NQF

NATIONAL QUALITY FORUM

EYE CARE AND MELANOMA

National Voluntary Consensus Standards for Ambulatory Care—Additional Eye Care and Melanoma Performance Measures

A CONSENSUS REPORT

Foreword

GLAUCOMA, CATARACTS, AND MACULAR DEGENERATION are common eye conditions that threaten the eyesight of many patients annually. The American Cancer Society estimated that about 62,480 new melanomas would be diagnosed in the United States during 2008, occurring—unlike other common cancers—in young and old people.

To fill the significant gaps in the endorsed measures for ambulatory care in the areas of eye and skin care, NQF has endorsed six measures in these topic areas. These consensus standards are designed to improve the quality of healthcare, via accountability and public reporting, by standardizing quality measurement in all relevant care settings.

These NQF-endorsed measures are fully disclosed and available for use by any interested parties. The eye care and melanoma consensus standards are intended for use at clinician- and group-level assessment.

NQF thanks the members of the Additional Eye Care and Melanoma Measures Steering Committee and NQF Members for their dedication to ensuring clinician performance will be measured in these areas of eye and skin care that affect so many Americans each year.

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.

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Permissions
National Quality Forum
601 13th Street NW
Suite 500 North
Washington, DC 20005
Fax 202-783-3434
www.qualityforum.org

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Executive Summary

IN THE PAST SEVERAL YEARS the National Quality Forum (NQF) has addressed the great interest in information about the quality of physician performance and clinician-level measurement by endorsing more than 100 clinician-level ambulatory care performance measures in a variety of areas. During the 2007 review, candidate eye care (cataracts) and skin care (melanoma) measures were not endorsed despite the importance and impact of these conditions. Six revised and updated measures in these topic areas have been reviewed to fill the gaps in the endorsed measures for ambulatory care.

The Steering Committee used NQF's standardized measure evaluation criteria, revised August 2008, to evaluate the measures. This report recommends six performance measures for eye care and melanoma for time-limited endorsement as voluntary consensus standards:

National Voluntary Consensus Standards for Ambulatory Care: Additional Eye Care and Melanoma Performance Measures

- Melanoma coordination of care
- Melanoma: appropriate use of imaging studies
- Primary open-angle glaucoma: reduction of intraocular pressure by 15 percent or documentation of a plan of care
- Cataracts: complications within 30 days following cataract surgery requiring additional surgical procedures
- Age-related macular degeneration (AMD): counseling on antioxidant supplement
- Cataracts: 20/40 or better visual acuity within 90 days following cataract surgery

The purpose of these consensus standards is to improve the quality of healthcare, via accountability and public reporting, by standardizing quality measurement in all relevant care settings. All NQF-endorsed measures are fully disclosed and available for use by any interested parties. The eye care and melanoma consensus standards are intended for use at clinician- and group-level assessment.

National Voluntary Consensus Standards for Ambulatory Care—Additional Eye Care and Melanoma Performance Measures: A Consensus Report

Background

IN THE PAST SEVERAL YEARS the National Quality Forum (NQF) has addressed the great interest in information about the quality of physician performance and clinician-level measurement by endorsing more than 80 clinician-level ambulatory care performance measures in a variety of areas: asthma/respiratory illness, bone and joint conditions, diabetes, heart disease, hypertension, medication management, mental health and substance abuse, obesity, prenatal care, and prevention/immunization/screening.[1] Twenty additional measures for clinician-level specialty care in the ambulatory setting were endorsed in 2007[2] for the areas of bone and joint conditions (osteoporosis), emergency care, eye care, geriatrics, and gastrointestinal conditions. During the 2007 review, candidate eye care (cataracts) and skin care (melanoma) measures were not endorsed despite the importance and impact of these conditions. Six revised and updated measures in these topic areas have been reviewed to fill the gaps in the endorsed measures for ambulatory care.

Strategic Directions for NQF

NQF's mission includes three parts: 1) establishing priorities and goals for performance improvement; 2) endorsing performance measures; and 3) education and outreach. As greater numbers of quality measures are developed and brought to NQF for consideration of endorsement, it is incumbent on NQF to assist stakeholders to "measure what makes a difference" and address what is important to achieve the best outcomes for patients and populations. An updated measurement framework, reviewed by NQF Members in December 2007, promotes shared accountability and measurement across episodes of care with a focus on outcomes, appropriateness, and cost/resource use measures, coupled with quality measures.

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

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

EMPHASIZE ON 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 OUTCOMES MEASUREMENT. Outcomes measures provide information of intense interest to consumers and purchasers, and, when coupled with healthcare process measures, 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 process, teamwork, and coordinated action on the part of many providers.

