List of Measures under Consideration for December 1, 2012

Overview

CMS is issuing this List of Measures under Consideration to comply with Section 1890A of the Social Security Act (Act), which requires the Department of Health and Human Services (DHHS) to publicly present quality and efficiency measures it is considering for adoption through rulemaking for the Medicare program. Because the list contains measures we are considering that were suggested to us by the public, this list is larger than what will ultimately be adopted by CMS for optional or mandatory reporting programs in Medicare. When organizations, such as physician specialty societies, request that CMS consider measures, CMS attempts to include them and make these measures available to the public so that the Measure Applications Partnership (MAP), the multi-stakeholder groups convened as required under 1890A of the Act, can provide their input. CMS will continue its goal of aligning measures across programs. Measure alignment includes establishing core measure sets for use across similar programs, and looking first to existing program measures for use in new programs. Further, CMS programs must balance competing goals of establishing parsimonious sets of measures, while including sufficient measures to facilitate multi-specialty provider participation. For example, the Physician Quality Reporting System (PQRS) program accounts for the bulk of the measures under consideration in this list (281 measures out of 507),with the vast majority of these measures requested by physician specialty groups.

Statutory Requirement

Section 3014 of the Affordable Care Act (ACA) (P.L. 111-148) created a new Section 1890A of the Act, which requires the establishment of a federal pre-rulemaking process for the selection of quality and efficiency measures used by DHHS. Measures include those used under certain Medicare programs listed under section 1890(b)(7)(B)(i)(I) of the Act as well as those used in reporting performance information to the public. The pre-rulemaking process includes:

1. Making publicly available, by December 1st annually, a list of measures DHHS is considering for adoption through the federal rulemaking process for qualifying programs and for reporting performance information to the public;
2. Providing the opportunity for multi-stakeholder groups to provide input by February 1st annually to DHHS on the selection of quality and efficiency measures and for DHHS to consider the multi-stakeholder groups' input in selecting measures;
3. Publishing the rationale for the use of any quality and efficiency measures that are not endorsed by the consensus based entity under contract with the DHHS under Section 1890 of the Act, currently the National Quality Forum (NQF)[1]; and
4. Assessing the quality and efficiency impact of the use of endorsed measures and making that assessment available to the public at least every three years (the first report was released in March 2012). Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/NationalImpactAssessmentofQualityMeasuresFINAL.PDF

Fulfilling Multi-Stakeholder Group Input Requirements

The attached List of Measures under Consideration, which will be posted for CMS on the NQF's website (www.qualityforum.org/MAP/), satisfies the first and second requirements of the pre-rulemaking process. Additionally, CMS will update the webpage that describes this process and submission of the measures list to the NQF MAP for posting.

Included Measures. The current List of Measures under Consideration identifies the quality and efficiency measures under consideration by the Secretary of DHHS for the Medicare program. The measures are described under Section 1890(b)(7)(B) of the Act, which was added by Section 3014 of the ACA. Quality and efficiency measures include:

1. Measures for use in the Medicare quality programs specifically listed in Section 1890(b)(7)(B)(i)(I) of the Act;

[1] The rationale for adopting measures not endorsed by the consensus based entity will be published in regulations where such measures are proposed and finalized

2. Measures for use in reporting performance data to the public; and

3. Measures that have been developed for use in health care programs other than for use under the Social Security Act.

Measures that fall into one or more of the above categories would belong on the pre-rulemaking list if we are considering those measures for use under the Medicare program. Measures that appear on this list but are not selected for a Medicare program will remain under consideration for future rulemaking cycles.

Applicable Programs

The following programs implementing measures have been identified to meet the criteria listed above. Accordingly, measures from these programs are eligible to be included in the List of Measures under Consideration:

1. Ambulatory Surgical Center Quality Reporting
2. E-Prescribing Incentive Program
3. End Stage Renal Disease Quality Improvement Program
4. Home Health Quality Reporting
5. Hospice Quality Reporting
6. Hospital Acquired Condition Payment Reduction (ACA 3008)
7. Hospital Inpatient Quality Reporting
8. Hospital Outpatient Quality Reporting
9. Hospital Readmission Reduction Program
10. Hospital Value-Based Purchasing
11. Inpatient Psychiatric Facility Quality Reporting
12. Inpatient Rehabilitation Facility Quality Reporting
13. Long-term Care Hospital Quality Reporting
14. Medicare and Medicaid EHR Incentive Program for Eligible Professionals
15. Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
16. Medicare Shared Savings Program
17. Medicare Physician Quality Reporting System (PQRS)
18. Physician Compare
19. Physician Feedback
20. Value-Based Modifier Program
21. Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting

Measures List Highlights

Through publication of this list, CMS will make publicly available and seek multi-stakeholder group input on 50 new measures under consideration for use in the Medicare program.

