NQF

NATIONAL QUALITY FORUM

CLINICIAN MEASURES

National Voluntary Consensus Standards for Clinicians—Additional Performance Measures 2008

A CONSENSUS REPORT

Foreword

INTEREST IN USING PERFORMANCE MEASURES to assess the quality of healthcare in the United States has increased greatly over the past decade. Performance measurement, public reporting, and payment incentives are commonplace for various facilities, including hospitals and nursing homes, as well as for individual clinicians. Measurement at the clinician level is being addressed on numerous fronts. The basic tools for all of these efforts are evidence-based performance measures that are important, scientifically sound, feasible, and usable.

During 2006 and 2007, NQF endorsed 141 consensus standards that focus on the clinician practice for a wide variety of conditions, including asthma/respiratory disease, bone and joint conditions, diabetes, heart disease, hypertension, mental health and substance abuse, and stroke; cross-cutting areas such as medication management, geriatrics, emergency care, obesity, and prevention, immunization, and screening; specialty areas, including cardiac surgery, eye disease, and prenatal care; and patient experience with care instruments. The measures reflect aspects of care (processes and outcomes) that are substantially influenced by the clinician performance.

This report presents 67 additional performance measures, including 3 measure pairs, and additional specifications for 3 currently endorsed measures in the areas of cancer care, infectious disease, perioperative care, and licensed independent practitioners. The measures apply to physicians (medical doctors/osteopathic doctors) as well as appropriately licensed independent practitioners.

NQF thanks the members of the Clinician Steering Committees and NQF Members for their dedication to improving measurement of clinician performance in these areas.

Janet M. Corrigan, PhD, MBA
President and Chief Executive Officer

National Quality Forum

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

Funding for this project has been provided by the Centers for Medicare & Medicaid Services (www.cms.hhs.gov).

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Executive Summary

THE DEVELOPMENT AND USE OF QUALITY MEASUREMENT at the clinician level is being addressed on numerous fronts through various ongoing activities such as the Robert Wood Johnson Foundation-sponsored Aligning Forces for Quality: The Regional Market project, many specialty boards' physician certification and maintenance of certification programs, the National Committee for Quality Assurance and health plan provider recognition programs, the Centers for Medicare & Medicaid's (CMS's) Better Quality Information to Improve Care for Medicare Beneficiaries Project, and CMS's Physician Quality Reporting Initiative. The basic tools for all of these efforts are evidence-based performance measures that are important, scientifically sound, feasible, and useable.

To date, the National Quality Forum has endorsed 141 performance measures that focus on clinician practice for a wide variety of conditions, such as diabetes, heart disease, mental health, and substance use, as well as cross-cutting areas such as medication management, geriatrics, emergency care, and obesity. The measures reflect an aspect of care (processes and outcomes) that are substantially influenced by clinician performance. This report presents 67 additional performance measures, including 3 measure pairs and additional specifications for 3 currently endorsed measures, in 4 areas. The purpose of these consensus standards is to improve the quality of healthcare—through accountability and public reporting—by standardizing quality measurement in all care settings. The clinician-level consensus standards are intended for use at all levels of analysis, including individual practitioners and small and large groups.

National Voluntary Consensus Standards for Clinicians: Additional Performance Measures 2008

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*Addition of foot and ankle codes to previously endorsed measures.

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Chapter 1: Introduction

Background

OVER THE PAST DECADE, interest in using performance measures to assess the quality of healthcare in the United States has skyrocketed. Performance measurement, public reporting, and payment incentives are commonplace for various facilities, including hospitals and nursing homes, as well as for individual clinicians. Measurement at the clinician level is being addressed on numerous fronts through ongoing activities such as the Robert Wood Johnson Foundation-sponsored Aligning Forces for Quality: The Regional Market project, many specialty boards' physician certification and maintenance of certification programs, the National Committee for Quality Assurance and health plan provider recognition programs, the Centers for Medicare & Medicaid Services (CMS's) Better Quality Information to Improve Care for Medicare Beneficiaries Project, and CMS's Physician Quality Reporting Initiative. The basic tools for all of these efforts are evidence-based performance measures that are important, scientifically sound, feasible, and useable.

Strategic Directions for NQF

NQF's mission includes three parts: 1) setting national priorities and goals for performance improvement, 2) endorsing national consensus standards for measuring and publicly reporting on performance, and 3) promoting the attainment of national goals through education and outreach programs. As greater numbers of quality measures are developed and brought to NQF for consideration, NQF must assist stakeholders in measuring "what makes a difference" and addressing what is important to achieve the best outcomes for patients and populations. An updated Measurement Framework promotes shared accountability and measurement across episodes of care with a focus on outcomes and patient engagement in decisionmaking coupled with measures of the healthcare process and cost/resource use. For more information, see www.qualityforum.org.

Several strategic issues have been identified to guide the consideration of candidate consensus standards:

DRIVE TOWARD HIGH PERFORMANCE. Over time, the bar of performance expectations should be raised to encourage the achievement of higher levels of system performance.

EMPHASIZE COMPOSITE MEASURES. Composite measures provide much-needed summary information pertaining to multiple dimensions of performance and are more comprehensible to patients and consumers.

MOVE TOWARD OUTCOME MEASUREMENT. Outcome measures provide information of keen interest to consumers and purchasers, and, when coupled with healthcare process measures, they provide useful and actionable information to providers. Outcome measures also focus attention on much-needed system-level improvements, because achieving the best patient outcomes often requires carefully designed care processes, teamwork, and coordinated action on the part of many providers.

FOCUS ON DISPARITIES IN ALL THAT WE DO. Some of the greatest performance gaps relate to care of minority populations. Particular attention should be focused on the most relevant race/ethnicity/language/socioeconomic strata to identify relevant measures for reporting.

NQF-Endorsed Voluntary Consensus Standards for Clinicians

During 2006 and 2007, NQF endorsed 141 consensus standards that focus on the clinician practice for a wide variety of conditions, including asthma/respiratory disease, bone and joint conditions, diabetes, heart disease, hypertension, mental health and substance abuse, and stroke; cross-cutting areas such as medication management, geriatrics, emergency care, obesity and prevention, immunization, and screening; specialty areas, including cardiac surgery, eye disease, and prenatal care; and patient experience with care instruments. The measures reflect aspects of care (processes and outcomes) that are substantially influenced by the clinician performance. The currently endorsed measures[i] apply to physicians (medical doctors/osteopathic doctors [MDs/DOs]) as well as appropriately licensed independent practitioners.

This report presents 67 additional performance measures, including 3 measure pairs, and additional specifications for 3 currently endorsed measures in the following areas:

- cancer care;
- infectious disease;
- perioperative care; and
- licensed independent practitioners—that is, nonphysician (non-MD/DO) professionals.

See Appendix A for the measure specifications.

[i] See
http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care–Part_1.aspx
http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care–Part_2.aspx

Purpose

The purpose of these consensus standards is to improve the quality of healthcare—through accountability and public reporting—by standardizing quality measurement in all care settings. All NQF-endorsed® measures are fully open source. The clinician-level consensus standards are intended for use at all levels of analysis, including individual practitioners and small and large groups. Implementing organizations should decide rules of attribution, sample size requirements, and statistical significance based on the characteristics and goals of the measurement program.

Evaluating Potential Consensus Standards

Candidate consensus standards were solicited though a Call for Measures in November 2007 and a search of the National Quality Measures Clearinghouse. All candidate standards were evaluated by one of four Steering Committees (Appendix B) using standardized criteria derived from the work of the NQF Strategic Framework Board and endorsed by NQF[1,2]:

1. Important—the extent to which a measure reflects a variation in quality and low levels of overall performance and captures key aspects of the flow of care.
2. Scientifically acceptable—the extent to which the measure is evidence based and will produce consistent and credible results when implemented.
3. Usable—the extent to which intended audiences (e.g., consumers, purchasers) can understand the results of the measure and are likely to find them useful for decisionmaking.
4. Feasible—the extent to which data can be obtained within the normal flow of clinical care and the extent to which an implementation plan can be achieved.

Time-Limited Endorsement

In December 2006, the NQF Board of Directors approved a recommendation from an ad hoc Committee to review the Consensus Development Process that "NQF should establish a 'time-limited endorsement' for measures that meet all evaluation criteria with the exception of adequate field testing." The ad hoc Committee noted the enormous pressures from public and private purchasers to introduce robust public reporting and pay-for-performance efforts for all settings and types of providers including individual clinicians and specialty providers. For some types of providers, performance measures that have been adequately tested to satisfy all of the NQF criteria or meet all of the thresholds or evidence grades may not yet exist. The ad hoc Committee advised that, "NQF should be flexible during this period of extraordinary transition in the healthcare industry."

The Steering Committees were advised that NQF's time-limited endorsement policy should be considered during their evaluation of candidate consensus standards. Additionally, the Steering Committees frequently noted that the testing required by the time-limited

endorsement would provide needed information on baseline performance and "gaps in care," as well as the reliability and feasibility of the measures.

Performance Versus Competence

Many stakeholders commented that some measures require such a low threshold for performance that they reflect basic competence and therefore do not provide valuable information on quality. The Steering Committees considered the differing views on what constitutes a "low-bar" measure. At times, Steering Committees chose to recommend a low-bar measure rather than not recommend the measure and be judged as silent on a measure that addresses an important topic. In most cases, the Steering Committees strongly recommended that the measure developers revise or create more robust measures.

Relationship to Other NQF-Endorsed Consensus Standards

This report does not represent the entire scope of NQF work relevant to the quality of cancer, infectious disease, and perioperative care. Particularly in the areas of cancer and perioperative care, the measures in this report expand upon consensus standards that were previously endorsed in other NQF projects.

Cancer Care

- *National Voluntary Consensus Standards for Quality of Cancer Care* (2006) presented a basic framework for cancer care quality measurement and endorsed 16 consensus standards for breast cancer, colorectal cancer, and end-of-life care.
- *National Voluntary Consensus Standards for Ambulatory Care: Phase III* (2006) endorsed three measures for breast cancer, colorectal cancer, and cervical cancer screening.
- *Toward a Comprehensive Cancer Measure Set—Episodes of Care* (ongoing) will build upon the work of the NQF priority-setting pilot project, which developed a measurement framework for evaluating efficiency across episodes of care. The aim of this project is to provide recommendations for a path forward for cancer quality measurement and a defined research agenda.

Perioperative Care

- *National Voluntary Consensus Standards for Hospital Care* (2004) endorsed three consensus standards for hospital surgical care.
- *National Voluntary Consensus Standards for Cardiac Surgery* (2004) endorsed 21 measures pertinent to hospital performance in the area of cardiac surgery.
- *National Voluntary Consensus Standards for Hospital Care: Specialty Physician Performance Measures* (2007) endorsed six consensus standards for clinicians in the areas of venous thromboembolism and antibiotic prophylaxis and cardiac surgery.
- *National Voluntary Consensus Standards for Hospital Care: Additional Priority Areas* (2007) and *Healthcare-Associated Infections* (2007) endorsed three consensus standards for the reduction of surgical complications.

The area of infectious disease, particularly hepatitis and HIV/AIDS, has not been addressed previously. This report represents the initial efforts to endorse measures in this area.

The full constellation of consensus standards provides a growing number of NQF-endorsed voluntary consensus standards that directly and indirectly reflect the importance of measuring and improving quality of care. Organizations that adopt these consensus standards will promote the development of safer and higher-quality care for patients throughout the nation.

Notes

1 The Strategic Framework Board's design for a national quality measurement and reporting system, *Med Care,* 2003;(Suppl 1):I-1–I-89.

2 National Quality Forum (NQF), *A National Framework for Healthcare Quality Measurement and Reporting: A Consensus Report,* Washington, DC: NQF; 2002.

Chapter 2: Cancer Care

Introduction

IN 2008, APPROXIMATELY 1.4 million men and women in the United States were expected to be diagnosed with some form of cancer, and half a million were expected to die of cancer.[1] A huge financial burden is associated with the high incidence of cancer in the United States, estimated at $219.2 billion for 2007.[2] Significant racial, ethnic, and geographic disparities in the burden of cancer exist.[3] Although great strides have been made in preventing, diagnosing, and treating the disease, variations in medical practice remain. Variations in the quality of care for cancer have been documented in the areas of diagnostic evaluation, surgery, adjuvant therapy, management of treatment toxicity, and post-treatment surveillance, which suggests that substantial opportunities for improvement exist.[4,5,6,7] To date, NQF has endorsed performance measures for clinician-level cancer screening and for cancer care at the institutional level (e.g., hospitals, health plans).

The Cancer Care Steering Committee evaluated 19 candidate consensus standards using the standard criteria that are appropriate for accountability and public reporting. This chapter presents the 14 measures and 1 measure pair that were recommended for evaluating the performance of clinicians caring for patients with cancer in the areas of general hematology and oncology (including radiation oncology), prostate cancer, and pathology pertaining to cancer.

Table 2.1: National Voluntary Consensus Standards for Clinicians: Cancer Care

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Hematology: myelodysplastic syndrome (MDS) and acute leukemias—baseline cytogenetic testing performed on bone marrow*	0377	Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow (CA-001-07)	ASH AMA PCPI
Hematology: documentation of iron stores in patients receiving erythropoietin therapy*	0378	Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy (CA-002-07)	ASH AMA PCPI
Hematology: chronic lymphocytic leukemia (CLL)—baseline flow cytometry*	0379	Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed (CA-003-07)	ASH AMA PCPI
Hematology: multiple myeloma—treatment with bisphosphonates*	0380	Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period (CA-004-07)	ASH AMA PCPI

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*Time-limited endorsement.

[a] Upon NQF endorsement, each measure receives a unique NQF measure ID number.

[b] Review number.

[c] IP owner(s)—intellectual property owner(s) and copyright holder(s). For the most current specifications and supporting information, please refer to the IP owner(s):
AMA PCPI - American Medical Association Physician Consortium for Performance Improvement (www.physicianconsortium.org)
ASCO - American Society of Clinical Oncology (www.asco.org)
ASH - American Society of Hematology (www.hematology.org)
ASTRO - American Society for Radiation Oncology (www.astro.org)
AUA - American Urological Association (www.auanet.org)
CAP - College of American Pathologists (www.cap.org)
NCCN - National Comprehensive Cancer Network (www.nccn.org)

Table 2.1: National Voluntary Consensus Standards for Clinicians: Cancer Care

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Radiation oncology: treatment summary documented and communicated*	0381	Percentage of patients with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment (CA-005-07)	ASTRO ASCO AMA PCPI
Radiation oncology: radiation dose limits to normal tissues*	0382	Percentage of patients with a diagnosis of pancreatic or lung cancer who had documentation in medical record that normal tissue dose constraints were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues (CA-006-07)	ASTRO ASCO AMA PCPI
Paired Measures[d]			
Medical oncology and radiation oncology: plan of care for pain*	0383	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain (CA-007-07) *AND*	ASTRO ASCO AMA PCPI
Medical oncology and radiation oncology: pain intensity quantified*	0384	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy in which pain intensity is quantified (CA-017-07)	ASTRO ASCO NCCN AMA PCPI
Medical oncology: chemotherapy for stage IIIA through IIIC colon cancer patients*	0385	Percentage of patients aged 18 years and older with stage IIIA through IIIC colon cancer who are referred for chemotherapy, prescribed chemotherapy, or who have previously received adjuvant chemotherapy within the 12-month reporting period (CA-013-07)	ASTRO ASCO NCCN AMA PCPI

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[d] "Paired measures" are individual measures that theoretically could have been approved singly but are recommended for NQF endorsement only if both are approved and implemented as one unit.

Table 2.1: National Voluntary Consensus Standards for Clinicians: Cancer Care

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Oncology: cancer stage documented*	0386	Percentage of patients with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline American Joint Committee on Cancer (AJCC) cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12-month reporting period (CA-014-07)	ASTRO ASCO AMA PCPI
Medical oncology: hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer*	0387	Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) within the 12-month reporting period (CA-016-07)	ASTRO ASCO NCCN AMA PCPI
Prostate cancer: three-dimensional radiotherapy*	0388	Percentage of patients with prostate cancer receiving external beam radiotherapy to the prostate only who receive 3D-CRT (three-dimensional conformal radiotherapy) or IMRT (intensity modulated radiation therapy) (CA-008-07)	AUA AMA PCPI
Prostate cancer: avoidance of overuse measure—isotope bone scan for staging low-risk patients*	0389	Percentage of patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have an isotope bone scan performed at any time since diagnosis with prostate cancer (CA-009-07)	AUA AMA PCPI
Prostate cancer: adjuvant hormonal therapy for high-risk patients*	0390	Percentage of patients with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist) (CA-010-07)	AUA AMA PCPI

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Table 2.1: National Voluntary Consensus Standards for Clinicians: Cancer Care

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Pathology: breast cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade*	0391	Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade (CA-018-07)	CAP AMA PCPI
Pathology: colorectal cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade*	0392	Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade (CA-019-07)	CAP AMA PCPI

Endorsed Measures

0377[i] Hematology: myelodysplastic syndrome (MDS) and acute leukemias—baseline cytogenetic testing performed on bone marrow

(ASH/AMA PCPI) *CA-001-07*[ii]

The Steering Committee noted that cytogenetic testing is important for prognosis and therapeutic decisionmaking for patients with MDS and acute leukemias. However, there is little information on current performance, variations in performance, or significant opportunities for improvement. A Committee member suggested that preliminary information on current performance could be obtained from an insurer's claims database. In the absence of current data, the Committee supported the measure as an important process of care.

0378 Hematology: documentation of iron stores in patients receiving erythropoietin therapy

(ASH/AMA PCPI) *CA-002-07*

The Steering Committee enthusiastically supported this measure, because erythropoiesis-stimulating agents (ESA) are expensive and commonly used drugs for anemia associated with chemotherapy and MDS represent

[i] NQF measure ID number.
[ii] Review number.

65 percent of Medicare spending on chemotherapy. ESA therapy is not effective in patients with low iron stores; therefore, measuring iron stores before therapy will reduce the ineffective use of ESA, which can be costly. There are no data on current performance, but Steering Committee members agreed that measuring iron stores is not being done regularly. Because appropriate use of ESA therapy is not just an issue for hematologists, the Committee strongly recommended that the measure be broadened to include all patients on ESA therapy. The measure developers agreed to expand the measure to include all hematologic malignancies in the near future.

0379 **Hematology: chronic lymphocytic leukemia (CLL)—baseline flow cytometry**

(ASH/AMA PCPI) *CA-003-07*

The Steering Committee generally considered CLL to be an important area, because it is the most common low-grade leukemia. But some Steering Committee members had reservations regarding the importance of this measure, because in many cases treatment and prognosis are similar regardless of the specific diagnosis, and testing might be most relevant prior to active treatment. Some Committee members stated that even though some diagnoses, such as mantle cell lymphoma, have a very different prognosis, the diagnosis would soon become apparent without the testing. Although the Committee encouraged the measure developers to link the baseline cytometry testing to treatment, the measure developers reaffirmed their intention to focus this measure on the diagnostic tool only.

0380 **Hematology: multiple myeloma—treatment with bisphosphonates**

(ASH/AMA PCPI) *CA-004-07*

The Steering Committee strongly supported this measure, because there is strong evidence to support the use of bisphosphonates to reduce fractures—a quality-of-life issue—and that the quality of care varies. The Committee noted that because "received" is the goal, the measure should not include "prescribed." The measure developers provided examples in the exclusions and noted that specialists may not know that the patient received the medication, because patients often follow up with the referring physician. A Committee member suggested that the numbers might be low for individual clinicians, because a large number of patients might be legitimately excluded.

0381 **Radiation oncology: treatment summary documented and communicated**

(ASTRO/ASCO/AMA PCPI) *CA-005-07*

The Steering Committee believed that this measure addresses the important area of coordination/transitions in care. A wide variation in documenting and communicating treatment summaries has been identified. Based on the Steering Committee's recommendation, the measure developers modified this measure to specify that the patient also should receive the treatment summary.

0382 **Radiation oncology: radiation dose limits to normal tissues**
(ASTRO/ASCO/AMA PCPI) *CA-006-07*

The Steering Committee agreed that this measure effectively addresses the safety of radiation to the normal tissues surrounding the tissues targeted for radiation. The evidence suggests there is variation in care. The measure developers modified the measure title to more adequately communicate the intent of the measure to multistakeholder audiences.

Paired Measures[iii]

0383 **Medical oncology and radiation oncology: plan of care for pain**
(ASTRO/ASCO/AMA PCPI) *CA-007-07*

AND

0384 **Medical oncology and radiation oncology: pain intensity quantified**
(ASTRO/ASCO/NCCN/AMA PCPI) *CA-017-07*

The Steering Committee noted that pain assessment and management are critical for cancer patients. It is important that these measures be implemented together, because the quantification of pain should be linked to the development of a plan to manage any identified pain. The Committee urged the measure developers to explore the development of a related outcome measure to track pain improvement/stabilization over time.

0385 **Medical oncology: chemotherapy for stage IIIA through IIIC colon cancer patients**
(ASTRO/ASCO/NCCN/AMA PCPI) *CA-013-07*

The Steering Committee supported this measure as one that addresses a critical area of cancer care. Some variations in care and racial disparities have been documented. The Committee noted that this measure might be construed as reflecting "base competency" and recommended that a measure that reflects adherence to specific, evidence-based, treatment guidelines should be developed in the future.

0386 **Oncology: cancer stage documented**
(ASTRO/ASCO/AMA PCPI) *CA-014-07*

The Steering Committee acknowledged that cancer staging is very important for prognosis, treatment selection, and care coordination but noted that the "locked in the chart" stage is not useful. The Committee felt that requiring only documentation sets a very low bar of baseline competency and that the actual stage should be reported, particularly because Current Procedural Terminology (CPT) II codes exist for stages. The measure developers stated that physicians often do not report stage accurately, and documentation was a place to start. Steering Committee members noted that the Centers for Medicare & Medicaid (CMS) is evaluating an earlier CMS effort to collect stage information from physicians.

[iii] "Paired measures" are individual measures that theoretically could have been approved singly but are recommended for NQF endorsement only if both are implemented as a unit.