CONSIDER DISPARITIES IN ALL THAT WE DO. All Americans should receive quality healthcare, regardless of their race, ethnicity, language, and socioeconomic status. Unfortunately, significant healthcare disparities persist. Particular attention should be focused on identifying disparity-sensitive measures and strategies that move toward routine data collection of race, ethnicity, and language data and stratification of disparities-sensitive performance measures for reporting purposes.

Evaluating Potential Consensus Standards

During the initial review of eye and skin care measures, the Steering Committee and Technical Advisory Panels made numerous suggestions on revising and improving candidate consensus standards in these topic areas. Four updated skin care (melanoma) measures and six eye care measures were submitted to NQF to fill important gaps in the ambulatory care measure set. The Ambulatory Care Steering Committee evaluated the candidate standards using the standardized criteria revised in August 2008.[3] The revisions to the criteria were made to achieve:

- a stronger link to national priorities and higher-level performance measures;
- greater measure harmonization;
- greater emphasis on outcome measures; and
- for process measures, a tighter outcomes-process linkage.

The revised standardized criteria are:

***Important to measure and report*—**The specific measure focus (i.e., what is measured) should be important enough to expend resources for measurement and reporting, not merely that it is related to an important broad topic area. *Important to measure and report* is a "must pass" criterion, which emphasizes that finite resources for collecting and reporting quality measures should be used only for the most important measures that will drive improvement in healthcare quality.

Scientific acceptability of measure properties—This criterion applies to measure properties (e.g., reliability and validity) and all the subcriteria reflect that focus. This criterion still includes: precise specifications, reliability, validity, discrimination, and risk adjustment. The modifications clearly indicate that testing is expected to demonstrate reliability and validity.

Usable—This criterion demonstrates that the measure results are meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement. This is consistent with NQF policy of not endorsing measures solely for quality improvement.

Feasible—Feasibility is important to adoption and ultimate impact of the measure and needs to be assessed through testing or actual operational use of the measures.

Relationship to Other NQF-Endorsed Consensus Standards

NQF has endorsed four eye care measures at the clinician-level:

- Primary open angle glaucoma: optic nerve evaluation (AAO/AMA PCPI/NCQA)
- Age-related macular degeneration: dilated macular examination (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)

No measures for melanoma were endorsed during the 2007 review; however, it was noted that measures assessing dermatologic care are urgently needed. Recommendations were made for measure development measures of coordination and continuity of care as well as measures in other dermatologic areas besides melanoma.

NQF-Endorsed Voluntary Consensus Standards for Eye Care and Melanoma

This report recommends six performance measures for eye care and melanoma for time-limited endorsement as voluntary consensus standards (see Appendix A, p. A-1). The purpose of these consensus standards is to improve the quality of healthcare, via accountability and public reporting, by standardizing quality measurement in all relevant care settings. All NQF-endorsed measures are fully disclosed and available for use by any interested parties. The eye care and melanoma consensus standards are intended for use at clinician- and group-level assessment.

The Steering Committee determined that one of the melanoma measures, AED-02-08 Melanoma continuity of care—recall system, would be better considered by the Care Coordination project that has recently begun. The Committee noted that recall systems may be important aspects of care coordination but

questioned whether multiple condition-specific recall system measures would be the best approach. The Committee recommended that the Care Coordination Steering Committee consider this measure within a global consideration of care coordination.

Melanoma

The American Cancer Society estimates that about 62,480 new melanomas will be diagnosed in the United States during 2008. Incidence of melanoma increased sharply at about 6 percent per year in the 1970s. During the 1980s and 1990s, the rate of increase slowed to a little less than 3 percent per year. Since 2000, the rate has been fairly stable. About 8,420 people in the United States are expected to die of melanoma during 2008. The death rate has been stable since the 1990s for those older than 50, and has been dropping for those younger than 50.

Melanoma is more than 10 times more common in Caucasians than in African Americans. It is slightly more common in males than in females. Overall, the lifetime risk of getting melanoma is about 2 percent (1 in 50) for whites, 0.1 percent (1 in 1,000) for African Americans, and 0.5 percent (1 in 200) for Hispanics. Unlike many other common cancers, melanoma has a wide age distribution. It occurs in younger as well as older people. Rates continue to increase with age and are highest among those in their 80s, but melanoma is not uncommon even among those younger than 30. In fact, it is one of the more common cancers in adolescents and young adults.