We note several important points to consider and highlight:

- Of the applicable programs covered by the ACA 3014 pre-rulemaking process, 19 programs contributed measures to include in this list (e.g., 2 programs did not contribute measures).
- If CMS chooses not to adopt a measure under this list for the current rulemaking cycle, those measures remain under consideration by the Secretary and may be considered in subsequent rulemaking cycles.
- External stakeholders contributed to and support the majority of measures on this list.
- The NQF already endorses many of the measures contained in this list with other measures pending endorsement.
- Some measures are part of a mandatory reporting program. However, a number of measures, if adopted, would be part of an optional reporting program. Under this type of program, providers or suppliers can choose whether to participate.
- CMS sought to be inclusive of new measures in the pre-rulemaking measure list to be responsive to stakeholder feedback. For example, although we anticipate that only a subset of measures will actually be their adopted, the Physician Quality Reporting System (PQRS) program has a large number of measures under consideration to address many of the specialty societies that wish to offer a robust set of measures applicable to providers. Out of the 507 measures under consideration, 281 are under consideration for PQRS in response to an annual Call for Measures that is held to encourage increased participation.
- Particular CMS programs must balance competing goals of establishing parsimonious sets of measures, while including sufficient measures to facilitate multi-specialty provider participation. CMS will continue aligning measures across programs, including establishing "core" measure sets, and when choosing measures for new programs, it will look first to measures that are currently in existing programs. CMS's goal is to fill critical gaps in measurement that align with and support the National Quality Strategy.
- The measures list includes measures which CMS is currently considering for the Medicare program. Inclusion of a measure on this list does not require CMS to select the measure for the identified program. Further, a measure not selected by CMS under this list remains under consideration for future rulemaking cycles.

Table Legend:

A list of terms used in the ACA 3014 Measures List is included for clarity and consistency. They are presented below in the order in which they appear as headings in the List of Measures under Consideration.

Measure ID: Gives users an identifier to refer to a measure.

CMS Programs: Refers to the list of Medicare programs included in the List of Measures under Consideration and contains measures that CMS may adopt through rulemaking in the future.

Measure Title: Title of the measure, including the name of the organization proposing the measure, where applicable.

Description: Gives users more detailed information about the measure, such as medical conditions to be measured, particular outcomes or results that could or should/should not result from the care and patient populations.

Numerator: The numerator reflects the subset of patients in the denominator for whom a particular service has been provided or for whom a particular outcome has been achieved.

Denominator: The lower part of a fraction used to calculate a rate, proportion, or ratio. The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements.

Exclusions: Are patients included in an initial population for whom there are valid reasons a process or outcome of care has not occurred. These cases are removed from the denominator. When clinical judgment is allowed, these are referred to as "exceptions". Denominator exceptions fall into three general categories: medical reasons, patients' reasons, and system reasons. Exceptions must be captured in a way that they could be reported separately.

Condition: Refers to the topic or condition under which the measure can be classified.

Sub-Condition: Refers to the sub-topic or sub-condition under which the measure can be classified.

Measure Type: Refers to the domain of quality that a measure assesses:

- Process: Refers to a measure that focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.
- Outcome: Refers to a measure that assesses the results of health care that are experienced by patients.
- Intermediate Outcome: Refers to a measure which aims to meet specific thresholds of health outcomes.
- Structure: Refers to a measure that assesses aspects of the health care infrastructure that generally are broad in scope, system wide (for example, staffing level).
- Efficiency: Refers to a measure of cost of care associated with a specified level of health outcome.
- Patient Perspective: Refers to a measure which focuses on a patient's report concerning observations of and participation in health care.
- Cost/Resource Use: Refers to broadly applicable and comparable measures of health services counts (in terms of units or dollars) applied to a population or event (broadly defined to include diagnoses, procedures, or encounters). A resource use measure counts the frequency of defined health system resources; some may further apply a dollar amount (for example, allowable charges, paid amounts, or standardized prices) to each unit of resource use—that is, monetizes the health service or resource use units.
- Composite: Refers to a measure which contains two or more individual measures, resulting in a single measure and a single score. Composite measures may be composed of one or more process and/or one or more outcome measures.