0387 **Medical oncology: hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer**

(ASTRO/ASCO/NCCN/AMA PCPI) *CA-016-07*

The Steering Committee's strong support of this measure was based on evidence that there is underprescribing of hormonal therapy when appropriate, as well as concerns about the timeliness of prescribing. This measure has been used and tested in large-scale studies.

0388 **Prostate cancer: three-dimensional radiotherapy**

(AUA/AMA PCPI) *CA-008-07*

The Steering Committee agreed that this measure addresses an important, guideline-supported practice that maximizes outcomes. The measure would be stronger, however, if it captured patients under active surveillance instead of patients under active treatment. The Committee recommended that the measure include risk stratification based on the Prostate-Specific Antigen (PSA), the Gleason score, and staging data. However, the measure developers asserted that risk stratification is not necessary, because three-dimensional conformal techniques or intensity modulated radiation treatment should be used whenever external beam radiotherapy is employed. The Committee accepted this assertion and supported this measure without risk stratification.

0389 **Prostate cancer: avoidance of overuse measure—isotope bone scan for staging low-risk patients**

(AUA/AMA PCPI) *CA-009-07*

The Steering Committee supported this measure as one that addresses an area of cancer care in which overuse has been documented. The measure developers defined "low risk" for this measure as having a PSA level of ≤ 10 mg/ml, a Gleason score of 6 or less, and a clinical stage of T1c or T2a2.

0390 **Prostate cancer: adjuvant hormonal therapy for high-risk patients**

(AUA/AMA PCPI) *CA-010-07*

The Steering Committee strongly supported this measure as one that addresses an important area of cancer care, although the data on current performance under this measure are not available. Based on the Committee's recommendation, the measure developers revised the definition of "high risk" for this measure to include patients with clinically localized stage T3a, a Gleason score of 8-10, or a PSA level of > 20 mg/ml (the original measure defined high risk as only stage T2c or greater).

0391 **Pathology: breast cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade**

(CAP/AMA PCPI) *CA-018-07*

The Steering Committee agreed that appropriate pathology reporting is important, because pathology reports contain critical information for prognosis and therapeutic decisionmaking, and variation in care has been documented. This measure addresses a few critical components of the NQF-endorsed® College of American Pathology Breast Cancer Pathology protocol. The Committee discussed at length the inclusion of additional pathology markers, such as hormone receptor status, that could significantly improve the quality of breast cancer care. The Committee asked the measure developers why the entire protocol was not included in the measure. The measure developers responded that the measure denominator only captures specimens from resection, not initial biopsy, and therefore the entire protocol would be inappropriate, because hormonal markers would have tested on the biopsy specimen.

0392 **Pathology: colorectal cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade**

(CAP/AMA PCPI) *CA-019-07*

Again, the Steering Committee agreed that appropriate pathology reporting is important, because pathology reports contain critical information for prognosis and therapeutic decisionmaking, and variation in care has been documented. This measure also addresses a few critical components of the NQF-endorsed College of American Pathology Breast Cancer Pathology protocol. Because standards for pathology reporting are often set at a system level, this measure might be more appropriate as a facility-level measure.

Measures Not Endorsed

PROSTATE CANCER: TREATMENT OPTIONS FOR PATIENTS WITH CLINICALLY LOCALIZED DISEASE

(AUA/AMA PCPI) *CA-012-07*

Although the Steering Committee members agreed that the discussion of treatment options is critical for proper informed consent and shared decisionmaking, they were not convinced that this measure would encourage the thorough discussions that are needed. Committee members believed that the measure would give credit for minimal or biased information. To address this concern, the measure developers plan to develop a question regarding patients' perception of counseling for treatment options that could be included in a patient-survey instrument. The Committee fully supported this plan and looks forward to this patient-centered measure being fully developed and ready for endorsement consideration.

MEDICAL ONCOLOGY: PLAN FOR CHEMOTHERAPY DOCUMENTED

(ASTRO/ASCO/AMA PCPI) *CA-015-07*

Although the Steering Committee agreed that this measure addresses an important area of cancer care, some members expressed concern about the potential for variation in what might constitute a "plan for chemotherapy." The measure developers provided further clarification

in the specifications. However, the measure developers were unwilling to accommodate the Committee's recommendation that the measure include patients on both IV and oral chemotherapy.

The Consensus Standards Approval Committee (CSAC) determined that this measure represents a very low level of performance, which is not outweighed by the burden of measurement, and did not recommend endorsement.

PROSTATE CANCER: INITIAL EVALUATION (AUA/AMA PCPI) *CA-011-07*

When developing a treatment plan for prostate cancer, which is a high-frequency condition, it is important to evaluate patient risk to ensure optimal outcomes. Steering Committee members believed that reporting the actual values of the stage/PSA/Gleason score would be more valuable than just documenting that the staging and grading have been done. The measure captures only patients under active treatment and misses the large number of patients under active surveillance. The measure developers responded that current CPT coding practices cannot report specific laboratory values. A narrow majority of the Committee recommended the measure. However, the CSAC agreed with the Committee minority that considered this to be a baseline competency measure not worth the burden of measurement and did not recommend endorsement.

Research Recommendations

During its deliberations the Steering Committee recommended the following:

- The AMA CPT Committee should consider the development of methods for recording numerical laboratory values on claims.
- Measure(s) should be developed for pain stabilization and improvement over time.
- Further research should be conducted to better understand what "patient refusal" (a frequently used exclusion category) really means, as well as informed consent in general.
- Measure(s) should be developed for adherence to guidelines for selecting chemotherapy treatment.
- Conduct research about and develop measures in the area of appropriate chemotherapy use and possible overuse. Also develop measures for overuse in patients with poor performance status as well as for treatment of patients with drugs that are not recommended.

Notes

1 American Cancer Society (ACS), *Cancer Facts and Figures, 2008,* Atlanta, GA: ACS; 2008, p. 63. Available at www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf. Last accessed November 2008.

2 Ibid., p. 3.

3 American Cancer Society (ACS), *Cancer Facts and Figures, 2008,* Atlanta, GA: ACS; 2008. Available at www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf. Last accessed November 2008.

4 Malin JL, Schneider EC, Epstein AM, et al., Results of the National Initiative for Cancer Care Quality: how can we improve the quality of cancer care in the United States? *J Clin Oncol,* 2006;24(4):626-634.

5 Miller DC, Spencer BA, Ritchey J, et al., Treatment choice and quality of care for men with localized prostate cancer, *Med Care,* 2007;45(5):401-409.

6 Saigal CS, Litwin MS, The economic costs of early stage prostate cancer, *Pharmacoeconomics,* 2002;20(13):869-878.

7 Shahinian VB, Kuo YF, Freeman JL, et al., Determinants of androgen deprivation therapy use for prostate cancer: role of the urologist, *J Natl Cancer Inst,* 2006;98(12):839-845.

Chapter 3: Infectious Disease

Introduction

WITHIN THE CURRENT LANDSCAPE FOR QUALITY MEASURES, there is a lack of performance measures for infectious disease prevention, treatment, and management, particularly in the areas of hepatitis and HIV/AIDS. In the United States, it is estimated that four to five million individuals have been infected with hepatitis C virus (HCV), which is a major cause of chronic liver disease, including cirrhosis and liver cancer. HCV-associated chronic liver disease is the most frequent indication for liver transplantation among adults. The Centers for Disease Control and Prevention (CDC) estimated that 1,039,000 to 1,185,000 U.S. residents were living with HIV/AIDS at year end 2003, with 24 to 27 percent undiagnosed and unaware of their infection.[1] Additionally, the cumulative estimated number of diagnoses of AIDS through 2005 in the United States and dependent areas was 984,155.[2]

Despite an urgent need for them, there are very few NQF-endorsed® performance measures pertaining to infectious disease. Additionally, caring for patients with hepatitis and HIV/AIDS is complex and often involves a great deal of care coordination and management of comorbid conditions. This chapter presents 19 measures and 2 paired measures for evaluating the performance of clinicians caring for patients with hepatitis and HIV/AIDS for time-limited endorsement. The Infectious Disease Steering Committee evaluated 28 candidate consensus standards using the standard criteria for voluntary consensus standards that are appropriate for accountability and public reporting in the areas of hepatitis and HIV/AIDS prevention and management.

Table 3.1: National Voluntary Consensus Standards for Clinicians: Infectious Disease

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Hepatitis C: testing for chronic hepatitis C—confirmation of hepatitis C viremia*	0393	Percentage of patients ≥18 years with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed (IF-001-07)	AMA PCPI
Hepatitis C: counseling regarding use of contraception prior to antiviral treatment*	0394	Percentage of female patients aged 18 to 44 years and all men ≥18 years with a diagnosis of chronic hepatitis C who are receiving antiviral treatment who were counseled regarding contraception prior to the initiation of antiviral treatment (IF-002-07)	AMA PCPI
Paired Measures[d]			
Hepatitis C: hepatitis C RNA testing before initiating treatment*	0395	Percentage of patients ≥18 years with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment (IF-003-07) *AND*	AMA PCPI
Hepatitis C: HCV genotype testing prior to treatment*	0396	Percentage of patients ≥18 years with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom HCV genotype testing was performed within 6 months prior to initiation of antiviral treatment (IF-004-07)	AMA PCPI

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*Time-limited endorsement.

[a] Upon NQF endorsement, each measure receives a unique NQF measure ID number.

[b] Review number.

[c] IP owner(s)—intellectual property owner(s) and copyright holder(s). For the most current specifications and supporting information, please refer to the IP owner(s):
AMA PCPI - American Medical Association Physician Consortium for Performance Improvement (www.physicianconsortium.org)
Asian Liver Center at Stanford University (http://liver.stanford.edu)
NCQA - National Committee for Quality Assurance (www.ncqa.org)

[d] "Paired measures" are individual measures that theoretically could have been approved singly but are recommended for NQF endorsement only if both are approved and implemented as one unit.

Table 3.1: National Voluntary Consensus Standards for Clinicians: Infectious Disease

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Hepatitis C: prescribed antiviral therapy*	0397	Percentage of patients ≥18 years with a diagnosis of chronic hepatitis C who were prescribed peginterferon and ribavirin therapy within the 12-month reporting period (IF-005-07)	AMA PCPI
Hepatitis C: HCV RNA testing at week 12 of treatment*	0398	Percentage of patients ≥18 years with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at 12 weeks from initiation of antiviral treatment (IF-007-07)	AMA PCPI
Paired Measures			
Hepatitis C: hepatitis A vaccination*	0399	Percentage of patients ≥18 years with a diagnosis of hepatitis C who have received hepatitis A vaccination or who have documented immunity (IF-008-07) *AND*	AMA PCPI
Hepatitis C: hepatitis B vaccination*	0400	Percentage of patients ≥18 years with a diagnosis of hepatitis C who have received hepatitis B vaccination or who have documented immunity (IF-009-07)	AMA PCPI
Hepatitis C: counseling regarding risk of alcohol consumption*	0401	Percentage of patients ≥18 years with a diagnosis of hepatitis C who received counseling regarding the risk of alcohol consumption at least once within the 12-month reporting period (IF-010-07)	AMA PCPI
Screening foreign-born adults for chronic hepatitis B*	0402	Percentage of adults ≥18 years born in an HBV-endemic country and tested for hepatitis B surface antigen and antibody (IF-024-07)	Asian Liver Center at Stanford University
HIV/AIDS: medical visit*	0403	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least 2 medical visits during the measurement year, with a minimum of 60 days between each visit (IF-011-07)	NCQA AMA PCPI

more

Table 3.1: National Voluntary Consensus Standards for Clinicians: Infectious Disease

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
HIV/AIDS: CD4+ cell count* or CD4+ percentage performed*	0404	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ percentage was performed at least once every 6 months (IF-012-07)	NCQA AMA PCPI
HIV/AIDS: *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis*	0405	Percentage of patients: aged 6 years and older with a diagnosis of HIV/AIDS who were prescribed *Pneumocystis jiroveci* pneumonia (PCP) Prophylaxis within 3 months of a CD4 count below 200 cells/mm^3; aged 1 through 5 years with a diagnosis of HIV/AIDS who were prescribed *Pneumocystis jiroveci* pneumonia (PCP) Prophylaxis within 3 months of a CD4 count below 500 cells/mm^3; aged 1 month through 12 months with a diagnosis of HIV or who are HIV indeterminate who were prescribed *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis (IF-013-07)	NCQA AMA PCPI
Adolescent and adult clients with AIDS who are prescribed potent antiretroviral therapy*	0406	Percentage of clients with a diagnosis of AIDS with at least two visits during the measurement year, with at least 60 days between each visit: aged 13 years and older who have a history of a nadir CD4+ cell count below 350 cells/mm^3; aged 13 years and older who have a history of an AIDS-defining illness, regardless of CD4+ cell count; or who are pregnant, regardless of CD4+ cell count or age, who were prescribed potent antiretroviral therapy** (IF-014-07) ***Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials.*	NCQA AMA PCPI

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Table 3.1: National Voluntary Consensus Standards for Clinicians: Infectious Disease

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
HIV RNA control after six months of potent antiretroviral therapy*	0407	Percentage of patients ≥13 years with a diagnosis of HIV/AIDS with at least 2 visits during the measurement year, with at least 60 days between each visit, who are receiving potent antiretroviral therapy,* who have a viral load below limits of quantification** after at least 6 months of potent antiretroviral therapy,* *OR* whose viral load is not below limits of quantification** after at least 6 months of potent antiretroviral therapy and has documentation of a plan of care*** (IF-015-07) **Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials.* ***Using laboratory cutoff level for reference laboratory used by that clinic or provider.* ****A plan of care may include: altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessment of viral load at a specified future date.*	NCQA AMA PCPI
HIV/AIDS: TB screen*	0408	Percentage of patients aged 3 months and older with a diagnosis of HIV/AIDS for whom tuberculosis (TB) screening test was performed and results interpreted at least once since the diagnosis of HIV infection (IF-017-07)	NCQA AMA PCPI
HIV/AIDS: chlamydia and gonorrhea screening*	0409	Percentage of patients ≥13 years with a diagnosis of HIV/AIDS for whom chlamydia and gonorrhea screenings were performed at least once since the diagnosis of HIV infection (IF-018-07)	NCQA AMA PCPI

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Table 3.1: National Voluntary Consensus Standards for Clinicians: Infectious Disease

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
HIV/AIDS: syphilis screening*	0410	Percentage of patients ≥13 years with a diagnosis of HIV/AIDS for whom syphilis screening was performed in the last 12 months (IF-020-07)	NCQA AMA PCPI
HIV/AIDS: hepatitis B screen*	0411	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS for whom hepatitis B screening was performed at least once since the diagnosis of HIV infection or for whom there is documented immunity (IF-021-07)	NCQA AMA PCPI
HIV/AIDS: hepatitis B vaccination*	0412	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who have received at least one hepatitis B vaccination or who have documented immunity (IF-022-07)	NCQA AMA PCPI
HIV/AIDS: screening for high-risk behavior*	0413	Percentage of patients, aged 13 years and older, who were screened* at least once in a 12-month measurement period for high-risk sexual behavior (IF-023-07) **Screening is defined as documentation that a discussion regarding high-risk sexual behavior took place or documentation that a standardized tool was used.*	NCQA AMA PCPI
HIV/AIDS: hepatitis C screen*	0414	Percentage of patients ≥13 years with a diagnosis of HIV/AIDS for whom hepatitis C screening was performed at least once since the diagnosis of HIV infection or for whom there is documented immunity (IF-025-07)	NCQA AMA PCPI
HIV/AIDS: screening for injection drug use*	0415	Percentage of patients, aged 13 years and older, who were screened at least once in a 12-month measurement period for injection drug use (IF-026-07) **Screening is defined as documentation that a discussion regarding injection drug use took place, or documentation that a standardized tool was used.*	NCQA AMA PCPI

Endorsed Measures

Hepatitis

0393[i] Hepatitis C: testing for chronic hepatitis C—confirmation of hepatitis C viremia

(AMA PCPI) *IF-001-07*[ii]

Current American Association for the Study of Liver Diseases (AASLD) practice guidelines state that RNA testing should be performed on any patient with a positive anti-HCV (hepatitis C viremia) test.[3] The Steering Committee noted that this measure defines the denominator for the other hepatitis-related measures. This measure can be evaluated in two ways: either to confirm chronic infection or to initiate appropriate treatment. RNA testing is usually performed in conjunction with treatment initiations, and other tests are also performed to confirm chronic HCV infection. Confirmation of the diagnosis is particularly important because of the stigma attached to hepatitis infection.

0394 Hepatitis C: counseling regarding use of contraception prior to antiviral treatment

(AMA PCPI) *IF-002-07*

Antiviral therapy for hepatitis can cause birth defects. Prevention of pregnancy during treatment is a critical aspect of patient care. The Steering Committee questioned the upper and lower age limits for females in the specifications. Although the Committee members agreed that contraception counseling is important, some were concerned that the measure covers only antiviral therapy and not all category 4, potentially teratogenic, medications. The measure developer believed that expanding this measure was beyond its scope, but agreed to explore a broader measure in the future. Although the Committee ultimately recommended this measure, it urged the measure developer to develop a measure that encompasses counseling for any potentially teratogenic medication and appropriate informed consent. This measure would then be replaced with the harmonized, more encompassing measure.

Paired Measures[iii]

0395 Hepatitis C: hepatitis C RNA testing before initiating treatment

(AMA PCPI) *IF-003-07*

AND

0396 Hepatitis C: HCV genotype testing prior to treatment

(AMA PCPI) *IF-004-07*

Current AASLD practice guidelines state that RNA testing and genotyping should be performed on any patient prior to initiating treatment.[4] These measures would assist with confirming the diagnosis and with prescribing

[i] NQF measure ID number.

[ii] Review number.

[iii] "Paired measures" are individual measures that theoretically could have been approved singly but are recommended for NQF endorsement only if both are implemented as a unit.

the correct treatment. The Steering Committee decided that the inclusion of patients younger than 18 years in the denominator is less important because of the low prevalence/incidence of hepatitis C in that population. The Committee recommended pairing the measures, because both RNA testing and HCV genotyping are important to appropriate evaluation and treatment.

0397 Hepatitis C: prescribed antiviral therapy

(AMA PCPI) *IF-005-07*

As originally submitted, this measure focused on whether the provider considered antiviral therapy. The Steering Committee believed it was more important to focus on whether a discussion about therapy occurred between the provider and the patient. Moreover, the Committee suggested that the measure would be difficult to implement, because therapy may not be considered for many reasons or it may not happen within the 12-month reporting period. Consequently, the AMA PCPI workgroup changed "considered" to "prescribed" and added language about decisionmaking, which better reflects the intent of the measure.

0398 Hepatitis C: HCV RNA testing at week 12 of treatment

(AMA PCPI) *IF-007-07*

The Steering Committee recommended this consensus standard as a clinically important standard of care that is easily measured. However, it does not capture what, if any, action was taken after the testing was completed. Ultimately, the Committee decided that implementing the measure will be important in determining the current performance benchmark and the existence of a quality problem.

Paired Measures

0399 Hepatitis C: hepatitis A vaccination

(AMA PCPI) *IF-008-07*

AND

0400 Hepatitis C: hepatitis B vaccination

(AMA PCPI) *IF-009-07*

Current guidelines state that all patients with chronic hepatitis C should be vaccinated against hepatitis A, and nonimmune persons with risk factors for hepatitis B virus (HBV) should be vaccinated against hepatitis B.[5] Additionally, studies have found significant gaps in the numbers for those who should be vaccinated and for those who are vaccinated.[6]

Steering Committee members noted that the eligibility requirements in these measures are broader than those in the CDC guidelines, recommended that the measures reflect vaccinations that are received instead of just recommended, and expressed concerns with the measures' exclusion of patients younger than 18 years and their lack of harmonization with other vaccination measures. AMA PCPI revised the measures to include only vaccinated patients and agreed to pair the measures to recognize the importance of both vaccinations. Although the Committee had some remaining concerns, it recommended these much-needed

vaccination measures, with hopes that they will be replaced with more harmonized measures in the future.

0401 **Hepatitis C: counseling regarding risk of alcohol consumption**

(AMA PCPI) *IF-010-07*

Excessive alcohol use plays an important role in promoting the development of progressive liver disease, with strong evidence for the detrimental effects of 30 g/day in men and 20 g/day in women; 30 g is approximately equivalent to two beers, two glasses of wine, or two mixed drinks.[7] Providers should recommend that alcoholic patients abstain before and during antiviral treatment, and treatment of alcohol abuse should be linked with efforts to treat hepatitis C in alcoholic patients.[8] The Steering Committee agreed that this measure addresses a clinically important process, even though appropriate education is difficult to measure. The Committee recommended that the measure specifications incorporate an evidence-based, patient-centered assessment to provide guidance to clinicians. The AMA PCPI workgroup agreed to revise the measure to capture "counseling," which is more patient centered, instead of "education." Additionally, the workgroup incorporated into the specifications a broader definition of counseling, which includes documentation of a discussion regarding the risks of alcohol or a notation to decrease or abstain from alcohol intake.

0402 **Screening foreign-born adults for chronic hepatitis B**

(Asian Liver Center at Stanford University) *IF-024-07*

Liver cancer is the sixth most common newly diagnosed cancer and the third most common cause of cancer mortality in the world.[9] Additionally, chronic or persistent infection with HBV is responsible for the majority of liver cancer worldwide and is also the basis for one of the starkest racial/ethnic health disparities in the United States.[10,11] The Steering Committee noted that this measure addresses screening to identify those adults who are chronically infected, which is important for the prevention of liver cancer. The greater impact of liver disease on Asian and other racial populations suggests that this measure will be important to the assessment of healthcare disparities. Some Steering Committee members expressed concern that the denominator will be difficult to define and that the data will be difficult to collect. The Committee encouraged the measure developer to incorporate guidance regarding the collection of race/ethnicity data into the measure specifications.

HIV and AIDS

The Steering Committee began deliberation of the HIV measures with a robust discussion of the denominator used in many of the measures. The measure developers explained that the denominator includes patients who have been seen twice, with at least 60 days between visits to allow for the attribution of patients to individual providers. Although the Committee agreed, it emphasized the importance of

quantifying the patients who do not return for follow-up care. The Committee recommended that the measures that use this denominator be endorsed but requested that structural measures that assess access to care and follow-up care also be put in place.

