the year prior, allowing those with no finding of retinopathy to have an exam every other year.

- The Committee reviewed the comments and developer's response during the September 25, 2018 Post-Comment Web Meeting. A Committee member agreed there are challenges in capturing the data for this measure, as patients can go to many different locations for the eye exam (not just ophthalmologists) and noted that claims data would be more effective. Related, Committee members also noted issues with penalizing performance of one provider based on acquiring data from another provider. The developer explained that providers are incentivized as part of Merit-based Incentive Payment System (MIPS) and also noted that the health plan level of analysis allows both claims data and medical documentation but does not allow verbal patient report of eye exam. Further, the developer noted the concerns and stated they will work to improve the feasibility issues at the physician level. The Committee was satisfied with the developer's response and willingness to work on the feasibility issues of the measure. The Committee maintained the decision to recommend re-endorsement.

8. Consensus Standards Approval Committee (CSAC) Vote (October 23, 2018): Yes-17; No-0

Decision: Approved for continued endorsement.

9. Appeals

No appeals were received.

0056 Comprehensive Diabetes: Foot Exam

Submission | **Specifications**

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

Numerator Statement: Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period.

Denominator Statement: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year.

Exclusions: -Patients with a diagnosis of secondary diabetes due to another condition (e.g. a diagnosis of gestational or steroid-induced diabetes)

-Patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period.

-Exclude patients who were in hospice care during the measurement year

Adjustment/Stratification: No risk adjustment or risk stratification

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

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/21/2018

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-20; L-0; I-0**; 1b. Performance Gap: **H-5; M-15; L-0; I-0**

Rationale:

- The Committee agreed that the updated evidence presented from clinical practice guidelines from the American Diabetes Association (2018) and the American Geriatrics Society (2013) supported the measure intervention, as the performance of foot exams leads to identification of improper foot care, treatment to prevent further damage to the foot, and improvement in diabetes complications and quality of life.
- The developer provided performance data for NCQA's Diabetes Recognition Program (DRP) from 2015, 2016, and 2017. The mean ranged from 71.7%-75.2%. The developer also provided performance data from the 2015 PQRS reporting year with a mean of 56.3%. The Committee agreed that the results indicated a continued opportunity for improvement.
- The developer did not provide disparities data for the measure but cited the Centers for Disease Control and Prevention data (2010) that examined diabetic adults that received a foot exam in a given year. The data was categorized based on race/ethnicity, age, sex, and education level. The Committee agreed that the data show variation in performance rates between subpopulations and reflect disparities in care.

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-20; M-; L-; I-**; 2b. Validity: **H-7; M-13; L-0; I-0**

<u>Rationale</u>:

- The measure was tested for reliability at the level of the measure score using the beta binomial method. The Committee concluded the measure was reliable, as the majority of reliability results were above .90.
- The measure was tested for validity using a Pearson correlation test. The Committee agreed that testing results showed relevant association with other measures of quality in NCQA's DRP, which NCQA hypothesized to be related measures in the DRP and that the measure has sufficient validity. Face validity was also assessed with several panels of experts from diverse backgrounds. The panel of experts concluded with good agreement that the measure as specified is measuring what it intends to measure and that the results of the measurement allow users to make the correct conclusions about the quality of care that is provided and will accurately differentiate quality across providers.
- Committee members stated concern that the upper age limit of 75 specified in the denominator was not justified by the evidence and recommended that the developer remove the upper age limit. The developer recognized the Committee's concern, but noted that this measure is part of a bundle and therefore the age limit has been standardized across measures.

3. Feasibility: H-2; M-12; L-6; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee expressed concern that currently there is no common data element that collects the information in the form of structured data without requiring extra work for the clinician. Members noted that the measure requires three actions to occur in order to meet the requirements of the measure, which may create confusion regarding proper documentation. Some members believed this may result in difficulties extracting accurate data.
- Ultimately the Committee agreed that the measure was feasible to implement, as the measure has already been in use and the data elements necessary to compute the measure score are generated during care and are easily captured.

4. Use and Usability: <u>The measure meets the Use and Usability criteria</u>

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-20; No Pass-0;** 4b. Usability: **H-1; M-19; L-0; I-0**

<u>Rationale</u>:

- The measure is currently used in NQCA's DRP and in the CMS Quality Payment Program (QPP).
- According to the developer, performance rates have stayed stable, despite a decrease in the number of reporting physicians seeking recognition in the NCQA's DRP since 2015. The

Committee acknowledged that there has been little improvement in performance of the measure over time.

- The Committee agreed that there is room for performance improvement, and that the measure does not present unintended consequences to individuals or populations.

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5. Related and Competing Measures

- This measure is competing with measure 0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation. The developer noted differences between measures 0056 and 0417 in that measure 0056 identifies adults with diabetes (age 18-75) who had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year. In addition, data sources vary for these two measures. Measure 0056 is specified for paper medical records, administrative claims and electronic clinical data while measure 0417 is specified for administrative claims only.
- 0417 was not reviewed in this current cycle and will undergo maintenance review in the upcoming Fall 2018 cycle. The Committee will not be charged with selecting a best-in-class measure during the current review cycle. During a discussion about the two competing measures, some committee members believed strongly that the measures address a common measure focus and should be harmonized, while other committee members believed that the measures fulfill different purposes and target different clinicians, and therefore should not be harmonized. One Committee member would like measure 0056 to include patients with dementia as a denominator exclusion, which is already present in the specification for 0417. Another Committee member noted that while 0417 requires an extensive lower extremity neurological examination, it was unsure clear whether there was evidence supporting that clinical practice. Overall, the Committee agreed that no final recommendations can be made on harmonization or selection of best-in-class of the two measures until 0417 undergoes NQF's measure evaluation maintenance review in the Fall 2018 cycle.

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6. Standing Committee Recommendation for Endorsement: **Yes-19; No-0**

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7. Public and Member Comment

- NQF received two post-evaluation comments. One comment supports the Committee's recommendations to re-endorse the measure. The other comment does not support the Committee's decision to recommend the measure due to several concerns. The commenter noted a lack of evidence to support the benefits of regular pulse exams and raised concerns that implementation of the measure could promote the overuse of Ankle Brachial Index and procedures for peripheral arterial disease. The commenter recommended that the developer make several revisions to the specifications.

  Measure Steward/Developer Response

  Thank you for this comment. This measure is aligned with the evidence and current clinical guideline recommendation from the American Diabetes Association.
- The Committee reviewed the comments and developer's response during the September 25, 2018 Post-Comment Web Meeting. The Committee agreed that they understand the concerns,

but the measure aligns with the ADA guidelines. The Committee maintained the decision to recommend re-endorsement.

8. Consensus Standards Approval Committee (CSAC) Vote (October 23, 2018): Yes-17; No-0

Decision: Approved for continued endorsement.

9. Appeals

No appeals were received.

0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

Submission | **Specifications**

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

Numerator Statement: Patients who had an HbA1c test performed during the measurement year.

Denominator Statement: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):

-Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/21/2018

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-5; M-14; L-0; I-0**; 1b. Performance Gap: **H-4; M-15; L-0; I-0**

Rationale:

- The Committee agreed that the updated evidence presented from clinical practice guidelines from the American Diabetes Association (2018), the American Geriatrics Society (2013), and

systematic review from VA/DoD (2010) supported the measure. While this measure focuses on HbA1c testing, the Committee acknowledged the presence of new guidelines from the American College of Physicians related to HbA1c targets in certain populations.

- The Developer provided performance data extracted from Healthcare Effectiveness Data and Information Set (HEDIS) data from 2014 to 2016. The mean performance rates ranged from 89.42% to 89.91% for commercial plans, 86.31 % to 86.66% for Medicaid, and 92.72% to 93.54% for Medicare.
- The developer did not provide disparities data but cited the Centers for Disease Control and Prevention data (2010) that examined diabetic adults that received two or more HbA1c tests within the last year. The data were categorized based on race/ethnicity, age, sex, and education level. The Committee agreed that the data show variation in performance rates between subpopulations and reflect disparities in care.

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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-3; M-16; L-0; I-0**; 2b. Validity: **H-5; M-14; L-0; I-0**

<u>Rationale</u>:

- The Committee determined that the measure specifications were precise and the specifications were consistent with the evidence presented.
- The measure was tested for reliability at the measure score level using the beta binomial method. The Committee concluded the measure was reliable, as the majority of reliability ratings for the different health plans were greater than 0.96.
- The measure was tested for validity using a Pearson correlation test. The Committee agreed that testing results showed relevant association with other measures of quality in NCQA's Diabetes Recognition Program (DRP), which NCQA hypothesized to be related measures in the DRP and that the measure has sufficient validity. Face validity was also assessed with several panels of experts from diverse backgrounds. The panel of experts concluded with that the measure as specified is measuring what it intends to measure and that the results of the measurement allow users to make the correct conclusions about the quality of care that is provided and will accurately differentiate quality across providers.
- The Committee agreed with the NQF staff preliminary ratings of moderate for both the reliability and validity criteria and did not pursue further discussion.

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3. Feasibility: H-15; M-4; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee noted that the data for this measure are easily captured through structured fields from lab results.
- Overall, the Committee agreed that the data elements are routinely generated, used during care delivery and the measure is highly feasible to implement.

4. Use and Usability: <u>The measure meets the Use and Usability criteria</u>

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-19; No Pass-0;** 4b. Usability: **H-10; M-5; L-3; I-0**

<u>Rationale</u>:

- The measure is used for both public reporting and in accountability programs. The developer described seven current accountability uses of the measure. The Committee had no concerns about the use of the measure.
- A Committee member did note that the performance scores for this measure may soon become topped out and inquired if this measure is still a good assessment of quality. Other Committee members believed that while the performance scores are relatively high and the measure may become topped out in the future, there is still great value in this measure. The measure is easily collectible and also helps to identify patients on a practice-level with gaps in care.
- The Committee agreed that there are many benefits from using this measure and that many unintended consequences could result from its retirement.
- A Committee member did note that there is increasing resistance in the field for lower impact process measures and that this could pose an issue in the future.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: Yes-**18**; No-**0**

7. Public and Member Comment

- NQF received two post-evaluation comment supporting the Committee's decision to recommend the measure. One comment simply supported the measure. The second comment made recommendations to enhance the measure to target patients who have a diagnosis of diabetes and are engaged with the clinician. The commenter stated that the measure as currently specified favors larger health systems.

  Measure Steward/Developer Response

  Thank you for this comment. As noted, this measure is aligned with current clinical guideline recommendations from the American Diabetes Association. With regard to HbA1c results from ED admissions, the measure does not explicitly allow that. However, NCQA will evaluate whether that is an issue with the current specification during the next re-evaluation of the measure.
- The Committee reviewed the comments and developer's response during the September 25, 2018 Post-Comment Web Meeting. The Committee did not have any concerns with either the comment or the developer's response. The Committee maintained the decision to recommend re-endorsement.

8. Consensus Standards Approval Committee (CSAC) Vote (October 23, 2018): Yes-17; No-0

CSAC Decision: Approved for continued endorsement

9. Appeals

No appeals were received.

0062 Comprehensive Diabetes Care: Medical Attention for Nephropathy

Submission | **Specifications**

Description: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or monitoring test or had evidence of nephropathy during the measurement year.

Numerator Statement: Patients receiving a nephropathy screening or monitoring test or having evidence of nephropathy during the measurement year

Denominator Statement: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):

-Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year

-Exclude patients 65 and older with an advanced illness condition and frailty

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Health Plan, Clinician : Individual

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Other, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/21/2018

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

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-18; L-0; I-0**; 1b. Performance Gap: **H-0; M-18; L-0; I-0**

Rationale:

- The Committee agreed that the updated evidence presented from clinical practice guidelines from the American Diabetes Association (2018) the American Geriatrics Society (2013), and the

American Association of Clinical Endocrinologists (2015) supported the link between nephropathy screening and improvement in diabetes complications and quality of life.

- The Developer provided performance data extracted from Healthcare Effectiveness Data and Information Set (HEDIS) data from 2014 to 2016. The mean performance rates ranged from 83.0% to 89.1% for commercial plans, 80.9 % to 89.9% for Medicaid, and 91.5% to 95.6% for Medicare.
- The developer did not provide disparities data but cited the Centers for Disease Control and Prevention data (2008) that report the incidence of end stage renal disease (ESRD). The data were categorized based on race/ethnicity, age, sex, and education level. The Committee agreed that the data show variation in performance rates between subpopulations and reflect disparities in care.

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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-10; M-8; L-0; I-0**; 2b. Validity: **H-1; M-16; L-1; I-0**

<u>Rationale</u>:

- The Committee had questions about the numerator's inclusion of patients on angiotensin converting enzyme inhibitors (ACEI) or angiotensin-receptor blockers (ARB) being noted as sufficient screening for nephropathy. A patient could be on these medications for a condition other than nephropathy. The Committee concluded that most practitioners would be monitoring nephropathy for individuals on these medications.
- The Committee had questions about the numerator's inclusion of patients with end stage renal disease or those utilizing renal replacement therapy. Members were concerned that this inclusion would not accurately reflect the quality of care for patients at risk for nephropathy. The Committee discussed the purpose of this measure and clarified that this measure focuses solely on whether patients are being evaluated for nephropathy. The management of care quality should be captured in a different measure. The developer also noted that this measure is used as part of a bundle of measures to assess overall diabetes care quality.
- A Committee member suggested for future development that glomerular filtration rate (GFR) be included in the numerator. The developer is working with the National Kidney Foundation on measures in this area.
- The measure was tested for reliability at the level of the measure score using the beta binomial method. The Committee concluded the measure was reliable, as the majority of reliability ratings for the different health plans and physicians were greater than 0.9.
- The measure was tested for validity using a Pearson correlation test. The Committee agreed that testing results showed relevant association with other measures of quality in NCQA's Diabetes Recognition Program (DRP), which NCQA hypothesized to be related measures in the DRP and that the measure has sufficient validity. Face validity was also assessed with several panels of experts from diverse backgrounds. The panel of experts concluded with good agreement that the measure as specified is measuring what it intends to measure and that the results of the measurement allow users to make the correct conclusions about the quality of care that is provided and will accurately differentiate quality across providers.

3. Feasibility: H-5; M-13; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee noted a potential challenge to measurement since dialysis is often not done in the provider's office, the information related to dialysis treatment needed for this measure is often captured within a different system.
- Overall, the Committee agreed that the data elements are routinely generated, used during care delivery and the measure is moderately feasible to implement.