NQF Endorsed Status: Describes the status of the measure along the NQF endorsement continuum:

- Endorsed: Refers to measures that are formally endorsed by NQF through the Consensus Development Process (CDP). The CDP is NQF's process to build consensus and endorse quality measures.

- Time Limited Endorsed (TLE): Refers to measures that meet all of NQF's endorsement criteria with the exception of field testing and are critical to advancing quality improvement and are granted this two-year endorsement during which the measure developers
must test the measure and return results to NQF within the two-year window of time-limited endorsement.
- Not Endorsed: Refers to measures that have not been formally endorsed by the NQF.
- Endorsement Maintenance: Refers to measures that are undergoing the NQF CDP for review and/or re-evaluation to ensure currency of the measure's evidence and specifications.
- Under Review: Refers to newly submitted measures which are being reviewed by their respective committees, and no final decision has been made whether NQF will or will not endorse the measure.
- Candidate Standards: Refers to measures which have not formally been NQF-endorsed but are undergoing review by the Consensus Standards Approval Committee (CSAC) for endorsement determination.
- De-endorsed: Refers to measures which no longer fulfill the criteria for NQF-endorsement or the measure steward no longer maintains the measure.

NQF ID: The number given to the measure when endorsed by the NQF. The number does not change if a measure is De-endorsed.

Measure Steward: Refers to the primary (and secondary, if applicable) party responsible for updating and maintaining a measure.

List of Measures under Consideration for December 1, 2012

CMS PROGRAM	NUMBER OF MEASURES UNDER CONSIDERATION
Ambulatory Surgical Center Quality Reporting	5
End Stage Renal Disease Quality Improvement Program	21
E-Prescribing Incentive Program	0
Home Health Quality Reporting	2
Hospice Quality Reporting	7
Hospital Acquired Condition Payment Reduction (ACA 3008)	25
Hospital Inpatient Quality Reporting	20
Hospital Outpatient Quality Reporting	7
Hospital Readmission Reduction Program	6
Hospital Value-Based Purchasing	17
Inpatient Psychiatric Facility Quality Reporting	5
Inpatient Rehabilitation Facility Quality Reporting	10
Long-Term Care Hospital Quality Reporting	29
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	2
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	1
Medicare Shared Savings Program	0
Medicare Physician Quality Reporting System (PQRS)[2]	281
Physician Compare/Physician Feedback/Value-Based Modifier[3]	50
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	19
Total	507

[2] Medicare Physician Quality Reporting System (PQRS):
PQRS is the primary means of collecting physician quality data in the Medicare program. As Physician Compare, Physician Feedback, and Value-Based Modifier programs all take physician quality performance into account, all quality measures under consideration for PQRS would also be under consideration for the Physician Compare, Physician Feedback, and Value-Based Modifier programs.

[3] Physician Compare/Physician Feedback/Value-Based Modifier:
The Physician Compare, Physician Feedback, and Value-Based Modifier programs are being combined for the List of Measures under Consideration since the same measures are generally under consideration for all of these programs (to the extent that a measure has not already been finalized for any of the individual programs). However, they continue to operate as separate programs. All quality measures under consideration for the Medicare Physician Quality Reporting System (PQRS), Hospital Inpatient Quality Reporting (IQR), and Hospital Outpatient Quality Reporting (OQR) would also be under consideration for the Physician Compare, Physician Feedback, and Value-Based Modifier Programs and may not be specifically duplicated on the List of Measures under Consideration (MUC). Additionally, measures that are already finalized and remain current for PQRS, IQR, and OQR that are not specifically included on this list may also be considered for the Physician Compare, Physician Feedback, and Value-Based Modifier programs. Therefore, for future regulatory action for Physician Compare, Physician Feedback, and Value-Based Modifier Programs, CMS may consider measures that were included in the 2011 and 2012 lists of Measures under Consideration; measures that have been finalized and remain current in the 2007 – 2013 Physician Fee Schedule Final Rules, 2002 – 2013 Inpatient Prospective Payment System Final Rules, and 2008 – 2013 Hospital Outpatient Prospective Payment System Final Rules. The unique measures developed for these specific programs, such as cost measures, that are not found in the Medicare PQRS program are also included on this list.