Endorsed Measures

0561 **Melanoma coordination of care**

(AAD/AMA PCPI/NCQA) *AED-003-08*

Guidelines from the National Institute for Health and Clinical Excellence (UK) (NICE) state that there should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the specialist to the primary care provider.

The Steering Committee noted that this measure supports the National Priorities Partnership (NPP) priority of care coordination, though information on current performance is lacking. Patients who self-refer to specialists are of particular concern as the primary care physician (PCP) may not receive any information. The measure developer responded to the Committee's request for clarification on the meaning of communication: "Communication may include: documentation in the medical record indicating that the physician treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) providing continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma." The measure developer also clarified a question about timing, specifically "around one month," which was defined as

"from the time the biopsy result is reported by the pathologist." The Committee agreed that this measure is intended to measure the clinician managing the melanoma, regardless of specialty.

During the comment period, the Centers for Medicare & Medicaid Services (CMS) advised that experience in the field identified difficulties in implementing this measure. The measure developers addressed CMS's difficulties with revisions of the specifications to add ICD-9 and CPT procedure codes to better align with office work flow.

0562 **Melanoma: appropriate use of imaging studies**

(AAD/AMA PCPI/NCQA) *AED-004-08*

Ninety percent of new melanomas are stage 0-1A, and there are 700,000 people with the diagnosis. The measure developer noted that melanoma care costs $240 million/year and as much as 50 percent is related to routine imaging ordered by a host of providers, including dermatologists and primary care physicians. The benefit of the routine use of imaging studies in early stage melanoma has not been demonstrated to impact outcomes. Several studies support the overall perception that imaging studies are performed much too frequently and are not only clinically unnecessary, but also costly.[4,5,6,7,8] This measure addresses the NPP goal of overuse. The technical advisor noted that the National Comprehensive Cancer Network guideline for not imaging in stage 0-1A melanoma is in response to a general perception of widespread overuse.

In response to the Committee's request for clarification on the intent of the measure, the developer responded that "**any** imaging studies ordered during the one year measurement time frame would be considered as a failure of the measure, unless an exception is documented." The measure is intended to measure any clinician who manages melanoma and applies to "all patients, regardless of age, with stage 0 or IA melanoma, seen for an office visit during the one-year measurement period."

During the comment period, NQF received many supportive comments; however, it was suggested that a more appropriate name for the measure would read "appropriate use" rather than "overuse." The measure developer has renamed the measure "Appropriate use of imaging studies."

Eye Care

Glaucoma, cataracts, and macular degeneration are common eye conditions that threaten the eyesight of many patients annually:

Glaucoma – According to the Glaucoma Research Foundation over 4 million Americans have glaucoma but only half of those know they have it, accounting for 9 percent to 12 percent of all cases of blindness in the United States. Glaucoma is the leading cause of blindness among African Americans. Glaucoma is 6 to 8 times more common in African Americans than in Caucasians and African Americans ages 45-65 are 14 to 17 times more likely to go blind from glaucoma than Caucasians with glaucoma in the same age group. Glaucoma accounts for over

7 million visits to physicians each year. In terms of Social Security benefits, lost income tax revenues, and health care expenditures, the cost to the U.S. government is estimated to be over $1.5 billion annually. (National Eye Institute, Report of Glaucoma Panel, Fall 1998)

Cataracts—According to the National Eye Institute and Prevent Blindness America (2002), cataracts affect nearly 20.5 million Americans age 40 and older. By age 80, more than half of all Americans have cataracts. It is estimated that the federal government spends more than $3.4 billion each year treating cataracts through the Medicare program.[9]

Age-related macular degeneration (AMD)—Age-related macular degeneration affects more than 1.75 million individuals in the United States. Owing to the rapid aging of the U.S. population, this number will increase to almost 3 million by 2020.[10]

Endorsed Measures

0563 **Primary open-angle glaucoma: reduction of intraocular pressure by 15 percent or documentation of a plan of care**

(AAO/AMA PCPI/NCQA) *AED-005-08*

This is a combined process and outcome measure designed by the developers as a "failure measure" rather than as an assessment of optimal management. The technical advisors noted that this level of treatment may not prevent blindness and questioned why the measure developer chose a 15 percent reduction in intraocular pressure (IOP) rather than the 18 percent indicated by studies. The measure developer noted that 15 percent is more easily calculated, particularly for clinicians in the office. During the review period, several comments supported the concern that the 15 percent reduction might not be the appropriate target. The measure developer responded that "the glaucoma measure was developed in a similar manner as other NQF-endorsed measures including the NQF-endorsed measure, #0059, 'Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0 percent (poor control)' measure." A slightly less aggressive target was selected, a 15 percent reduction, because this is constructed as a "failure" measure: everyone can agree that a reduction of 15 percent is the floor or minimum reduction. If this reduction cannot be achieved, then treatment has "failed" and a new plan of care is required. It is for this reason that the threshold set for this measure differs from the figures found in the scientific evidence and in the American Academy of Ophthalmology's Preferred Practice Pattern.