4. Use and Usability: The measure meets the Use and Usability criteria

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-18; No Pass-0;** 4b. Usability: **H-10; M-8; L-0; I-0**

Rationale:

- The measure is used for both public reporting and in accountability programs. The developer described seven current accountability uses of the measure. The Committee had no concerns about the use of the measure.
- The Committee did not have any questions or comments on Usability.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-18; No-0**

7. Public and Member Comment

- NQF received two post-evaluation comment supporting the Committee's decision to recommend the measure. One comment simply supported the measure. While the other comment also supported the measure, they recommended that the developer expand the denominator exclusion to include patients with dementia and in hospice/palliative care. The commenter also expressed concern about using test results from emergency department (ED) admissions which potentially could induce action on false positive results. Finally, the commenter expressed concern with the high performance rate.

  Measure Steward/Developer Response

  Thank you for this comment. NCQA will consider the appropriateness of exclusions for dementia and patients with life limiting diagnoses during the next re-evaluation of the measure. Please note that the measure currently does exclude patients receiving hospice care. With regard to test results from ED admissions, the measure does not explicitly allow that. However, NCQA will also evaluate whether that is an issue with the current specification during the next re-evaluation of the measure.

- The Committee reviewed the comments and developer's response during the September 25, 2018 Post-Comment Web Meeting. The Committee did not have additional comments and appreciated the developer's willingness to consider the commenter's recommendations the next time their advisory panels review the measure. The Committee maintained the decision to recommend re-endorsement.

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8. Consensus Standards Approval Committee (CSAC) Vote (October 23, 2018): Yes-17; No-0

Decision: Approved for continued endorsement.

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9. Appeals

No appeals were received.

Measure Not Endorsed

0037 Osteoporosis Testing in Older Women (OTO)

Submission

Description: The percentage of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis.

Numerator Statement: The number of women who report having ever received a bone mineral density test of the hip or spine.

Denominator Statement: Women age 65-85.

Exclusions: Women who received hospice care during the year.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Instrument-Based Data

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/21/2018

1. Importance to Measure and Report: Consensus was not reached on the Evidence criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-6; L-2; I-12**; 1b. Performance Gap: **H-0; M-14; L-0; I-6**

Rationale:

- The Committee overall agreed that the draft US Preventive Services Task Force Recommendation (2018) supported screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women age 65 years and older.
- However, Committee members raised concern about how asking a question in a survey to the patient/proxy will lead to a better health outcome and that the intervention of patient self-reporting of a bone density test is not supported by the evidence.
- One Committee member noted there is no evidence to support that self-awareness of osteoporosis screening adds value to the patients.
- Performance data extracted from Healthcare Effectiveness Data and Information Set (HEDIS) data suggest a persistent performance gap. The mean performance rates for the years 2013-2015 for Medicare ranged from 74.4% to 75%.
- The Committee did not express any major concerns with the disparities data on osteoporosis screening in women.
- Due to concerns about the evidence noted above, the Committee did not reach consensus on the Evidence criterion.

2. Scientific Acceptability of Measure Properties: <u>Consensus was not reached on the Reliability criterion. The measure did not meet the Validity criterion.</u>

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

2a. Reliability: **H-0; M-9; L-4; I-7**; 2b. Validity: **H-0; M-5; L-0; I-15**

<u>Rationale</u>:

- The measure was tested for reliability at the level of the measure score using the beta binomial method (ratio of signal to noise). Generally, a minimum reliability score of 0.7 is used to indicate sufficient signal strength to discriminate performance between accountable entities. This measure had an overall reliability score of 0.995 from 2012 HEDIS data.
- The Committee acknowledged that the measure captures a large patient population at the health plan level; however, several Committee members had concerns about whether the patient/proxy recall about having had a bone density test is accurate, given that no testing has been done to support that the patient response is valid.
- The Committee again expressed concern regarding the lack of evidence supporting patient self-reporting leading to a better health outcome.
- Due to the concern about the measure being dependent on patient recollection and understanding of a bone density test, the Committee did not reach consensus on the Reliability criterion and did not pass the measure on the Validity criterion.

3. Feasibility: N/A

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

- The Committee did not discuss or vote on this criterion because the measure did not pass the Validity criterion

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **N/A** 4b. Usability: **N/A**

- The Committee did not discuss or vote on this criterion because the measure did not pass the Validity criterion

5. Related and Competing Measures

- The Committee did not discuss related and competing measures because the measure did not pass the Validity criterion

6. Standing Committee Recommendation for Endorsement: **N/A**

- The Committee did not discuss or vote on recommendation for endorsement because the measure did not pass the Validity criterion

7. Public and Member Comment

- NQF received one post-evaluation comment supporting the Committee's decision to not recommend the measure. The commenter agreed with the Committee's concern that the measures relies on patient recall and self-reporting of a bone density test. If the measure loses NQF endorsement, the commenter recommends that the developer consider retiring the measure from the HEDIS measure set.

  Measure Steward/Developer Response

  The USPSTF recommends osteoporosis screening for all women age 65 and older, and this measure addresses an important known quality gap in receiving such screenings. If the measure loses NQF endorsement, NCQA will work with CMS to identify alternative methods of capturing osteoporosis screening for Medicare Advantage members.
- The Committee reviewed the comments and developer's response during the September 25, 2018 Post-Comment Web Meeting. The Committee thanked the commenter for their comments and had no additional concerns to discuss. The Committee maintained the decision to not recommend re-endorsement.

8. Consensus Standards Approval Committee (CSAC) Vote (October 23, 2018): Yes-17; No-0

Decision: Approved Standing Committee recommendation to not continue endorsement.

9. Appeals

This measure did not go out for appeals since it was not endorsed.

Appendix B: Primary Care and Chronic Illness Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs Finalized or Implemented as of June 12, 2018
0046	Screening for Osteoporosis for Women 65-85 Years of Age	Medicare Physician Quality Reporting System, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier, Merit-Based Incentive Payment System (MIPS) Program
0047	Asthma: Pharmacologic Therapy for Persistent Asthma	Medicare Physician Quality Reporting System, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier
0053	Osteoporosis Management in Women Who Had a Fracture	Medicare Physician Quality Reporting System, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier, Merit-Based Incentive Payment System (MIPS) Program
0054	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Medicare Physician Quality Reporting System, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier, Medicare Part C Star Rating
0055	Comprehensive Diabetes Care: Eye Exam (retinal) performed	Medicare Shared Savings Program, Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals, Merit-Based Incentive Payment System (MIPS) Program, Qualified Health Plan (QHP) Quality Rating System (QRS), Medicare Part C Star Rating
0056	Comprehensive Diabetes Care: Foot Exam	Merit-Based Incentive Payment System (MIPS) Program, Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals
0057	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Medicaid, Qualified Health Plan (QHP) Quality Rating System (QRS)
0058	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier, Qualified Health Plan (QHP) Quality Rating System (QRS)
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid, Medicare Shared Savings Program, Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals, Merit-Based Incentive Payment System (MIPS) Program, Medicare Part C Star Rating
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals, Merit-Based Incentive Payment System (MIPS) Program, Qualified Health Plan (QHP) Quality Rating System (QRS), Medicare Part C Star Rating

[a] Per CMS Measures Inventory Tool as of 6/12/2018

NQF #	Title	Federal Programs Finalized or Implemented as of June 12, 2018
0086	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals, Merit-Based Incentive Payment System (MIPS) Program
0087	Age-Related Macular Degeneration: Dilated Macular Examination	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier
0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals, Merit-Based Incentive Payment System (MIPS) Program
0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals, Merit-Based Incentive Payment System (MIPS) Program
0091	COPD: Spirometry Evaluation	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program
0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals, Merit-Based Incentive Payment System (MIPS) Program
0409	Physician Feedback/Quality Resource Use Report	Medicare Physician Quality Reporting System
0519	Diabetic Foot Care and Patient Education Implemented	Home Health Quality Reporting
0541	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Qualified Health Plan (QHP) Quality Rating System (QRS)
0566	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier
0575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Qualified Health Plan (QHP) Quality Rating System (QRS)
0653	Acute Otitis Externa: Topical Therapy	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier

NQF #	Title	Federal Programs Finalized or Implemented as of June 12, 2018
0654	Acute Otitis Externa: Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier
0657	Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use	Merit-Based Incentive Payment System (MIPS) Program
0729	Optimal Diabetes Care	Medicare Physician Quality Reporting System, Physician Compare
1800	Asthma Medication Ratio	Medicaid
2079	HIV medical visit frequency	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier
2082	HIV viral load suppression	Medicaid, Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier
2083	Prescription of HIV Antiretroviral Therapy	Medicare Physician Quality Reporting System, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier

Appendix C: Primary Care and Chronic Illness Standing Committee and NQF Staff

SPRING 2018 CYCLE STANDING COMMITTEE

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Adam Thompson, BA (Co-Chair)
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Madison Jung
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Appendix D: Measure Specifications

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

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis.

TYPE

Process

DATA SOURCE

Electronic Health Data, Electronic Health Records, Paper Medical Records This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the Quality Payment Program this measure is coded using G-codes specific to quality measurement.

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Outpatient Services

NUMERATOR STATEMENT

The number of women who have documentation in their medical record of having received a DXA test of the hip or spine.

NUMERATOR DETAILS

Documentation of a central dual-energy x-ray absorptiometry (DXA) test ever being performed.

The numerator criteria is met by documentation in the medical record that the patient has had a central dual-energy x-ray absorptiometry test. This measure is also collected in the Quality Payment Program using the following codes specific to the quality measure:

Performance Met: G8399 Patient with documented results of a central Dual-energy X-Ray Absorptiometry (DXA) ever being performed.

Performance Not Met: G8400 Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented, reason not given.

DENOMINATOR STATEMENT

Women age 65-85.

DENOMINATOR DETAILS

Women who had a documented patient encounter (see Table 1 for encounter codes) during the reporting period.

Table 1: Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

EXCLUSIONS

Diagnosis of osteoporosis at the time of the encounter.

Patient receiving hospice services anytime during the measurement period.

EXCLUSION DETAILS

The denominator exclusion criteria is met by documentation in the medical record of a diagnosis of osteoporosis at the time of the encounter (see Table 2 for diagnosis codes).

Table 2: Diagnosis of osteoporosis on date of encounter (ICD-10-CM): M80.00XA, M80.00XD, M80.00XG, M80.00XK, M80.00XP, M80.00XS, M80.011A, M80.011D, M80.011G, M80.011K, M80.011P, M80.011S, M80.012A, M80.012D, M80.012G, M80.012K, M80.012P, M80.012S, M80.019A, M80.019D, M80.019G, M80.019K, M80.019P, M80.019S, M80.021A, M80.021D, M80.021G, M80.021K, M80.021P, M80.021S, M80.022A, M80.022D, M80.022G, M80.022K, M80.022P, M80.022S, M80.029A, M80.029D, M80.029G, M80.029K, M80.029P, M80.029S, M80.031A, M80.031D, M80.031G, M80.031K, M80.031P, M80.031S, M80.032A, M80.032D, M80.032G, M80.032K, M80.032P, M80.032S, M80.039A, M80.039D, M80.039G, M80.039K, M80.039P, M80.039S, M80.041A, M80.041D, M80.041G, M80.041K, M80.041P, M80.041S, M80.042A, M80.042D, M80.042G, M80.042K, M80.042P, M80.042S, M80.049A, M80.049D, M80.049G, M80.049K, M80.049P, M80.049S, M80.051A, M80.051D, M80.051G, M80.051K, M80.051P, M80.051S, M80.052A, M80.052D, M80.052G, M80.052K, M80.052P, M80.052S, M80.059A, M80.059D, M80.059G, M80.059K, M80.059P, M80.059S, M80.061A, M80.061D, M80.061G, M80.061K, M80.061P, M80.061S, M80.062A, M80.062D, M80.062G, M80.062K, M80.062P, M80.062S, M80.069A, M80.069D, M80.069G, M80.069K, M80.069P, M80.069S, M80.071A, M80.071D, M80.071G, M80.071K, M80.071P, M80.071S,M80.072A, M80.072D, M80.072G, M80.072K, M80.072P, M80.072S, M80.079A, M80.079D, M80.079G, M80.079K, M80.079P, M80.079S, M80.08XA, M80.08XD, M80.08XG, M80.08XK, M80.08XP, M80.08XS, M80.80XA, M80.80XD, M80.80XG, M80.80XK, M80.80XP, M80.80XS, M80.811A, M80.811D, M80.811G, M80.811K, M80.811P, M80.811S, M80.812A, M80.812D, M80.812G, M80.812K, M80.812P, M80.812S, M80.819A, M80.819D, M80.819G, M80.819K, M80.819P, M80.819S, M80.821A, M80.821D, M80.821G, M80.821K, M80.821P, M80.821S, M80.822A, M80.822D, M80.822G, M80.822K, M80.822P, M80.822S, M80.829A, M80.829D, M80.829G, M80.829K, M80.829P, M80.829S, M80.831A, M80.831D, M80.831G, M80.831K, M80.831P, M80.831S, M80.832A, M80.832D, M80.832G, M80.832K, M80.832P, M80.832S, M80.839A, M80.839D, M80.839G, M80.839K, M80.839P, M80.839S, M80.841A, M80.841D, M80.841G, M80.841K, M80.841P, M80.841S, M80.842A, M80.842D, M80.842G, M80.842K, M80.842P, M80.842S, M80.849A, M80.849D, M80.849G, M80.849K, M80.849P, M80.849S, M80.851A, M80.851D, M80.851G, M80.851K, M80.851P, M80.851S, M80.852A, M80.852D, M80.852G, M80.852K, M80.852P, M80.852S, M80.859A, M80.859D, M80.859G, M80.859K, M80.859P, M80.859S, M80.861A, M80.861D, M80.861G, M80.861K, M80.861P, M80.861S, M80.862A, M80.862D, M80.862G, M80.862K, M80.862P, M80.862S, M80.869A, M80.869D, M80.869G, M80.869K, M80.869P, M80.869S, M80.871A, M80.871D, M80.871G, M80.871K, M80.871P, M80.871S, M80.872A, M80.872D, M80.872G, M80.872K, M80.872P, M80.872S, M80.879A, M80.879D,

M80.879G, M80.879K, M80.879P, M80.879S, M80.88XA, M80.88XD, M80.88XG, M80.88XK, M80.88XP, M80.88XS, M81.0, M81.6, M81.8

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-Sex: Females

-Age: 65-85 years of age

-Patient encounter during the reporting period (12 months)

Step 2: Exclude from the eligible population in step 1 patients who have a diagnosis of osteoporosis at time of encounter.