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3003	Ambulatory Surgical Center Quality Reporting	Complications within 30 Days following Cataract Surgery Requiring Additional Surgical Procedures	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of the specified list of surgical procedures in the 30 days following cataract surgery that would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power Intraocular Lens (IOL), 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	All patients aged 18 and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate	Patients with specific comorbid conditions impacting the surgical complication rate	Patient Safety	Complications	Outcome	TLE	0564	AMA-PCPI
2782	Ambulatory Surgical Center Quality Reporting	Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients.	Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	All patients aged 50 years or older receiving screening colonoscopy without biopsy or polypectomy.	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep)	Cancer	Colorectal	Process	TLE	0658	AMA-PCPI
2783	Ambulatory Surgical Center Quality Reporting	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use.	Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report.	Patients who had an interval of 3 or more years since their last colonoscopy.	All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy.	Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas) OR Documentation of a system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete).	Health Services Administration	Patient Care Management	Process	TLE	0659	AMA-PCPI
2781	Ambulatory Surgical Center Quality Reporting	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older who had cataract surgery function achieved within 90 days following the cataract surgery.	Patients 18 years and older in sample who had improvement in visual function achieved within 90 days following cataract surgery, based on completing a pre-operative and post-operative visual function instrument.	All patients aged 18 years and older in sample who had cataract surgery.	None	Eyes/Vision		Outcome	Endorsed	1536	American Academy of Ophthalmology and the Hoskins Center for

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												Quality Eye Care
2785	Ambulatory Surgical Center Quality Reporting	Intra-procedure colonoscopy complication rate: percentage of patients who developed one or more intra-procedure complications.	This measure assesses the percentage of patients who developed one or more intra-procedure colonoscopy complications.	Number of patients from the denominator who developed one or more intra-procedure complications.	Patients undergoing colonoscopy procedure (CPT codes 45378-45385) at the ambulatory health care organization.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	AHRQ
198	End Stage Renal Disease Quality Improvement Program	Influenza Vaccination in the ESRD Population	Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccination.	Number of patients from the denominator who 1. received the influenza vaccination as documented by the provider or reported receipt from another provider by the patient (computed and reported separately); 2. were assessed and offered an influenza vaccination but declined (computed and reported separately): or 3. were assessed and determined to have a medical contraindication of anaphylactic hypersensitivity to eggs or other components of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (within 6 months prior to encounters between October 1 and March 31) (computed and reported separately).	All ESRD patients aged 6 months and older receiving hemodialysis and/or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31.	None	Renal & Genitourinary	End-Stage Renal Disease	Process	Endorsed	0226	Kidney Care Quality Alliance

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2190	End Stage Renal Disease Quality Improvement Program	0251 Vascular Access—Functional AVF or AV Graft or Evaluation by Vascular Surgeon for Placement	Percentage of end stage renal disease (ESRD) patients aged 18 years and older receiving hemodialysis during the 12-month reporting period and on dialysis >90 days who: (1) have a functional autogenous AVF (defined as two needles used or a single-needle device [NOT one needle used in a two-needle device]) (computed and reported separately); (2) have a functional AV graft (computed and reported separately); or (3) have a catheter but have been seen/evaluated by a vascular surgeon, other surgeon qualified in the area of vascular access, or interventional nephrologist trained in the primary placement of vascular access for a functional autogenous AVF or AV graft at least once during the 12-month reporting period (computed and reported separately). Reporting should be stratified by incident versus prevalent patients, as defined by USRDS	Number of patients from the denominator who: (1) have a functional autogenous AVF (defined as two needles used or a single-needle device) (computed and reported separately); or (2) have a functional AV graft (computed and reported separately); or (3) have a catheter but have been seen/evaluated by a vascular surgeon, other surgeon qualified in the area of vascular access, or interventional nephrologist trained in the primary placement of vascular access for a functional autogenous AVF (defined as two needles used or a single needle device) or AV graft at least once during the 12-month reporting period (computed and reported separately). Reporting should be stratified by incident versus prevalent patients, as defined by USRDS.	All ESRD patients aged 18 years and older receiving hemodialysis during the 12-month reporting period and on dialysis for greater than 90 days. This measure includes both in-center and home hemodialysis patients.	Patients enrolled in hospice..	Renal & Genitourinary	End-Stage Renal Disease	Process	Endorsed	0251	Kidney Care Quality Alliance
2058	End Stage Renal Disease Quality Improvement Program	Measurement of Serum Phosphorus Concentration	Percentage of adult (>= 18 years old) HD and PD patients with serum phosphorus measured at least once within the month	Number of adult (>= 18 years of age) dialysis patients included in denominator with serum phosphorus measured at least once within month	All adult peritoneal dialysis and hemodialysis patients included in the sample for analysis. Exclusion: Transient dialysis patients (in unit < 30 days), pediatric patients and kidney transplant recipients with a functioning graft	Transient dialysis patients (in unit < 30 days), pediatric patients and kidney transplant recipients with a functioning graft	Renal & Genitourinary	End-Stage Renal Disease	Process	Endorsed	0255	CMS
674	End Stage Renal Disease Quality Improvement Program	The Consumer Assessment of Healthcare Providers and Systems (CAHPS) In-Center Hemodialysis Survey	The proportion of patients answering each of response options for each of the items summed across the items within a composite to yield the composite measure score.	Number of responses to each grouping of responses.	Number of responses to the item.	1. Deceased (In some cases, a household or family member may inform you of the death of the respondent). 2. Ineligible (Respondent has been a patient at the facility for less than three months, is not a patient at the facility, or is no longer receiving in-center hemodialysis (received a transplant or has switched to peritoneal dialysis).	Renal & Genitourinary	End-Stage Renal Disease	Patient Perspective	Endorsed	0258	AHRQ