Current performance data was not provided though many perceive the gap in performance to be as much as 50 percent. According to the measure developer, "plan of care" includes documentation of allergies to medications and surgical alternatives. Several comments questioned how this measure is reported since it contains both a process and an outcome component. The measure developer clarified that there should be three rates reported:

1. percentage of patients for whom either the intermediate outcome was achieved or the process of care was completed—percentage of patients whose most recent IOP was

reduced by at least 15 percent from the pre-intervention level OR, if it was not reduced by at least 15 percent, a plan of care was documented;

2. percentage of patients for whom the intermediate outcome was achieved—percentage of patients whose most recent IOP was reduced by at least 15 percent from the pre-intervention level; and
3. percentage of patients for whom the process of care was completed—percentage of patients whose most recent IOP was not reduced by at least 15 percent but a plan of care was documented.

0564 Cataracts: complications within 30 days following cataract surgery requiring additional surgical procedures

(AAO/AMA PCPI/NCQA) *AED-007-08*

This measure of adverse outcomes for patients undergoing cataract surgery is important to patients and providers alike. The developer noted that use of this measures based on administrative data in a "major payer" group identified a complication rate of 1 percent to 2 percent. Steering Committee members were concerned with the large number of exclusions allowed—the measure developer reported that in the same "major payer" analysis, only 25 percent of patients were excluded. The developer also noted that due to the large number of exclusions, for the remaining patients complications are "never event" and the target should be 0 percent. The measure applies to all sites of care including hospitals and ambulatory surgery centers. A Steering Committee member asked if a more traditional method of outcomes measurement, such as a registry with a risk model, could be developed. The AAO measure developer noted that attempts to establish a registry have not been successful to date.

During the comment period, one reviewer asked how the number of exclusions affects the reliability and validity of the measure. The measure developer responded "as the measure was developed, a large insurance company ran its claims to gather information for this measure. Only about one-third of the claims were dropped because of these exclusions. Thus, by defining an uncomplicated cataract, it provides a 'clean' indicator that captures care for the large majority of patients undergoing cataract surgery. This preservation of over two-thirds of cataract surgery cases for analysis was also seen in the results of the Cataract Appropriateness Project at RAND. As this measure will be endorsed as time-limited, we will continue to explore the reliability and validity of the measure including the exclusions, which serve as a proxy for risk adjustment."

0565 Cataracts: 20/40 or better visual acuity within 90 days following cataract surgery

(AAO/AMA PCPI/NCQA) *AED-008-08*

Even though the measure assesses a readily understandable and important outcome, the Steering Committee questioned the value of a measure for which data on current performance is already very high. Committee members noted that the reference submitted by the measure developer of the NEON[11] study reports a 96 percent performance for uncomplicated cataract surgery (complicated cases

are excluded from this measure). Technical advisors noted that detecting differences among providers at such a high performance level would require large numbers of patients. It was also noted that CMS does not use visual acuity for determining the need for cataract surgery, but uses activities of daily living instead. Initially, the Committee felt the measure did not meet the "importance to measure and report" criteria, specifically on the "demonstrated quality problem and opportunity for improvement."

In response, the measure developer submitted additional information which explained that AAO's NEON database report "was not a representative sample, but rather a small (249 out of 15,000 practicing ophthalmologists), self-selected sample of ophthalmologists who chose to participate on a voluntary basis, and may not have reported on all of their cases. There was never any audit to verify the accuracy or completeness of data reporting." The Committee looked at other sources for current performance. A review of the literature regarding cataract surgery outcome also reported high levels of performance on populations that sometimes included more pre-existing ocular disease to range from 91 percent to 95 percent.[12,13,14,15] Some Committee members concluded that current performance across the nation may be variable and some opportunity for quality improvement may be possible; others were not convinced that this measure would provide meaningful and actionable information, particularly in determining differences among providers, compared to the cost of data collection and measurement.

During the comment period, numerous comments were submitted in support of the measure, which cited the importance of outcome measures, the high volume of cataract surgery, and the lack of data on current performance for non-academic or community practitioners. The Steering Committee considered the review comments and a majority recommended the measure for time-limited endorsement.