Step 3: Identify the number of patients with a central dual-energy x-ray absorptiometry test documented.

Step 4: Calculate the rate (number of patients who had a central dual-energy x-ray absorptiometry test documented divided by the eligible population).

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0053 Osteoporosis Management in Women Who Had a Fracture

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records Health Plan Level:

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

Physician Level:

This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the Quality Payment Program, this measure is collected using G-codes specific to quality measurement.

LEVEL

Clinician : Group/Practice, Health Plan, Clinician: Individual, Integrated Delivery System

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis after a fracture occurs.

NUMERATOR DETAILS

Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after a fracture. Appropriate testing or treatment for osteoporosis after the fracture is defined by any of the following criteria:

- A bone mineral density test (see Table OMW-X) in any setting, on earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture. If the earliest date of service with the diagnosis of fracture was during an inpatient stay, a bone mineral density test taking place during the inpatient stay counts.

- Osteoporosis therapy, including long-acting injectables, on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture. If the earliest date of

service with the diagnosis of fracture was an inpatient stay, long-acting osteoporosis medication received during the inpatient stay counts.

- A dispensed prescription to treat osteoporosis (see Table OMW-C) on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture.

Table OMW-X: Bone Mineral Density Tests

Central dual-energy x-ray absorptiometry, computed tomography, single energy x-ray absorptiometry, ultrasound

Table OMW-C: Osteoporosis Medication

Biphosphates: Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid

Other: Calcitonin, Denosumab, Raloxifene, Teriparatide

The numerator for this measure can be identified using either administrative claims or review of medical records. The following criteria are used to identify the numerator criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.

For Medical Record Review Methodology (Physician Level)

When using the medical record as the data source, the numerator criteria is met by documentation that a Bone Mineral Density Test was performed or an osteoporosis therapy was prescribed. This may include a prescription given to patient for treatment of osteoporosis at one or more encounters during the reporting period. This measure is also collected in the Quality Payment Program, previously referred to as the Physician Quality Reporting System, using G-codes specific to the quality measure:

- 3095F Central Dual-energy X-Ray Absorptiometry (DXA) results documented

- G8633 Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

For Administrative Methodology (Health Plan Level)

When using administrative claims as the data source, the numerator criteria is met by one or more codes in the following value sets:

Bone Mineral Density Tests Value Set

Osteoporosis Medications Value Set

A pharmacy claim for a medication listed in Table OMW-C

See S.2b. (Data Dictionary Code Table) for all value sets.

DENOMINATOR STATEMENT

Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure:

Women age 50-64

Women age 65-85

Women age 50-85

DENOMINATOR DETAILS

The denominator for this measure is identified by administrative codes which are specific to the level of reporting. When reporting this measure at the health plan level include all individuals with fractures enrolled in the health plan (i.e. all individuals with encounters for fractures in the

health plan – inpatient and outpatient). When reporting this measure at the physician level include all individuals with fractures seen by the eligible provider (i.e., all individuals with encounters for fracture with the eligible provider).

Health Plan Level Denominator Details:

Women who had an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. This is the index fracture. If the patient had more than one fracture during the intake period, include only the first fracture. See S.2b. (Data Dictionary Code Table) for all value sets.

Physician Level Denominator Details:

Women who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set).

Table 1: Patient encounter during the reporting period:

CPT Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

CPT Procedure codes: 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22510, 22511, 22513, 22514, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

EXCLUSIONS

- Exclude women who had a bone mineral density test during the 24 months prior to the index fracture.

- Exclude women who had a claim/encounter for osteoporosis treatment during 12 months prior to the index fracture.

- Exclude women who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the index fracture.

- Exclude women who are enrolled in a Medicare Institutional Special Needs Plan (I-SNP) or living long-term in an institution any time during the measurement year.

- Exclude women receiving hospice care during the measurement year.

EXCLUSION DETAILS

1) Exclude patients with a previous fracture: patients with an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 60 days (2 months) prior to the earliest date of service with a diagnosis of fracture. For index fractures requiring an inpatient stay, use the admission date as the earliest date of service with a diagnosis of fracture. For direct transfers, use the first admission date as the earliest date of service with a diagnosis of fracture.

2) Exclude patients who had a Bone Mineral Density test (see Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the earliest date of service with a diagnosis of fracture.

3) Exclude patients who had a claim/encounter for osteoporosis therapy (see Osteoporosis Medications Value Set) or received a dispensed prescription to treat osteoporosis (see Table

OMW-C) during the 365 days (12 months) prior to the earliest date of service with a diagnosis of fracture.

4) Exclude patients who live long-term in Institutional settings (as identified by the LTI flag in the Medicare Part C monthly membership file) or are enrolled in a Medicare Institutional Special Needs Plan during the measurement year.

5) Exclude patients who are in hospice care during the measurement year (as identified by the Medicare plan's enrollment file).

Table OMW-C: Osteoporosis Therapies

Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Teriparatide

The denominator exclusions for this measure can be identified using administrative claims, health plan enrollment data or review of medical record. The following criteria are used to identify the denominator exclusion criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.

For Medical Record Review Methodology (Physician Level)

When using the medical record as the data source, the denominator exclusion criteria can be met by documentation that a previous fracture occurred, a bone mineral density test was performed or an osteoporosis therapy was prescribed during the specified timeframe prior to the fracture. In the Physician Quality Reporting System (PQRS) this exclusion is collected using G-codes specific to quality measurement:

- 3095F or 4005F with 1P: Documentation of medical reason(s) for not performing a bone mineral density test or not prescribing pharmacologic therapy for osteoporosis (i.e. history of fracture in 60 days prior to index fracture, bone mineral density test in 24 months prior to index fracture, or pharmacologic treatment for osteoporosis in 12 months prior to index fracture).

For Administrative Methodology (Health Plan Level)

When using administrative claims as the data source, the denominator exclusion criteria is met using the following value sets referenced above during the specified time frame prior to the fracture.

Outpatient Value Set

ED Value Set

Nonacute Inpatient Value Set

Acute Inpatient Value Set

Fractures Value Set

Bone Mineral Density Tests Value Set

Osteoporosis Medications Value Set

See S.2b. (Data Dictionary Code Table) for all value sets.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Health Plan Level:

Step 1: Identify all female patients who had a new fracture during the intake period (12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year).

Step 2: Exclude patients who had previous bone mineral density test and patients who had previous osteoporosis treatment. Also exclude patients living long-term in institutional settings and patients receiving hospice care.

Step 3: Of those patients remaining after Step 2 (i.e., the denominator), identify those who received bone mineral density testing or osteoporosis treatment in the 6-month period following the fracture.

Step 4: To calculate the rate, take the number of patients who received testing or treatment and divide by the number of people calculated to be in the denominator.

Physician Level:

Step 1: Identify all female patients in each age strata who had a documented patient encounter with the eligible provider with a new diagnosis of fracture.

Step 2: Exclude patients who had who had previous bone mineral density test and patients who had previous osteoporosis treatment. Also exclude patients living long-term in institutional settings and patients receiving hospice care.

Step 3: Of those patients remaining after Step 2 (i.e., the denominator), identify all patients who had a documented bone mineral density test or pharmacologic treatment after the fracture.

Step 4: To calculate the rate, take the number of patients who received testing or pharmacologic treatment and divide by the number of people calculated to be in the denominator.

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0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Paper Medical Records This measure uses a combination of administrative claims data and medical records. Eye screening for diabetic retinal disease can be identified by the following administrative data:

-Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.

-A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

-Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

Codes in the following value sets will meet these criteria:

-Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.

-Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional during the year prior to the measurement year, with a negative result (negative for retinopathy).

-Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications

-Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the measurement year.

-Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).

-Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.

-Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (Bilateral Modifer Value Set)

-Two unilateral eye enucleations (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more part.

-Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) and right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service

The minimum medical record documentation includes one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.

- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

-Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.

-Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).

Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

LEVEL

Clinician : Group/Practice, Health Plan, Clinician : Individual

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following:

-a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year

–a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

-Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

For exams performed in the year prior to the measurement year, a result must be available.

NUMERATOR DETAILS

Time period for data: a measurement year (12 months)

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD: At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.

- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

-Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.

-Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).

Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

The patient is numerator compliant if the eye exam was performed in the measurement year or a negative eye exam was documented in the year prior to the measurement year. The patient is not numerator compliant if the eye exam or negative result are missing. Ranges and thresholds do not meet criteria for this measure.

DENOMINATOR STATEMENT

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

DENOMINATOR DETAILS

Patients with diabetes can be identified two ways:

-CLAIM/ENCOUNTER DATA: Patients who had two face-to-face encounters, in an outpatient setting, observations visits, ED setting on different dates of service, or nonacute inpatient setting with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. Organizations may count services that occur over both years.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

-PHARMACY DATA: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (TABLE CDC-A):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-saxagliptin, Metformin-sitagliptin , Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

EXCLUSIONS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):

-Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year

-Exclude patients 65 and older with an advanced illness condition and frailty

EXCLUSION DETAILS

ADMINISTRATIVE CLAIMS:

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD:

-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and had a diagnosis of polycystic ovaries any time in the patient's history through December 31 of the measurement year.

OR

-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-AGES: 18-75 years as of December 31 of the measurement year.

-EVENT/DIAGNOSIS: Identify patients with diabetes in two ways: by claim/encounter data and by pharmacy data.

Claim/Encounter Data:

-Patients who had at least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.

-Patients with at least one acute inpatient encounter with a diagnosis of diabetes.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

Pharmacy Data:

Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

*SEE PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES IN QUESTION S.7

STEP 2. Determine the number of patients in the eligible population who had a recent eye exam (retinal) performed during the measurement year through the search of administrative data systems.

STEP 3. Identify patients with a most recent eye exam (retinal) performed and the result.

STEP 4. Identify the most recent eye exam (retinal) during the measurement year or a negative result prior to the measurement year (numerator compliant). Identify missing eye exam or missing eye exam result (not numerator compliant).

STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured.

*SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.8

STEP 6. Calculate the rate (number of patients with an eye exam (retinal) performed during the measurement year or negative result prior to the measurement year).

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0056 Comprehensive Diabetes: Foot Exam

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

TYPE

Process

DATA SOURCE

Electronic Health Data, Paper Medical Records This measure uses a combination of electronic health data and medical records. Foot exams can be identified by the following administrative data: receipt of a foot exam (visual inspection and sensory exam with mono filament and a pulse exam).

Codes in the following value set will meet these criteria:

-Any code in the Physical Exam, Performed: Visual Exam of Foot value set

-Any code in the Physical Exam, Performed: Sensory Exam of Foot

-Any code in Physical Exam, Performed: Pulse Exam of Foot

The minimum medical record documentation includes a note indicating the date when the exam was performed and the result.

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period.

NUMERATOR DETAILS

Time period for data: a measurement year (12 months)

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the exam was performed and the result. The patient is numerator compliant if a foot exam during the measurement year and result are documented. The patient is not numerator compliant if the result for the foot exam and result during the measurement year are missing. Ranges and thresholds do not meet criteria for this measure.

DENOMINATOR STATEMENT

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year.

DENOMINATOR DETAILS

ENCOUNTER: Patients who had a visit (office visit, face to face encounter, preventive care services, home healthcare services, annual wellness) during the measurement period

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES:

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-saxagliptin, Metformin-sitagliptin , Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

EXCLUSIONS

-Patients with a diagnosis of secondary diabetes due to another condition (e.g. a diagnosis of gestational or steroid-induced diabetes)

-Patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period.

-Exclude patients who were in hospice care during the measurement year

EXCLUSION DETAILS

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD

Exclusionary evidence in the medical record must include a note indicating a diagnosis of gestational or steroid-induced diabetes, patients who had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee, or who are in hospice care.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-AGES: 18-75 years as of December 31 of the reporting period.

-EVENT/DIAGNOSIS:

Identify patients who had a diagnosis of diabetes with a visit during the measurement period.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S2.B

STEP 2. Determine the number of patients in the eligible population who had a recent foot exam (visual inspection with a sensory exam and a pulse exam) exam during the measurement year through the search of administrative data systems.

STEP 3. Identify patients with a most recent foot exam performed and the result.

STEP 4. Identify the most recent foot exam with a result during the reporting period (numerator compliant). Identify the most recent result foot exam without a result or a missing foot exam (not numerator compliant).

STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured. *SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.9

STEP 6. Calculate the rate (number of patients that received a foot exam during the measurement year).

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0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation 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.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients who had an HbA1c test performed during the measurement year.

NUMERATOR DETAILS

ADMINISTRATIVE CLAIMS: An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record:

- A1c.
- HbA1c
- HgbA1c.
- Hemoglobin A1c.
- Glycohemoglobin A1c.

• Glycohemoglobin.
• Glycated hemoglobin.
• Glycosylated hemoglobin.

DENOMINATOR STATEMENT

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

DENOMINATOR DETAILS

Patients with diabetes can be identified two ways:

-CLAIM/ENCOUNTER DATA: Patients who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, or ED setting on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. Organizations may count services that occur over both years.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

-PHARMACY DATA: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (TABLE CDC-A):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

EXCLUSIONS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):

-Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.

EXCLUSION DETAILS

ADMINISTRATIVE CLAIMS:

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD:

-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and had a diagnosis of polycystic ovaries any time in the patient's history through December 31 of the measurement year.

OR

-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-AGES: 18-75 years as of December 31 of the measurement year.

-EVENT/DIAGNOSIS: Identify patients with diabetes in two ways: by claim/encounter data and by pharmacy data.

Claim/Encounter Data:

-Patients who had at least two outpatient visits, observation visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.

-Patients with at least one acute inpatient encounter with a diagnosis of diabetes.

-Patients with at least one ED visit with a diagnosis of diabetes.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

Pharmacy Data:

Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. *SEE PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES IN S.7

STEP 2. Determine the number of patients in the eligible population who had a recent HbA1c test during the measurement year through the search of administrative data systems.

STEP 3. Identify patients with a most recent HbA1c test performed.

STEP 4. Identify the most recent HbA1c test with result (numerator compliant). Identify a missing result or no HbA1c test done during the measurement year (not numerator compliant).

STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured. *SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.8

STEP 6. Calculate the rate (number of patients that had an HbA1c test).