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2059	End Stage Renal Disease Quality Improvement Program	Measurement of Serum Calcium Concentration - HD & PD Combined	Percentage of adult (>= 18 years old) HD and PD patients with serum calcium measured at least once within the month	Number of adult (>= 18 years of age) dialysis patients included in denominator with serum calcium measured at least once within month	All adult peritoneal dialysis and hemodialysis patients included in the sample for analysis. Adjustment: Transient dialysis patients (in unit < 30 days), pediatric patients and kidney transplant recipients with a functioning graft	None	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	0261	CMS
212	End Stage Renal Disease Quality Improvement Program	Dialysis Facility Risk-adjusted Standardized Mortality Ratio	Risk-adjusted standardized mortality ratio for dialysis facility patients.	Number of deaths among eligible patients at the facility during the 4-year time period.	Number of deaths that would be expected among eligible dialysis patients at the facility during the 4-year time period, given the mortality rate is at the national average and the patient mix at the facility.	Deaths from street drugs or accidents unrelated to treatment are excluded from the calculation (corresponding time at risk is not excluded).	Mortality		Outcome	Endorsed	0369	CMS
1344	End Stage Renal Disease Quality Improvement Program	Frequency of adequacy measurement for pediatric hemodialysis patients	Percentage of all pediatric (less than 18 years old) patients receiving in-center hemodialysis (HD) (irrespective of frequency of dialysis) with documented monthly adequacy measurements (spKt/V) or its components in the calendar month	Number of patients in the denominator with monthly adequacy measurements (spKt/V) or its components in the calendar month.	Number of pediatric patients (less than 18 years) receiving in-center hemodialysis (irrespective of frequency of dialysis)who are in the facility and on hemodialysis for the entire study period.	Patients on home dialysis, patients not in the facility for the entire calendar month.	Renal & Genitourinary	End-Stage Renal Disease	Process	Endorsed	1418	CMS
1352	End Stage Renal Disease Quality Improvement Program	Monthly hemoglobin measurement for pediatric patients	Percentage of all pediatric (less than 18 years old) hemodialysis and peritoneal dialysis patients who have monthly measures for hemoglobin	Number of pediatric (less than 18 years old) hemodialysis and peritoneal dialysis patients who have monthly measures for hemoglobin. The hemoglobin value reported for the end of each reporting month (end-of month hemoglobin) is used for the calculation.	All pediatric (less than 18 years old) hemodialysis and peritoneal dialysis patients.	Patients who are not in the facility for the entire calendar month.	Renal & Genitourinary	End-Stage Renal Disease	Process	Endorsed	1424	CMS
1347	End Stage Renal Disease Quality Improvement Program	Measurement of nPCR for pediatric hemodialysis patients	Percentage of pediatric (less than 18 years old) in-center HD patients (irrespective of frequency of dialysis) with documented monthly nPCR measurements	Number of patients in the denominator with monthly nPCR measurements.	Number of all pediatric (less than 18 years old) in-center hemodialysis patients (irrespective of frequency of dialysis).	Patients on home dialysis, patients not in the facility for the entire one-month study period.	Renal & Genitourinary	End-Stage Renal Disease	Process	TLE	1425	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1351	End Stage Renal Disease Quality Improvement Program	Use of iron therapy for pediatric patients	Percentage of all pediatric (less than 18 years old) hemodialysis and peritoneal dialysis patients with hemoglobin less than11.0 g/dL and in whom simultaneous values of serum ferritin concentration was less than100 ng/ml and transferrin saturation (TSAT) was less than20% who received IV iron or were prescribed oral iron within the following 3 months	Number of patients in the denominator who received IV iron or were prescribed oral iron within three months following the first occurrence of serum ferritin less than100 ng/mL and transferrin saturation (TSAT) less than20% during the study period.	All pediatric (less than 18 years old) in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients with hemoglobin less than 11 g/dL and in whom serum ferritin was less than 100 ng/mL and TSAT less than 20% during the three month study per	None	Renal & Genitourinary	End-Stage Renal Disease	Process	TLE	1433	CMS
796	End Stage Renal Disease Quality Improvement Program	Periodic Assessment of Post-Dialysis Weight by Nephrologists	Proportion of patients who have documentation of receiving a new post-dialysis weight prescription from a nephrologist in the reporting month.	Number of patients in denominator who have documentation of receiving a new post-dialysis weight prescription from a nephrologist in the reporting month, irrespective of whether or not a change in post dialysis weight prescription was made.	All adult and pediatric in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients.	None	Renal & Genitourinary	End-Stage Renal Disease	Process	TLE	1438	CMS