0403 HIV/AIDS: medical visit

(NCQA/AMA PCPI) *IF-011-07*

The Steering Committee agreed that this measure reports how well a physician follows up with patients with HIV/AIDS. However, the Committee expressed concern that 1) this measure defines the denominator for many of the other HIV/AIDS measures and 2) it may be difficult to define a population that may not belong to a single provider. Although the Committee believed that the medical visit measure was an important measure of quality, the denominator of other measures should not necessarily be so narrowly defined. The Committee suggested that the measure developers better define "medical visit" and expand the numerator. The measure developers redefined "medical visit" to mean any visit with a healthcare professional who provides routine primary care to the patient with HIV/AIDS (may be, but is not limited to, a primary care clinician, OB/GYN, pediatrician, infectious diseases specialist). The measure developers also revised the numerator to read as "Patients with at least two medical visits during the measurement year with a minimum of 60 days between each visit." The measure developers' workgroup believed it was important to specify at least 60 days between visits, because this group of measures developed by AMA PCPI is meant to assess the quality of care for chronic HIV infection. The Committee strongly recommended that a measure that includes patients without regular follow-up care in the denominator be developed.

0404 HIV/AIDS: CD4+ cell count or CD4+ percentage performed

(NCQA/AMA PCPI) *IF-012-07*

As originally submitted, the denominator for this measure included only those patients who have been seen twice during the year, with six months between visits. In response to the Steering Committee's concern that patients without regular or follow-up care after initial diagnosis would be excluded, the measure developers' workgroup changed the denominator to read as "All patients, regardless of age, with a diagnosis of HIV/AIDS who had at least two visits during the measurement year, with at least 60 days between each visit." This change does not directly address the Committee's concern regarding attrition, but the workgroup asserted that a considerable number of patients (particularly those who visit public health clinics) will visit a practice once with no intention of becoming a regular patient of that practice (e.g., a patient recently released from the hospital or jail). For individual provider-level measures, it is reasonable to expect that there is some type of care relationship between the provider and the patient. There is also a precedent for the "two visits per year" requirement—other AMA PCPI and NCQA chronic disease measures require that a patient have two visits per year. Requiring that all providers meet performance measures for patients that they only see once (and who may be receiving their primary care

elsewhere) may lead to overuse of services and increased costs. The workgroup also believed that many of the aspects of care in this measurement set are especially important for patients seen only once, and systems/practices should measure CD4+ cell counts closely. However, a two-visit requirement seems most reasonable when assessing the quality of an individual provider's performance. The Committee recommended this measure but strongly urged the development of a complimentary measure at the facility level that reports the number of patients lost for follow-up who have not received a CD4+ cell count.

0405 **HIV/AIDS: *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis**

(NCQA/AMA PCPI) *IF-013-07*

The Steering Committee was very concerned that the denominator for this measure includes only those patients who have been seen twice during the year (with six months between visits) and who have had a CD4+ cell count. This excludes all patients who have not had regular follow-up. The Committee considered pairing the measure with NQF# 0404, but ultimately decided not to because both measures will be reported. The Committee believed that measures NQF# 0393, NQF# 0404, and NQF# 0405 and should have the same denominators. The measure developers' workgroup changed the denominator to read as "All patients, regardless of age, with a diagnosis of HIV/AIDS who had at least two visits during the measurement year, with at least 60 days between each visit." The Committee recommended this measure but strongly urged the development of a complimentary measure at the facility level that reports the number of patients lost for follow-up who have not received PCP prophylaxis.

0406 **Adolescent and adult clients with AIDS who are prescribed potent antiretroviral therapy**

(NCQA/AMA PCPI) *IF-014-07*

The Steering Committee noted that this measure captures the percentage of patients who are on potent antiretroviral therapy (ART) and the denominator is split into three different populations based on Department of Health and Human Services (DHHS) 2007 Guidelines.[12] The Committee believed its intention is to discover how many patients are eligible for but not prescribed ART. The Committee members suggested it would be preferable to refer to the current DHHS guidelines, because medications change so frequently. The measure developers' workgroup changed the denominator to read as "All patients, regardless of age, with a diagnosis of HIV/AIDS who had at least two visits during the measurement year, with at least 60 days between each visit." The workgroup also deleted the lower age limit from Denominator b—"any patient, regardless of age, who is pregnant should receive potent ART"—and inserted specific reference to DHHS guidelines so that the measure reflects the most recent guidelines. Ultimately, the Committee recommended the measure for time-limited endorsement.

0407 HIV RNA control after six months of potent antiretroviral therapy

(NCQA/AMA PCPI) *IF-015-07*
(combined *IF-015-07* **and** *IF-016-07***)**

The Steering Committee agreed that this measure addresses an important standard of care but may not be realistic in its expectation that results for patients who are first-time users of ART ("naïve") will be undetectable or under control after only six months. The measure represents the outcome of good care, which includes patient education and medication adherence support in order to take the therapy properly so that there is reduction in viral loads. The measure developers' workgroup changed the denominator to read as "All patients aged 13 years or older with a diagnosis of HIV/AIDS who had at least 2 visits during the measurement year, with at least 60 days between each visit" and deleted "documentation that patient is stable" from the numerator. The workgroup noted that there should be a documented plan of care in the medical records for patients who are not able to achieve viral load beneath limit of quantification (BLQ). A plan of care may include altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessing the viral load at a specified future date. The workgroup agreed that the primary goal should be achieving BLQ. If not achieved, documentation of a treatment plan or rationale for acceptance of not achieving BLQ should be included in the medical record.

0408 HIV/AIDS: TB screen

(NCQA/AMA PCPI) *IF-017-07*

The Steering Committee was concerned that this measure focused only on giving the test, not on reading and acting on the results. Also, Committee members questioned the appropriateness of the test for HIV-positive individuals. The measure developers' workgroup agreed to change the numerator to read as "TB screening performed and results interpreted" and the denominator to read as "All patients aged 3 months or older with a diagnosis of HIV/AIDS who had at least 2 visits during the measurement year, with at least 60 days between each visit" and added an exclusion for patients with a history of positive PPD test. The workgroup believed that the numerator was revised to include TB screening tests other than PPD (i.e., Quantiferon). As CDC-approved tests are validated in HIV-infected populations, codes in the measure specifications will be expanded to include those tests.

0409 HIV/AIDS: chlamydia and gonorrhea screening

(NCQA/AMA PCPI) *IF-018-07*

The Steering Committee considered this measure to be important, because of the serious impact of untreated sexually transmitted diseases (STDs) on HIV viral load and on the transmissibility of HIV. However, the Committee expressed concern that the measure does not specify the site of testing. The measure developers changed the denominator to be consistent with the other HIV/AIDS-related measures.

0410 **HIV/AIDS: syphilis screening**
(NCQA/AMA PCPI) *IF-020-07*

The Steering Committee believed that stratification is not needed, because the increased rates of syphilis in certain subpopulations of HIV-infected persons and the progression of neurosyphilis in HIV-positive persons dictate that screening be performed during the initial visit. The measure developers changed the denominator to be consistent with the other HIV/AIDS-related measures.

0411 **HIV/AIDS: hepatitis B screen**
(NCQA/AMA PCPI) *IF-021-07*

The Steering Committee believed that hepatitis B is a significant comorbid condition in patients with HIV/AIDS. Providers must carefully choose treatments for co-infected patients. Current guidelines suggest that providers choose two nucleosides with activity against hepatitis B. The Committee again recommended that the denominator read as "All patients, regardless of age, with a diagnosis of HIV/AIDS who had at least 2 visits during the measurement year, with at least 60 days between each visit," which was agreed to by the measure developer's workgroup.

0412 **HIV/AIDS: hepatitis B vaccination**
(NCQA/AMA PCPI) *IF-022-07*

The Steering Committee expressed concern that this measure stipulated receipt of only the initial dose and not of all three doses, and recommended that the measure be paired with a structural measure that shows the percentage of patients at the facility who received all three doses and postvaccination testing. The measure developers' workgroup responded that requiring the provider to ensure receipt of all three doses raises the measure to the system level, because the provider may have difficulty extracting this information from administrative or medical record data. The workgroup added that an existing structural measure at the facility level measures the completion of the vaccination series, and it may be possible to pair these two measures. Ultimately, the Steering Committee decided that at a minimum the provider should be held accountable for the initial dose. The workgroup did not believe that the evidence supports follow-up serology; however, as the guidelines change, the measure will be updated.

0413 **HIV/AIDS: screening for high-risk behavior**
(NCQA/AMA PCPI) *IF-023-07*

This measure captures patients who are screened at least once for high-risk sexual behaviors, which includes multiple sexual partners within the last six months, sex with anonymous partners or partners of unknown serostatus, and infrequent use of a condom/dental dam. The Steering Committee believed that such screening is a critically important area of care for patients with HIV/AIDS but acknowledged that providers may not be prepared to appropriately screen for high-risk behaviors or for substance use, alcohol abuse, or mental health conditions. The Steering Committee expressed concern that a screening tool is not specified and that the data audit

tool, which will be used to abstract data, will become a screening tool by default. The measure developers' workgroup changed the denominator to read as "All patients aged 13 years and older with a diagnosis of HIV/AIDS who had at least 2 visits during the measurement year, with at least 60 days between each visit." The workgroup also included a definition for screening: "Screening is defined as documentation that a discussion regarding high-risk sexual behavior took place, or documentation that a standardized tool was used."

0414 **HIV/AIDS: hepatitis C screen**
(NCQA/AMA PCPI) *IF-025-07*

The Steering Committee noted that patients co-infected with HIV and hepatitis C tend to have more progressive disease. Recent data indicate that patients with HIV disease are now dying more from liver disease than from HIV.[13]

0415 **HIV/AIDS: screening for injection drug use**
(NCQA/AMA PCPI) *IF-026-07*

The Steering Committee noted that there are many other abused substances as significant as IDU, such as methamphetamine, crack cocaine, and alcohol. The measure developers' workgroup changed the denominator to read as, "All patients aged 13 years and older with a diagnosis of HIV/AIDS who had at least 2 visits during the measurement year, with at least 60 days between each visit." The workgroup also included a definition for screening: "Screening is defined as documentation that a discussion regarding injection drug use took place, or documentation that a standardized tool was used."

Measures Not Endorsed

HEPATITIS C: COMBINATION ANTIVIRAL THERAPY (AMA PCPI) *IF-006-07*

The Steering Committee noted that this measure did not reflect current practice, because combination therapy is the standard of care, and there is no evidence to suggest that patients, once in the hands of providers, receive inappropriate treatment. A more appropriate measure would be one that captures patients who are eligible for but do not have access to combination therapy. The measure developer subsequently withdrew the measure.

Withdrawn Measure

HIV/AIDS: GONORRHEA SCREENING (NCQA/AMA PCPI) *IF-019-07*

Prior to review by the Steering Committee, the measure developers removed the measure from consideration and combined it with IF-018-07 HIV/AIDS: Chlamydia Screening to form IF-018-07 HIV/AIDS: Chlamydia and Gonorrhea Screening.

Research Recommendations

During its deliberations of the hepatitis consensus standards, the Steering Committee recommended that the following measures be developed to provide important information on the quality of care for patients with hepatitis:

- a measure that determines whether patients with initial anti-HCV tests were appropriately followed up with confirmatory assays;
- a measure that encompasses counseling for all potentially teratogenic medications and appropriate informed consent;
- a patient-centered measure that addresses shared decisionmaking about treatment, or a measure that captures the components that go into considering a patient for treatment;
- a measure for hepatitis A and B vaccinations that incorporates all populations and delineates specific requirements for HCV and HIV/AIDS infected populations; and
- measures that assess hepatitis B treatment and management.

During its deliberations of the HIV/AIDS consensus standards, the Steering Committee recommended that the following measures be developed to provide important information on the quality of care for patients with HIV/AIDS:

- a measure that captures late HIV/AIDS diagnosis;
- a measure that tracks the time interval between diagnosis of HIV/AIDS and a patient's entry into care;
- a measure that incorporates site-specific STD testing;
- a measure that screens for HIV in the hepatitis population;
- structural or facility-level measures to pair with the above measures to capture patients lost to follow-up;
- a measure that assesses substance use outside of IDU;
- a measure to pair with the Adolescent and Adult Clients with AIDS Who Are Prescribed Potent Antiretroviral Therapy measure to determine whether the prescription was filled and taken;
- a complimentary set of measures aimed at children 13 years and younger; and
- a set of measures that addresses hepatitis B prevention, treatment, and care.

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Chapter 4: Perioperative Care

Introduction

NQF HAS ENDORSED a number of performance measures applicable to perioperative care, specifically for ambulatory care surgical centers, cardiac surgery, and hospital-based surgery, as well as several clinician-level measures. However, significant areas of perioperative care have not been addressed. This chapter presents 13 clinician-level performance measures in the areas of critical care and anesthesiology; perioperative management; and general thoracic surgery. Additionally, prophylactic antibiotic measures endorsed earlier this year have been updated to include foot and ankle procedures.

Table 4.1: National Voluntary Consensus Standards for Clinicians: Perioperative Care

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Recording of clinical stage prior to surgery for lung cancer or esophageal cancer resection*	0455	During a 12-month period, the percentage of all surgical patients ≥18 years of age, undergoing treatment procedures for lung or esophageal cancer that had clinical TNM staging provided prior to surgery (PO-001-07)	STS
Participation in a systematic national database for general thoracic surgery*	0456	Participation for a 12-month period in at least one multicenter, standardized data collection and feedback program that provides benchmarking of the physician's data relative to national and regional programs and uses process and outcome measures (PO-002-07)	STS
Recording of performance status prior to lung or esophageal cancer resection* (Zubrod, Karnofsky, WHO, or ECOG Performance Status)	0457	During a 12-month period, the percentage of patients undergoing resection of a lung or esophageal cancer who had their performance status (Zubrod, Karnofsky, WHO, or ECOG Performance Status) recorded within two weeks prior to the surgery date (PO-003-07)	STS
Pulmonary function tests (PFTs) before major anatomic lung resection (pneumonectomy, lobectomy, or formal segmentectomy)*	0458	During a 12-month period the percentage of thoracic surgical patients ≥18 years of age who underwent at least one pulmonary function test no more than 12 months prior to a major lung resection (pneumonectomy, lobectomy, or formal segmentectomy) (PO-004-07)	STS

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*Time-limited endorsement.

[a] Upon NQF endorsement, each measure receives a unique NQF measure ID number.

[b] Review number.

[c] IP owner(s)—intellectual property owner(s) and copyright holder(s). For the most current specifications and supporting information, please refer to the IP owner(s):
AMA PCPI - American Medical Association Physician Consortium for Performance Improvement (www.physicianconsortium.org)
ASA - American Society of Anesthesiologists (www.asahq.org)
NCQA - National Committee for Quality Assurance (www.ncqa.org)
STS - The Society of Thoracic Surgeons (www.sts.org)
SVS - Society for Vascular Surgery (www.vascularweb.org)
VSGNNE - Vascular Study Group of Northern New England (www.vsgnne.org)

Table 4.1: National Voluntary Consensus Standards for Clinicians: Perioperative Care

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Risk-adjusted morbidity: length of stay >14 days after elective lobectomy for lung cancer*	0459	During a 12-month period, the percentage of patients ≥18 years undergoing elective lobectomy for lung cancer that have a hospital length of stay >14 days (PO-005-07)	STS
Risk-adjusted morbidity and mortality for esophagectomy for cancer*	0460	During a 12-month period, the percentage of patients ≥18 years undergoing elective esophagectomy for esophageal cancer who had the presence of any of the following postoperative conditions: bleeding requiring reoperation, anastomosis requiring medical or surgical treatment, reintubation, ventilation, pneumonia, or discharge mortality (PO-006-07)	STS
Discontinuation of prophylactic antibiotics (foot and ankle procedures)*	0271	Percentage of noncardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time [foot and ankle procedures only] (PO-009-07)	AMA PCPI NCQA
Selection of prophylactic antibiotic—first- OR second-generation cephalosporin (foot and ankle procedures)*	0268	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first- OR second-generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis [foot and ankle procedures only] (PO-010-07)	AMA PCPI NCQA

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Table 4.1: National Voluntary Consensus Standards for Clinicians: Perioperative Care

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Timing of antibiotic prophylaxis—ordering physician (foot and ankle procedures)*	0270	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) [foot and ankle procedures only] (PO-011-07)	AMA PCPI NCQA
Anesthesiology and critical care: prevention of catheter-related bloodstream infections (CRBSI)—central venous catheter (CVC) insertion protocol*	0464	Percentage of patients who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis) [or acceptable alternative antiseptics, per current guideline] followed (PO-012-07)	ASA AMA PCPI
Anesthesiology and critical care: perioperative temperature management (clinician level)*	0454	Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes' duration or longer for whom either active warming was used interoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (PO-013-07)	ASA AMA PCPI
Perioperative antiplatelet therapy for patients undergoing carotid endarterectomy*	0465	Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an antiplatelet agent (aspirin or clopidogrel) within 48 hours of surgery and at discharge from hospital (PO-014-07)	VSGNNE SVS
Use of patch during conventional carotid endarterectomy*	0466	Patients over age 18 undergoing conventional (non-eversion) CEA who have patch closure of the arteriotomy (PO-018-07)	VSGNNE SVS

Endorsed Measures

0455[i] **Recording of clinical stage prior to surgery for lung cancer or esophageal cancer resection**
(STS) *PO-001-07*[ii]

0457 **Recording of performance status prior to lung or esophageal cancer resection (Zubrod, Karnofsky, WHO, or ECOG Performance Status)**
(STS) *PO-003-07*

0458 **Pulmonary function tests (PFTs) before major anatomic lung resection (pneumonectomy, lobectomy, or formal segmentectomy)**
(STS) *PO-004-07*

These three measures assess the perioperative evaluation for patients undergoing lung or esophageal cancer surgery. The Steering Committee agreed with the importance of staging, PFTs, and performance assessment in the preoperative assessment but noted that simply recording the information will not ensure appropriate clinical decisionmaking.[1,2,3] The Committee recommended that the measure developer consider bundling several of the preoperative assessment measures into a single, multipart (all or none) measure for lung cancer surgery (staging, PFTs, performance assessment) and esophageal cancer surgery (staging and performance assessment) that would be more robust than the individual measures. The measure developer responded by noting that measures PO-001-07 and PO-003-07 could be bundled; measure PO-004-07 applies only to major anatomic lung resection, so it could not be bundled with the other two measures. The measure developer added that further study would be required to determine if a bundled measure would indeed be better than the individual measures.

The Committee hoped that more robust measures to assess the appropriateness of surgical therapy and the accuracy of staging would be developed without delay. Additionally, Committee members noted that stage should be established for all patients undergoing therapy for cancer. The Committee recommended clarification of the staging measure to "staging prior to surgery." The measure developer stated that it is accepted clinical practice to base specific treatment decisions (i.e., surgical versus medical treatment or vice versa) on the results of these tests; therefore, performing these tests should lead to appropriate clinical decisionmaking.

[i] NQF measure ID number.
[ii] Review number.

0456 **Participation in a systematic national database for general thoracic surgery**

(STS) *P0-002-07*

The Steering Committee strongly supported this measure whereby participants contribute data to a national database and receive feedback on their performance. The measure developer advised the Committee that any physician who performs general thoracic surgical procedures is encouraged to participate.[iii,4] Participation in the database is voluntary and is not subject to a minimum case requirement. Data from participants who submit fewer than 10 cases would not be included in the data analysis for reporting. The measure is appropriate at both the clinician and facility levels of analysis. The Committee strongly recommended adding "publicly available" to the characteristics of the database.

It was noted that now that NQF has endorsed several measures related to "participation in a surgical database," including the STS measure for cardiac surgery, strong consideration should be given to consolidating all surgical database measures into a single measure.

0459 **Risk-adjusted morbidity: length of stay >14 days after elective lobectomy for lung cancer**

(STS) *P0-005-07*

The Steering Committee recommended this outcome measure as an appropriately sophisticated risk model but noted that use outside the STS database will generate sampling and auditing issues. The measure developer clarified the measure title and the timeframe (12 months) and provided details of the risk model.[iv]

0460 **Risk-adjusted morbidity and mortality for esophagectomy for cancer**

(STS) *P0-006-07*

The Steering Committee agreed that surgery for esophageal cancer is a highly morbid procedure that should be assessed.[5] The Committee had concerns that combining morbidity and mortality is not appropriate (i.e., do stakeholders view and value prolonged intubation the same as death?) and may be problematic, although death is one type of morbidity. The Committee will evaluate how the morbidity and mortality measures perform together and separately. The risk model was published in *The Annals of Thoracic Surgery* in June 2008.[6]

[iii] Participation fees for the STS General Thoracic Surgeons Database are paid by individual physicians, not hospitals. The cost is $400/year for STS members and $500/year for nonmembers.

[iv] See www.qualityforum.org for the risk model "review" page for this draft report.

0271 **Discontinuation of prophylactic antibiotics (foot and ankle procedures)**

(AMA PCPI/NCQA) *P0-009-07*

0268 **Selection of prophylactic antibiotic—first- OR second-generation cephalosporin (foot and ankle procedures)**

(AMA PCPI/NCQA) *P0-010-07*

0270 **Timing of antibiotic prophylaxis—ordering physician (foot and ankle procedures)**

(AMA PCPI/NCQA) *P0-011-07*

The Steering Committee evaluated additional foot and ankle procedures for these surgical antibiotic prophylaxis measures that were endorsed in July 2007. The Committee was concerned that the evidence is extrapolated from the orthopedic literature rather than being based specifically on podiatry surgeries. Specific evidence for improved outcomes for podiatric procedures, independent of orthopedic procedures, would be preferred. Additionally, no information on current performance for foot and ankle procedures was provided.