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0062 Comprehensive Diabetes Care: Medical Attention for Nephropathy

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or monitoring test or had evidence of nephropathy during the measurement year.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Other, Paper Medical Records This measure uses a combination of administrative claims data and medical records. A nephropathy screening or monitoring test or evidence of nephropathy during the measurement year can be identified by the following administrative data:

-A nephropathy screening or monitoring test (Urine Protein Tests Value Set).

-Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).

-Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).

-Evidence of ESRD (ESRD Value Set).

-Evidence of kidney transplant (Kidney Transplant Value Set).

-A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).

-At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor/ARB Medications List).

Medical record documentation includes:

-A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria: 24-hour urine for albumin or protein, timed urine for albumin or protein, spot urine (e.g., urine dipstick or test strip) for albumin or protein, urine for albumin/creatinine ratio, 24-hour urine for total protein, random urine for protein/creatinine ratio.

-Documentation of a visit to a nephrologist.

-Documentation of a renal transplant.

-Documentation of medical attention for any of the following (no restriction on provider type): diabetic nephropathy, ESRD, chronic renal failure (CRF), chronic kidney disease (CKD), renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), dialysis, hemodialysis or peritoneal dialysis.

-Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor/ARB therapy during the measurement year. Any of the following meet criteria: Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year, Documentation that a prescription for an ACE inhibitor/ARB was filled during the measurement year, Documentation that the member took an ACE inhibitor/ARB during the measurement year.

LEVEL

Clinician : Group/Practice, Health Plan, Clinician : Individual

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients receiving a nephropathy screening or monitoring test or having evidence of nephropathy during the measurement year

NUMERATOR DETAILS

Time period for data: a measurement year (12 months)

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the nephropathy screening or monitoring test was performed or nephropathy evidence documented. The patient is numerator compliant if the nephropathy screening was performed or nephropathy evidence is documented. The patient is not numerator compliant if nephropathy screening and result are missing or if nephropathy evidence is not documented. Ranges and thresholds do not meet criteria for this measure.

Any of the following meet criteria for a nephropathy screening or monitoring test of evidence of nephropathy:

-A urine test for albumin or protein (At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Documentation includes: 24-hour urine for albumin or protein, Timed urine for albumin or protein., Spot urine (e.g., urine dipstick or test strip) for albumin or protein, Urine for albumin/creatinine ratio, 24-hour urine for total protein, random urine for protein/creatinine ratio.)

-Documentation of a visit to a nephrologist.

-Documentation of a renal transplant.

-Documentation of medical attention for any of the following (no restriction on provider type): Diabetic nephropathy, ESRD, Chronic renal failure (CRF), Chronic kidney disease (CKD), Renal insufficiency, Proteinuria, Albuminuria, Renal dysfunction, Acute renal failure (ARF), Dialysis, hemodialysis or peritoneal dialysis.

-Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor/ARB therapy during the measurement year. Any of the following meet criteria:, Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year, Documentation that a prescription for an ACE

inhibitor/ARB was filled during the measurement year, Documentation that the member took an ACE inhibitor/ARB during the measurement year.

DENOMINATOR STATEMENT

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

DENOMINATOR DETAILS

Patients with diabetes can be identified two ways:

-CLAIM/ENCOUNTER DATA: Patients who had two face-to-face encounters, in an inpatient setting or nonacute inpatient setting, or ED setting on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. Organizations may count services that occur over both years.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

-PHARMACY DATA: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (TABLE CDC-A):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-saxagliptin, Metformin-sitagliptin , Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

EXCLUSIONS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):

-Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year

-Exclude patients 65 and older with an advanced illness condition and frailty

EXCLUSION DETAILS

ADMINISTRATIVE CLAIMS:

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD:

-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and had a diagnosis of polycystic ovaries any time in the patient's history through December 31 of the measurement year.

OR

-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-AGES: 18-75 years as of December 31 of the measurement year.

-EVENT/DIAGNOSIS: Identify patients with diabetes in two ways: by claim/encounter data and by pharmacy data.

Claim/Encounter Data:

-Patients who had at least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.

-Patients with at least one acute inpatient encounter with a diagnosis of diabetes.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

Pharmacy Data:

Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

*SEE PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES IN QUESTION S.7

STEP 2. Determine the number of patients in the eligible population who had a recent nephropathy screening or monitoring test or evidence of nephropathy or treatment of nephropathy during the measurement year through the search of administrative data systems.

STEP 3. Identify patients with a nephropathy screening or monitoring test or evidence of nephropathy.

STEP 4. Identify the most recent nephropathy screening or monitoring test or evidence of nephropathy during the measurement year (numerator compliant). Identify the missing nephropathy screenings or monitoring tests or no evidence of nephropathy (not numerator compliant).

STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured.

*SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.8

STEP 6. Calculate the rate (number of patients with nephropathy screening or monitoring test or evidence of nephropathy during the measurement year or year prior?).

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Appendix E1: Related and Competing Measures (Tabular format)

Comparison of NQF 0037, NQF 0046, and NQF 0053

	0037 Osteoporosis Testing in Older Women (OTO)	0046 Screening for Osteoporosis for Women 65-85 Years of Age	0053 Osteoporosis Management in Women Who Had a Fracture
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	The percentage of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis.	Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis.	The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.
Type	Process	Process	Process
Data Source	Instrument-Based Data The Medicare Health Outcome Survey can be administered by mail or telephone using a CATI protocol. It is offered in English, Spanish, and Chinese (mailed survey only). Detailed instructions for the administration of the Health Outcomes Survey and the complete survey can be found at www.hosonline.org. Available at measure-specific web page URL identified in S.1 No data dictionary	Electronic Health Data, Electronic Health Records, Paper Medical Records This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the Quality Payment Program this measure is coded using G-codes specific to quality measurement. No data collection instrument provided No data dictionary	Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records Health Plan Level: This measure is based on administrative claims collected in the course of providing care to health plan patients. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Maintenance Organizations and Preferred Provider Organizations via NCQA's online data submission system. Physician Level: This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the Quality Payment Program, this measure is collected using G-codes specific to quality measurement. No data collection instrument provided Attachment 0053_OMW_Value_Sets.xlsx
Level	Health Plan	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System
Setting	Outpatient Services	Outpatient Services	Outpatient Services
Numerator Statement	The number of women who report having ever received a bone mineral density test of the hip or spine.	The number of women who have documentation in their medical record of having received a DXA test of the hip or spine.	Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis after a fracture occurs.
Numerator Details	The number of female patients 65-85 years of age who responded "yes" to question 52 in the Medicare Health Outcomes Survey. Question 52: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip."	Documentation of a central dual-energy x-ray absorptiometry (DXA) test ever being performed. The numerator criteria is met by documentation in the medical record that the patient has had a central dual-energy x-ray absorptiometry test. This measure is also collected in the Quality Payment Program using the following codes specific to the quality measure: Performance Met: G8399 Patient with documented results of a central Dual-energy X-Ray Absorptiometry (DXA) ever being performed. Performance Not Met: G8400 Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented, reason not given.	Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after a fracture. Appropriate testing or treatment for osteoporosis after the fracture is defined by any of the following criteria: - A bone mineral density test (see Table OMW-X) in any setting, on earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture. If the earliest date of service with the diagnosis of fracture was during an inpatient stay, a bone mineral density test taking place during the inpatient stay counts. - Osteoporosis therapy, including long-acting injectables, on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture. If the earliest date of service with the diagnosis of fracture was an inpatient stay, long-acting osteoporosis medication received during the inpatient stay counts. - A dispensed prescription to treat osteoporosis (see Table OMW-C) on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture. Table OMW-X: Bone Mineral Density Tests Central dual-energy x-ray absorptiometry, computed tomography, single energy x-ray absorptiometry, ultrasound Table OMW-C: Osteoporosis Medication Biphosphates: Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid Other: Calcitonin, Denosumab, Raloxifene, Teriparatide The numerator for this measure can be identified using either administrative claims or review of medical records. The following criteria are used to identify the numerator criteria for each method. *Note this measure

	0037 Osteoporosis Testing in Older Women (OTO)	0046 Screening for Osteoporosis for Women 65-85 Years of Age	0053 Osteoporosis Management in Women Who Had a Fracture
			has been tested using medical record review at the physician level and administrative data at the health plan level. For Medical Record Review Methodology (Physician Level) When using the medical record as the data source, the numerator criteria is met by documentation that a Bone Mineral Density Test was performed or an osteoporosis therapy was prescribed. This may include a prescription given to patient for treatment of osteoporosis at one or more encounters during the reporting period. This measure is also collected in the Quality Payment Program, previously referred to as the Physician Quality Reporting System, using G-codes specific to the quality measure: - 3095F Central Dual-energy X-Ray Absorptiometry (DXA) results documented - G8633 Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed For Administrative Methodology (Health Plan Level) When using administrative claims as the data source, the numerator criteria is met by one or more codes in the following value sets: Bone Mineral Density Tests Value Set Osteoporosis Medications Value Set A pharmacy claim for a medication listed in Table OMW-C See S.2b. (Data Dictionary Code Table) for all value sets.
Denominator Statement	Women age 65-85.	Women age 65-85.	Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure: Women age 50-64 Women age 65-85 Women age 50-85
Denominator Details	The number of women 65-85 years of age who responded to question 52 on the Medicare Health Outcome Survey. Question 52: “Have you ever had a bone density test to check for osteoporosis, sometimes thought of as ‘brittle bones’? This test would have been done to your back or hip.”	Women who had a documented patient encounter (see Table 1 for encounter codes) during the reporting period. Table 1: Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	The denominator for this measure is identified by administrative codes which are specific to the level of reporting. When reporting this measure at the health plan level include all individuals with fractures enrolled in the health plan (i.e. all individuals with encounters for fractures in the health plan – inpatient and outpatient). When reporting this measure at the physician level include all individuals with fractures seen by the eligible provider (i.e., all individuals with encounters for fracture with the eligible provider). Health Plan Level Denominator Details: Women who had an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. This is the index fracture. If the patient had more than one fracture during the intake period, include only the first fracture. See S.2b. (Data Dictionary Code Table) for all value sets. Physician Level Denominator Details: Women who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set). Table 1: Patient encounter during the reporting period: CPT Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402 CPT Procedure codes: 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22510, 22511, 22513, 22514, 25600, 25605, 25606, 25607,

	0037 Osteoporosis Testing in Older Women (OTO)	0046 Screening for Osteoporosis for Women 65-85 Years of Age	0053 Osteoporosis Management in Women Who Had a Fracture
			25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248
Exclusions	Women who received hospice care during the year.	Diagnosis of osteoporosis at the time of the encounter. Patient receiving hospice services anytime during the measurement period.	- Exclude women who had a bone mineral density test during the 24 months prior to the index fracture. - Exclude women who had a claim/encounter for osteoporosis treatment during 12 months prior to the index fracture. - Exclude women who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the index fracture. - Exclude women who are enrolled in a Medicare Institutional Special Needs Plan (I-SNP) or living long-term in an institution any time during the measurement year. - Exclude women receiving hospice care during the measurement year.
Exclusion Details	Women who responded to the Medicare Health Outcomes Survey who were identified with the 'Hospice Flag' in the survey response data file.	The denominator exclusion criteria is met by documentation in the medical record of a diagnosis of osteoporosis at the time of the encounter (see Table 2 for diagnosis codes). Table 2: Diagnosis of osteoporosis on date of encounter (ICD-10-CM): M80.00XA, M80.00XD, M80.00XG, M80.00XK, M80.00XP, M80.00XS, M80.011A, M80.011D, M80.011G, M80.011K, M80.011P, M80.011S, M80.012A, M80.012D, M80.012G, M80.012K, M80.012P, M80.012S, M80.019A, M80.019D, M80.019G, M80.019K, M80.019P, M80.019S, M80.021A, M80.021D, M80.021G, M80.021K, M80.021P, M80.021S, M80.022A, M80.022D, M80.022G, M80.022K, M80.022P, M80.022S, M80.029A, M80.029D, M80.029G, M80.029K, M80.029P, M80.029S, M80.031A, M80.031D, M80.031G, M80.031K, M80.031P, M80.031S, M80.032A, M80.032D, M80.032G, M80.032K, M80.032P, M80.032S, M80.039A, M80.039D, M80.039G, M80.039K, M80.039P, M80.039S, M80.041A, M80.041D, M80.041G, M80.041K, M80.041P, M80.041S, M80.042A, M80.042D, M80.042G, M80.042K, M80.042P, M80.042S, M80.049A, M80.049D, M80.049G, M80.049K, M80.049P, M80.049S, M80.051A, M80.051D, M80.051G, M80.051K, M80.051P, M80.051S, M80.052A, M80.052D, M80.052G, M80.052K, M80.052P, M80.052S, M80.059A, M80.059D, M80.059G, M80.059K, M80.059P, M80.059S, M80.061A, M80.061D, M80.061G, M80.061K, M80.061P, M80.061S, M80.062A, M80.062D, M80.062G, M80.062K, M80.062P, M80.062S, M80.069A, M80.069D, M80.069G, M80.069K, M80.069P, M80.069S, M80.071A, M80.071D, M80.071G, M80.071K, M80.071P, M80.071S,M80.072A, M80.072D, M80.072G, M80.072K, M80.072P, M80.072S, M80.079A, M80.079D, M80.079G, M80.079K, M80.079P, M80.079S, M80.08XA, M80.08XD, M80.08XG, M80.08XK, M80.08XP, M80.08XS, M80.80XA, M80.80XD, M80.80XG, M80.80XK, M80.80XP, M80.80XS, M80.811A, M80.811D, M80.811G, M80.811K, M80.811P, M80.811S, M80.812A, M80.812D, M80.812G, M80.812K, M80.812P, M80.812S, M80.819A, M80.819D, M80.819G, M80.819K, M80.819P, M80.819S, M80.821A, M80.821D, M80.821G, M80.821K, M80.821P, M80.821S, M80.822A, M80.822D, M80.822G, M80.822K, M80.822P, M80.822S, M80.829A, M80.829D, M80.829G, M80.829K, M80.829P, M80.829S, M80.831A, M80.831D, M80.831G, M80.831K, M80.831P, M80.831S, M80.832A, M80.832D, M80.832G, M80.832K,	1) Exclude patients with a previous fracture: patients with an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 60 days (2 months) prior to the earliest date of service with a diagnosis of fracture. For index fractures requiring an inpatient stay, use the admission date as the earliest date of service with a diagnosis of fracture. For direct transfers, use the first admission date as the earliest date of service with a diagnosis of fracture. 2) Exclude patients who had a Bone Mineral Density test (see Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the earliest date of service with a diagnosis of fracture. 3) Exclude patients who had a claim/encounter for osteoporosis therapy (see Osteoporosis Medications Value Set) or received a dispensed prescription to treat osteoporosis (see Table OMW-C) during the 365 days (12 months) prior to the earliest date of service with a diagnosis of fracture. 4) Exclude patients who live long-term in Institutional settings (as identified by the LTI flag in the Medicare Part C monthly membership file) or are enrolled in a Medicare Institutional Special Needs Plan during the measurement year. 5) Exclude patients who are in hospice care during the measurement year (as identified by the Medicare plan's enrollment file). Table OMW-C: Osteoporosis Therapies Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Teriparatide The denominator exclusions for this measure can be identified using administrative claims, health plan enrollment data or review of medical record. The following criteria are used to identify the denominator exclusion criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level. For Medical Record Review Methodology (Physician Level) When using the medical record as the data source, the denominator exclusion criteria can be met by documentation that a previous fracture occurred, a bone mineral density test was performed or an osteoporosis therapy was prescribed during the specified timeframe prior to the fracture. In the Physician Quality Reporting System (PQRS) this exclusion is collected using G-codes specific to quality measurement: - 3095F or 4005F with 1P: Documentation of medical reason(s) for not performing a bone