0566 **Age-related macular degeneration (AMD): counseling on antioxidant supplement**

(AAO/AMA PCPI/NCQA) *AED-010-08*

The AREDS Research Group reported that if all patients at risk received supplements, more than 300,000 (95 percent confidence interval, 158,000–487,000) would avoid advanced AMD and any associated vision loss during the next 5 years.[16] The measure developer noted that this measure is revised from a measure considered two years ago in which the supplements were "prescribed." As a result of concerns revealed in a February 2007 article in the *Journal of the American Medical Association,*[17] the measure was changed from definitive therapy to counseling for all patients. The developer noted that the American Academy of Ophthalmology has clear guidelines on who is appropriate for treatment. It is expected that the record will indicate a discussion with all patients, including those for whom the supplements are not indicated. The Steering Committee requested clarification on how counseling is defined, particularly the frequency and the level of documentation. The measure developer clarified the definition in the measure specifications.

Measures Not Endorsed

MELANOMA FOLLOW-UP MEASURE
(Add Measure Developer?) *AED-01-08*

This measures assesses the percentage of patients with a new diagnosis of melanoma or a history of melanoma who received all of the following aspects of care within the 12 month reporting period: 1) patient was asked about new and changing moles, AND 2) patient received a complete physical skin examination, AND 3) patient was counseled to perform a monthly self skin examination. The Steering Committee noted this process has little documented relationship to patient outcomes even though it should be a routine part of care. Committee members were concerned that it is too easy to simply document an exam regardless of how thoroughly performed; the developer believed that it took only a few minutes to conduct a proper exam.

PRIMARY OPEN ANGLE GLAUCOMA: COUNSELING ON GLAUCOMA IMPORTANCE DISCUSSION
(AAO/AMA PCPI/NCQA) *AED-006-08*

This measure addresses the percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma or their caregiver who were counseled within 12 months about 1) the potential impact of glaucoma on their visual functioning and quality of life, AND 2) the importance of treatment adherence. Studies suggest that patient education and informed participation in treatment decisions may improve adherence.[18] The Steering Committee felt this measure did not meet the criteria for opportunity for improvement since current performance is unclear; it rated low on relationship to outcomes because the effectiveness of counseling is unclear.

The Steering Committee reviewed several comments requesting reconsideration of this measure because it addresses an NPP area of patient engagement and because treatment adherence is a concern that impacts outcomes. The Steering Committee reconsidered this measure but again did not recommend it for endorsement due to continuing concerns about the meaning and likely variability in the quality of "counseling" and the ultimate relationship to outcomes.

COMPREHENSIVE PRE-OPERATIVE ASSESSMENT FOR CATARACT SURGERY WITH INTRAOCULAR LENS (IOC) PLACEMENT
(AAO/AMA PCPI/NCQA) *AED-009-08*

This measure evaluates the percentage of patients aged 18 years and older with a procedure of cataract surgery with IOC placement who received a comprehensive preoperative assessment of 1) dilated fundus exam; 2) axial length, corneal keratometry measurement, and method of IOC power calculation; and 3) functional or medical indication(s) for surgery prior to the cataract surgery with IOC placement within 12 months prior to cataract surgery. The Steering Committee agreed that appropriate pre-operative assessment is important for good quality care, but felt that the reported 10 percent to 30 percent compliance gap represents a documentation issue rather than true poor performance.

The Steering Committee reviewed several comments requesting reconsideration of this measure because it is a measure of "appropriateness" for a frequently performed surgical procedure. The Steering Committee reconsidered the measure; however, again the majority did not recommend the measure for endorsement

because of the concern that the compliance gap could represent a documentation issue rather than an indication of poor performance.

Notes

1 National Quality Forum (NQF), *National Voluntary Consensus Standards for Ambulatory Care: Parts 1 and 2,* Washington, DC: NQF;2006.

2 National Quality Forum (NQF), *National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures,* Washington, DC: NQF;2007.

3 National Quality Forum (NQF), *Measure Evaluation Criteria: August 2008,* Washington, DC: NQF;2008. Available at **http://www.qualityforum.org/uploadedFiles/Quality_Forum/Measuring_Performance/Consensus_Development_Process's_Principle/EvalCriteria2008-08-28Final.pdf?n=4701.** Last accessed November 2009.

4 Grange F, Vitry F, Granel-Brocard F, et al., Variations in management of stage I to stage III cutaneous melanoma: a population-based study of clinical practices in France, *Arch Dermatol* 2008;144:629-636.

5 Yancovitz M, Finelt N, Warycha MA, et al., Role of radiologic imaging at the time of initial diagnosis of stage T1b-T3b melanoma, *Cancer,* 2007;110:1107-1114.