0464 **Anesthesiology and critical care: prevention of catheter-related bloodstream infections (CRBSI)—central venous catheter (CVC) insertion protocol**

(ASA/AMA PCPI) *P0-012-07*

The Steering Committee commented that this patient safety measure could be better harmonized with the NQF-endorsed, facility-level Central Line Bundle Compliance measure, which includes hand hygiene, maximal barrier precautions, chlorhexidine skin antisepsis, and optimal site selection. The Committee asked the measure developers to clarify the term "emergency" under exclusions and to provide evidence to support excluding emergency insertions or provide alternative language. The Committee also asked who will be responsible for documenting that the technique was completed. Committee members recommended that the measure be made consistent with the Centers for Disease Control and Prevention (CDC) guideline, which does not mandate chlorhexidine as the only agent.

The measure developers agreed to revise the exclusion example to read as "including increased risk of harm to patient if adherence to aseptic technique would cause delay in CVC insertion." In the numerator, the measure developers agreed to add "or acceptable alternative antiseptics, per current guideline" after "2% chlorhexidine for cutaneous antisepsis."[7]

0454 **Anesthesiology and critical care: perioperative temperature management (clinician level)**

(ASA/AMA PCPI) *P0-013-07*

The Steering Committee supported the intent of this measure but insisted that it be harmonized with the Surgical Care Improvement Project (SCIP) recommendations to record temperature within 15 minutes, rather than 30 minutes. The Committee requested that consideration also be given to using this measure in a perioperative care composite measure rather than as a standalone measure. Complete harmonization of the facility- and clinician-level measures was achieved.

0465 **Perioperative antiplatelet therapy for patients undergoing carotid endarterectomy**

(VSGNNE/SVS) *P0-014-07*

Antiplatelet therapy has been shown to reduce the risk of postoperative complications for patients undergoing carotid endarterectomy. The Steering Committee expressed concern with the evidence base for the dose and formulation of aspirin or clopidogrel and the lack of dose specification in the measure. The measure developers responded that they believe that the literature supports low-dose ASA and that the additional work required to achieve this specificity would not yield benefit, because any ASA dose would be better than none, and most physicians now prescribe 81-325 mg/day; the dose of clopidogrel is standard at 75 mg/day.[8,9,10] The Committee was advised that unpublished data from the VSGNNE registry have demonstrated that preoperative antiplatelet therapy was significantly associated with a lower risk of ipsilateral stroke and death after CEA in a multivariate analysis with an odds ratio of 0.42. This is the first documentation of the benefit of preoperative ASA or clopidogrel in a regional vascular registry, which includes hospitals ranging in size from 25 to 615 inpatient beds.[11]

0466 **Use of patch during conventional carotid endarterectomy**

(VSGNNE/SVS) *P0-018-07*

This measure evaluates the use of conventional CEA patching to reduce stroke, death, and re-stenosis. A 2007 analysis of the VSGNNE database of nearly 3,000 conventional CEAs showed that the use of patching varied from 60 percent to 100 percent (mean 90 percent) among 11 hospitals.[12] The Steering Committee recommended the measure but noted that there are no specific codes for the patch. The measure developers indicated that they will apply to the Centers for Medicare & Medicaid Services for a G-code. Committee members also questioned whether the information could be obtained from the hospital billing data for the patch.

Measures Not Endorsed

RECORDING OF SMOKING STATUS FOR PATIENTS UNDERGOING PULMONARY RESECTION FOR LUNG CANCER (STS) *P0-015-07*

The Steering Committee did not recommend this measure because it is a minimum documentation measure. Additionally, there is some evidence that smoking cessation in the immediate perioperative period may lead to increased complications. All Committee members agreed that smoking cessation counseling is important for all patients and that NQF has already endorsed ambulatory care measures for smoking cessation that can be applied to pre- or postoperative patients.

ANESTHESIOLOGY AND CRITICAL CARE: PREVENTION OF VENTILATOR-ASSOCIATED PNEUMONIA—HEAD ELEVATION (AMA PCPI) *P0-007-07*

The Steering Committee asked the measure developer to explain this measure's lack of harmonization with the NQF-endorsed®, facility-level Ventilator Bundle measure, which contains four components (elevation of the head 30 degrees or greater, daily sedation interruption, substance use disorder prophylaxis, and deep vein thrombosis prophylaxis) and to justify the need for a clinician-level measure if a facility-level measure already has been endorsed. The Committee also recommended that the codes be expanded to include the Post-Anesthesia Care Unit/Recovery Room.

The measure developer was willing to revise the denominator to read as "All patients aged 18 years and older receiving care in the PACU or ICU who receive mechanical ventilation." However, the measure developer was not willing to revise the measure numerator to the Committee-recommended "Patients whose physician documented the assessment of the patient's head elevation on the first ventilator day" from the original "Patients whose physician ordered on the first ventilator day for head of bed elevation." The Committee decided that the measure does not sufficiently evaluate the appropriate care action as an "ordered" measure.

RISK-ADJUSTED MORTALITY AFTER ESOPHAGECTOMY FOR CANCER (STS) *P0-008-07*

The measure developer decided to withdraw this measure until further testing has been completed. See the notes under NQF# 0460 Risk-Adjusted Morbidity and Mortality for Esophagectomy for Cancer for more details.

POSTOPERATIVE STROKE OR DEATH IN ASYMPTOMATIC PATIENTS UNDERGOING CAROTID ENDARTERECTOMY (VSGNNE/SVS) *P0-017-07*

The Steering Committee acknowledged that the intent of the measure is to discourage surgery in high-risk patients if the benefit is small (e.g., 10 percent reduction in the likelihood of stroke over five years). The Committee asked for clarification of the criteria for "asymptomatic patient."[13] The measure developers proposed that patients need to be asymptomatic regarding the ipsilateral carotid territory for at least one year to qualify for this measure based on the Asymptomatic Carotid Atherosclerosis Study trial, which demonstrated the benefit of CEA in asymptomatic patients in the United States and that these patients had never had ipsilateral carotid TIA or stroke.[14]

In response to a request from the Committee, the measure developers defined stroke to be "an acute neurological deficit due to an occlusive or hemorrhagic brain lesion that persists more than 24 hours." It can be substantiated by a new stroke seen on brain imaging, but this is not a requirement—that is, clinical symptoms alone are sufficient. Both minor and major strokes will be counted, as long as the symptoms persist more than 24 hours. Stroke in either carotid distribution or vertebrobasilar stroke (i.e., any postoperative new neurologic deficit attributed to an occlusive or hemorrhagic brain lesion lasting more than 24 hours) is included. From an operational standpoint, postoperative new stroke is defined by the medical record code ICD-9-CM 997.02.

The Committee questioned the timeframe for measure data collection. In lieu of specifying a timeframe, the measure developers suggested analyzing the last 100 CEAs performed by each surgeon/hospital, as described in a 2002 SVS credentialing recommendation.[15] Until a surgeon/hospital has performed 100 CEAs (or when the measure is first introduced and no historical data has been entered), each surgeon/hospital is initially assumed to have 100 complication-free (i.e., without a death or stroke) hypothetical cases. When an actual CEA is performed, it is added to the 100 and a hypothetical CEA is removed from the 100, to maintain a moving 100-case base. In this way, at any time, the stroke or death rate can be calculated on the basis of a 100-case experience. Thus, if the first CEA performed by a surgeon/hospital results in stroke or death, the event rate becomes 1 percent. After the second such event, the rate would become 2 percent, etc. Several NQF Members and the Consensus Standards Approval Committee believed that providing "hypothetical cases" to new or low-volume surgeons could mask a poorly performing surgeon and was not a suitable methodology for public reporting.

Research Recommendations

During its deliberations of this set of measures, the Steering Committee recommended that the following measures be developed to provide important information on the quality of perioperative care:

- measures to assess the appropriateness of surgical therapy and the accuracy of staging; and
- outcome measures to provide consumers with more information about surgery and perioperative care when making decisions about their healthcare.

Notes

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Chapter 5: Licensed Independent Practitioners

Introduction

PROVIDING HIGH-LEVEL HEALTHCARE requires a multidisciplinary approach. When the clinical expertise of multiple healthcare professionals is merged, the patient is receiving the best possible care available. Although the 141 currently endorsed clinician-level consensus standards have mainly targeted physician (medical doctor/osteopathic doctor [MD/DO]) practices, many apply to the scopes of practice for licensed independent practitioners (LIPs).

Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants

Many of the currently endorsed measures, particularly in primary care, encompass the scopes of practices of these licensed independent practitioners, and it would be appropriate to evaluate their performance in the following areas:

- prevention, screening, and immunization;
- cross-cutting areas such as medication management, obesity, geriatrics, and patient experience with care; and
- condition-specific areas such as asthma/respiratory illness, diabetes, heart disease, hypertension, and mental health and substance use disorders.

Optometrists

In 2007 the National Quality Forum (NQF) endorsed four consensus standards for eye care professionals:

- Primary open angle glaucoma: optic nerve evaluation (American Academy of Ophthalmology [AAO]/AMA PCPI/NCQA)
- Age-related macular degeneration: antioxidant supplement prescribed/recommended (AAO/AMA PCPI/NCQA)

- Diabetic retinopathy: documentation of presence or absence of macular edema and level of severity of retinopathy (AAO/AMA PCPI/NCQA)
- Diabetic retinopathy: communication with the physician managing ongoing diabetes care (AAO/AMA PCPI/NCQA)

Chiropractors

In 2007, NQF endorsed a set of 15 structure and process measures for comprehensive care of low back pain. Most of these measures address the scope of practice for chiropractors.

Nurse Anesthetists (Certified Registered Nurse Anesthetists [CRNAs])

Several NQF consensus standards address the scope of practice for nurse anesthetists:

- Timing of prophylactic antibiotic administration—administering clinician (AMA PCPI)
- BMI in adults (New York City Department of Health and Mental Hygiene [NYC-DHMH])
- BMI in children 2-18 years (National Initiative for Children's Healthcare Quality [NICHQ])
- Tobacco use assessment/tobacco cessation intervention (AMA PCPI)
- Anesthesiology and critical care: perioperative temperature management (clinician level) (ASA/AMA PCPI)

Nurse Midwives

The scope of practice for nurse midwives can be assessed by several NQF consensus standards:

- prenatal measures including:
  - Screening for HIV (AMA PCPI)
  - Anti-D immune globulin (AMA PCPI)
  - Blood groups (ABO), D (Rh) type (AMA PCPI),
  - Blood group antibody testing (AMA PCPI);
- prevention, screening, and immunization measures; and
- cross-cutting measures such as medication management and obesity.

Podiatrists

The practice of Doctors of Podiatry can be evaluated with one endorsed consensus standard, Diabetes—Foot Exam (Alliance/NCQA), and several proposed measures for perioperative care (see Chapter 4):

- Discontinuation of prophylactic antibiotics (foot and ankle procedures) (AMA PCPI/NCQA)
- Selection of prophylactic antibiotic—first- OR second-generation cephalosporin (foot and ankle procedures) (AMA PCPI/NCQA)
- Timing of antibiotic prophylaxis—ordering physician (foot and ankle procedures) (AMI PCPI/NCQA)

Clinical Psychologists

Several NQF consensus standards pertaining to mental health and substance use disorders address the scope of practice for clinical psychologists:

- Major depressive disorder: diagnostic evaluation (AMA PCPI)
- Major depressive disorder: suicide risk assessment (AMA PCPI)
- Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents, Institute for Clinical Systems Improvement (ICSI)
- Bipolar disorder and major depression: assessment for manic or hypomanic behaviors, The Standards for Bipolar Excellence Project (STABLE)
- Initiation and engagement of alcohol and other drug dependence treatment, National Committee for Quality Assurance/ Washington Circle (NCQA/WC)
- Tobacco use assessment/tobacco cessation intervention (AMA PCPI)

Clinical Social Workers

NQF-endorsed measures for mental health and substance use disorders are appropriate for clinical social workers:

- Major depressive disorder: diagnostic evaluation (AMA PCPI)
- Major depressive disorder: suicide risk assessment (AMA PCPI)
- Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents (ICSI)
- Bipolar disorder and major depression: assessment for manic or hypomanic behaviors (STABLE)
- Initiation and engagement of alcohol and other drug dependence treatment (NCQA/WC]
- Tobacco use assessment/tobacco cessation intervention (AMA PCPI)

Dieticians/Nutritionists

NQF-endorsed consensus standards for obesity are within the scopes of practice for dieticians and nutritionists.

Physical Therapists (PTs) and Occupational Therapists (OTs)

None of the current NQF consensus standards addresses the scopes of practice for PT/OTs.

Speech-Language Pathologists

Several patient outcomes measures were initially discussed under this project, and consideration of the measures will continue under an upcoming NQF project that will focus on care of patient with a stroke.

Oral Surgeons and Dentists

Several cross-cutting consensus standards would be appropriate for oral surgeons and dentists:

- Tobacco use assessment/tobacco cessation intervention (AMA PCPI)
- Documentation of the medication lists in the outpatient record (CMS/NCQA)
- Documentation of allergies and adverse reactions in the outpatient record (CMS/NCQA)

Additional candidate consensus standards that address the performance of oral surgeons and dentists could not be identified for consideration. Development of performance measures in this area is urgently needed.

This focus on nonphysician professionals certainly does not preclude the use of the measures by MDs and DOs when appropriate; that is, a primary care provider will likely not have been trained to formally assess the proper fit of footwear on a diabetic nor have the equipment in his/her office to do so. It is also not meant to limit care that falls within a professional scope of practice. An optometrist may be assessing body mass index (BMI) on his/her patients, but it is not expected across the entire profession.

This report presents 15 additional performance measures to expand the current endorsed consensus standards that address the scopes of practice for nonphysician licensed independent practitioners. Many of the submitted measures are outcomes measures from existing databases. But these existing measures were not developed and are not currently used to publicly report at the individual professional level. These measures have been endorsed on a time-limited basis to allow for adequate testing at the individual professional level.

Table 5.1: National Voluntary Consensus Standards for Clinicians: Licensed Independent Practitioners

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Diabetic foot & ankle care, ulcer prevention—evaluation of footwear*	0416	Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing during one or more office visits within 12 months (NP-009-07)	APMA
Diabetic foot & ankle care, peripheral neuropathy—neurological evaluation*	0417	Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities during one or more office visits within 12 months (NP-010-07)	APMA
Screening for clinical depression and follow-up*	0418	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool (NP-012-07)	QIP CMS
Universal documentation and verification of current medications in the medical record*	0419	Percentage of patients aged 18 years and older with written provider documentation that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative (NP-014-07)	QIP CMS
Pain assessment prior to initiation of patient therapy and follow-up*	0420	Percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity, and description) through discussion with the patient or through use of a standardized tool on each initial evaluation prior to initiation of therapy (NP-015-07)	QIP CMS

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*Time-limited endorsement.

[a] Upon NQF endorsement, each measure receives a unique NQF measure ID number.

[b] Review number.

[c] IP owner(s)—intellectual property owner(s) and copyright holder(s). For the most current specifications and supporting information, please refer to the IP owner(s):
APMA - American Podiatric Medical Association (www.apma.org)
BU - Boston University (www.bu.edu)
CMS - Centers for Medicare & Medicaid Services (www.cms.gov)
FOTO - Focus on Therapeutic Outcomes (www.fotoinc.com)
QIP - Quality Insights of Pennsylvania (www.qipa.org/pa)

Table 5.1: National Voluntary Consensus Standards for Clinicians: Licensed Independent Practitioners

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Adult weight screening	0421	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during current visit documented in the medical record AND if the most recent BMI is outside parameters a follow-up plan is documented. Parameters: Age 65 and older BMI ≥30 or <22; Age 18-64 BMI ≥25 or <18.5.	QIP CMS
Functional status change for patients with knee impairments*	0422	Functional status change in patients aged 18 or older with a knee impairment associated with a functional deficit that had their functional status assessed at the beginning and end of rehabilitation (NP-001-07)	FOTO
Functional status change for patients with hip impairments*	0423	Functional status change in patients aged 18 or older with a hip impairment associated with a functional deficit that had their functional status assessed at the beginning and end of rehabilitation (NP-002-07)	FOTO
Functional status change for patients with foot/ ankle impairments*	0424	Functional status change in patients aged 18 or older with a foot/ankle impairment associated with a functional deficit that had their functional status assessed at the beginning and end of rehabilitation (NP-003-07)	FOTO
Functional status change for patients with lumbar spine impairments*	0425	Functional status change in patients aged 18 or older with a lumbar spine impairment associated with a functional deficit that had their functional status assessed at the beginning and end of rehabilitation (NP-004-07)	FOTO

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Table 5.1: National Voluntary Consensus Standards for Clinicians: Licensed Independent Practitioners

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	IP OWNER(S)[c]
Functional status change for patients with shoulder impairments*	0426	Functional status change in patients aged 18 or older with a shoulder impairment associated with a functional deficit that had their functional status assessed at the beginning and end of rehabilitation (NP-005-07)	FOTO
Functional status change for patients with elbow, wrist, or hand impairments*	0427	Functional status change in patients aged 18 or older with an elbow, wrist, or hand impairment associated with a functional deficit that had their functional status assessed at the beginning and end of rehabilitation (NP-006-07)	FOTO
Functional status change for patients with general orthopedic impairments*	0428	Functional status change in patients aged 18 or older with a general orthopedic impairment associated with a functional deficit that had their functional status assessed at the beginning and end of rehabilitation (NP-007-07)	FOTO
Change in basic mobility*	0429	Basic mobility domain has been identified, which consists of functional tasks that cover the following areas: transfers, walking, wheelchair skills, stairs, bend/lift/carrying tasks (NP-033-07)	BU
Change in daily activities*	0430	Daily activity domain has been identified, which consists of functional tasks that cover the following areas: feeding, meal preparation, hygiene, grooming, and dressing (NP-034-07)	BU

Endorsed Measures

0416[i] Diabetic foot & ankle care, ulcer prevention—evaluation of footwear

(APMA) *NP-009-07*[ii]

0417 Diabetic foot & ankle care, peripheral neuropathy—neurological evaluation

(APMA) *NP-010-07*

The Steering Committee agreed that the management of diabetes-related foot conditions is very important to consumers and that both measures are also appropriate for physical therapists and dieticians who are diabetic nurse educators. The Committee strongly recommended that the evaluations be tied to a treatment plan. The evaluation of footwear measure was deemed important, because the first mechanism of injury that may result in skin breakdown is prolonged low pressure over a bony prominence (i.e., bunion or hammertoe deformity). This generally causes wounds over the medial, lateral, and dorsal aspects of the forefoot and is associated with tight or ill-fitting shoes.[1] The neurological evaluation measure is based on guidelines from the American Podiatric Medical Association (APMA) and is more stringent than the currently endorsed measure, because it requires that *all* stated evaluations must occur. NQF previously endorsed a measure for foot exams in diabetes that follows the American Diabetes Association (ADA) guidelines, which allow for other types of evaluation besides the monofilament exam. These two measures are recommended for time-limited endorsement for podiatrists, physical therapists, and dieticians/diabetes educators.

0418 Screening for clinical depression and follow-up

(QIP/CMS) *NP-012-07*

The Steering Committee agreed that screening for depression is very important, does not happen as often as it should, and should be performed in a variety of settings even though the CPT codes in the denominator apply only to behavioral health and occupational therapy. The Committee reviewed the different screening tools that are available and determined that screening by any validated tool is appropriate. Patients undergoing treatment are excluded. The measure developers added a follow-up component to the measure in response to the Committee's insistence that screening must be tied to a specific action (e.g., referral or further evaluation) to be of value.

0419 Universal documentation and verification of current medications in the medical record

(QIP/CMS) *NP-014-07*

The Steering Committee noted that this measure is more specific than the current NQF-endorsed® measure, because it includes nonpharmaceuticals such as herbal supplements and requires documentation of verification with the patient.

[i] NQF measure ID number.
[ii] Review number.

The Committee suggested that the minimum age requirement be removed. After discussions with the measure developers, it was agreed that further work is needed to determine the value of including patients under 18 years of age. Verification and documentation should be performed by the clinician. The Committee noted that evaluation of medication lists by nonphysician providers is important because of possible impact on the practitioner's evaluation and therapy for the patient as well as possible medication side effects. The measure applies to all nonphysician practitioners in the outpatient setting.

0420 **Pain assessment prior to initiation of patient therapy and follow-up**

(QIP/CMS) *NP-015-07*

The Steering Committee agreed that it is important for practitioners to assess pain before initiating therapy but felt that the measure could be strengthened by requiring a discussion with the patient and the use of a standardized assessment tool. The measure developers added a follow-up component in response to the Committee's comment that a follow-up plan should be tied to the assessment for each episode of care. The CPT codes for the denominator apply to physical therapy, occupational therapy, and chiropractors.

0421 **Adult weight screening and follow-up**

(QIP/CMS) *NP-017-07*

The Steering Committee supports this measure, which enhances the currently endorsed measures by including follow-up. The Committee insisted that the measure should apply to all patients, including children, and should use the appropriate normal BMI values from the American Dietetic Association.[2,3] After further investigation, it was discovered that there is no consensus for BMI thresholds for the population under 18 years of age. The measure developers modified the measure to apply to patients aged 18 years and older, with the appropriate high and low thresholds to facilitate a follow-up plan of care. The issue of the appropriate use of abdominal girth in conjunction with or in lieu of BMI was discussed, and a research recommendation was developed, because the evidence was not conclusive.

0422 **Functional status change for patients with knee impairments**

(Focus on Therapeutic Outcomes, Inc. FOTO) *NP-001-07*

0423 **Functional status change for patients with hip impairments**

(FOTO) *NP-002-07*

0424 **Functional status change for patients with foot/ankle impairments**

(FOTO) *NP-003-07*

0425 **Functional status change for patients with lumbar spine impairments**
(FOTO) *NP-004-07*

0426 **Functional status change for patients with shoulder impairments**
(FOTO) *NP-005-07*

0427 **Functional status change for patients with elbow, wrist, or hand impairments**
(FOTO) *NP-006-07*

0428 **Functional status change for patients with general orthopedic impairments**
(FOTO) *NP-007-07*

The *Guide to Physical Therapist Practice* describes five elements of patient management, all of which are impacted by the assessment of patient function and activity level.[4] The FOTO measures were initially presented for consideration without the risk-adjustment methodology as part of the intellectual property agreement. The Steering Committee felt strongly that the measures must be risk adjusted to provide useful data for public accountability and pay-for-performance use. The measure developer agreed to make the risk-adjustment methodology available for public use. Although the measures have been in use for the past few years, they have not been fully tested as measures of individual care for accountability and, therefore, were endorsed as time limited to allow for additional analyses.