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		M80.832P, M80.832S, M80.839A, M80.839D, M80.839G, M80.839K, M80.839P, M80.839S, M80.841A, M80.841D, M80.841G, M80.841K, M80.841P, M80.841S, M80.842A, M80.842D, M80.842G, M80.842K, M80.842P, M80.842S, M80.849A, M80.849D, M80.849G, M80.849K, M80.849P, M80.849S, M80.851A, M80.851D, M80.851G, M80.851K, M80.851P, M80.851S, M80.852A, M80.852D, M80.852G, M80.852K, M80.852P, M80.852S, M80.859A, M80.859D, M80.859G, M80.859K, M80.859P, M80.859S, M80.861A, M80.861D, M80.861G, M80.861K, M80.861P, M80.861S, M80.862A, M80.862D, M80.862G, M80.862K, M80.862P, M80.862S, M80.869A, M80.869D, M80.869G, M80.869K, M80.869P, M80.869S, M80.871A, M80.871D, M80.871G, M80.871K, M80.871P, M80.871S, M80.872A, M80.872D, M80.872G, M80.872K, M80.872P, M80.872S, M80.879A, M80.879D, M80.879G, M80.879K, M80.879P, M80.879S, M80.88XA, M80.88XD, M80.88XG, M80.88XK, M80.88XP, M80.88XS, M81.0, M81.6, M81.8	mineral density test or not prescribing pharmacologic therapy for osteoporosis (i.e. history of fracture in 60 days prior to index fracture, bone mineral density test in 24 months prior to index fracture, or pharmacologic treatment for osteoporosis in 12 months prior to index fracture). For Administrative Methodology (Health Plan Level) When using administrative claims as the data source, the denominator exclusion criteria is met using the following value sets referenced above during the specified time frame prior to the fracture. Outpatient Value Set ED Value Set Nonacute Inpatient Value Set Acute Inpatient Value Set Fractures Value Set Bone Mineral Density Tests Value Set Osteoporosis Medications Value Set See S.2b. (Data Dictionary Code Table) for all value sets.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	N/A	N/A
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify the eligible population – Of those who were selected to receive a survey, identify all female patients age 65-85 who answered Question 52: “Have you ever had a bone density test to check for osteoporosis, sometimes thought of as ‘brittle bones’? This test would have been done to your back or hip.” Step 2: Determine the number of patients in the eligible population who responded “Yes”. Step 3: Calculate a rate (the number of patients who responded “yes” divided by the eligible population)	Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria. -Sex: Females -Age: 65-85 years of age -Patient encounter during the reporting period (12 months) Step 2: Exclude from the eligible population in step 1 patients who have a diagnosis of osteoporosis at time of encounter. Step 3: Identify the number of patients with a central dual-energy x-ray absorptiometry test documented. Step 4: Calculate the rate (number of patients who had a central dual-energy x-ray absorptiometry test documented divided by the eligible population).	Health Plan Level: Step 1: Identify all female patients who had a new fracture during the intake period (12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year). Step 2: Exclude patients who had previous bone mineral density test and patients who had previous osteoporosis treatment. Also exclude patients living long-term in institutional settings and patients receiving hospice care. Step 3: Of those patients remaining after Step 2 (i.e., the denominator), identify those who received bone mineral density testing or osteoporosis treatment in the 6-month period following the fracture. Step 4: To calculate the rate, take the number of patients who received testing or treatment and divide by the number of people calculated to be in the denominator. Physician Level: Step 1: Identify all female patients in each age strata who had a documented patient encounter with the eligible provider with a new diagnosis of fracture. Step 2: Exclude patients who had who had previous bone mineral density test and patients who had previous osteoporosis treatment. Also exclude patients living long-term in institutional settings and patients receiving hospice care. Step 3: Of those patients remaining after Step 2 (i.e., the denominator), identify all patients who had a documented bone mineral density test or pharmacologic treatment after the fracture. Step 4: To calculate the rate, take the number of patients who received testing or pharmacologic treatment and divide by the number of people calculated to be in the denominator.
Submission items	5.1 Identified measures: 0046 : Screening for Osteoporosis for Women 65-85 Years of Age 0053 : Osteoporosis Management in Women Who Had a Fracture 2417 : Risk Assessment/Treatment After Fracture 5a.1 Are specs completely harmonized? Yes	5.1 Identified measures: 0045 : Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older 0048 : Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	5.1 Identified measures: 0046 : Screening for Osteoporosis for Women 65-85 Years of Age 0037 : Osteoporosis Testing in Older Women (OTO) 2416 : Laboratory Investigation for Secondary Causes of Fracture 2417 : Risk Assessment/Treatment After Fracture

	0037 Osteoporosis Testing in Older Women (OTO)	0046 Screening for Osteoporosis for Women 65-85 Years of Age	0053 Osteoporosis Management in Women Who Had a Fracture
	5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: There are multiple NQF-endorsed measures of osteoporosis prevention and management. During the last measure update in 2014, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0037) and the most closely related measure, 0046. Measure 0046 assesses the percentage of women who have a bone mineral density test to screen for osteoporosis. Measure 0046 is collected using medical record review and is only specified for physician level reporting). The rationale for different data sources is the availability of data for the level of reporting. Measure 0037 is a health plan level measure. Since the recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk, the measure is specified as "ever" having a bone mineral density test. It is not feasible for a Medicare Advantage plan to have access to enough historical claims data or medical record data to determine if its entire member population has ever had a bone mineral density test. Therefore, a survey method is the recommended data source for collecting this type of historical data. Measure 0046 is a physician level measure. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, this measure looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on past care. The harmonized measure elements described below are reflective of the most recent measure versions submitted for endorsement. Harmonized Measure Elements between 0037 and 0046: - Type of Test: Because measure 0037 is a survey measure, the term "bone mineral density test" is used to refer to dual energy x-ray absorptiometry test. The simplified term is used because cognitive testing indicated it was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however 0046 is able to capture more specificity about the type of test done due to the data source used for measure collection. - Eligible Population: Both measures are focused on women age 65-85 years of age. - Timeframe for testing: Both measures address whether testing was done at least once in the woman's lifetime. Given the two different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however, the two measures address the same quality gap for different levels of accountability. - Measure 0037 addresses whether a health plan is addressing the risk for osteoporosis in the patient population by determining the percent of the population that had a bone mineral density test regardless who their provider is. This test may have been done	0053 : Osteoporosis Management in Women Who Had a Fracture 0037 : Osteoporosis Testing in Older Women (OTO) 2416 : Laboratory Investigation for Secondary Causes of Fracture 2417 : Risk Assessment/Treatment After Fracture 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Although 0037 and 0046 have the same measure focus and same target population they are specified for different levels of analysis and accountability, and use different data sources. We have described above where the measures are conceptually harmonized and the rationale for where the measures cannot be harmonized in their technical specifications due to the level of analysis and data source. RESPONSE TO 5a.2 (insufficient space above): There are multiple NQF-endorsed measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0046) and the most closely related measure, 0037. Measure 0046 assesses the percentage of women who have a bone mineral density test to screen for osteoporosis. Measure 0046 is collected using medical record review and is only specified for physician level reporting. The rationale for different data sources is the availability of data for the level of reporting. - Measure 0037 is a health plan level measure. Since the recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk, the measure is specified as "ever" having a bone mineral density test. It is not feasible for a Medicare Advantage plan to have access to enough historical claims data or medical record data to determine if the entire member population ever had a bone mineral density test. Therefore a survey method is the recommended data source for collecting this type of historical data. - Measure 0046 is a physician level measure. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, this measure looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on past care. The harmonized measure elements described below are reflective of the most recent measure versions submitted for endorsement. Harmonized Measure Elements between 0037 and 0046: - Type of Test: Because measure 0037 is a survey measure, the term "bone mineral density test" is used to refer to "dual energy x-ray absorptiometry test." This term is used because cognitive testing indicated the term was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however, 0046 is able to capture more	5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Insufficient Space - please see 5b.1. 5b.1 If competing, why superior or rationale for additive value: Response to 5a.2 (insufficient space above): There are multiple measures of osteoporosis prevention and management. During the last measure update in 2014, this measure was harmonized to align with applicable existing NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0053) and the most closely related measures, 0037, 0046, 2416, 2417. NCQA OWNED RELATED MEASURES 0037: Osteoporosis Testing in Older Women 0046: Screening for Osteoporosis for Women 65-85 Years of Age Measures 0037 and 0046 assess the number of women 65-85 who report ever having received a bone density test to check for osteoporosis. These measures focus on screening for osteoporosis in the general population, whereas measure 0053 is focused on secondary prevention in a population of women who have experienced a fracture. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures. OTHER RELATED MEASURES The other osteoporosis management related measures are more narrowly focused than the NCQA measures. These measures (2416, 2417) are hospital-level accountability measures and focus solely on women who were hospitalized for fractures. 2416: Laboratory Investigation for Secondary Causes of Fracture Measure 2416 assesses the percentage of patients age 50 and over who were hospitalized for a fragility fracture and had the appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from an inpatient hospitalization. This measure has a different focus from measure 0053 (identifying cause of fracture as opposed to screening/treatment for osteoporosis). While the target population of this measure overlaps with the target population of 0053, measure 2416 is restricted to fractures that require hospitalization whereas 0053 focuses on a broader population. Therefore, we consider these measures to be related but not competing. Measure 2416 captures some of the same quality focus as 0053 but is designed to be appropriate for hospital-level accountability and is therefore restricted to hospitalized individuals. The differences between this measure and 0053 are reflective of the different measure intents and level of accountability. 2417: Risk Assessment/Treatment After Fracture Measure 2417 assesses the number of patients age 50 and over who were hospitalized for a fragility fracture and have either a dual-energy x-ray absorptiometry (DXA) scan ordered or performed, a prescription for FDA-approved pharmacotherapy, or are linked to a fracture liaison service prior to discharge from an inpatient hospitalization. If DXA is not available and documented, then any other specified fracture risk assessment method may be ordered or performed. This measure

	0037 Osteoporosis Testing in Older Women (OTO)	0046 Screening for Osteoporosis for Women 65-85 Years of Age	0053 Osteoporosis Management in Women Who Had a Fracture
	outside of the context of their primary care provider. - Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction. Measure 0053 addresses a different population than 0037 (i.e., women who have experienced a fragility fracture), and is therefore focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Measure 2417 also focuses on those who had a fragility fracture and then received secondary prevention. Therefore, we consider these measures to be related but not competing. The differences between these measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures.	specific about the type of test done due to the data source used for measure collection. - Eligible Population: Both measures are focused on women age 65-85 years of age. - Timeframe for testing: Both measures address whether testing was done at least once in the woman's lifetime. Given the two different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however, the two measures address the same quality gap for different levels of accountability. - Measure 0037 addresses whether a health plan is addressing the risk for osteoporosis in the patient population by determining the percent of the population that had a bone mineral density test regardless who their provider is. This test may have been done outside of the context of their primary care provider. - Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction. Measures 0045, 0048, 0053, 2416, and 2417 address a different population than 0046. These measures address women who have experienced a fracture, and are focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Therefore, we consider these measures to be related but not competing. The differences between these measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence we have aligned the measures.	has a similar focus to 0053 and an overlapping target population (individuals hospitalized for a fragility fracture). Therefore, this measure could be considered competing with 0053; however, 2417 is designed to focus on hospital-level accountability and therefore is only inclusive of populations and services provided within the hospital setting. Measure 0053 is designed to be broader and capture both outpatient and inpatient populations and services. Response to 5b.1: This measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure:2417 Risk Assessment/Treatment After Fracture. Measure 0053 is designed to be as broad as possible to include the largest possible population (all women age 50 and over with a fracture other than face, finger, toe, and skull) and include the broadest possible settings of care (inpatient and outpatient). The measure is designed for both health plan and outpatient physician level accountability. It is focused on guideline recommended care for osteoporosis management after a fracture. Measure 2417 is designed to be appropriate for hospital-level accountability and therefore focuses on a smaller population (all patients 50 and over hospitalized for a fragility fracture) and includes a single setting of care (inpatient). While some post-fracture care occurs in the inpatient setting, much of the responsibility for providing follow-up care for osteoporosis management in women rests with the outpatient care system and providers. Additionally, many patients who suffer a fracture may not be treated with an inpatient hospitalization. Therefore, it is important to have a measure that captures a broader population and settings of care for osteoporosis management following a fracture.