6 Choi EA, Gershenwald JE, Imaging studies in patients with melanoma, *Surg Onc Clin N Am,* 2007;16:402-430.

7 Hoffman U, Szedlak M, Rittgen W, et al., Primary staging and follow-up in melanoma patients—monocenter evaluation of methods, costs, and patient survival, *Br J Cancer,* 2002;87:151-157.

8 Hengge UR, Wallerand A, Stutzki A, et al., Cost-effectiveness of reduced follow-up in malignant melanoma, *JDDG,* 2007;5:898-907.

9 National Eye Institute and Prevent Blindness America, *Vision Problems in the U.S.,* 2002 [Need place of publication & name of publication or URL]

10 *Arch Ophthal.* 2004;122:564-572 [Please provide article title and author.]

11 Lum F, Schein O, Schachat AP, et al. Initial two years of experience with the AAO National Eyecare Outcomes Network (NEON) cataract surgery database, *Ophthalmology,* 2000;107:691-697. Best-corrected visual acuity of 20/40 was achieved by 89 percent of all NEON patients and 96 percent of NEON patients without preoperative ocular comorbid conditions (AAO 2006).[Please clarify the role of this parenthetical expression—it looks like a citation within a citation. If so, we should list only the most recent publication.]

12 Blomquist PH, Rugwani RM. Visual outcomes after vitreous loss during cataract surgery performed by residents, *J Cataract Refract Surg,* 2002;28:847-52.

13 Randleman JB, Srivastava SK, Aaron MM, Phacoemulsification with topical anesthesia performed by resident surgeons, *J Cataract Refract Surg,* 2004;30:149-154.

14 Thompson AM, Sachdev N, Wong T, et al., The Auckland Cataract Study: 2-year postoperative assessment of aspects of clinical, visual, corneal topographic and satisfaction outcomes, *Br J Ophthalmol,* 2004;88:1042-1048.

15 Norregaard JC, Hindsberger C, Alonso J, et al., Visual outcomes of cataract surgery in the United States, Canada, Denmark, and Spain: report from the International Cataract Surgery Outcomes Study, *Arch Ophthalmol,* 1998;116:1095-1100.

16 Bressler NM, Bressler SB, Congdon NG, et al., Age-Related Eye Disease Study Research Group. Potential public health impact of age-related eye disease study results: AREDS Report No. 11, *Arch Ophthal,* 2003;121(11):1621-1624.

17 Bjelakov G, Nikolova D, Gluud L, et al., Mortality in randomized trials of antioxidant supplements for primary and secondary prevention: systematic review and meta-analysis, *JAMA* 2007;297:842-847.

18 Osterberg L, Blaschke T, Adherence to medication, *N Engl J Med* 2005;353:487-497.

Appendix A
Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Additional Eye Care and Melanoma Performance Measures

THE FOLLOWING TABLE PRESENTS the detailed specifications for the National Quality Forum (NQF)-endorsed® *National Voluntary Consensus Standards for Ambulatory Care — Additional Eye Care and Melanoma Performance Measures 2009*. All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agrees to such modification during the NQF Consensus Development Process) and is current as of October 30, 2009. All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed. Measures were developed by the American Academy of Dermatology, the American Academy of Ophthalmology, the American Medical Association-convened Physician Consortium for Performance Improvement, and the National Committee for Quality Assurance.

Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care: Additional Eye Care and Melanoma Performance Measures

MEASURE TITLE	MEASURE NUMBER	MEASURE STEWARD	MEASURE DESCRIPTION	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Melanoma							
Melanoma coordination of care	0561*	AAD/AMA PCPI/NCQA[1,2]	Percentage of patients seen with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis	Patients who have a treatment plan* documented in the chart that was communicated** to the physician(s) providing continuing care within a month of diagnosis **A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.* ***Communication may include: documentation in the medical record indicating that the physician treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) p roviding continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.*	All patients, regardless of age, diagnosed with a new occurrence of melanoma ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9 *AND* CPT E/M codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *OR* 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9 *AND*	Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated to physician(s) providing continuing care) Append modifier to CPT Category II code: 5050F-2P Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (e.g., patient does not have a PCP or referring physician) Append modifier to CPTII Category II code: 5050-3P	Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other

*more

*Time-limited endorsement.

[1] Measure steward and copyright owners. ALL RIGHTS RESERVED. For the most current specifications and supporting information, please refer to the measure stewards:
AAD – American Academy of Dermatology **(www.aad.org)**
AAO – American Academy of Ophthalmology **(www.aao.org)**
AMA PCPI – American Medical Association-convened Physician Consortium for Performance Improvement **(http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement.shtml)**
NCQA—National Committee for Quality Assurance **(www.ncqa.org)**

[2] Measure developers.