0429 **Change in basic mobility**
(BU) *NP-033-07*

0430 **Change in daily activities**
(BU) *NP-034-07*

These measures, based on the Activity Measure-Post Acute Care (AMPAC) tool, are calculated by completing specific short forms and using a risk-adjustment methodology to determine the change in functional status in the specific function domain.[5] The Steering Committee discussion focused on how to calculate the risk adjustment and on setting targets. The Committee recommended the measures as time limited based on the lack of testing for use at the clinician level.

Measures Not Endorsed

DIABETIC FOOT & ANKLE CARE, PERIPHERAL ARTERIAL DISEASE—ANKLE BRACHIAL INDEX (ABI) (APMA) *NP-011-07*

The Steering Committee recommended this measure for time-limited endorsement, because newer, less onerous treatments are available as alternatives to major vascular surgery, and the measure is consistent with clinical practice guidelines. The Committee acknowledged concerns about false-negatives in ABI values, which occur in patients with incompressible vessels (estimated at 10 percent to 15 percent occurrence) resulting from the calcification of vessel walls. However, it supported the measure, because although the ABI is recommended in the literature, the evidence suggests that most providers do not follow the American College

of Cardiology/American Heart Association guidelines, which recommend using the ABI to screen diabetics over the age of 50 years.

The Consensus Standards Approval Committee (CSAC) reviewed the issues raised by Members during comment and based its voting on the U.S. Preventive Services Task Force guidelines, which do not recommend (i.e., "D" recommendation) screening with the ABI. These guidelines do, however, recommend that clinicians should be alert to symptoms of peripheral artery disease in persons at increased risk (persons over age 50, smokers, diabetics) and should evaluate patients who have clinical evidence of vascular disease. The CSAC determined that screening with the ABI would not improve outcomes for diabetics, beyond the secondary prevention for cardiovascular disease (e.g., lipid and BP control) that is already recommended. The CSAC sustained its recommendation on appeal.

FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH COMPLEX ORTHOPEDIC, MEDICAL, OR NEUROLOGICAL IMPAIRMENTS (FOTO) *NP-008-07*

The Steering Committee did not recommend this measure, because psychometric testing of the instrument at the patient level is in process, and performance data are not available.

SCREENING FOR COGNITIVE IMPAIRMENT (QIP/CMS) *NP-013-07*

The Steering Committee did not recommend this measure, because the American Academy of Neurology does not recommend routine screening in all populations of asymptomatic patients, and screening is not tied to patient outcomes.

PATIENT CO-DEVELOPMENT OF PLAN OF CARE (QIP/CMS) *NP-018-07*

The Steering Committee strongly supported active patient participation in developing a plan of care. However, Committee members were concerned with the original language that suggested that the patient both co-developed and agreed with the plan of care, which would not be feasible, because the patient may participate in the plan of care plan but not necessarily agree to it. The measure developers agreed to the recommended edits, and the Committee recommended the measure for time-limited endorsement.

The CSAC did not recommend this measure despite its general support of measures that assess patient involvement in their own care. This particular measure raised concerns, because it relies solely on the health professional's assessment of the patient's participation in the development of his/her own plan of care. The CSAC concluded that, as a general rule, measures of patient engagement should seek to capture more direct information from patients.

CHANGE IN APPLIED COGNITION FUNCTION (BU) *NP-035-07*

The Steering Committee did not recommend this measure, because the definition of cognitive impairment continues to evolve in the literature.

Research Recommendations

Due to the broad nature of this project, research recommendations were specific to individual measures or sets of measures and focused on refining the recommended measures or developing new measures to compliment these measures.

NP-001-07 **FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH KNEE IMPAIRMENTS**

NP-002-07 **FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH HIP IMPAIRMENTS**

NP-003-07 **FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH FOOT/ANKLE IMPAIRMENTS**

NP-004-07 **FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH LUMBAR SPINE IMPAIRMENTS**

NP-005-07 **FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH SHOULDER IMPAIRMENTS**

NP-006-07 **FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH ELBOW, WRIST, OR HAND IMPAIRMENTS**

NP-007-07 **FUNCTIONAL STATUS CHANGE FOR PATIENTS WITH GENERAL ORTHOPEDIC IMPAIRMENTS**

- Investigate the use of residual scores to measure clinician performance.
- Investigate minimal clinical differences and setting thresholds.
- Investigate how this instrument compares to other similar instruments.

NP-009-07 **DIABETIC FOOT & ANKLE CARE, ULCER PREVENTION—EVALUATION OF FOOTWEAR**

- Investigate the feasibility of adding hospital consult codes (99251-99255) in the future (would need Evaluation and Management codes and possibly exclusions).
- Investigate how the data react when the debridement codes 11040-11044 are used.

NP-011-07 **DIABETIC FOOT & ANKLE CARE, PERIPHERAL ARTERIAL DISEASE—ANKLE BRACHIAL INDEX (ABI)**

- Define appropriate treatment plans.

NP-012-07 **SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP**

- Expand developed measures to cover all professions.
- Expand to other mental health professionals that were not included in the original testing.
- Refine and target the list of scales that can be used.

NP-014-07 **UNIVERSAL DOCUMENTATION AND VERIFICATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD**

- Expand to children and adolescents.

NP-017-07 **ADULT WEIGHT SCREENING AND FOLLOW-UP**

- Investigate the feasibility of using abdominal girth (i.e., waist circumference) as adjunct to or in lieu of BMI.
- Identify the appropriate BMI for the population under 18 years of age based on the 2008 guidelines once consensus is reached.

NP-033-07 **CHANGE IN BASIC MOBILITY**

NP-034-07 **CHANGE IN DAILY ACTIVITIES**

- Conduct research to better understand the ideal "threshold" that patients must achieve.
- Perform an analysis of using the measures for certain diagnostic groups rather than for one large heterogeneous group.
- Pursue additional work on the adequacy of the risk-adjustment strategy.

Notes

1 Frykberg RG, Zgonis T, Armstrong DG, et al., Diabetic foot disorders: a clinical practice guideline, *J Foot Ankle Surg,* 2006;45(Suppl 5):S2-S66.

2 National Health Lung and Blood Institute (NHLBI), *National Institutes of Health (NIH), Assessment of Weight and Body Fat, from Guidelines on Overweight and Obesity: Electronic Textbook,* Bethesda, MD: NHLBI. Available at www.nhlbi.nih.gov/guidelines/obesity/e_txtbk/txgd/411.htm. Last accessed January 2008.

3 A validated measure of nutrition status serves as an indicator of overnourishment and undernourishment. Nutrition Screening Initiative (American Academy of Family Physicians, American Dietetic Association, National Council on Aging), *Nutrition Interventions Manual for Professionals Caring for Older Americans;* 2002. Available at www.eatright.org/ada/files/NSIOlderAmericansComplete1.pdf. Last Accessed January 2009.

4 American Physical Therapy Association, Guide to physical therapist practice, *Phys Ther,* 2001;81(1):9-746.

5 Jette AM, Haley SM, Contemporary measurement techniques for rehabilitation outcome assessment, *J Rehabil Med,* 2005;37(6):339-345.

Appendix A
Specifications of the National Voluntary Consensus Standards for Clinicians—Additional Performance Measures 2008

THE FOLLOWING TABLE PRESENTS the detailed specifications for the National Quality Forum (NQF)-endorsed® *National Voluntary Consensus Standards for Clinicians: Additional Performance Measures 2008*. All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF Consensus Development Process). All specifications have been confirmed by the measure developers as of October 28, 2008. All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed.

CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hematology: myelodysplastic syndrome (MDS) and acute leukemias—baseline cytogenetic testing performed on bone marrow	Measure ID #: 0377 Review #: CA-001-07	ASH AMA PCPI[b] *© Copyright 2006 AMA and ASH. All Rights Reserved.*	Patients who had baseline cytogenetic testing* performed on bone marrow. *Baseline cytogenetic testing refers to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. CPT® Category II code: 3155F-Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment. CPT Category I: 88237, 88264, 88271, 88291. SNOMED: 64643009, 73735000, 399681006.	All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia. ICD-9 diagnosis codes: 204.00, 205.00, 206.00, 207.00, 207.20, 208.00, 238.72, 238.73, 238.74, 238.75 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not performing baseline cytogenetic testing-Append modifier to CPT Category II code: 3155F-1P. Documentation of patient reason(s) for not performing baseline cytogenetic testing-Append modifier to CPT Category II code: 3155F-2P. Documentation of system reason(s) for not performing baseline cytogenetic testing-Append modifier to CPT Category II code: 3155F-3P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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AMA PCPI - American Medical Association Physician Consortium for Performance Improvement (www.physicianconsortium.org)
APMA - American Podiatric Medical Association (www.apma.org)
ASA - American Society of Anesthesiologists (www.asahq.org)
ASCO - American Society of Clinical Oncology (www.asco.org)
ASH - American Society of Hematology (www.hematology.org)
Asian Liver Center at Stanford University (http://liver.stanford.edu)
ASTRO - American Society for Radiation Oncology (www.astro.org)
AUA - American Urological Association (www.auanet.org)
BU - Boston University (www.bu.edu)
CAP - College of American Pathologists (www.cap.org)
CMS - Centers for Medicare & Medicaid Services (www.cms.gov)
FOTO - Focus on Therapeutic Outcomes (www.fotoinc.com)
NCCN - National Comprehensive Cancer Network (www.nccn.org)
NCQA - National Committee for Quality Assurance (www.ncqa.org)
QIP - Quality Insights of Pennsylvania (www.qipa.org/pa)
STS - The Society of Thoracic Surgeons (www.sts.org)
SVS - Society for Vascular Surgery (www.vascularweb.org)
VSGNNE - Vascular Study Group of Northern New England (www.vsgnne.org)

[b] These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium). Neither the AMA, Consortium nor its members shall be responsible for any use of the Measures.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hematology: documentation of iron stores in patients receiving erythropoietin therapy	Measure ID #: 0378 Review #: CA-002-07	ASH AMA PCPI *© Copyright 2006 American Medical Association and American Society of Hematology. All Rights Reserved.*	Patients with documentation* of iron stores prior to initiating erythropoietin therapy. *Documentation includes either: bone marrow examination including iron stain *OR* serum iron measurement by ferritin or serum iron and TIBC. CPT Category II code: 3160F-Documentation of iron stores prior to initiating erythropoietin therapy. CPT Category I: Option 1 87209 *OR* Option 2 CPT Category I: 82728 *OR* 83540 *AND* CPT Category I: 83550. LOINC: Option 1 LOINC: 13513-7 *OR* Option 2 LOINC: 14723-1, 20567-4, 2276-4 *OR* 13452-8, 14797-5, 14798-3, 14800-7, 14801-5, 22753-8, 2498-4, 2500-7, 2501-5, 2502-3, 2505-6, 39778-6, 44326-7 *AND* 14800-7, 22753-8, 2500-7, 2501-5, 2505-6, 39778-6.	All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy. ICD-9 diagnosis codes: 238.72, 238.73, 238.74, 238.75 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* Patients aged 18 years and older *AND* CPT Category II code: 4090F-Patient receiving erythropoietin therapy *OR* HCPCS code to identify erythropoietin therapy: J0881, J0885 *OR* SNOMED: 67353006.	Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy-Append modifier to CPT Category II code: 3160F-3P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hematology: chronic lymphocytic leukemia (CLL)—baseline flow cytometry	Measure ID #: 0379 Review #: CA-003-07	ASH AMA PCPI *© Copyright 2006 American Medical Association and American Society of Hematology. All Rights Reserved.*	Patients who had baseline flow cytometry* studies performed. *Baseline flow cytometry studies refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy. CPT Category II code: 3170F-Baseline flow cytometry studies performed. CPT Category I: 88182, 88184, 88187, 88188, 88189. SNOMED: 29274000, 50183007, 64444005.	All patients aged 18 years and older with a diagnosis of Chronic Lymphocytic Leukemia (CLL). ICD-9 diagnosis codes: 204.10 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not performing baseline flow cytometry-Append modifier to CPT Category II code: 3170F-1P. Documentation of patient reason(s) for not performing baseline flow cytometry-Append modifier to CPT Category II code: 3170F-2P. Documentation of system reason(s) for not performing baseline flow cytometry-Append modifier to CPT Category II code: 3170F-3P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.
Hematology: multiple myeloma—treatment with bisphosphonates	Measure ID #: 0380 Review #: CA-004-07	ASH AMA PCPI *© Copyright 2006 American Medical Association and American Society of Hematology. All Rights Reserved.*	Patients who were prescribed or received intravenous bisphosphonate therapy* within the 12-month reporting period. *For the purpose of this measure, bisphosphonate therapy includes the following medications: pamidronate and zoledronate. CPT Category II code: 4100F-Intravenous bisphosphonate therapy prescribed or received. SNOMED codes: 96281001, 372907000.	All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission. ICD-9 diagnosis codes: 203.00 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not prescribing bisphosphonates (e.g., patients who do not have bone disease, patients with dental disease, patients with renal insufficiency)-Append modifier to CPT Category II code: 4100F-1P. Documentation of patient reason(s) for not prescribing bisphosphonates-Append modifier to CPT Category II code: 4100F-2P.	Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Radiation oncology: treatment summary documented and communicated	Measure ID #: 0381 Review #: CA-005-07	ASTRO ASCO AMA PCPI *© Copyright 2007 American Medical Association. All Rights Reserved.*	Patients who have a treatment summary* report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment. *Treatment Summary definition-a report that includes mention of all of the following components: 1) dose delivered; 2) relevant assessment of tolerance to and progress towards the treatment goals; and 3) subsequent care plans. CPT Category II code: XXXXF-Treatment summary report communicated to physician(s) managing continuing care and to the patient within one month of completing treatment.	All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy. CPT codes for external beam radiation therapy, weekly management or brachytherapy: 77427, 77431, 77432, 77435, 77470, 77761, 77762, 77763, 77776, 77777, 77778, 77781, 77782, 77783, 77784 *AND* ICD-9 diagnosis codes: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9 (lip, oral cavity and pharynx cancer), 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1,	Documentation of patient reason(s) for not communicating the treatment summary report to the physician(s) proving continuing care (e.g., patient requests that report not be sent) and to the patient-Append modifier to CPT Category II code: 5020F-2P. Documentation of system reason(s) for not communicating the treatment summary report to the physician(s) proving continuing care (e.g., patient does not have any physician responsible for providing continuing care) and to the patient-Append modifier to CPT Category II code: XXXXF-3P.	Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record, Hybrid.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Radiation oncology: treatment summary documented and communicated *(continued)*				155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9 (digestive organs and peritoneum cancer), 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9 (respiratory and intrathoracic cancer), 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9 (bone, connective tissue, skin and breast cancer), 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Radiation oncology: treatment summary documented and communicated *(continued)*				188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9 (genitourinary organs cancer), 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193., 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1 (other or unspecified cancer), 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 300.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 300.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 300.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 300.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 300.73, 200.74, 200.75, 200.76, 200.77,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Radiation oncology: treatment summary documented and communicated *(continued)*				200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Radiation oncology: treatment summary documented and communicated *(continued)*				202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.10, 203.11, 203.80, 203.81, 204.00, 204.01, 204.10, 204.11, 204.20, 204.21, 204.80, 204.81, 204.90, 204.91, 205.00, 205.01, 205.10, 205.11, 205.20, 205.21, 205.30, 205.31, 205.80, 205.81, 205.90, 205.91, 206.00, 206.01, 206.10, 206.11, 206.20, 206.21, 206.80, 206.81, 206.90, 206.91, 207.00, 207.01, 207.10, 207.11, 207.20, 207.21, 207.80, 207.81, 208.00, 208.01, 208.10, 208.11, 208.20, 208.21, 208.80, 208.81, 208.90, 208.91 (lymphatic and hematopoietic tissue cancer), 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 238.8, 238.9 (neoplasms of uncertain behavior), 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.8, 239.9 (neoplasms of unspecified nature).		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Radiation oncology: radiation dose limits to normal tissues	Measure ID #: 0382 Review #: CA-006-07	ASTRO ASCO AMA PCPI *© Copyright 2007 American Medical Association. All Rights Reserved.*	Patients who had documentation in medical record that normal tissue dose constraints were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues. CPT Category II code: XXXXF-Normal tissue dose constraints established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/ organs.	All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy. CPT code for radiation therapy 3D simulation: 77295 *AND* ICD-9 diagnosis codes: 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9 (malignant neoplasm of pancreas); 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9 (malignant neoplasm of bronchus and lung).	None.	Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record, Hybrid.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
PAIRED MEASURES:						
Medical oncology and radiation oncology: plan of care for pain	Measure ID #: 0383 Review #: CA-007-07	ASTRO ASCO AMA PCPI *© Copyright 2007 American Medical Association. All Rights Reserved.*	Patient visits that included a documented plan of care* to address pain. *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval. CPT Category II code: 0521F–Plan of care to address pain documented.	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain. ICD-9 diagnosis codes: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9 (lip, oral cavity and pharynx cancer), 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1,	None.	Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: plan of care for pain *(continued)*				159.8, 159.9 (digestive organs and peritoneum cancer), 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9 (respiratory and intrathoracic cancer), 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9 (bone, connective tissue, skin and breast cancer), 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9 (genitourinary organs		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: plan of care for pain *(continued)*				cancer), 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1 (other or unspecified cancer), 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 200.30, 200.31, 200.32, 300.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: plan of care for pain *(continued)*				200.42, 300.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 300.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 300.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 300.73, 200.74, 200.75, 200.76, 200.77, 200.78, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: plan of care for pain *(continued)*				202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.10, 203.11, 203.80, 203.81, 204.00, 204.01, 204.10, 204.11, 204.20, 204.21, 204.80, 204.81, 204.90, 204.91, 205.00, 205.01, 205.10, 205.11, 205.20, 205.21, 205.30, 205.31, 205.80, 205.81, 205.90, 205.91, 206.00, 206.01, 206.10, 206.11, 206.20, 206.21, 206.80, 206.81, 206.90, 206.91, 207.00, 207.01, 207.10, 207.11, 207.20, 207.21, 207.80, 207.81, 208.00, 208.01, 208.10, 208.11, 208.20, 208.21, 208.80, 208.81, 208.90, 208.91 (lymphatic and hematopoietic tissue cancer), 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.8, 236.9, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.7, 237.8, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.7, 238.8, 238.9 (neoplasms of uncertain behavior), 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.8 (neoplasms of unspecified nature)		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: plan of care for pain *(continued)*				*AND* All patients, regardless of age *AND* either option 1 or 2: Option 1. CPT E/M service code: 99201, 99202, 99203, 99204, 99205 (office-new patient), 99212, 99213, 99214, 99215 (office-established patient) *AND* CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415-96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521-96523, 96542, 96549 (intravenous chemotherapy administration) *OR* Option 2. CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470 ***AND* (in addition to codes in Option 1 or 2)** CPT Category II code: 1125F-Pain severity quantified; pain present.		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
AND						
Medical oncology and radiation oncology: pain intensity quantified	Measure ID #: 0384 Review #: CA-017-07	ASTRO ASCO NCCN AMA PCPI *© Copyright 2007 American Medical Association. All Rights Reserved.*	Number of patient visits in which pain intensity is quantified.* * Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale. Report the following CPT Category II codes: 1125F-Pain severity quantified; pain present ***OR*** 1126F-Pain severity quantified; no pain present.	All visits for patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy. ICD-9 diagnosis codes: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9 (lip, oral cavity and pharynx cancer), 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9 (digestive organs and	None.	Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: pain intensity quantified *(continued)*				peritoneum cancer), 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9 (respiratory and intrathoracic cancer), 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9 (bone, connective tissue, skin and breast cancer), 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9 (genitourinary organs cancer), 190.0, 190.1, 190.2, 190.3,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: pain intensity quantified *(continued)*				190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1 (other or unspecified cancer), 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 300.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 300.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 300.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 300.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 300.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: pain intensity quantified *(continued)*				200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72,		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: pain intensity quantified *(continued)*				202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.10, 203.11, 203.80, 203.81, 204.00, 204.01, 204.10, 204.11, 204.20, 204.21, 204.80, 204.81, 204.90, 204.91, 205.00, 205.01, 205.10, 205.11, 205.20, 205.21, 205.30, 205.31, 205.80, 205.81, 205.90, 205.91, 206.00, 206.01, 206.10, 206.11, 206.20, 206.21, 206.80, 206.81, 206.90, 206.91, 207.00, 207.01, 207.10, 207.11, 207.20, 207.21, 207.80, 207.81, 208.00, 208.01, 208.10, 208.11, 208.20, 208.21, 208.80, 208.81, 208.90, 208.91 (lymphatic and hematopoietic tissue cancer), 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.8, 236.9, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.7, 237.8, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.7, 238.8, 238.9 (neoplasms of uncertain behavior), 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.8 (neoplasms of unspecified nature) *AND*		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology and radiation oncology: pain intensity quantified *(continued)*				Report CPT Category II code: 1125F-Pain severity quantified; pain present *AND* either option 1 or 2: 1. Chemotherapy CPT E/M service codes: 99201, 99202, 99203, 99204, 99205 (office-new patient), 99212, 99213, 99214, 99215 (office-established patient) *AND* CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415-96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521-96523, 96542, 96549 (intravenous chemotherapy administration) *OR* 2. Radiation therapy CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470.		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology: chemotherapy for stage IIIA through IIIC colon cancer patients	Measure ID #: 0385 Review #: CA-013-07	ASTRO ASCO NCCN AMA PCPI *© Copyright 2007 American Medical Association, American Society of Clinical Oncology, and National Comprehensive Cancer Network. All Rights Reserved.*	Patients who are referred for chemotherapy, prescribed chemotherapy, or who have previously received adjuvant chemotherapy* within the 12-month reporting period. *According to current NCCN guidelines, the following therapies are recommended: 5-fluorouracil/leucovorin or capecitabine, or 5-fluorouracil/leucovorin/oxaliplatin. CPT Category II code: XXXXF-Adjuvant chemotherapy prescribed or previously received for Stage IIIA through Stage IIIC colon cancer or patient referred for chemotherapy.	All patients aged 18 years and older with Stage IIIA through IIIC colon cancer. CPT E/M Service code: 99201, 99202, 99203, 99204, 99205 (office-new patient), 99212, 99213, 99214, 99215 (office-established patient) *AND* ICD-9 diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9 (malignant neoplasm of colon) *AND* Patients aged 18 years and older *AND* CPT Category II code for Stage IIIA through IIIC cancer from the following table: 3309F-AJCC Cancer Stage IIIA, documented 3310F-AJCC Cancer Stage IIIB, documented 3311F-AJCC Cancer Stage IIIC, documented.	Documentation of medical reason(s) for not prescribing or receiving adjuvant chemotherapy or not referring for chemotherapy within the 12-month reporting period (e.g., diagnosis date more than 5 years prior to the current visit date; patient's cancer has metastasized; medical contraindication/allergy; poor performance status)-Append modifier to CPT Category II code (in development): XXXXF-1P. Documentation of patient reason(s) for not prescribing or receiving adjuvant chemotherapy within the 12-month reporting period (e.g., patient refusal)-Append modifier to CPT Category II code (in development): XXXXF-2P. Documentation of system reason(s) for not prescribing or receiving adjuvant chemotherapy within the 12-month reporting period (e.g., patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)-Append modifier to CPT Category II code (in development): XXXXF-3P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Oncology: cancer stage documented	Measure ID #: 0386 Review #: CA-014-07	ASTRO ASCO AMA PCPI *© Copyright 2007 American Medical Association, American Society of Clinical Oncology, and American Society for Therapeutic Radiology and Oncology. All rights reserved.*	Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once during the 12-month reporting period. *Cancer stage refers to stage at diagnosis. Report one of the following CPT Category II codes: 3300F-American Joint Committee on Cancer (AJCC) stage documented and reviewed *OR* 3301F-Cancer stage documented in medical record as metastatic and reviewed.	All patients with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting. ICD-9 diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 (malignant neoplasm of female breast), 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9 (malignant neoplasm of colon), 154.0, 154.1, 154.2, 154.3, 154.8 (malignant neoplasm of rectum and anus) *AND* either option 1 or 2 1. Chemotherapy ▌ CPT E/M service code: 99201, 99202, 99203, 99204, 99205 (office-new patient), 99212, 99213, 99214, 99215 (office-established patient), 99241, 99242, 99243, 99244, 99245 (outpatient consult), *OR* 2. Radiation therapy ▌ CPT codes for radiation treatment planning: 77261, 77262, 77263.	None.	Paper Medical Record, Administrative Claims Data using CPT II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Medical oncology: hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer	Measure ID #: 0387 Review #: CA-016-07	ASTRO ASCO NCCN AMA-PCPI *© Copyright 2007 American Medical Association, American Society of Clinical Oncology, and National Comprehensive Cancer Network. All Rights Reserved.*	Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period. Report the following CPT Category II code: 4179F-Tamoxifen or aromatase inhibitor (AI) prescribed.	All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer. ICD-9 diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 (malignant neoplasm of female breast) *AND* CPT E/M service codes: 99201, 99202, 99203, 99204, 99205 (office-new patient), 99212, 99213, 99214, 99215 (office-established patient) *AND* CPT Category II code for Stage IC through IIIC cancer from the following table: XXXXF-AJCC Cancer Stage t1C, documented XXXXF-AJCC Cancer Stage IIA, documented XXXXF-AJCC Cancer Stage IIB, documented XXXXF-AJCC Cancer Stage IIIA, documented XXXXF-AJCC Cancer Stage IIIB, documented XXXXF-AJCC Cancer Stage IIIC, documented *AND* CPT Category II code for estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer: 3315F *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period-Append modifier to CPT Category II code: 4179F-1P. Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (AI) within the 12-month reporting period-Append modifier to CPT Category II code: 4179F-2P. Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (AI) within the 12-month reporting period-Append modifier to CPT Category II code: 4179F-3P.	