Comparison of NQF 0056 and NQF 0417

	0056 Diabetes: Foot Exam	0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation
Steward	National Committee for Quality Assurance	American Podiatric Medical Association
Description	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.	Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months
Type	Process	Process
Data Source	Electronic Health Data, Paper Medical Records This measure uses a combination of electronic health data and medical records. Foot exams can be identified by the following administrative data: receipt of a foot exam (visual inspection and sensory exam with mono filament and a pulse exam). Codes in the following value set will meet these criteria: -Any code in the Physical Exam, Performed: Visual Exam of Foot value set -Any code in the Physical Exam, Performed: Sensory Exam of Foot -Any code in Physical Exam, Performed: Pulse Exam of Foot The minimum medical record documentation includes a note indicating the date when the exam was performed and the result. No data collection instrument provided Attachment 0056_CDC_Foot_Exam_Value_Set_.xlsx	Claims, Other, Paper Medical Records DATA COLLECTION TOOL To assist with the data collection at each physician practice site, an On-Site Adjudication Tool (OSAT) was developed by Telligen. The tool was customized to capture the data elements for Evaluation of Footwear and Neurological Evaluation performance measures. In addition to assisting the auditor with verification of age, diabetes mellitus, and history of bilateral foot/leg amputation, the tool provided the ability to capture location of documentation for each individual data element. Upon completion of abstraction at each on-site visit, the auditors performed back-up onto an encrypted flash drive. At the completion of the audit, the case results were exported from the tool and analyzed. No patient or physician identifiable information was captured. The tool provided the ability to enter data for a maximum of 100 cases per practice site. OSAT was developed using the Product Designer Module. The module is used to compose abstraction resource files which define abstraction components. The module allows for unique project creation, while tailoring features to each customer's needs. Questions, answers, and measures are added as defined by the project. In addition, the tool is sophisticated enough to allow for the creation of skip, edit, and measure logic, based on the needs of the project. Skip logic defines rules for enabling questions based on defined patterns. Edit logic defines validations to be performed on answers provided by users of the tool. During the design phase, functionality tests were conducted with ongoing abstractor recommendations being incorporated into the application. Once the design functionality was complete, an OSAT build was created and tested to ensure readiness for field use. Available in attached appendix at A.1 Attachment NQF_0417_codes-635284935772565257.xlsx
Level	Clinician : Group/Practice, Clinician : Individual	Clinician : Individual
Setting	Outpatient Services	Outpatient Services
Numerator Statement	Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period.	Patients who had a lower extremity neurological exam performed at least once within 12 months Definition: Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation. Numerator Quality-Data Coding Options for Reporting Satisfactorily: Lower Extremity Neurological Exam Performed G8404: Lower extremity neurological exam performed and documented OR Lower Extremity Neurological Exam not Performed for Documented Reasons G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure OR Lower Extremity Neurological Exam not Performed G8405: Lower extremity neurological exam not performed
Numerator Details	Time period for data: a measurement year (12 months) ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b. MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the exam was performed and the result. The patient is numerator compliant if a foot exam during the measurement year and result are documented. The patient is not numerator compliant if the result for the foot exam and result during the measurement year are missing. Ranges and thresholds do not meet criteria for this measure.	GXXXX- Lower extremity neurological exam performed, GXXXX Lower Extremity Neurologcial Exam not Performed for Documented Reasons, OR GXXXX Lower Extremity Neurological Exam not performed
Denominator Statement	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year.	All patients aged 18 years and older with a diagnosis of diabetes mellitus
Denominator Details	ENCOUNTER: Patients who had a visit (office visit, face to face encounter, preventive care services, home healthcare services, annual wellness) during the measurement period PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES: Alpha-glucosidase inhibitors: Acarbose, Miglitol	Denominator Criteria (Eligible Cases): Patients aged = 18 years on date of encounter AND Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33,

	0056 Diabetes: Foot Exam	0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation
	Amylin analogs: Pramlinitide Antidiabetic combinations: Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-saxagliptin, Metformin-sitagliptin , Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, insulin human inhaled Meglitinides: Nateglinide, Repaglinide Glucagon-like peptide-1 (GLP1) agonists: Dulaglutide, Exenatide, Liraglutide, Albiglutide Sodium glucose cotransporter 2 (SGLT2) inhibitor: Canagliflozin, Dapagliflozin, Empagliflozin Sulfonylureas: Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone Dipeptidyl peptidase-4 (DDP-4) inhibitors: Alogliptin, Linagliptin, Saxagliptin, Sitagliptin	250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93 Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9 AND Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
Exclusions	-Patients with a diagnosis of secondary diabetes due to another condition (e.g. a diagnosis of gestational or steroid-induced diabetes) -Patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period. -Exclude patients who were in hospice care during the measurement year	Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer's, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation.
Exclusion Details	ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b. MEDICAL RECORD Exclusionary evidence in the medical record must include a note indicating a diagnosis of gestational or steroid-induced diabetes, patients who had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee, or who are in hospice care.	896.2 Amputation, foot, bilateral, partial or complete, traumatic, not complicated 896.3 Amputation, foot, bilateral, partial or complete, traumatic, complicated 897.0 Amputation, below knee, unilateral, traumatic, not complicated 897.1 Amputation, below knee, unilateral, traumatic, complicated 897.2 Amputation, at or above knee, unilateral, traumatic, not complicated 897.3 Amputation, at or above knee, unilateral, traumatic, complicated 897.6 Amputation, bilateral, any level, traumatic, not complicated 897.7 Amputation, bilateral, any level, traumatic, complicated
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	
Type Score	Rate/proportion better quality = higher score	Ratio better quality = higher score
Algorithm	STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria. -AGES: 18-75 years as of December 31 of the reporting period. -EVENT/DIAGNOSIS: Identify patients who had a diagnosis of diabetes with a visit during the measurement period. *SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S2.B STEP 2. Determine the number of patients in the eligible population who had a recent foot exam (visual inspection with a sensory exam and a pulse exam) exam during the measurement year through the search of administrative data systems. STEP 3. Identify patients with a most recent foot exam performed and the result. STEP 4. Identify the most recent foot exam with a result during the reporting period (numerator compliant). Identify the most recent result foot exam without a result or a missing foot exam (not numerator compliant).	A (# of patients meeting numerator criteria)/ PD (# of patients in denominator) – C (# of patients with valid denominator exclusions)

	0056 Diabetes: Foot Exam	0417 Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation
	STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured. *SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.9 STEP 6. Calculate the rate (number of patients that received a foot exam during the measurement year).	
Submission items	5.1 Identified measures: 0417 : Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0056 identifies adults with diabetes (age 18-75) that had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year. 5b.1 If competing, why superior or rationale for additive value: 0056 has a long history of use and is implemented in two national programs (PRQS and DRP). RESPONSE TO 5a.2 (insufficient space above) Measure 0056 identifies adults with diabetes (age 18-75) that had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year. HARMONIZED ELEMENTS: Both measures are harmonized on the target population of diabetic adults and the measure focus of lower extremity exam. The denominator for each measure are harmonized to include all adult patients with a diagnosis of diabetes mellitus. The care setting is harmonized for measure 0056 and 0417 in at least one care setting (Ambulatory Care: Clinician Office/ Clinic). In addition, the data source (administrative claims) and level of analysis (clinicians: individual) are harmonized for both measures. UNHARMONIZED MEASURE ELEMENTS: Data Source: Measure 0056 is specified for paper medical records, administrative claims and electronic clinical data while measure 0417 is specified for administrative claims only. Measure 0056 is included in the CMS PQRS program and in NCQA's Diabetes Recognition Program (DRP) for physician reporting. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN: Measure 0056 provide more options for reporting based on available data sources. Measure 0417 is specified for only administrative claims.	5.1 Identified measures: 0056 : Diabetes: Foot Exam 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Age range of 18-75 years in measure 0056 limits data collection and leaves an vulnerable population unaddressed. 5b.1 If competing, why superior or rationale for additive value: The most significant factor related to the development of a diabetic foot ulceration is the loss of protective sensation related to peripheral neuropathy. Visual inspection and vascular evaluation have shown little predictive value related to development of diabetic foot ulcerations. Measure 0056 only requires a sensory exam by monofilament, yet the ADA 2014 Standards of Care under Foot Exam specify the following: "For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (LOPS) (10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold)." The above description for a neurological examination is exactly reflected in measure 0417. With the discrepancy in age and the difference in the exams required, measure 0417 should be maintained. Ideally, a composite measure that incorporates all components of an annual diabetic foot exam should be implemented. APMA is working on the development of such a measure and it is included as part of the USWR QCDR for 2014. This should help with testing of this composite measure as well as developing measure specifications. Until such a measure is approved, it would make sense to maintain both measure 0056 and 0417. Also, measure 0056 previously in PQRS was described as doing one of the three components to report (either visual inspection, sensory exam or pulse evaluation) so any data reported prior to 2014 would not necessarily include a neurological examination. The measure has changed for PQRS 2014 to now require all three elements, but prior to 2014 could be achieved with just visual inspection--a very low level requirement with questionable value.

Appendix E2: Related and Competing Measures (narrative format)

Comparison of NQF 0037, NQF 0046, and NQF 0053

0037 Osteoporosis Testing in Older Women (OTO)
0046 Screening for Osteoporosis for Women 65-85 Years of Age
0053 Osteoporosis Management in Women Who Had a Fracture

Steward

0037 Osteoporosis Testing in Older Women (OTO)

National Committee for Quality Assurance

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

National Committee for Quality Assurance

0053 Osteoporosis Management in Women Who Had a Fracture

National Committee for Quality Assurance

Description

0037 Osteoporosis Testing in Older Women (OTO)

The percentage of women 65-85 years of age who report ever having received a bone density test to check for osteoporosis.

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

Percentage of women 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) test to check for osteoporosis.

0053 Osteoporosis Management in Women Who Had a Fracture

The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.

Type

0037 Osteoporosis Testing in Older Women (OTO)

Process

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

Process

0053 Osteoporosis Management in Women Who Had a Fracture

Process

Data Source

0037 Osteoporosis Testing in Older Women (OTO)

Instrument-Based Data The Medicare Health Outcome Survey can be administered by mail or telephone using a CATI protocol. It is offered in English, Spanish, and Chinese (mailed survey only). Detailed instructions for the administration of the Health Outcomes Survey and the complete survey can be found at www.hosonline.org.

Available at measure-specific web page URL identified in S.1 No data dictionary

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

Electronic Health Data, Electronic Health Records, Paper Medical Records This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the Quality Payment Program this measure is coded using G-codes specific to quality measurement.

No data collection instrument provided No data dictionary

0053 Osteoporosis Management in Women Who Had a Fracture

Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records Health Plan Level:

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

Physician Level:

This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the Quality Payment Program, this measure is collected using G-codes specific to quality measurement.

No data collection instrument provided Attachment 0053_OMW_Value_Sets.xlsx

Level

0037 Osteoporosis Testing in Older Women (OTO)

Health Plan

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

Clinician : Group/Practice, Clinician : Individual

0053 Osteoporosis Management in Women Who Had a Fracture

Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System

Setting

0037 Osteoporosis Testing in Older Women (OTO)

Outpatient Services

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

Outpatient Services

0053 Osteoporosis Management in Women Who Had a Fracture

Outpatient Services

Numerator Statement

0037 Osteoporosis Testing in Older Women (OTO)

The number of women who report having ever received a bone mineral density test of the hip or spine.

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

The number of women who have documentation in their medical record of having received a DXA test of the hip or spine.

0053 Osteoporosis Management in Women Who Had a Fracture

Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis after a fracture occurs.

Numerator Details

0037 Osteoporosis Testing in Older Women (OTO)

The number of female patients 65-85 years of age who responded "yes" to question 52 in the Medicare Health Outcomes Survey.

Question 52: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip."

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

Documentation of a central dual-energy x-ray absorptiometry (DXA) test ever being performed.

The numerator criteria is met by documentation in the medical record that the patient has had a central dual-energy x-ray absorptiometry test. This measure is also collected in the Quality Payment Program using the following codes specific to the quality measure:

Performance Met: G8399 Patient with documented results of a central Dual-energy X-Ray Absorptiometry (DXA) ever being performed.

Performance Not Met: G8400 Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented, reason not given.

0053 Osteoporosis Management in Women Who Had a Fracture

Patients who received either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after a fracture. Appropriate testing or treatment for osteoporosis after the fracture is defined by any of the following criteria:

- A bone mineral density test (see Table OMW-X) in any setting, on earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture. If the earliest date of service with the diagnosis of fracture was during an inpatient stay, a bone mineral density test taking place during the inpatient stay counts.

- Osteoporosis therapy, including long-acting injectables, on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture. If the earliest date of service with the diagnosis of fracture was an inpatient stay, long-acting osteoporosis medication received during the inpatient stay counts.

- A dispensed prescription to treat osteoporosis (see Table OMW-C) on the earliest date of service with the diagnosis of fracture or in the 180-day (6-month) period after the fracture.

Table OMW-X: Bone Mineral Density Tests

Central dual-energy x-ray absorptiometry, computed tomography, single energy x-ray absorptiometry, ultrasound

Table OMW-C: Osteoporosis Medication

Biphosphates: Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid

Other: Calcitonin, Denosumab, Raloxifene, Teriparatide

The numerator for this measure can be identified using either administrative claims or review of medical records. The following criteria are used to identify the numerator criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.

For Medical Record Review Methodology (Physician Level)

When using the medical record as the data source, the numerator criteria is met by documentation that a Bone Mineral Density Test was performed or an osteoporosis therapy was prescribed. This may include a prescription given to patient for treatment of osteoporosis at one or more encounters during the reporting period. This measure is also collected in the Quality Payment Program, previously referred to as the Physician Quality Reporting System, using G-codes specific to the quality measure:

- 3095F Central Dual-energy X-Ray Absorptiometry (DXA) results documented

- G8633 Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

For Administrative Methodology (Health Plan Level)

When using administrative claims as the data source, the numerator criteria is met by one or more codes in the following value sets:

Bone Mineral Density Tests Value Set

Osteoporosis Medications Value Set

A pharmacy claim for a medication listed in Table OMW-C

See S.2b. (Data Dictionary Code Table) for all value sets.

Denominator Statement

0037 Osteoporosis Testing in Older Women (OTO)

Women age 65-85.

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

Women age 65-85.

0053 Osteoporosis Management in Women Who Had a Fracture

Women who experienced a fracture, except fractures of the finger, toe, face or skull. Three denominator age strata are reported for this measure:

Women age 50-64

Women age 65-85

Women age 50-85

Denominator Details

0037 Osteoporosis Testing in Older Women (OTO)

The number of women 65-85 years of age who responded to question 52 on the Medicare Health Outcome Survey.

Question 52: “Have you ever had a bone density test to check for osteoporosis, sometimes thought of as ‘brittle bones’? This test would have been done to your back or hip.”

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

Women who had a documented patient encounter (see Table 1 for encounter codes) during the reporting period.

Table 1: Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

0053 Osteoporosis Management in Women Who Had a Fracture

The denominator for this measure is identified by administrative codes which are specific to the level of reporting. When reporting this measure at the health plan level include all individuals with fractures enrolled in the health plan (i.e. all individuals with encounters for fractures in the health plan – inpatient and outpatient). When reporting this measure at the physician level include all individuals with fractures seen by the eligible provider (i.e., all individuals with encounters for fracture with the eligible provider).