824	End Stage Renal Disease Quality Improvement Program	Proportion of patients with hypercalcemia	Proportion of patients with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL.	Number of patients in the denominator with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL	Number of adult (greater than or equal to 18 years old) in-center hemodialysis, home hemodialysis, or peritoneal dialysis patients under the care of the dialysis facility for at least 30 days who have been on dialysis for greater than 90 days with at least one calcium measurement during the prior 90 days.	None	Renal & Genitourinary	End-Stage Renal Disease	Outcome	Endorsed	1454	CMS
1392	End Stage Renal Disease Quality Improvement Program	National Healthcare Safety Network (NHSN) Bloodstream Infection Measure	Number of hemodialysis outpatients with positive blood cultures per 100 hemodialysis patient-months.	The number of new positive blood culture events based on blood cultures drawn as an outpatient or within 1 calendar day after a hospital admission. A positive blood culture is considered a new event and counted only if it occurred 21 days or more after a previous positive blood culture in the same patient.	Number of maintenance hemodialysis patients treated in the outpatient hemodialysis unit on the first 2 working days of the month.	Patients receiving inpatient hemodialysis are excluded	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	1460	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
822	End Stage Renal Disease Quality Improvement Program	Standardized Hospitalization Ratio for Admissions	Risk-adjusted standardized hospitalization ratio for admissions for dialysis facility patients.	Number of inpatient hospital admissions among eligible patients at the facility during the reporting period.	Number of hospital admissions that would be expected among eligible patients at the facility during the reporting period, given the patient mix at the facility.	None	Renal & Genitourinary	End-Stage Renal Disease	Outcome	Endorsed	1463	CMS
3010	End Stage Renal Disease Quality Improvement Program	Pneumococcal Vaccination	Inpatients 65 years and older and 6-64 years of age who have a high risk condition who are screened for 23-valent Pneumococcal Polysaccharide Vaccine (PPV23) status and vaccinated prior to discharge if indicated.	Inpatient discharges who were screened for PPV23 status and received PPV23 prior to discharge if indicated.	Inpatient discharges 65 years of age and older and 6-64 years of age who have a high risk condition.	Excluded patients consist of the following; Patients who expire prior to the hospital discharge, patients with an organ transplant during the current hospitalization and pregnant women.	Immunizations	Adult Immunization	Process	Endorsed	1653	CMS
2132	End Stage Renal Disease Quality Improvement Program	30 Day Readmission Measure	Ratio of the number of index hospital discharges that resulted in a readmission within 30 days of discharge for Medicare-covered dialysis patients treated at a particular dialysis facility to the number of readmissions that would be expected given the discharging hospitals and the characteristics of the patients.	Each facility's observed number of index hospital discharges for which the next admission is an unplanned readmission that occurs within 30 days of discharge. Index hospital events are counted as events in the numerator if the next hospital admission occurs within 30 days and is an unplanned readmission. A readmission is considered planned if the patient undergoes a procedure that is always considered planned (bone marrow transplant) or has a primary diagnosis that always indicates the hospitalization is planned (maintenance chemotherapy), or, in some cases, if patient undergoes a procedure that is not accompanied by an acute diagnosis.	The expected number of readmissions in each facility, which is derived from a model that accounts for patient characteristics and discharging hospital.	Index hospital discharges are all hospital discharges except those that: Are not live discharges Are followed by a patient dying within 30 days of discharge with no readmission Are against medical advice Include a primary diagnosis for cancer, mental health, or rehabilitation Occur after a patient's 6th readmission in the calendar year Are from a PPS-exempt cancer hospital Result in a transfer to another hospital on the same day	Readmission		Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2769	End Stage Renal Disease Quality Improvement Program	Risk-adjusted facility level transfusion rate "STrR"	Risk adjusted facility level transfusion rate "STrR" for dialysis patients. It is a ratio of observed number of red blood cell transfusion events for each facility over the measurement period to expected number based on national experience and adjusted for patient mix.	Number of observed red blood cell transfusion events (defined as transfer of one or more units of blood or blood products into the recipient's blood stream) among eligible patients at the facility during the reporting period.	