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Prostate cancer: three-dimensional radiotherapy	Measure ID #: 0388 Review #: CA-008-07	AUA AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT). CPT Category II code: 4165F-Three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT) received.	All patients with prostate cancer receiving external beam radiotherapy to the prostate only (no metastases). ICD-9 diagnosis codes: 185 *AND* Not ICD-9 diagnosis codes: 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.8 *AND* CPT service codes: 77401, 77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418 (external beam radiotherapy) *AND* CPT II code for patient receiving external beam radiotherapy to the prostate only: 4200F.	None.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Prostate cancer: avoidance of overuse measure—isotope bone scan for staging low-risk patients	Measure ID #: 0389 Review #: CA-009-07	AUA AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who did not have an isotope bone scan performed at any time since diagnosis of prostate cancer. CPT Category II code: 3270F-Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer.	All patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, *OR* external beam radiotherapy to the prostate, *OR* radical prostatectomy, *OR* cryotherapy. Risk strata definitions: Low Risk: PSA ≤10 mg/dL; *AND* Gleason score 6 or less; *AND* clinical stage T1c or T2a2 Intermediate Risk: PSA >10 to 20 mg/dL; *OR* Gleason score 7; *OR* clinical stage T2b, and not qualifying for high risk High Risk: PSA >20 mg/dL; *OR* Gleason score 8 to 10; *OR* clinical stage T2c or greater; and not qualifying for very high risk. Note: Only patients with prostate cancer with low risk of recurrence will be counted in the denominator of this measure. ICD-9 diagnosis codes: 185 *AND* CPT service codes: 77776, 77777, 77778, 77784 (brachytherapy); 77411, 77412, 77413, 77414, 77416, 77418, (external beam radiotherapy); 55810, 55812, 55815 (perineal prostatectomies); 55840, 55842,	Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons)-Append modifier to CPT Category II code: 3269F-1P-Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer. Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician)-Append modifier to CPT Category II code: 3269F-3P-Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Prostate cancer: avoidance of overuse measure—isotope bone scan for staging low-risk patients *(continued)*				55845 (retropubic prostatectomies); 55866 (laparoscopic prostatectomy); 55873 (cryotherapy) *AND* CPT Category II code: 3271F-Low risk of recurrence, prostate cancer *OR* SNOMED: 113120007 (brachytherapy); 8782006, 26294005, 28579000, 37851009, 41416003, 65551008, 72388004, 176261008, 176262001, 176263006 (prostatectomies); 265589001 (cryotherapy).		

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Prostate cancer: adjuvant hormonal therapy for high-risk patients	Measure ID #: 0390 Review #: CA-010-07	AUA AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist). CPT Category II code: 4164F-Adjuvant (i.e., in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/ administered *OR* SNOMED: 108772001, 116101001.	All patients with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate. Risk strata definitions: Low Risk: PSA ≤10 mg/dL; *AND* Gleason score 6 or less; *AND* clinical stage T1c or T2a2 Intermediate Risk: PSA >10 to 20 mg/dL; *OR* Gleason score 7; *OR* clinical stage T2b, and not qualifying for high risk High Risk: PSA >20 mg/dL; *OR* Gleason score 8 to 10; *OR* clinical stage T3a or greater; and not qualifying for very high risk. Note: Only patients with prostate cancer with high risk of recurrence will be counted in the denominator of this measure. ICD-9 diagnosis code: 185 *AND* CPT service codes: 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418 (external beam radiotherapy) *AND* CPT Category II code: 3273F-High risk of recurrence, prostate cancer.	Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (GnRH agonist or antagonist)-Append modifier to CPT Category II code: 4164F-1P *OR* ICD: 995.21, 995.27 WITH E932.2. Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy (GnRH agonist or antagonist)-Append modifier to CPT Category II code: 4164F-2P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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CANCER CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Pathology: breast cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Measure ID #: 0391 Review #: CA-018-07	CAP AMA PCPI *© 2007 AMA and CAP All Rights Reserved.*	Reports that include the pT category, the pN category, and the histologic grade. CPT Category II code: 3260F-pT (primary tumor), pN (regional lymph node), and histologic grade documented in pathology report.	All breast cancer resection pathology reports (excluding biopsies). ICD-9 diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9 *AND* CPT service codes: 88307, 88309.	Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (e.g., re-excision without residual tumor; non-carcinomas)-Append modifier to CPT Category II code: 3260F-1P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.
Pathology: colorectal cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Measure ID #: 0392 Review #: CA-019-07	CAP AMA PCPI *© 2007 AMA and CAP All Rights Reserved.*	Reports that include the pT category, the pN category and the histologic grade. CPT Category II code: 3260F-pT (primary tumor), pN (regional lymph node), and histologic grade documented in pathology report.	All colon and rectum cancer resection pathology reports. ICD-9 diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8 *AND* CPT service code: 88309.	Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (e.g., re-excision without residual tumor; non-carcinomasanal canal)-Append modifier to CPT Category II code: 3260F-1P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hepatitis C: testing for chronic hepatitis C—confirmation of hepatitis C viremia	Measure ID #: 0393 Review #: IF-001-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients for whom HCV RNA testing was ordered or previously performed. CPT Category II code: 3265F-Ribonucleic acid (RNA) testing for hepatitis C viremia ordered or results documented. SNOMED: 50711007, 62944002, 121204002, 122366001, 186634008, 187033005, 397662006, 406104003, 406105002. LOINC: 10676-5, 11011-4, 11259-9, 20416-4, 20571-6, 29609-5, 34703-9, 34704-7, 38180-6, 42617-1.	All patients aged 18 years and older with a diagnosis of hepatitis C seen for initial evaluation. There are two ways the denominator may be captured: (1) for new patients and (2) for established/consult patients. This allows for all physicians who see a patient for an initial evaluation for hepatitis C to utilize the measure. Patients aged 18 years and older *AND* 1. New Patients: ICD-9 diagnosis codes: 070.51, 070.54, 070.70 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205. 2. Established/Consult Patients: ICD-9 diagnosis codes: 070.51, 070.54, 070.70 *AND* CPT service codes: 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* CPT Category II code: 1119F-Initial evaluation for condition.	Documentation of medical reason(s) for not ordering or performing HCV RNA testing-Append modifier to CPT Category II code: 3265F-1P. Documentation of patient reason(s) for not ordering or performing HCV RNA testing-Append modifier to CPT Category II code: 3265F-2P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hepatitis C: counseling regarding use of contraception prior to antiviral treatment	Measure ID #: 0394 Review #: IF-002-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who were counseled regarding contraception prior to the initiation of treatment. CPT Category II code: 4159F-Counseling regarding contraception received prior to initiation of antiviral treatment. SNOMED: 315926003, 389095005, 398780007, 408968008.	All female patients aged 18 to 44 years and all male patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment. ICD-9 diagnosis codes: 070.54, 070.70 *AND* CPT service code: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* CPT Category II code: 4150F-Patient receiving antiviral treatment for hepatitis C *OR* SNOMED: 32249005, 410842008 *AND* Female patients aged 18 years to 44 years *OR* Male patients aged 18 years and older.	Documentation of medical reason(s) for not counseling patient regarding contraception-Append modifier to CPT Category II code: 4159F-1P-Documentation of medical reason(s) for not counseling patient regarding contraception.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
PAIRED MEASURES:						
Hepatitis C: hepatitis C RNA testing before initiating treatment ***AND***	Measure ID #: 0395 Review #: IF-003-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients for whom quantitative HCV RNA testing was performed within 6 months prior to the initiation of antiviral treatment. CPT Category II code: 3218F-RNA testing for hepatitis C documented as performed within 6 months prior to initiation of antiviral treatment for hepatitis C. SNOMED: 50711007, 62944002, 121204002, 122366001, 186634008, 187033005, 397662006, 406104003, 406105002. LOINC: 10676-5, 11011-4, 11259-9, 20416-4, 20571-6, 29609-5, 34703-9, 34704-7, 38180-6, 42617-1.	All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment. ICD-9 diagnosis codes: 070.54, 070.70 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* CPT Category II code: 4150F-Patient receiving antiviral treatment for hepatitis C *OR* SNOMED: 32249005, 410842008 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not performing quantitative HCV RNA testing within 6 months prior to the initiation of treatment-Append modifier to CPT Category II code: 3218F-1P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.
Hepatitis C: HCV genotype testing prior to treatment	Measure ID #: 0396 Review #: IF-004-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients for whom HCV genotype testing was performed prior to the initiation of antiviral treatment. CPT Category II code: 3266F-Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for hepatitis C.	All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment. ICD-9 diagnosis codes: 070.54, 070.70 *AND* CPT service code: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	None.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hepatitis C: HCV genotype testing prior to treatment *(continued)*				*AND* CPT Category II code: 4150F-Patient receiving antiviral treatment for hepatitis C *OR* SNOMED: 32249005, 410842008 *AND* Patients aged 18 years and older.		
Hepatitis C: prescribed antiviral therapy	Measure ID #: 0397 Review #: IF-005-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who were prescribed peginterferon and ribavirin therapy within the 12-month reporting period. CPT Category II codes: 4153F-Combination peginterferon and ribavirin therapy prescribed. SNOMED: 410842008.	All patients aged 18 years and older with a diagnosis of chronic hepatitis C. ICD-9 diagnosis codes: 070.54, 070.70 *AND* CPT service code: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not prescribing peginterferon and ribavirin therapy (e.g., patient was not a candidate for therapy, could not tolerate)-Append modifier to CPT Category II code: 4153F-1P. SNOMED: 292840003, 294380004. ICD-9: 995.21, 995.27 WITH E931.7. Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy (e.g., patient refused, unable to afford medication)-Append modifier to CPT Category II code: 4153F-2P. Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy (e.g., patient has no insurance coverage, therapy not covered)-Append modifier to CPT Category II code: 4153F-3P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hepatitis C: HCV RNA testing at week 12 of treatment	Measure ID #: 0398 Review #: IF-007-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment. CPT Category II code: 3220F-Hepatitis C quantitative RNA testing documented as performed at 12 weeks from the initiation of antiviral treatment. LOINC: 10676-5, 11011-4, 20416-4, 20571-6, 29609-5, 34703-9, 34704-7, 38180-6, 42617-1.	All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment. ICD-9 diagnosis codes: 070.54, 070.70 *AND* CPT service code: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* CPT Category II code: 4150F-Patient receiving antiviral treatment for hepatitis C *OR* SNOMED: 32249005, 410842008 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not performing quantitative HCV RNA testing at 12 weeks from the initiation of antiviral treatment-Append modifier to CPT Category II code: 3220F-1P. Documentation of patient reason(s) for not performing quantitative HCV RNA testing at 12 weeks-Append modifier to CPT Category II code: 3220F-2P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
PAIRED MEASURES:						
Hepatitis C: hepatitis A vaccination ***AND***	Measure ID #: 0399 Review #: IF-008-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A. CPT Category II codes: 4148F-Hepatitis A vaccine injection administered or previously received. CPT Category I: 90632, 90636. SNOMED: 14745005, 170378007, 170379004, 170380001, 170381002, 170436000, 243789007, 312868009, 313188000, 313189008, 314177003, 333702001, 333703006, 333707007, 333708002, 348045000, 351451004, 376207008 *OR* 3215-Patient has documented immunity to hepatitis A. SNOMED: 278971009.	All patients aged 18 years and older with a diagnosis of hepatitis C. ICD-9 diagnosis codes: 070.51, 070.54, 070.70 *AND* CPT service code: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not receiving at least one injection of hepatitis A vaccine-Append modifier to CPT Category II code: 4148F-1P. ICD: 995.21, 995.27 WITH E949.6. SNOMED: 293126009, 294663006. Documentation of patient reason(s) for not receiving at least one injection of hepatitis A vaccine-Append modifier to CPT Category II code: 4148F-2P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.
Hepatitis C: hepatitis B vaccination	Measure ID #: 0400 Review #: IF-009-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who have received at least one injection of hepatitis B vaccine, or who have documented immunity to hepatitis B. CPT Category II codes: 4149F-hepatitis B vaccine injection administered or previously received. CPT Category I: 90636, 90746.	All patients aged 18 years and older with a diagnosis of hepatitis C. ICD-9 diagnosis codes: 070.51, 070.54, 070.70 *AND* CPT service code: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Documentation of medical reason(s) for not receiving at least one injection of hepatitis B vaccine-Append modifier to CPT Category II code: 4149F-1P. ICD: 995.21, 995.27 WITH E949.6. SNOMED: 293110008, 294646007.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Hepatitis C: hepatitis B vaccination *(continued)*			SNOMED: 16584000, 34689006, 170437009, 170371001, 170434002, 170435001, 170436000, 170542003, 333566002, 312868009, 333568001, 333573007, 333702001, 333703006, 377091000, 376210001, 377090004 *OR* 3216F-Patient had documented immunity to hepatitis B. SNOMED: 271511000.	*AND* Patients aged 18 years and older.	Documentation of patient reason(s) for not receiving at least one injection of hepatitis B vaccine- Append modifier to CPT Category II code: 4149F-2P.	
Hepatitis C: counseling regarding risk of alcohol consumption	Measure ID #: 0401 Review #: IF-010-07	AMA PCPI *© 2007 American Medical Association. All Rights Reserved.*	Patients who were counseled* about the risks of alcohol use at least once in the 12-month reporting period. *Definition-counseling may include documentation of a discussion regarding the risks of alcohol, or notation to decrease or abstain from alcohol intake. CPT Category II code: 4158F-Patient counseled* about risks of alcohol use. SNOMED: 281078001, 408947007, 413473000.	All patients aged 18 years and older with a diagnosis of hepatitis C. ICD-9 diagnosis codes: 070.51, 070.54, 070.70 *AND* CPT service code: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND* Patients aged 18 years and older.	None.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Screening foreign-born adults for chronic hepatitis B	Measure ID #: 0402 Review #: IF-024-07	Asian Liver Center at Stanford University	Number of adults aged 18 years and above, born in a hepatitis B virus (HBV)-endemic country, with serological test results for hepatitis B surface antigen (HBsAg) and hepatitis B surface antibody (anti-HBs) during adulthood documented in the medical record; calculated annually on a per-facility basis.	Number of adults aged 18 years and above, born in a country with intermediate or high HBV endemicity (all African countries; all East Asian countries; all East European and North Asian countries except Hungary; all South Asian countries except Sri Lanka; all Southeast Asian countries; all South Pacific countries and territories except Australia and New Zealand; all Middle Eastern countries except Cyprus; also, Greece, Malta, Portugal, Spain, Greenland natives, Alaska natives, North Canada indigenous populations, Argentina, Bolivia, Brazil, Ecuador, Guyana, Suriname, Venezuela, Amazonian areas of Colombia and Peru, Antigua and Barbuda, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, Puerto Rico, St. Kitts and Nevis, St. Lucia, St. Vincent and Grenadines, Trinidad and Tobago, and Turcs and Caicos; see CDC, 2006, p. 7); calculated annually on a per-facility basis.	None.	Paper Medical Record, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: medical visit	Measure ID #: 0403 Review #: IF-011-07	NCQA AMA PCPI	Patients with at least 2 medical visits* during the measurement year with a minimum of 60 days between each visits. *Definition of "medical visit"-any visit with a health care professional who provides routine primary care for the patient with HIV/AIDS (may be but is not limited to a primary care clinician, OB/GYN, pediatrician, infectious diseases specialist). Report CPT Procedure code for medical visit: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245, 99401, 99402, 99403, 99404.	All patients, regardless of age, with a diagnosis of HIV/AIDS seen within a 12-month period. ICD-9 diagnosis codes: 042, V08, 079.53 *AND* CPT sevice codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245, 99401, 99402, 99403, 99404.	Documentation of patient reason for not having at least 2 medical visits in each 6 month period with a minimum of 60 days between each visit (e.g., patient is incarcerated for more than a third of the year, patient moves out of the country).	Paper Medical Record, Administrative Claims Data, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: CD4+ cell count or CD4+ percentage performed	Measure ID #: 0404 Review #: IF-012-07	NCQA AMA PCPI	Patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months. Report: CPT procedure code: 86361, 86360, 86359 *OR* Report the CPT Category II code (in development) designated for this numerator: XXXXF.	All patients, regardless of age, with a diagnosis of HIV/AIDS who had at least 2 visits during the measurement year, with at least 60 days between each visit. Report: ICD-9-CM diagnosis code to identify diagnosis of HIV/AIDS: 042, V08, 079.53 *AND* CPT Procedure code to identify a medical visit: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394,99395, 99396, 99397.	None.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.
HIV/AIDS: *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis	Measure ID #: 0405 Review #: IF-013-07	NCQA AMA PCPI	A. Patients who were prescribed *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis within 3 months B. Patients who were prescribed *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis within 3 months C. Patients who were prescribed *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis. Report CPTv procedure codes 94642 *OR*	A. All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm^3 who had at least 2 visits during the measurement year, with at least 60 days in between each visit; and B. All patients aged 1 through 5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm^3 who had at least 2 visits during the measurement year, with at least 60 days in between each visit; and,		Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis *(continued)*			CPT Category II code XXXXF (in development).	C. All patients aged 1 month through 12-months with a diagnosis of HIV or who are HIV indeterminate who had at least 2 visits during the measurement year, with at least 60 days in between each visit. A. Report ICD-9-CM diagnosis codes: 042, V08, 079.53 *AND* CPT Category II code (in development) XXXXF: CD4 Count less than 200 cells/mm^3 *AND* CPT Procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397. B. Report ICD-9-CM diagnosis codes: 042, V08, 079.53 *AND* CPT Category II code: (in development) XXXXF: CD4 count less than 500 cells/mm^3 or a CD4 percentage below 15% *AND*		

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: *Pneumocystis jiroveci* pneumonia (PCP) prophylaxis *(continued)*				CPT procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99381, 99382, 99383, 99391, 99392, 99393. C. Report ICD-9-CM diagnosis codes: 042, V08, 079.53 *AND* CPT procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99381, 99391.		
Adolescent and adult clients with AIDS who are prescribed potent anti-retroviral therapy	Measure ID #: 0406 Review #: IF-014-07	NCQA AMA PCPI	Patients who were prescribed potent antiretroviral* therapy. *Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. Report the following CPT Category II code: XXXXF in development.	A. All patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least 2 medical visits during the measurement year with at least 60 days between each visit, who have a history of a nadir** CD4+ count below 350/mm^3; and B. All patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least 2 medical visits during the measurement year with at least 60 days between each visit, who have a history of an AIDS-defining illness, regardless of CD4+ count; and	None.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Adolescent and adult clients with AIDS who are prescribed potent antiretroviral therapy *(continued)*				C. All patients with a diagnosis of HIV/AIDS, with at least 2 medical visits during the measurement year with at least 60 days between each visit, who are pregnant, regardless of CD4+ count or age. **Nadir (lowest ever) CD4 count may be the present count. ICD-9 diagnosis codes: 042, V08, 079.53 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245 *AND EITHER* CPT II in development: XXXXF-Lowest ever CD4 count <350/mm^3 *OR* ICD-9 code for AIDS-defining illness *OR* ICD-9 code for pregnancy: V22.0, V22.1, V22.2, V23.0, V23.1, V23.2, V23.3, V23.41, V23.49, V23.5, V23.7, V23.81, V23.82, V23.83, V23.84, V23.89, V23.9.		