Health Plan Level Denominator Details:

Women who had an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. This is the index fracture. If the patient had more than one fracture during the intake period, include only the first fracture. See S.2b. (Data Dictionary Code Table) for all value sets.

Physician Level Denominator Details:

Women who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set).

Table 1: Patient encounter during the reporting period:

CPT Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

CPT Procedure codes: 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22510, 22511, 22513, 22514, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

Exclusions

0037 Osteoporosis Testing in Older Women (OTO)

Women who received hospice care during the year.

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

Diagnosis of osteoporosis at the time of the encounter.

Patient receiving hospice services anytime during the measurement period.

0053 Osteoporosis Management in Women Who Had a Fracture

- Exclude women who had a bone mineral density test during the 24 months prior to the index fracture.

- Exclude women who had a claim/encounter for osteoporosis treatment during 12 months prior to the index fracture.

- Exclude women who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the index fracture.

- Exclude women who are enrolled in a Medicare Institutional Special Needs Plan (I-SNP) or living long-term in an institution any time during the measurement year.

- Exclude women receiving hospice care during the measurement year.

Exclusion Details

0037 Osteoporosis Testing in Older Women (OTO)

Women who responded to the Medicare Health Outcomes Survey who were identified with the 'Hospice Flag' in the survey response data file.

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

The denominator exclusion criteria is met by documentation in the medical record of a diagnosis of osteoporosis at the time of the encounter (see Table 2 for diagnosis codes).

Table 2: Diagnosis of osteoporosis on date of encounter (ICD-10-CM): M80.00XA, M80.00XD, M80.00XG, M80.00XK, M80.00XP, M80.00XS, M80.011A, M80.011D, M80.011G, M80.011K, M80.011P, M80.011S, M80.012A, M80.012D, M80.012G, M80.012K, M80.012P, M80.012S, M80.019A, M80.019D, M80.019G, M80.019K, M80.019P, M80.019S, M80.021A, M80.021D, M80.021G, M80.021K, M80.021P, M80.021S, M80.022A, M80.022D, M80.022G, M80.022K, M80.022P, M80.022S, M80.029A, M80.029D, M80.029G, M80.029K, M80.029P, M80.029S, M80.031A, M80.031D, M80.031G, M80.031K, M80.031P, M80.031S, M80.032A, M80.032D, M80.032G, M80.032K, M80.032P, M80.032S, M80.039A, M80.039D, M80.039G, M80.039K, M80.039P, M80.039S, M80.041A, M80.041D, M80.041G, M80.041K, M80.041P, M80.041S, M80.042A, M80.042D, M80.042G, M80.042K, M80.042P, M80.042S, M80.049A, M80.049D, M80.049G, M80.049K, M80.049P, M80.049S, M80.051A, M80.051D, M80.051G, M80.051K, M80.051P, M80.051S, M80.052A, M80.052D, M80.052G, M80.052K, M80.052P, M80.052S, M80.059A, M80.059D, M80.059G, M80.059K, M80.059P, M80.059S, M80.061A, M80.061D, M80.061G, M80.061K, M80.061P, M80.061S, M80.062A, M80.062D, M80.062G, M80.062K, M80.062P, M80.062S, M80.069A, M80.069D, M80.069G, M80.069K, M80.069P, M80.069S, M80.071A, M80.071D, M80.071G, M80.071K, M80.071P, M80.071S,M80.072A, M80.072D, M80.072G, M80.072K, M80.072P, M80.072S, M80.079A, M80.079D, M80.079G, M80.079K, M80.079P, M80.079S, M80.08XA, M80.08XD, M80.08XG, M80.08XK, M80.08XP, M80.08XS, M80.80XA, M80.80XD, M80.80XG, M80.80XK, M80.80XP, M80.80XS, M80.811A, M80.811D, M80.811G, M80.811K, M80.811P, M80.811S, M80.812A, M80.812D, M80.812G, M80.812K, M80.812P, M80.812S, M80.819A, M80.819D, M80.819G, M80.819K, M80.819P, M80.819S, M80.821A, M80.821D, M80.821G, M80.821K, M80.821P, M80.821S, M80.822A, M80.822D, M80.822G, M80.822K, M80.822P, M80.822S, M80.829A, M80.829D, M80.829G, M80.829K, M80.829P, M80.829S, M80.831A, M80.831D, M80.831G, M80.831K, M80.831P, M80.831S, M80.832A, M80.832D, M80.832G, M80.832K, M80.832P, M80.832S, M80.839A, M80.839D, M80.839G, M80.839K, M80.839P, M80.839S, M80.841A, M80.841D, M80.841G, M80.841K, M80.841P, M80.841S, M80.842A, M80.842D, M80.842G, M80.842K, M80.842P, M80.842S, M80.849A, M80.849D, M80.849G, M80.849K, M80.849P, M80.849S, M80.851A, M80.851D, M80.851G, M80.851K, M80.851P, M80.851S, M80.852A, M80.852D, M80.852G, M80.852K, M80.852P, M80.852S, M80.859A, M80.859D, M80.859G, M80.859K, M80.859P, M80.859S, M80.861A, M80.861D, M80.861G, M80.861K, M80.861P,

M80.861S, M80.862A, M80.862D, M80.862G, M80.862K, M80.862P, M80.862S, M80.869A, M80.869D, M80.869G, M80.869K, M80.869P, M80.869S, M80.871A, M80.871D, M80.871G, M80.871K, M80.871P, M80.871S, M80.872A, M80.872D, M80.872G, M80.872K, M80.872P, M80.872S, M80.879A, M80.879D, M80.879G, M80.879K, M80.879P, M80.879S, M80.88XA, M80.88XD, M80.88XG, M80.88XK, M80.88XP, M80.88XS, M81.0, M81.6, M81.8

0053 Osteoporosis Management in Women Who Had a Fracture

1) Exclude patients with a previous fracture: patients with an outpatient visit (see Outpatient Value Set), an observation visit (see Observation Value Set), an ED visit (see ED Value Set), a nonacute inpatient encounter (see Nonacute Inpatient Value Set) or an acute inpatient encounter (see Acute Inpatient Value Set) for a fracture (see Fractures Value Set) during the 60 days (2 months) prior to the earliest date of service with a diagnosis of fracture. For index fractures requiring an inpatient stay, use the admission date as the earliest date of service with a diagnosis of fracture. For direct transfers, use the first admission date as the earliest date of service with a diagnosis of fracture.

2) Exclude patients who had a Bone Mineral Density test (see Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the earliest date of service with a diagnosis of fracture.

3) Exclude patients who had a claim/encounter for osteoporosis therapy (see Osteoporosis Medications Value Set) or received a dispensed prescription to treat osteoporosis (see Table OMW-C) during the 365 days (12 months) prior to the earliest date of service with a diagnosis of fracture.

4) Exclude patients who live long-term in Institutional settings (as identified by the LTI flag in the Medicare Part C monthly membership file) or are enrolled in a Medicare Institutional Special Needs Plan during the measurement year.

5) Exclude patients who are in hospice care during the measurement year (as identified by the Medicare plan's enrollment file).

Table OMW-C: Osteoporosis Therapies

Alendronate, Alendronate-cholecalciferol, Ibandronate, Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Teriparatide

The denominator exclusions for this measure can be identified using administrative claims, health plan enrollment data or review of medical record. The following criteria are used to identify the denominator exclusion criteria for each method. *Note this measure has been tested using medical record review at the physician level and administrative data at the health plan level.

For Medical Record Review Methodology (Physician Level)

When using the medical record as the data source, the denominator exclusion criteria can be met by documentation that a previous fracture occurred, a bone mineral density test was performed or an osteoporosis therapy was prescribed during the specified timeframe prior to the fracture. In the Physician Quality Reporting System (PQRS) this exclusion is collected using G-codes specific to quality measurement:

- 3095F or 4005F with 1P: Documentation of medical reason(s) for not performing a bone mineral density test or not prescribing pharmacologic therapy for osteoporosis (i.e. history of fracture in 60 days prior to index fracture, bone mineral density test in 24 months prior

to index fracture, or pharmacologic treatment for osteoporosis in 12 months prior to index fracture).

For Administrative Methodology (Health Plan Level)

When using administrative claims as the data source, the denominator exclusion criteria is met using the following value sets referenced above during the specified time frame prior to the fracture.

Outpatient Value Set

ED Value Set

Nonacute Inpatient Value Set

Acute Inpatient Value Set

Fractures Value Set

Bone Mineral Density Tests Value Set

Osteoporosis Medications Value Set

See S.2b. (Data Dictionary Code Table) for all value sets.

Risk Adjustment

0037 Osteoporosis Testing in Older Women (OTO)

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

0053 Osteoporosis Management in Women Who Had a Fracture

No risk adjustment or risk stratification

Stratification

0037 Osteoporosis Testing in Older Women (OTO)

N/A

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

N/A

0053 Osteoporosis Management in Women Who Had a Fracture

N/A

Type Score

0037 Osteoporosis Testing in Older Women (OTO)

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

0053 Osteoporosis Management in Women Who Had a Fracture

Rate/proportion better quality = higher score

Algorithm

0037 Osteoporosis Testing in Older Women (OTO)

Step 1: Identify the eligible population – Of those who were selected to receive a survey, identify all female patients age 65-85 who answered Question 52: "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test would have been done to your back or hip."

Step 2: Determine the number of patients in the eligible population who responded "Yes".

Step 3: Calculate a rate (the number of patients who responded "yes" divided by the eligible population)

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

Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-Sex: Females

-Age: 65-85 years of age

-Patient encounter during the reporting period (12 months)

Step 2: Exclude from the eligible population in step 1 patients who have a diagnosis of osteoporosis at time of encounter.

Step 3: Identify the number of patients with a central dual-energy x-ray absorptiometry test documented.

Step 4: Calculate the rate (number of patients who had a central dual-energy x-ray absorptiometry test documented divided by the eligible population).

0053 Osteoporosis Management in Women Who Had a Fracture

Health Plan Level:

Step 1: Identify all female patients who had a new fracture during the intake period (12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year).

Step 2: Exclude patients who had previous bone mineral density test and patients who had previous osteoporosis treatment. Also exclude patients living long-term in institutional settings and patients receiving hospice care.

Step 3: Of those patients remaining after Step 2 (i.e., the denominator), identify those who received bone mineral density testing or osteoporosis treatment in the 6-month period following the fracture.

Step 4: To calculate the rate, take the number of patients who received testing or treatment and divide by the number of people calculated to be in the denominator.

Physician Level:

Step 1: Identify all female patients in each age strata who had a documented patient encounter with the eligible provider with a new diagnosis of fracture.

Step 2: Exclude patients who had who had previous bone mineral density test and patients who had previous osteoporosis treatment. Also exclude patients living long-term in institutional settings and patients receiving hospice care.

Step 3: Of those patients remaining after Step 2 (i.e., the denominator), identify all patients who had a documented bone mineral density test or pharmacologic treatment after the fracture.

Step 4: To calculate the rate, take the number of patients who received testing or pharmacologic treatment and divide by the number of people calculated to be in the denominator.

Submission items

0037 Osteoporosis Testing in Older Women (OTO)

5.1 Identified measures: 0046 : Screening for Osteoporosis for Women 65-85 Years of Age

0053 : Osteoporosis Management in Women Who Had a Fracture

2417 : Risk Assessment/Treatment After Fracture

5a.1 Are specs completely harmonized? Yes

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

5b.1 If competing, why superior or rationale for additive value: There are multiple NQF-endorsed measures of osteoporosis prevention and management. During the last measure update in 2014, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0037) and the most closely related measure, 0046.

Measure 0046 assesses the percentage of women who have a bone mineral density test to screen for osteoporosis. Measure 0046 is collected using medical record review and is only specified for physician level reporting). The rationale for different data sources is the availability of data for the level of reporting.

Measure 0037 is a health plan level measure. Since the recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk, the measure is specified as “ever” having a bone mineral density test. It is not feasible for a Medicare Advantage plan to have access to enough historical claims data or medical record data to determine if its entire member population has ever had a bone mineral density test. Therefore, a survey method is the recommended data source for collecting this type of historical data.

Measure 0046 is a physician level measure. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, this measure looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on past care.

The harmonized measure elements described below are reflective of the most recent measure versions submitted for endorsement.

Harmonized Measure Elements between 0037 and 0046:

- Type of Test: Because measure 0037 is a survey measure, the term “bone mineral density test” is used to refer to dual energy x-ray absorptiometry test. The simplified term is used because cognitive testing indicated it was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however 0046 is able to capture more specificity about the type of test done due to the data source used for measure collection.

- Eligible Population: Both measures are focused on women age 65-85 years of age.

- Timeframe for testing: Both measures address whether testing was done at least once in the woman's lifetime.

Given the two different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however, the two measures address the same quality gap for different levels of accountability.

- Measure 0037 addresses whether a health plan is addressing the risk for osteoporosis in the patient population by determining the percent of the population that had a bone mineral density test regardless who their provider is. This test may have been done outside of the context of their primary care provider.

- Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction.

Measure 0053 addresses a different population than 0037 (i.e., women who have experienced a fragility fracture), and is therefore focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Measure 2417 also focuses on those who had a fragility fracture and then received secondary prevention. Therefore, we consider these measures to be related but not competing. The differences between these measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures.

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

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

0048 : Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

0053 : Osteoporosis Management in Women Who Had a Fracture

0037 : Osteoporosis Testing in Older Women (OTO)

2416 : Laboratory Investigation for Secondary Causes of Fracture

2417 : Risk Assessment/Treatment After Fracture

5a.1 Are specs completely harmonized? Yes

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

5b.1 If competing, why superior or rationale for additive value: Although 0037 and 0046 have the same measure focus and same target population they are specified for different levels of analysis and accountability, and use different data sources. We have described above where the measures are conceptually harmonized and the rationale for where the measures cannot be harmonized in their technical specifications due to the level of analysis and data source.

RESPONSE TO 5a.2 (insufficient space above):

There are multiple NQF-endorsed measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure

focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0046) and the most closely related measure, 0037.

Measure 0046 assesses the percentage of women who have a bone mineral density test to screen for osteoporosis. Measure 0046 is collected using medical record review and is only specified for physician level reporting. The rationale for different data sources is the availability of data for the level of reporting.

- Measure 0037 is a health plan level measure. Since the recommended timeframe for osteoporosis testing is at least once since turning age 65 or prior to age 65 if at risk, the measure is specified as "ever" having a bone mineral density test. It is not feasible for a Medicare Advantage plan to have access to enough historical claims data or medical record data to determine if the entire member population ever had a bone mineral density test. Therefore a survey method is the recommended data source for collecting this type of historical data.