Number of red blood cell transfusion events (as defined in the numerator statement) that would be expected among eligible patients at a facility during the reporting period, given the patient mix at the facility. Starting with day 91 after onset of ESRD, patients to facilities are attributed according to the following rules. A patient is attributed to a facility once the patient has been treated there for 60 days. When a patient transfers from one facility to another, the patient continues to be attributed to the original facility for 60 days and then is attributed to the destination facility.	Any transfusions associated with transplant hospitalization are excluded. Also, patients in the target population with the following conditions will be excluded: • Hemoglobinopathy• Myelodysplasia • Myeloma• Active malignancy• Sickle cell	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	CMS
2771	End Stage Renal Disease Quality Improvement Program	Achieved Hgb level to avoid adverse outcomes	Percentage of adult (>= 18 years old) HD and PD patients whose ESA dose is unchanged or increased when the hemoglobin value reaches or exceeds 11.0 g/dl. This measure is consistent with 2011 FDA package insert for ESA use in dialysis dependent CKD.	Patient-months in the denominator in which the patient's reported hemoglobin was greater than or equal to 11 g/dL and ESA dose per session was greater than zero and unchanged or increased relative to the prior month.	Total number of patient-months for patients treated at a dialysis facility. (Adult patients 18 years or older on HD or PD treated at the facility for 6 or more dialysis sessions during the current month and prior month.)	Receiving dialysis < 90 days as of the previous months claim, or received more than one type of ESA or dialysis modality during both the reporting month and the previous month	Renal & Genitourinary	End-Stage Renal Disease	Intermediate Outcome	Not Endorsed	N/A	CMS
2772	End Stage Renal Disease Quality Improvement Program	Anemia management process measure	Percent of adult (>= 18 years old) HD and PD patient months at a facility during the year for which a patient had a low achieved hemoglobin (<10 g/dL or missing), a low ESA dose (<75 units/kg/session of epoetin alpha, <0.2 mcg/kg/session of darbepoetin alpha, or missing), and was followed in the subsequent month by a red blood cell (RBC) transfusion.	Patient-months in the denominator in which the patient's reported hemoglobin was less than 10 g/dL and ESA dose per session per kg was less than 75 units of Epoetin alfa or less than 25 mcg of Darbepoetin alfa, and there was at least one red blood cell transfusion event in the subsequent month.	Total number of patient-months for patients treated at a dialysis facility. (Adult patients 18 years or older on HD or PD treated at the facility for more than 6 sessions during the month.)	Receiving dialysis < 90 days, had < 6 sessions reported during the month, or received more than one type of ESA or dialysis modality during both the reporting month and the subsequent month. Excludes patients with hemoglobinopathy, myelodysplasia, myeloma, active malignancy, and sickle cell.	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2774	End Stage Renal Disease Quality Improvement Program	Blood Transfusion Appropriateness	Percentage of eligible patients for whom the facility has evaluated risks, benefits, and alternative treatment options for anemia and the patient participated in a decision regarding anemia treatment strategy.	Number of patients with attestation by the treating dialysis facility that risks, potential benefits, and alternative treatment options for anemia were evaluated and patient participated in decision regarding anemia treatment strategy.	All patients treated in the dialysis facility in the calendar year who have received ESA treatment.	None	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	CMS
2775	End Stage Renal Disease Quality Improvement Program	Phosphorus Concentrations	This measures report the percentage of adult hemodialysis and peritoneal dialysis patient-months in the following ranges of serum phosphorus: o <3.5 mg/dL o 3.5-4.5 mg/dL o 4.6-5.5 mg/dL o 5.6-7.0 mg/dL o >7.0 mg/dL (The normal range for serum phosphorus is 2.5 – 4.1 mg/dL)	Number of patient-months from the denominator during which the patient's serum phosphorus fell in the range specified (i.e., there are 5 numerators, which together add up to the denominator)	Number of patient-months for all dialysis patients 18 years and older who have been in the facility for the entire month and who have been on dialysis for at least 90 days and who have a serum phosphorus value.	1) Any month during which the patient was younger than 18 years as of the first day of the month; 2) any month that the patient was not in the facility for the entirety of the month; 3) any month that the patient had not been on dialysis for at least 90 days as of the first day of the month	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	CMS