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV RNA control after six months of potent antiretroviral therapy	Measure ID #: 0407 Review #: IF-015-07	NCQA AMA PCPI	**Patients with viral load below limits of quantification* *OR* patients with viral load not below limits of quantification* who have a documented plan of care.**** *Using laboratory cutoff level for reference laboratory used by that clinic or provider. **A plan of care may include: altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessment of viral load at a specified future date. **Report the following CPT Category II code: XXXXF-in development-Viral load below limits of quantification** ***OR*** **CPT Category II code: XXXXF-Viral load not below limits of quantification** ***AND*** **CPT Category II code: XXXXF-Plan of care to achieve viral load below limits of quantification, documented.**	**All patients aged 13 years or older with a diagnosis of HIV/AIDS with at least 2 visits in the measurement year, with at least 60 days between each visit, who received potent antiretroviral therapy*** 6 months.** ***Conditions included in the 1993 AIDS surveillance case definition: candidiasis of bronchi, trachea, or lungs; candidiasis, esophageal; cervical cancer, invasive; coccidiodomycosis, disseminated or extrapulmonary; cryptococcosis, extrapulmonary; crytosporidiosis, chronic intestinal (greater than 1 month's duration); cytomegalovirus disease (other than liver, spleen, or nodes); cytomegalovirus retinitis (with loss of vision); encephalopathy, HIV-related; herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis; histoplasmosis, disseminated or extrapulmonary; isosporiasis, chronic intestinal (greater than 1 month's duration); Kaposi's sarcoma; lymphoma, Burkitt's (or equivalent term); lymphoma, immunoblastic (or equivalent term); lymphoma, primary, of brain; *Mycobacterium avium* complex or *M. kansasii,* disseminated or extrapulmonary; *Mycobacterium tuberculosis,* any site (pulmonary or extrapulmonary); mycobacterium, other species or unidentified	None.	Paper Medical Record, Administrative Claims Data using CPT Category II codes.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV RNA control after six months of potent antiretroviral therapy *(continued)*				species, disseminated or extrapulmonary; *Pneumocystis carinii* pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; *Salmonella* septicemia, recurrent; toxoplasmosis of brain; wasting syndrome due to HIV (NYSDOH, 2007). Note: For potent antiretroviral therapy recommendations refer to current DHHS guidelines available at www.aids.gov. **ICD-9 diagnosis codes: 042, V08, 079.53** ***AND*** **CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245** ***AND*** **CPT II code-in development XXXXF-Patient receiving potent antiretroviral therapy for six months or longer.**		

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: TB screen	Measure ID #: 0408 Review #: IF-017-07	NCQA AMA PCPI	Patients for whom there was documentation that a tuberculosis (TB) screening test was placed and read at least once since the diagnosis of HIV infection. Report CPT procedure codes: 71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034, 86480, 86580, 87116, 87555, 87556, 87557 *OR* CPT Category II code (in development) XXXXF: Tuberculosis screening placed and read.	All patients aged 3 months and older with a diagnosis of HIV/AIDS who had at least 2 visits during the measurement year, with at least 60 days in between each visit. Report ICD-9-CM diagnosis codes: 042, V08, 079.53 *AND* CPT procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	Documentation of medical reason(s) for not placing and reading a tuberculosis (TB) screening test (e.g., patients with a history of treatment for TB)-Append modifier to CPT Category II code (in development): XXXXF-1P. Documentation of patient reason(s) for not placing and reading a tuberculosis (TB) screening test-Append modifier to CPT Category II code (in development): XXXXF-2P. Documentation of system reason(s) for not placing and reading a tuberculosis (TB) screening test-Append modifier to CPT Category II code (in development): XXXXF-3P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDs: chlamydia and gonorrhea screening	Measure ID #: 0409 Review #: IF-018-07	NCQA AMA PCPI	Patients screened for chlamydia and gonorrhea at least once since the diagnosis of HIV infection. Report CPT procedure code for chlamydia screening: 86631, 86632, 87110, 87270, 87320 *OR* Report the following CPT Category II code: XXXXF-in development-Chlamydia screening performed *AND* Report CPT procedure code for gonorrhea screening: 87590, 87591, 87592, 87850 *OR* Report the following CPT Category II code: XXXXF-in development-Gonorrhea screening performed.	All patients aged 13 years and older with a diagnosis of HIV/AIDS and who had at least 2 visits during the measurement year, with at least 60 days between visits. ICD-9 diagnosis codes: 042, V08, 079.53 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	Documentation of medical reason(s) for not performing chlamydia and gonorrhea screenings (e.g., patient reports no sexual activity)-Append modifier to CPT Category II code: XXXXF-1P: in development. Documentation of Patient Reason for not performing chlamydia and gonorrhea screenings-Append modifier to CPT Category II code: XXXXF-2P: in development. Documentation of System Reason for not performing chlamydia and gonorrhea screenings-Append modifier to CPT Category II code (in development): XXXXF-3P.	Paper Medical Record, Administrative Claims Data using CPT Category II, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: syphilis screening	Measure ID #: 0410 Review #: IF-020-07	NCQA AMA PCPI	Patients for whom syphilis screening was performed in the last 12-months. Report CPT procedure code for syphilis screening: 86592, 86593, 86781 *OR* CPT Category II code (in development): XXXXF-Syphilis screening performed.	All patients aged 13 years and older with a diagnosis of HIV/AIDS and who had at least 2 visits during the measurement year, with at least 60 days between visits. ICD-9 diagnosis codes: 042, V08, 079.53 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	Documentation of patient reason(s) for not performing syphilis screening-Append modifier to CPT Category II code-XXXXF-2P. Documentation of system reason(s) for not performing syphilis screening-Append modifier to CPT Category II code-XXXXF-3P.	Paper Medical Record, Administrative Claims Data using CPT II Codes, Electronic Health Record.
HIV/AIDS: hepatitis B screen	Measure ID #: 0411 Review #: IF-021-07	NCQA AMA PCPI	Patients for whom hepatitis B screening was performed at least once since the diagnosis of HIV infection or for whom there is documented immunity. CPT procedure codes for hepatitis B screening: 87340, 87341, 86704, 86705, 86706, 86706, 87515, 87516, 87517 *OR* ICD-9-CM diagnosis code for Chronic Hepatitis B: 070.32, 070.33 *OR* CPT Category II code (in development): XXXXF-Hepatitis B screening performed *OR* CPT Category II code: 3216F-Patient has documented immunity to hepatitis B.	All patients, regardless of age, who have been diagnosed with HIV/AIDS and who had at least 2 visits during the measurement year, with at least 60 days in between each visit. ICD-9 diagnosis codes: 042, V08, 079.53 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	Documentation of patient reason(s) for not performing hepatitis B screening-Append modifier to CPT Category II code-XXXXF-2P. Documentation of system reason(s) for not performing hepatitis B screening-Append modifier to CPT Category II code: XXXXF-3P.	Medical Record, Administrative Claims Data, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: hepatitis B vaccination	Measure ID #: 0412 Review #: IF-022-07	NCQA AMA PCPI	Patients who have received at least one hepatitis B vaccination, or who have documented immunity. CPT procedure codes: 90723, 90740, 90744, 90746, 90747, 90748 *OR* HCPCS code: G0010 *OR* CPT Category II code (in development): XXXXF-Hepatitis B vaccination received *OR* CPT Category II code: 3216F-Patient has documented immunity to hepatitis B.	All patients, regardless of age, with a diagnosis of HIV/AIDS with at least 2 visits in the measurement year, with at least 60 days in between each visit. ICD-9 diagnosis codes: 042, V08, 079.53 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	Documentation of patient reason(s) for not receiving hepatitis B vaccination-Append modifier to CPT Category II code: XXXXF-2P. Documentation of system reason(s) for not receiving hepatitis B vaccination-Append modifier to CPT Category II code XXXXF-3P.	Medical Record, Administrative Claims Data, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: screening for high-risk behavior	Measure ID #: 0413 Review #: IF-023-07	NCQA AMA PCPI	Patients who were screened,* at least once in a 12-month measurement period, for high risk sexual behaviors. *Screening is defined as documentation that a discussion regarding high risk sexual behaviors took place, or documentation that a standardized tool was used. Report the following CPT Category II code: XXXXF-in development.	All patients aged 13 years and older who have been diagnosed with HIV/AIDS with at least 2 visits in the measurement year, with at least 60 days in between each visit. ICD-9 diagnosis codes: 042, V08, 079.53 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	None.	Paper Medical Record, Administrative Claims Data using CPT Category II codes, Electronic Health Record.

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INFECTIOUS DISEASE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
HIV/AIDS: hepatitis C screen	Measure ID #: 0414 Review #: IF-025-07	NCQA AMA PCPI	Patients for whom hepatitis C (Hep C) screening was performed at least once since the diagnosis of HIV infection or for whom there is documented immunity. CPT procedure codes for hepatitis C screening: 86803, 87520, 87521, 87522, 86803, 86804, 87902 *OR* ICD-9-CM diagnosis code for chronic hepatitis C: 070.54, 070.70, V02.62 *OR* CPT category II code (in development): XXXXF Hepatitis C screening performed *OR* CPT category II code (in development): XXXXF-Patient has documented immunity to hepatitis	All patients aged 13 years and older with a diagnosis of HIV/AIDS who had at least 2 visits in the measurement year with at least 60 days in between each visit. ICD-9-CM diagnosis codes: 042, V08, 079.53 *AND* CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	Documentation of patient reason(s) for not receiving hepatitis C screening-Append modifier to CPT Category II code: XXXXF-2P. Documentation of system reason(s) for not receiving hepatitis C screening-Append modifier to CPT Category II code-XXXXF-3P.	
HIV/AIDS: Screening for injection drug use	Measure ID #: 0415 Review #: IF-026-07	NCQA AMA PCPI	Patients who were screened,* at least once in a 12-month measurement period, for injection drug use. *Screening is defined as documentation that a discussion regarding injection drug use took place, or documentation that a standardized tool was used. Report the following CPT Category II code: XXXXF-in development.	All patients aged 13 years and older who have been diagnosed with HIV/AIDS with at least 2 visits in the measurement year, with at least 60 days in between each visit. ICD-9 diagnoses codes: 042, V08, 079.53 *AND* CPT service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245.	None.	Paper Medical Record, Administrative Claims Data using CPT Category II codes, Electronic Health Record.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Recording of clinical stage prior to surgery for lung cancer or esophageal cancer resection	Measure ID #: 0455 Review #: PO-001-07	STS	During a 12-month period, the number of all surgical patients, ≥18 years of age, undergoing treatment procedures for lung or esophageal cancer who had clinical TNM staging provided prior to surgery.	During the 12-month period, the number of all surgical patients ≥18 years of age undergoing treatment procedures for lung or esophageal cancer. Applicable CPT codes: Lung Cancer-32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32500, 32503, 32504, 32657 Esophageal Cancer-43107, 43108, 43112, 43113, 43117, 43118, 43121, 43122, 43123.	NA.	Medical Record, Registry, Clinical Database, Electronic Health Record, Other.
Participation in a systematic national database for general thoracic surgery	Measure ID #: 0456 Review #: PO-002-07	STS	Participation for a 12-month period in a multi-center data collection and feedback program that provides benchmarking of the physician's data relative to national programs and uses structural, process, and outcome measures. Applicable CPT codes: 32100, 32160, 32215, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32500, 32503, 32504, 32540, 32650, 32657, 32906, 39200, 39220, 39502, 39541, 43107, 43108, 43112, 43113, 43117, 43118, 43121, 43122, 43123.	NA.	NA.	Medical Record, Electronic Health Record, Other.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Recording of performance status prior to lung or esophageal cancer resection (Zubrod, Karnofsky, WHO, or ECOG Performance Status)	Measure ID #: 0457 Review #: PO-003-07	STS	During a 12-month period, the number of patients ≥18 years of age undergoing resection of a lung or esophageal cancer who had their performance status recorded within two weeks prior to the surgery date.	During the 12-month period, the number of patients ≥18 years of age undergoing resection of a lung or esophageal cancer. Applicable CPT codes: Lung Cancer-32440, 32442, 32445, 32480, 32482, 32486, 32488, 32503, 32504 Esophageal Cancer-43107, 43108, 43112, 43113, 43117, 43118, 43121, 43122, 43123.	NA.	Medical Record, Registry, Clinical Database, Electronic Health Record, Other.
Pulmonary function tests (PFTs) before major anatomic lung resection (pneumonectomy, lobectomy, or formal segmentectomy)	Measure ID #: 0458 Review #: PO-004-07	STS	During a 12-month period, the number of thoracic surgical patients, ≥18 years of age, who underwent at least one pulmonary function test no more than 12-months prior to a major lung resection.	During the 12-month period, the number of thoracic surgical patients ≥18 years of age, who underwent a major lung resection. Applicable CPT codes: 32440, 32442, 32445, 32480, 32482, 32486, 32488, 32503, 32504, 32663.	Patients who are unable to perform pulmonary function testing (tracheostomy, patient inability to cooperate with pulmonary function test) or those with urgent/emergent need of lung resection (lung abscess, massive hemoptysis, bronchopleural fistula, etc.).	Medical Record, Registry, Clinical Database, Electronic Health Record, Other.
Risk-adjusted morbidity: length of stay >14 days after elective lobectomy for lung cancer	Measure ID #: 0459 Review #: PO-005-07	STS	During a 12-month period, the number of patients, ≥18 years of age undergoing elective lobectomy for lung cancer who have a hospital length of stay >14 days.	During the 12-month period, the number of patients, ≥18 years of age, undergoing elective lobectomy for lung cancer. Denominator Inclusion Criteria-All elective (not urgent or emergent) patients with lung cancer (ICD-9 codes 162.9, 162.5, 162.4, 162.3) undergoing a lobectomy (CPT code 32480, 32663) in a hospital.	Exclusion criteria-urgent/emergent lobectomy for lung cancer in a patient with complications of the cancer (bleeding, bronchopleural fistula, empyema). Risk-model: Available on NQF website "review" page.	Medical Record, Registry, Clinical Database, Electronic Health Record, Other.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Risk-adjusted morbidity and mortality for esophagectomy for cancer	Measure ID #: 0460 Review #: PO-006-07	STS	During a 12-month period, the number of patients, ≥18 years of age, undergoing elective esophagectomy for esophageal cancer who had the presence of any of the following postoperative conditions as defined by the STS: bleeding requiring reoperation, anastomosis requiring medical or surgical treatment, reintubation, ventilation, pneumonia, or discharge mortality.	During the 12-month period, the number of patients, ≥18 years of age, undergoing elective esophagectomy for esophageal cancer. ICD-9 codes: 151.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9 CPT codes: 43107, 43112, 43117, 43122, 43123.	Exclusion criteria: urgent/emergent operation, condition other than esophageal cancer leading to esophagectomy. Risk-model: Available on NQF website "review" page.	Medical Record, Registry, Clinical Database, Electronic Health Record, Other.
Discontinuation of prophylactic antibiotics (foot and ankle procedures)	Measure ID #: 0271 Review #: PO-009-07	AMA PCPI NCQA *© 2005-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.*	Noncardiac surgical patients who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time. Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 24 hours of surgical end time *OR* specifying a course of antibiotic administration limited to that 24-hour period (e.g., "to be given every 8 hours for three doses") *OR* documentation that prophylactic antibiotic was discontinued within 24 hours of surgical end time. CPT Category II codes: 4049F- Documentation that order was given to discontinue prophylactic antibiotics within 24	All non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics *AND* who received a prophylactic antibiotic. Instructions: For the purpose of this measure of antibiotic discontinuation, patients may be counted as having "received a prophylactic antibiotic" if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively. CPT II 4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively CPT II 4042F: Documentation that prophylactic antibiotics were neither given	Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time-Append modifier to CPT Category II code: 4046F-1P.	Paper Medical Record, Administrative Claims Data using CPT II, Electronic Health Record.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Discontinuation of prophylactic antibiotics (foot and ankle procedures) *(continued)*			hours of surgical end time, non-cardiac procedure. Note: CPT Category II code 4049F is provided for documentation that antibiotic discontinuation was ordered *OR* that antibiotic discontinuation was accomplished. Report CPT Category II code 4049F if antibiotics were discontinued within 24 hours.	within 4 hours prior to surgical incision nor given intraoperatively *AND* Foot & Ankle: 27702, 27703, 27704, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760 *AND* Patients aged 18 years and older.		

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Selection of prophylactic antibiotic—first- OR second-generation cephalosporin (foot and ankle procedures)	Measure ID #: 0268 Review #: PO-010-07	AMA PCPI NCQA *©2005-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.*	Surgical patients who had an order for cefazolin *OR* cefuroxime for antimicrobial prophylaxis. Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) for cefazolin or cefuroxime for antimicrobial prophylaxis *OR* documentation that cefazolin or cefuroxime was given. CPT Category II codes: CPT II 4041F-Documentation of order for cefazolin *OR* cefuroxime for antimicrobial prophylaxis. Note: CPT Category II code 4041F is provided for antibiotic ordered or antibiotic given. Report CPT Category II code 4041F if cefazolin *OR* cefuroxime was given for antimicrobial prophylaxis.	All surgical patients aged 18 years and older undergoing procedures with the indications for a first- or second-generation cephalosporin prophylactic antibiotic CPT procedure codes: Foot & Ankle: 27702, 27703, 27704, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not ordering cefazolin *OR* cefuroxime for antimicrobial prophylaxis-Append modifier to CPT Category II code: 4041F-1P.	Paper Medical Record, Administrative Claims Data using CPT II codes, Electronic Health Record.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Timing of antibiotic prophylaxis—ordering physician (foot and ankle procedures)	Measure ID #: 0270 Review #: PO-011-07	AMA PCPI NCQA *©2005-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.*	Surgical patients who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required). Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that antibiotic is to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) *OR* documentation that antibiotic has been given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required). The antimicrobial drugs listed below are considered prophylactic antibiotics for the purposes of this measure. ▌ Ampicillin/sulbactam ▌ Aztreonam ▌ Cefazolin ▌ Cefmetazole ▌ Cefotetan ▌ Cefoxitin ▌ Cefuroxime	All surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics. CPT procedure codes: Foot & Ankle: 27702, 27703, 27704, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760 *AND* Patients aged 18 years and older.	Documentation of medical reason(s) for not ordering antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required-Append modifier to CPT Category II code: 4047F-1P.	Paper Medical Record, Administrative Claims Data using CPT II codes, Electronic Health Record.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Timing of antibiotic prophylaxis—ordering physician (foot and ankle procedures) *(continued)*			▌ Ciprofloxacin ▌ Clindamycin ▌ Erythromycin base ▌ Gatifloxacin Gentamicin ▌ Levofloxacin ▌ Metronidazole ▌ Moxifloxacin ▌ Neomycin ▌ Vancomycin. CPT Category II codes: Identify patients with documentation of order for prophylactic antibiotic: CPT II 4047F: Documentation of order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required) *OR* Documentation that prophylactic antibiotic has been given within one hour prior to the surgical incision (or start of procedure when no incision is required). CPT II 4048F: Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required).			