- Measure 0046 is a physician level measure. Physicians are limited by the same lack of historical data, but also have limited resources to field and collect a survey of their patient population. Therefore, this measure looks for documentation in the medical record that a bone mineral density test was performed. This documentation may come from previous medical records requested by the current physician on past care.

The harmonized measure elements described below are reflective of the most recent measure versions submitted for endorsement.

Harmonized Measure Elements between 0037 and 0046:

- Type of Test: Because measure 0037 is a survey measure, the term "bone mineral density test" is used to refer to "dual energy x-ray absorptiometry test." This term is used because cognitive testing indicated the term was more understandable to survey respondents. We have harmonized the two measures by ensuring both measures only capture testing done of the hip or spine; however, 0046 is able to capture more specific about the type of test done due to the data source used for measure collection.

- Eligible Population: Both measures are focused on women age 65-85 years of age.

- Timeframe for testing: Both measures address whether testing was done at least once in the woman's lifetime.

Given the two different data sources, we do not expect the two measures (0037 and 0046) to have exactly comparable results; however, the two measures address the same quality gap for different levels of accountability.

- Measure 0037 addresses whether a health plan is addressing the risk for osteoporosis in the patient population by determining the percent of the population that had a bone mineral density test regardless who their provider is. This test may have been done outside of the context of their primary care provider.

- Measure 0046 addresses whether individual providers are addressing the risk for osteoporosis in their patient population by determining if an individual had a bone mineral density test to screen for osteoporosis and if their provider is aware of those results and can advise on appropriate risk reduction.

Measures 0045, 0048, 0053, 2416, and 2417 address a different population than 0046. These measures address women who have experienced a fracture, and are focused on secondary prevention of future fractures as opposed to screening for osteoporosis. Therefore, we consider these measures to be related but not competing. The differences

between these measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence we have aligned the measures.

0053 Osteoporosis Management in Women Who Had a Fracture

5.1 Identified measures: 0046 : Screening for Osteoporosis for Women 65-85 Years of Age

0037 : Osteoporosis Testing in Older Women (OTO)

2416 : Laboratory Investigation for Secondary Causes of Fracture

2417 : Risk Assessment/Treatment After Fracture

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Insufficient Space - please see 5b.1.

5b.1 If competing, why superior or rationale for additive value: Response to 5a.2 (insufficient space above): There are multiple measures of osteoporosis prevention and management. During the last measure update in 2014, this measure was harmonized to align with applicable existing NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0053) and the most closely related measures, 0037, 0046, 2416, 2417.

NCQA OWNED RELATED MEASURES

0037: Osteoporosis Testing in Older Women

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

Measures 0037 and 0046 assess the number of women 65-85 who report ever having received a bone density test to check for osteoporosis. These measures focus on screening for osteoporosis in the general population, whereas measure 0053 is focused on secondary prevention in a population of women who have experienced a fracture. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and secondary prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures.

OTHER RELATED MEASURES

The other osteoporosis management related measures are more narrowly focused than the NCQA measures. These measures (2416, 2417) are hospital-level accountability measures and focus solely on women who were hospitalized for fractures.

2416: Laboratory Investigation for Secondary Causes of Fracture

Measure 2416 assesses the percentage of patients age 50 and over who were hospitalized for a fragility fracture and had the appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from an inpatient hospitalization. This measure has a different focus from measure 0053 (identifying cause of fracture as opposed to screening/treatment for osteoporosis). While the target population of this measure overlaps with the target population of 0053, measure 2416 is restricted to fractures that require hospitalization whereas 0053 focuses on a broader population. Therefore, we consider these measures to be related but not competing. Measure 2416 captures some of the same quality focus as 0053 but is designed to be appropriate for hospital-level accountability and is therefore restricted to hospitalized individuals. The

differences between this measure and 0053 are reflective of the different measure intents and level of accountability.

2417: Risk Assessment/Treatment After Fracture

Measure 2417 assesses the number of patients age 50 and over who were hospitalized for a fragility fracture and have either a dual-energy x-ray absorptiometry (DXA) scan ordered or performed, a prescription for FDA-approved pharmacotherapy, or are linked to a fracture liaison service prior to discharge from an inpatient hospitalization. If DXA is not available and documented, then any other specified fracture risk assessment method may be ordered or performed. This measure has a similar focus to 0053 and an overlapping target population (individuals hospitalized for a fragility fracture). Therefore, this measure could be considered competing with 0053; however, 2417 is designed to focus on hospital-level accountability and therefore is only inclusive of populations and services provided within the hospital setting. Measure 0053 is designed to be broader and capture both outpatient and inpatient populations and services.

Response to 5b.1: This measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure:2417 Risk Assessment/Treatment After Fracture.

Measure 0053 is designed to be as broad as possible to include the largest possible population (all women age 50 and over with a fracture other than face, finger, toe, and skull) and include the broadest possible settings of care (inpatient and outpatient). The measure is designed for both health plan and outpatient physician level accountability. It is focused on guideline recommended care for osteoporosis management after a fracture. Measure 2417 is designed to be appropriate for hospital-level accountability and therefore focuses on a smaller population (all patients 50 and over hospitalized for a fragility fracture) and includes a single setting of care (inpatient). While some post-fracture care occurs in the inpatient setting, much of the responsibility for providing follow-up care for osteoporosis management in women rests with the outpatient care system and providers. Additionally, many patients who suffer a fracture may not be treated with an inpatient hospitalization. Therefore, it is important to have a measure that captures a broader population and settings of care for osteoporosis management following a fracture.

Comparison of NQF 0056 and NQF 0417

0056 Diabetes: Foot Exam

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

Steward

0056 Diabetes: Foot Exam

National Committee for Quality Assurance

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

American Podiatric Medical Association

Description

0056 Diabetes: Foot Exam

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

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

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

Type

0056 Diabetes: Foot Exam

Process

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

Process

Data Source

0056 Diabetes: Foot Exam

Electronic Health Data, Paper Medical Records This measure uses a combination of electronic health data and medical records. Foot exams can be identified by the following administrative data: receipt of a foot exam (visual inspection and sensory exam with mono filament and a pulse exam).

Codes in the following value set will meet these criteria:

-Any code in the Physical Exam, Performed: Visual Exam of Foot value set

-Any code in the Physical Exam, Performed: Sensory Exam of Foot

-Any code in Physical Exam, Performed: Pulse Exam of Foot

The minimum medical record documentation includes a note indicating the date when the exam was performed and the result.

No data collection instrument provided Attachment 0056_CDC_Foot_Exam_Value_Set_.xlsx

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

Claims, Other, Paper Medical Records DATA COLLECTION TOOL

To assist with the data collection at each physician practice site, an On-Site Adjudication Tool (OSAT) was developed by Telligen. The tool was customized to capture the data elements for Evaluation of Footwear and Neurological Evaluation performance measures. In addition to assisting the auditor with verification of age, diabetes mellitus, and history of bilateral foot/leg amputation, the tool provided the ability to capture location of documentation for each individual data element. Upon completion of abstraction at each on-site visit, the auditors performed back-up onto an encrypted flash drive. At the completion of the audit, the case results were exported from the tool and analyzed. No patient or physician identifiable information was captured. The tool provided the ability to enter data for a maximum of 100 cases per practice site.

OSAT was developed using the Product Designer Module. The module is used to compose abstraction resource files which define abstraction components. The module allows for unique project creation, while tailoring features to each customer's needs. Questions, answers, and measures are added as defined by the project. In addition, the tool is sophisticated enough to allow for the creation of skip, edit, and measure logic, based on the needs of the project. Skip logic defines rules for enabling questions based on defined patterns. Edit logic defines validations to be performed on answers provided by users of the tool. During the design phase, functionality tests were conducted with ongoing abstractor recommendations being incorporated into the application. Once the design functionality was complete, an OSAT build was created and tested to ensure readiness for field use.

Available in attached appendix at A.1 Attachment NQF_0417_codes-635284935772565257.xlsx

Level

0056 Diabetes: Foot Exam

Clinician : Group/Practice, Clinician : Individual

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

Clinician : Individual

Setting

0056 Diabetes: Foot Exam

Outpatient Services

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

Outpatient Services

Numerator Statement

0056 Diabetes: Foot Exam

Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period.

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

Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Lower Extremity Neurological Exam Performed

G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons

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

OR

Lower Extremity Neurological Exam not Performed

G8405: Lower extremity neurological exam not performed

Numerator Details

0056 Diabetes: Foot Exam

Time period for data: a measurement year (12 months)

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the exam was performed and the result. The patient is numerator compliant if a foot exam during the measurement year and result are documented. The patient is not numerator compliant if the result for the foot exam and result during the measurement year are missing. Ranges and thresholds do not meet criteria for this measure.

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

GXXXX- Lower extremity neurological exam performed, GXXXX Lower Extremity Neurologcial Exam not Performed for Documented Reasons, OR GXXXX Lower Extremity Neurological Exam not performed

Denominator Statement

0056 Diabetes: Foot Exam

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year.

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

All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Details

0056 Diabetes: Foot Exam

ENCOUNTER: Patients who had a visit (office visit, face to face encounter, preventive care services, home healthcare services, annual wellness) during the measurement period

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES:

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-saxagliptin, Metformin-sitagliptin , Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

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

Denominator Criteria (Eligible Cases):

Patients aged = 18 years on date of encounter

AND

Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

AND

Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Exclusions

0056 Diabetes: Foot Exam

-Patients with a diagnosis of secondary diabetes due to another condition (e.g. a diagnosis of gestational or steroid-induced diabetes)

-Patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period.

-Exclude patients who were in hospice care during the measurement year

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

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

Exclusion Details

0056 Diabetes: Foot Exam

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD

Exclusionary evidence in the medical record must include a note indicating a diagnosis of gestational or steroid-induced diabetes, patients who had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee, or who are in hospice care.

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

896.2

Amputation, foot, bilateral, partial or complete, traumatic, not complicated

896.3

Amputation, foot, bilateral, partial or complete, traumatic, complicated

897.0

Amputation, below knee, unilateral, traumatic, not complicated

897.1

Amputation, below knee, unilateral, traumatic, complicated

897.2

Amputation, at or above knee, unilateral, traumatic, not complicated

897.3

Amputation, at or above knee, unilateral, traumatic, complicated

897.6

Amputation, bilateral, any level, traumatic, not complicated

897.7

Amputation, bilateral, any level, traumatic, complicated

Risk Adjustment

0056 Diabetes: Foot Exam

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

Stratification

0056 Diabetes: Foot Exam

N/A

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

Type Score

0056 Diabetes: Foot Exam

Rate/proportion better quality = higher score

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

Ratio better quality = higher score

Algorithm

0056 Diabetes: Foot Exam

STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-AGES: 18-75 years as of December 31 of the reporting period.

-EVENT/DIAGNOSIS:

Identify patients who had a diagnosis of diabetes with a visit during the measurement period.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S2.B

STEP 2. Determine the number of patients in the eligible population who had a recent foot exam (visual inspection with a sensory exam and a pulse exam) exam during the measurement year through the search of administrative data systems.

STEP 3. Identify patients with a most recent foot exam performed and the result.

STEP 4. Identify the most recent foot exam with a result during the reporting period (numerator compliant). Identify the most recent result foot exam without a result or a missing foot exam (not numerator compliant).

STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured. *SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.9

STEP 6. Calculate the rate (number of patients that received a foot exam during the measurement year).

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

A (# of patients meeting numerator criteria)/

PD (# of patients in denominator) – C (# of patients with valid denominator exclusions)

Submission items

0056 Diabetes: Foot Exam

5.1 Identified measures: 0417 : Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0056 identifies adults with diabetes (age 18-75) that had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year.

5b.1 If competing, why superior or rationale for additive value: 0056 has a long history of use and is implemented in two national programs (PRQS and DRP).

RESPONSE TO 5a.2 (insufficient space above)

Measure 0056 identifies adults with diabetes (age 18-75) that had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year.

HARMONIZED ELEMENTS:

Both measures are harmonized on the target population of diabetic adults and the measure focus of lower extremity exam. The denominator for each measure are harmonized to include all adult patients with a diagnosis of diabetes mellitus. The care setting is harmonized for measure 0056 and 0417 in at least one care setting (Ambulatory

Care: Clinician Office/ Clinic). In addition, the data source (administrative claims) and level of analysis (clinicians: individual) are harmonized for both measures.

UNHARMONIZED MEASURE ELEMENTS:

Data Source: Measure 0056 is specified for paper medical records, administrative claims and electronic clinical data while measure 0417 is specified for administrative claims only. Measure 0056 is included in the CMS PQRS program and in NCQA's Diabetes Recognition Program (DRP) for physician reporting.

IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN: Measure 0056 provide more options for reporting based on available data sources. Measure 0417 is specified for only administrative claims.

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

5.1 Identified measures: 0056 : Diabetes: Foot Exam

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Age range of 18-75 years in measure 0056 limits data collection and leaves an vulnerable population unaddressed.

5b.1 If competing, why superior or rationale for additive value: The most significant factor related to the development of a diabetic foot ulceration is the loss of protective sensation related to peripheral neuropathy. Visual inspection and vascular evaluation have shown little predictive value related to development of diabetic foot ulcerations. Measure 0056 only requires a sensory exam by monofilament, yet the ADA 2014 Standards of Care under Foot Exam specify the following:

"For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and

amputations. The foot examination should include inspection,

assessment of foot pulses, and testing for loss of protective sensation (LOPS)

(10-g monofilament plus testing any one of the following: vibration using

128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration

perception threshold)."

The above description for a neurological examination is exactly reflected in measure 0417. With the discrepancy in age and the difference in the exams required, measure 0417 should be maintained. Ideally, a composite measure that incorporates all components of an annual diabetic foot exam should be implemented. APMA is working on the development of such a measure and it is included as part of the USWR QCDR for 2014. This should help with testing of this composite measure as well as developing measure specifications. Until such a measure is approved, it would make sense to maintain both measure 0056 and 0417. Also, measure 0056 previously in PQRS was described as doing one of the three components to report (either visual inspection, sensory exam or pulse evaluation) so any data reported prior to 2014 would not necessarily include a neurological examination. The measure has changed for PQRS 2014 to now require all three elements, but prior to 2014 could be achieved with just visual inspection--a very low level requirement with questionable value.

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ISBN 978-1-68248-100-4