MEASURE TITLE	MEASURE NUMBER	MEASURE STEWARD	MEASURE DESCRIPTION	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Melanoma coordination of care *(continued)*	0561*			CPT Category II code: 5050F-Treatment plan communicated to provider(s) managing continuing care within one month of diagnosis	11600, 11601, 11602, 11603,11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14300, 17311, 17313		
Melanoma: Appropriate use of imaging studies in stage 0-IA melanoma	0562*	AAD/AMA PCPI/NCQA[1,2]	Percentage of patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies were ordered	Patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies* were ordered **Diagnostic imaging studies include CXR, CT, ultrasound, MRI, PET, and nuclear medicine scans. Ordering any of these imaging studies during the one-year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exclusion.* CPT Category II code: 3320F–None of the following diagnostic imaging studies	All patients, regardless of age, with stage 0 or 1A melanoma, seen for an office visit during the one-year measurement period ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 [code correct?] *AND* CPT E/M codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 *AND*	Documentation of medical reason(s) for ordering diagnostic imaging studies (e.g., patient has signs or symptoms that justify imaging studies) Append modifier to CPT Category II code: 3319F-1P Documentation of system reason(s) for ordering diagnostic imaging studies (e.g., requirement for clinical trial enrollment, ordered by another provider) Append modifier to CPT Category II code: 3319F-3P	Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other

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MEASURE TITLE	MEASURE NUMBER	MEASURE STEWARD	MEASURE DESCRIPTION	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Melanoma: Appropriate use of imaging studies in stage 0-IA melanoma *(continued)*				ordered: chest x-ray, CT, ultrasound, MRI, PET, and nuclear medicine scans *OR* 3319F–One of the following diagnostic imaging studies ordered: chest X-ray, CT, ultrasound, MRI, PET, or nuclear medicine scans	CPT Category II code: 3321F–AJCC melanoma cancer stage 0-1A, documented *OR* 3322F–Melanoma greater than AJCC stage 0 or IA Note: *Only patients with melanoma stage 0 or IA will be counted in the performance denominator of this measure; if patient has melanoma greater than AJCC stage 0 or IA, numerator does not apply.*		

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MEASURE TITLE	MEASURE NUMBER	MEASURE STEWARD	MEASURE DESCRIPTION	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Eye Care							
Primary open-angle glaucoma: reduction of intraocular pressure by 15 percent or documentation of a plan of care	0563*	AAO/AMA PCPI/NCQA[1,2]	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent intraocular pressure (IOP) was reduced by at least 15 percent from the pre-intervention level) *OR* if the most recent IOP was not reduced by at least 15 percent from the pre-intervention level a plan of care was documented within 12 months	Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15 percent from the pre-intervention level) *OR* if the most recent IOP was not reduced by at least 15 percent from the pre-intervention level a plan of care was documented within 12 months Plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist CPT Category II code: 3284F- IOP reduced by a value of greater than or equal to 15 percent from the pre-intervention level *OR*	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma ICD-9 diagnosis codes: 365.01, 365.10, 365.11, 365.12, 365.15 *AND* CPT E/M Codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99215, 99241, 99242, 99243, 99244, 99245, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 *AND* Patients aged 18 years and older	Documentation of system reason(s) for not reducing the IOP by at least 15 percent from the pre-intervention level or not documenting a plan of care. Append modifier to CPT Category II code: 0517F-3P	Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other

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MEASURE TITLE	MEASURE NUMBER	MEASURE STEWARD	MEASURE DESCRIPTION	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Primary open-angle glaucoma: reduction of intraocular pressure by 15 percent or documentation of a plan of care *(continued)*				A. CPT Category II code: 3285F-IOP reduced by a value less than 15 percent from the pre-intervention level *AND* B. CPT Category II code: 0517F- Glaucoma plan of care documented			
Cataracts: complications within 30 days following cataract surgery requiring additional surgical procedures	0564*	AAO/AMA PCPI/NCQA[1,2]	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL [spell out at first use in measure], retinal detachment, or wound dehiscence.	Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL retinal detachment, or wound dehiscence CPT Procedure Codes: 65920, 66820, 66830, 66852, 65235, 67005, 67010, 67015, 67025, 67028, 65800, 65810, 65815, 67030, 67031, 67036, 67038, 67039, 66825, 66986, 67101, 67105, 67107, 67036, 67038, 67039, 67108, 67110, 67112, 67141, 67145, 66250, 67250, 67255, 65860, 65880, 65900, 65930, 66030	All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate CPT Procedure Codes: 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984 *AND* Patients aged 18 years and older	Patients with any of the following comorbid conditions impacting the surgical complication rate (see Denominator Exclusions Spreadsheet, attached)	Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other