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Anesthesiology and critical care: prevention of catheter-related bloodstream infections (CRBSI)—central venous catheter (CVC) insertion protocol	Measure ID #: 0464 Review #: PO-012-07	ASA AMA PCPI	Patients for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique (cap *AND* mask *AND* sterile gown *AND* sterile gloves *AND* a large sterile sheet *AND* hand hygiene *AND* 2% chlorhexidine for cutaneous antisepsis, or acceptable alternative antiseptics, per current guideline) followed. Note: For purposes of this measure, maximal sterile barrier technique during CVC insertion is defined to include use of: cap *AND* mask *AND* sterile gown *AND* sterile gloves *AND* a large sterile sheet *AND* hand hygiene *AND* 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline). CPT Category II code: XXXF-All elements of maximal sterile barrier technique including: cap *AND* mask *AND* sterile gown *AND* sterile gloves *AND* a large sterile sheet *AND* hand hygiene *AND* 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), followed.	All patients, regardless of age, who undergo CVC insertion. CPT codes for: Central Venous Access Device Insertion Procedures-36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571 Central Venous Access Device Replacement Procedures-36578, 36580, 36581, 36582, 36583, 36584, 36585 SNOMED: 233527006, 265547009, 398176008.	Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including increased risk of harm to patient if adherence to aseptic technique would cause delay in CVC insertion)-Append modifier to CPT Category II code: XXXF-1P.	Paper Medical Record, Administrative Claims Data using CPT II, Electronic Health Record.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Anesthesiology and critical care: perioperative temperature management (clinician level)	Measure ID #: 0454 Review #: PO-013-07	AMA PCPI	Patients for whom either: ▌ active warming was used intraoperatively for the purpose of maintaining normothermia *OR* ▌ at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time. Numerator definition: For purposes of this measure, "active warming" is limited to the following modalities only: forced-air warming, warm water garments. Report the following CPT Category II code: 4250F-Active warming used intraoperatively for the purpose of maintaining normothermia *OR* at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.	All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer. CPT codes for Anesthesia: 00100-01860, 01924-01952, 01961-01966, 01968-01969.	Documentation of one of the following medical reason(s) for not using active warming intra-operatively for the purpose of maintaining normothermia *OR* achieving at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time: ▌ intentional hypothermia ▌ not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, *OR* monitored anesthesia care Append modifier to CPT Category II code: 4250F-1P.	Claims, Medical Record, and Hybrid.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Perioperative antiplatelet therapy for patients undergoing carotid endarterectomy	Measure ID #: 0465 Review #: PO-014-07	VSGNNE SVS	Patients over age 18 undergoing carotid endarterectomy who received ASA and/or clopidogrel within 48 hours prior to the initiation of surgery *AND* are prescribed this medication at hospital discharge following surgery. This measure can be reported with G code Gxxx1: if oral antiplatelet therapy was given within 48 hours prior to surgical incision *AND* oral antiplatelet therapy was prescribed at hospital discharge. This can also be reported by SVS or VSGNNE registry or by chart review.	Patients over age 18 undergoing carotid endarterectomy. CPT code 35301 *OR* ICD-9 code 38.12. This can also be reported by SVS or VSGNNE registry or by chart review.	Patients with known intolerance to ASA and clopidogrel, or those on heparin or warfarin; patients with active bleeding or undergoing urgent or emergent operations or endarterectomy combined with cardiac surgery (Use medical exclusion modifier 1P). Exclusion coding: Modifier 1P: Medical reason(s) for not prescribing antiplatelet therapy: patient intolerance to both ASA and clopidogrel; patient admitted on heparin; patient admitted on warfarin; patient has active bleeding; patient admitted from emergency department or patient is a direct admit or patient has other cardiac procedures done during same operation as the CEA.	Medical Record, Administrative Claims Data, Registry, Clinical Database, Electronic Health Record.

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PERIOPERATIVE CARE

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Use of patch during conventional carotid endarterectomy	Measure ID #: 0466 Review #: PO-018-07	VSGNNE SVS	Patients over age 18 undergoing conventional (noneversion) CEA who have patch closure of the arteriotomy. This measure can be reported with a G code to establish patch use during conventional endarterectomy. Gxxx1: Patients undergoing conventional carotid endarterectomy who undergo patch closure of the arteriotomy. This can also be reported by SVS or VSGNNE registry or by chart review.	Patients over age 18 undergoing conventional CEA. CPT code 35301 *OR* ICD-9 code 38.12 Exclusion modifier 1P for patients undergoing eversion carotid endarterectomy. This can also be reported by SVS or VSGNNE registry or by chart review.	Patients undergoing eversion CEA (Use medical exclusion modifier 1P).	Medical Record, Administrative Claims Data, Registry, Clinical Database.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Diabetic foot & ankle care, ulcer prevention—evaluation of footwear	Measure ID #: 0416 Review #: NP-009-07	APMA	Patients who were evaluated for proper footwear and sizing at least once within 12-months. Definition: Evaluation for proper footwear includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. GXXXX-Footwear evaluation performed and documented *OR* GXXXX-Clinician documented that patient was not an eligible candidate for footwear evaluation measure *OR* GXXXX-Footwear evaluation was not performed.	All patients aged 18 years and older with a diagnosis of diabetes mellitus. ICD-9 diagnosis code and CPT E/M code are required. ICD-9 codes: 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.	Footwear evaluation not performed for documented reasons. For example bilateral amputee.	Administrative Claims Data.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Diabetic foot & ankle care, peripheral neuropathy—neurological evaluation	Measure ID #: 0417 Review #: NP-010-07	APMA	Patients who had a lower extremity neurological exam with risk categorization performed and a treatment plan established at least once within 12 months. Definition: A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 monofilament detection. GXXXX-Lower extremity neurological exam performed *OR* GXXXX-Lower extremity neurological exam not performed for documented reasons *OR* GXXXX-Lower extremity neurological exam not performed.	All patients aged 18 years and older with a diagnosis of diabetes mellitus. ICD-9 codes: 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 *AND* CPT E/M codes: 99201,99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, 99241, 99242, 99243, 99244, 99245, 97001, 97002 *OR* CPT procedure codes: 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740 *OR* G code: G0108.	Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee.	Administrative Claims Data.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Screening for clinical depression and follow-up	Measure ID #: 0418 Review #: NP-012-07	QIP CMS	Patient's screening for clinical depression is documented using a standardized tool and follow up plan is documented. G8431-Positive screen for clinical depression using a standardized tool and follow up plan documented *OR* GDEP4-Negative screen for depression documented using a standardized tool, patient not eligible/appropriate for follow up plan *OR* G8433-Screening for clinical depression using a standardized tool not documented, patient not eligible/appropriate *OR* G8432-Screening for clinical depression using a standardized tool not documented, reason not specified *OR* GDEP5-Screen for clinical depression using a standardized tool documented, follow up plan not documented, reason not specified.	Patient 18 years of age and older. 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97003.	A patient is not eligible if one or more of the following conditions exist: Patient refuses to participate Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases Patient was referred with a diagnosis of depression Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.	Administrative Claims Data.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Universal documentation and verification of current medications in the medical record	Measure ID #: 0419 Review #: NP-014-07	QIP CMS	Current medications with dosages and verification with patient or authorized representative is documented by the provider. G8427-List of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative documented by the provider *OR* G8430-Provider documentation that patient is not eligible for medication assessment *OR* GMED5-Provider documentation that patient is not eligible for patient verification of current medications G8428-Provider documentation of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) without documented patient verification *OR* G8429-Incomplete or no provider documentation that the patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed.	Patients 18 years of age and older. 00100-01999, 90801, 90802, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 98960,99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0270, 92004, 92014, 92012, 92002.	Not eligible-A patient is not eligible if one or more of the following condition(s) exist: Patient refuses to participate Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status Patient cognitively impaired and no authorized representative available.	Administrative Claims Data.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Pain assessment prior to initiation of patient therapy and follow-up	Measure ID #: 0420 Review #: NP-015-07	QIP CMS	Patient's pain assessment prior to initiation of treatment is documented through discussion with the patient including the use of a standardized tool and a follow up plan is documented. G8440 Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool *AND* a follow-up plan is documented *OR* G8442 Documentation that patient is not eligible for a pain assessment *OR* G8441 No documentation of pain assessment (including location, intensity and description) prior to initiation of treatment GPAN5 Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, patient not eligible *OR*	Patients 18 years of age and older. 90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942.	Not eligible-A patient is not eligible if the following condition(s) exist: Pain Assessment: Patient refuses to participate Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized pain assessment tools Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status Not an initial patient (this exclusion is intended for use by chiropractors). Follow-up Plan: Absences of pain on initial assessment	Administrative Claims Data.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Pain assessment prior to initiation of patient therapy and follow-up *(continued)*			GPAN4 Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, reason not specified.		Diagnosis/condition/illness is not situationally related to pain.	
Adult weight screening and follow-up	Measure ID #: 0421 Review #: NP-017-07	QIP CMS	Patients with BMI calculated in the past six months and a follow-up plan documented if the BMI is outside of parameters. G8420 Calculated BMI within normal parameters and documented *OR* G8417 Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record *OR* G8418 Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record *OR* G8422 Patient not eligible for BMI calculation *OR* G8421 BMI not calculated *OR* G8419 Calculated BMI outside normal parameters, no follow-up plan documented in the medical record.	Patients 18 years and older. 00100-01999, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0108, G0270.		Administrative Claims Data.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Functional status change for patients with knee impairments	Measure ID #: 0422 Review #: NP-001-07	FOTO	Total sum of risk-adjusted residual discharge functional status scores in patients who were treated by a clinician in a 12-month time period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to knee impairments (i.e., scale ranging from 0 to 100 with higher scores meaning higher functional abilities), who were treated in therapy for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy and are now ready for discharge from therapy.	All patients in a 12-month time period with functional status deficits related to knee impairments for whom the value of the functional status scale at start or resumption of care was not normal, for example the patient's knee functional status was less than 90 (i.e., it was possible for improvement in their functional status to occur). This measure is appropriate for patients with knee impairments, including but not limited to: disorders of muscle, synovium, tendon, bursa or enthesopathies (ICD-9 codes 726-729); uncomplicated post-surgical conditions (CPT codes 27405, 27437-27447, including repair arthroplasty patella, tibial plateau, femoral condyles, torn collateral ligament); arthropathies (ICD-9 codes 710-716, including osteoarthoses, rheumatoid arthritis); disorders of the bone and cartilage (ICD-9 codes 728-739 including chondromalacia); sprains and strains (ICD-9 codes 843-844, including sprain of medial collateral ligament, unspecified sprain or strain); and fractures (ICD-9 820-823 including patellar fractures). Status was less than 90 (i.e., it was possible for improvement in their functional status to occur).	▌Patients who do not have a functional deficit related to a knee impairment (scale value >90) ▌<18 years of age ▌Medical condition inappropriate for therapy. The knee functional status change measure is commonly risk adjusted by the following variables: intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance beliefs of physical activities if the patient has pain, and number of functional comorbidities. The public domain short form and internet CAT produce measures that can be risk adjusted. Detailed risk adjustment model can be found at www.fotoinc.com.	Registry, Clinical Database, Data Collection Instrument, Patient Survey. The FOTO data collection instrument is available on the NQF website review page for this report.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Functional status change for patients with hip impairments	Measure ID #: 0423 Review #: NP-002-07	FOTO	Total sum of risk-adjusted residual discharge functional status scores in patients who were treated by a clinician in a 12-month time period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to hip impairments (i.e., scale ranging from 0 to 100 with higher scores meaning higher functional abilities), who were treated in therapy for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy and are now ready for discharge from therapy.	All patients in a 12-month time period with functional status deficits related to hip impairments for whom the value of the functional status scale at start or resumption of care was not normal, for example, the patient's hip functional status was less than 90 (i.e., it was possible for improvement in their functional status to occur). This measure is appropriate for patients with hip impairments, including but not limited to: soft tissue disorders of muscle, synovium, tendon, bursa or enthesopathies (ICD-9 codes 725-729); uncomplicated post-surgical conditions (CPT codes 27097-27187, including partial and total hip replacement); spine pathology (ICD-9 codes 720-724); sprains and strains of hip (ICD-9 codes 843, 846, 847 including unspecified sprain or strain); arthropathies (ICD-9 codes 710-716, including osteoarthoses, rheumatoid arthritis); fractures (ICD-9 806, 808, 820-821, including femoral fractures); disorders of the bone and cartilage (ICD-9 codes 730-739, including osteoporosis of femur).	▪ Patients who do not have a functional deficit related to a hip impairment (scale value >90) ▪ <18 years of age ▪ Medical condition inappropriate for therapy. The hip functional status discharge measure is risk adjusted by the following variables: intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance beliefs of physical activities if the patient has pain, and number of functional comorbidities. Risk adjustment model can be found at www.fotoinc.com.	Registry, Clinical Database, Data Collection Instrument, Patient Survey.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Functional status change for patients with foot/ankle impairments	Measure ID #: 0424 Review #: NP-003-07	FOTO	Total sum of risk-adjusted residual discharge functional status scores in patients who were treated by a clinician in a 12-month time period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to foot or ankle impairments (i.e., scale ranging from 0 to 100 with higher scores meaning higher functional abilities), who were treated in therapy for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy and are now ready for discharge from therapy.	All patients in a 12-month time period with functional status deficits related to foot or ankle impairments for whom the value of the functional status scale at start or resumption of care was not normal, for example, the patient's foot or ankle functional status was less than 90 (i.e., it was possible for improvement in their functional status to occur). This measure is appropriate for patients with foot or ankle impairments, including but not limited to: soft tissue disorders of muscle, synovium, tendon, bursa, plantar fasciitis, or enthesopathies (ICD-9 codes 725-729); sprains and strains of the ankle or foot (ICD-9 codes 844-845 including unspecified sprain or strain); fractures (ICD-9 823-826 including ankle, tarsal, metatarsal bones, or phalanges of foot); arthropathies (ICD-9 codes 710-719, including osteoarthoses, rheumatoid arthritis); disorders of the bone and cartilage (ICD-9 codes 730-739); uncomplicated post-surgical (CPT codes 29894-29899, including arthroscopy of the ankle); and gait abnormality (ICD-9 code 781.2).	▌Patients who do not have a functional deficit related to a foot/ankle impairment (scale value >90) ▌<18 years of age ▌Medical condition inappropriate for therapy. The foot/ankle functional status change measure is commonly risk adjusted by the following variables: intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance beliefs of physical activities if the patient has pain, and number of functional comorbidities. Risk adjustment models can be found at www.fotoinc.com.	Registry, Clinical Database, Data Collection Instrument, Patient Survey.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Functional status change for patients with lumbar spine impairments	Measure ID #: 0425 Review #: NP-004-07	FOTO	Total sum of risk-adjusted residual discharge functional status scores in patients who were treated by a clinician in a 12-month time period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to lumbar spine impairments (i.e., scale ranging from 0 to 100 with higher scores meaning higher functional abilities), who were treated in therapy for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy and are now ready for discharge from therapy.	All patients in a 12-month time period with functional status deficits related to lumbar spine impairments for whom the value of the functional status scale at start or resumption of care was not normal, for example, the patient's lumbar spine functional status was less than 90 (i.e., it was possible for improvement in their functional status to occur). This measure is appropriate for patients with lumbar spine impairments, including but not limited to: spine pathology like lumbago, sciatica, intervertebral disc pathology, spondylosis, spinal stenosis (ICD-9 codes 720-724); arthropathies (ICD-9 codes 710-719, including osteoarthoses, rheumatoid arthritis); sprains and strains of the lumbar spine (ICD-9 codes 846-847 including unspecified sprain or strain); post-surgical (CPT codes 22808-22812 for fusions, 63075 for discectomy); and fractures (ICD-9 805-809 including lumbar vertebral column).	▌Patients who do not have a functional deficit related to a lumbar spine impairment (scale value >90) ▌<18 years of age ▌Medical condition inappropriate for therapy. The lumbar spine functional status change measure is commonly risk adjusted by the following variables: intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance beliefs of physical activities if the patient has pain, and number of functional comorbidities. The public domain short form and internet CAT produce a measure that can be risk adjusted. Detailed risk adjustment model can be found at www.fotoinc.com.	Registry, Clinical Database, Data Collection Instrument, Patient Survey.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Functional status change for patients with shoulder impairments	Measure ID #: 0426 Review #: NP-005-07	FOTO	Total sum of risk-adjusted residual discharge functional status scores in patients who were treated by a clinician in a 12-month time period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to shoulder impairments (i.e., scale ranging from 0 to 100 with higher scores meaning higher functional abilities), who were treated in therapy for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy and are now ready for discharge from therapy.	All patients in a 12-month time period with functional status deficits related to shoulder impairments for whom the value of the functional status scale at start or resumption of care was not normal, for example the patient's shoulder functional status was less than 90 (i.e., it was possible for improvement in their functional status to occur). This measure is appropriate for patients with shoulder impairments, including but not limited to: soft tissue disorders of muscle, synovium, tendon, bursa, or enthesopathies (ICD-9 codes 725-729); sprains and strains of the shoulder (ICD-9 code 840, including unspecified sprain or strain); fractures (ICD-9 codes 810-819, including clavicle, scapula, humerus); arthropathies (ICD-9 codes 710-719, including osteoarthoses, rheumatoid arthritis); disorders of the bone and cartilage (ICD-9 codes 730-739); dislocations of shoulder (ICD-9 codes 831); post-surgical (CPT codes including 23107 arthrotomy, 23405 tenotomy).	▌Patients who do not have a functional deficit related to a shoulder impairment (scale value >90) ▌<18 years of age ▌Medical condition inappropriate for therapy. The shoulder functional status change measure is commonly risk adjusted by the following variables: intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance beliefs of physical activities, and number of functional comorbidities. Detailed risk adjustment model available at www.fotoinc.com.	Registry, Clinical Database, Data Collection Instrument, Patient Survey.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Functional status change for patients with elbow, wrist, or hand impairments	Measure ID #: 0427 Review #: NP-006-07	FOTO	Total sum of risk-adjusted residual discharge functional status scores in patients who were treated by a clinician in a 12-month time period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to elbow, wrist or hand impairments (i.e., scale ranging from 0 to 100 with higher scores meaning higher functional abilities), who were treated in therapy for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy and are now ready for discharge from therapy.	All patients in a 12-month time period with functional status deficits related to elbow, wrist or hand impairments for whom the value of the functional status scale at start or resumption of care was not normal, for example the patient's elbow, wrist or hand functional status was less than 90 (i.e., it was possible for improvement in their functional status to occur). This measure is appropriate for patients with elbow, wrist or hand impairments, including but not limited to: soft tissue disorders of muscle, synovium, tendon, bursa, or enthesopathies (ICD-9 codes 725-729); sprains and strains of the elbow, wrist or hand (ICD-9 codes 841-842, including unspecified sprain or strain); fractures (ICD-9 813-819 including humerus, ulna, radius, carpal bones, metacarpals); arthropathies (ICD-9 codes 710-719, including osteoarthoses, rheumatoid arthritis); disorders of the bone and cartilage (ICD-9 codes 730-739); dislocations of elbow, wrist or fingers (ICD-9 codes 832-834); post-surgical (CPT codes including 24301 elbow muscle or tendon transfer, 64721 carpal tunnel decompression).	▌ Patients who do not have functional deficits related to elbow, wrist or hand impairments (scale value >90) ▌ <18 years of age ▌ Medical condition inappropriate for therapy. The elbow, wrist or hand functional status change measure is commonly risk adjusted by the following variables: intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance beliefs of physical activities if the patient has pain, and number of functional comorbidities. Detailed risk adjustment model can be found at www.fotoinc.com.	Registry, Clinical Database, Data Collection Instrument, Patient Survey.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Functional status change for patients with general orthopedic impairments	Measure ID #: 0428 Review #: NP-007-07	FOTO	Total sum of risk-adjusted residual discharge functional status scores in patients who were treated by a clinician in a 12-month time period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to general orthopedic impairments (i.e., scale ranging from 0 to 100 with higher scores meaning higher functional abilities), who were treated in therapy for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy and are now ready for discharge from therapy.	All patients in a 12-month time period with functional status deficits related to general orthopedic impairments for whom the value of the functional status scale at start or resumption of care was not normal, for example the patient's cervical spine functional status was less than 90 (i.e., it was possible for improvement in their functional status to occur). This measure is appropriate for patients with general orthopedic impairments, including but not limited to: soft tissue disorders of muscle, synovium, tendon, bursa, or enthesopathies (ICD-9 codes 725-729); sprains and strains of the cervical spine, ribs, or jaw (ICD-9 codes 847-848 including unspecified sprain or strain); fractures (ICD-9 800-807 including skull, jaw, cervical spine, ribs); arthropathies (ICD-9 codes 710-719, including osteoarthoses, rheumatoid arthritis); disorders of the bone and cartilage (ICD-9 codes 730-739); dislocations of jaw, cervical spine or ribs (ICD-9 codes 830, 839).	▌Patients who do not have a functional deficit related to a general orthopedic impairment (scale value >90) ▌<18 years of age ▌Medical condition inappropriate for therapy. The general orthopedic functional status change measure is commonly risk adjusted by the following variables: impairment, intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance beliefs of physical activities if the patient has pain, and number of functional comorbidities. Detailed risk adjustment models can be found at www.fotoinc.com.	Registry, Clinical Database, Data Collection Instrument, Patient Survey.

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Change in basic mobility	Measure ID #: 0429 Review #: NP-033-07	BU[c]	The number (or proportion) of a clinician's patients in a particular risk adjusted diagnostic category who meet a target threshold of improvement in Basic Mobility functioning. We recommend that the target threshold is based on the percentage of patients who exceed one or more Minimal Detectable Change (MDC) threshold. The percentage threshold is derived from a normative database used for benchmarking. MDC is considered the minimal amount of change that is not likely to be due to measurement error. It is one of the more common change indices, which can be used to identify reliable changes in an outcome like Basic Mobility function adjusting for the amount of measurement error inherent in the measurement. MDC can be reported at different confidence levels (see Haley & Fragala, 2006).	All patients in a risk adjusted diagnostic category with a mobility goal for an episode of care. Cases to be included in the denominator could be identified based on ICD-9 codes or, alternatively, based on CPT codes relevant to treatment goals focused on Basic Mobility function.	Those patients who did not have one or more mobility function goals for the episode of care. Risk adjusted for the following variables: diagnosis, age, gender, surgical status, baseline function score, payment source, acuity and/or severity of condition. Methodology pending.	Data Collection Instrument. (The AMPAC data collection instrument is available on the NQF website project page.)

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LICENSED INDEPENDENT PRACTITIONERS

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Change in daily activities	Measure ID #: 0430 Review #: NP-034-07	BU	The number (or proportion) of a clinician's patients in a particular risk adjusted diagnostic category who meet a target threshold of improvement in Daily Activity (i.e., ADL and IADL) functioning. We recommend that the target threshold is based on the percentage of patients who exceed one or more Minimal Detectable Change (MDC) thresholds. The percentage threshold is derived from a normative database used for benchmarking. MDC is considered the minimal amount of change that is not likely to be due to measurement error. It is one of the more common change indices, which can be used to identify reliable changes in an outcome like Daily Activity function adjusting for the amount of measurement error inherent in the measurement. MDC can be reported at different confidence levels (see Haley & Fragala, 2006).	All patients in a risk adjusted diagnostic category with a Daily Activity goal for an episode of care. Cases to be included in the denominator could be identified based on ICD-9 codes or, alternatively, based on CPT codes relevant to treatment goals focused on Daily Activity function.	Those patients who did not have one or more mobility function goals for the episode of care. Risk adjusted for the following variables: diagnosis, age, gender, surgical status, baseline function score, payment source, acuity and/or severity of condition. Methodology pending.	Data Collection Instrument.

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Appendix B
Clinician Steering Committees and Project Staff

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