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MEASURE TITLE	MEASURE NUMBER	MEASURE STEWARD	MEASURE DESCRIPTION	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Cataracts: 20/40 or better visual acuity within 90 days following cataract surgery	0565*	AAO/AMA PCPI/NCQA[1,2]	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery	Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery CPT Category II code: 4175F-Best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery	All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the visual outcome of surgery CPT Procedure Codes (with or without modifiers): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984 *AND* Patients aged 18 years and older	Patients with any of the following comorbid conditions that impact the visual outcome of surgery (See Denominator Exclusions Spreadsheet, attached)	Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other
Age-related macular degeneration (AMD): counseling on antioxidant supplement	0566*	AAO/AMA PCPI/NCQA[1,2]	Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD Definition of counseling: Documentation in the medical	Patients with AMD or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD CPT Category II code: 4177F-Counseling about the benefits and/or risks the AREDS formulation for preventing progression AMD provided to patient and/or caregiver(s)	All patients aged 50 years and older with a diagnosis of AMD ICD-9 diagnosis codes: 362.50, 362.51, 362.52 *AND* CPT E/M codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99215, 99241, 99242, 99243, 99244,	Documentation of system reason(s) for not counseling on the benefits and/or risks of the AREDS formulation with the patient or caregiver(s) Append modifier to CPT Category II code: 4177F-3P	Paper Medical Record, Electronic Claims, Electronic Health/Medical Record, Other

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MEASURE TITLE	MEASURE NUMBER	MEASURE STEWARD	MEASURE DESCRIPTION	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Age-related macular degeneration (AMD): counseling on antioxidant supplement *(continued)*			record should include a discussion of the risks and/or benefits of the AREDS formulation. This can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation. For example, patients who are smokers do not meet the criteria because beta-carotene can increase their risk of cancer. The ophthalmologist or optometrist can explain why these supplements are not appropriate for a patient's particular situation. Also, given some of the purported risks associated with anti-oxidant use, patients should be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate about overuse as well as appropriate use.	Definition of counseling: Documentation in the medical record should include a discussion of the risks and/or benefits of the AREDS formulation. This can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation. For example, patients who are smokers do not meet the criteria because beta-carotene can increase their risk of cancer. The ophthalmologist or optometrist can explain why these supplements are not appropriate for a particular patient's situation. Also, given some of the purported risks associated with antioxidant use, patients should be informed of the risks and benefits and make their choice based on valuation of vision loss versus other risks. As such, the measure seeks to educate about overuse as well as appropriate use.	99245, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 *AND* Patients aged 50 years and older		

Appendix B
Ambulatory Care: Additional Eye Care and Melanoma Measures Steering Committee

Jeffrey Kang, MD, MPH (Co-Chair)
Senior VP Clinical Programs and Policy, CIGNA
Hartford, CT

Alice Stollenwerk Petrulis, MD (Co-Chair)
Chief Medical Officer, KePRO
Seven Hills, OH

John Brookey, MD
Physician Director of Quality, Patient Safety, and Risk Management, Southern California Permanente Group
Pasadena, CA

Foster Gesten, MD
Medical Director, Office of Managed Care, NYS Dept of Health
Albany, NY

Michael Kulczycki, MBA
Executive Director, Accreditation Services Business Development, The Joint Commission
Oakbrook Terrace, IL

Arnold Milstein, MD, MPH
Medical Director, Pacific Business Group on Health and Consumer-Purchaser Disclosure Project
San Francisco, CA

Daniel Green, MD
Centers for Medicare and Medicaid Services
Baltimore, MD

Beth Ann Swan, PhD, CRNP,
Associate Professor, Thomas Jefferson University, Jefferson College of Health Professions
Philadelphia, PA

Technical Advisors

Russell S. Gonnering, MD
Gonnering Eye Consultants
Elm Grove, WI

Mary Loshin, OD
Assistant Medical Director, CompBenefits/Primary Plus
Plantation, FL

Allan C. Halpern, MD
Chief of Dermatology, Memorial Sloan Kettering Cancer Center
New York, NY

Robert Havlik, MD
Chief of Plastic Surgery, Riley Hospital for Children
Indianapolis, IN

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NATIONAL QUALITY FORUM
601 13th Street NW
Suite 500 North
Washington, DC 20005
202-783-1300
www.qualityforum.org

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