2766	Home Health Quality Reporting	Rehospitalization during first 30 days of Home Health	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay.	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 30 days following the start of the home health stay.	Number of home health stays for patients who had an acute inpatient hospitalization in the five days prior to the start of the home health stay that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.	General denominator exclusions: 1) Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 30 days following the start of the home health stay or until death. 2) Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. 3) Home health stays in which the patient receives service from multiple agencies during the first 30 days. 4) Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the home health stay. Prior hospitalizations that are excluded from being index hospitalizations: 1) Admissions for the treatment of cancer. 2) Admissions for the treatment of psychiatric diseases. 3) Admissions for rehabilitation care and the fitting of prostheses and adjustment devices. 4) Admission ending in the patient being discharged against medical advice.	Readmission		Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3047	Home Health Quality Reporting	Home Health Emergency Department Use without Readmission	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of the home health stay.	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 30 days following the start of the home health stay. The 30 day time window is calculated by adding 30 days to the "from" date in the first home health claim in the series of home health claims that comprise the home health stay. If the patient has any Medicare outpatient claims with any ER revenue center codes (0450-0459, 0981) during the 60 day window AND if the patient has no Medicare inpatient claims for admission to an acute care hospital (identified by the CMS Certification Number on the IP claim ending in 0001-0879, 0800-0899, or 1300-1399) during the 30 day window, then the stay is included in the measure numerator.	Number of home health stays for patients who had an acute inpatient hospitalization in the five days prior to the start of the home health stay and no additional care between inpatient discharge and the start of home health care. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.	General denominator exclusions: 1) Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 30 days following the start of the home health stay or until death. 2) Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. 3) Home health stays in which the patient receives service from multiple agencies during the first 30 days. 4) Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the home health stay. Prior hospitalizations that are excluded from being index hospitalizations: 1) Admissions for the treatment of cancer. 2) Admissions for the treatment of psychiatric diseases. 3) Admissions for rehabilitation care and the fitting of prostheses and adjustment devices. 4) Admission ending in the patient being discharged against medical advice.	Readmission		Outcome	Not Endorsed	N/A	CMS
2076	Hospice Quality Reporting	Family Evaluation of Hospice Care (FEHC)	Composite Score: Derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 to 100. Global Score: Percentage of best possible response (Excellent) to the overall rating question on the FEHC survey. Target Population: The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. Timeframe: The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service.	Composite Score: Numerator is the hospice´s composite score, which is the weighted incidence of problem scores derived from responses from 17 items on the FEHC survey. The 17 questions focus on the following aspects of hospice care: symptom management, communication, provision of information, emotional support, and care coordination. Global Score: Numerator is the number of best possible responses (excellent) to the overall rating question on the FEHC survey.	Composite Score: 100 (100 is the best possible composite score which indicates 0% incidence of problem scores). Global Score: Total number of responses to the overall rating of care quality on the FEHC survey, question G1.	Composite Score: If a survey respondent did not enter a response to more than 14 of the 17 FEHC survey questions included in calculation of the composite score then a composite score will not be calculated for that survey and the survey will not be included in the calculation of a composite score for the hospice. Global Score: If survey respondent has not entered a response to overall rating question (G1), the question is not included in the denominator	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0208	National Hospice and Palliative Care Organization

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
778	Hospice Quality Reporting	Patients Treated with an Opioid who are Given a Bowel Regimen	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed	Vulnerable adults who are given a new prescription for an opioid	None	Chronic and Elder Care	Palliative Care	Process	Endorsed	1617	RAND
761	Hospice Quality Reporting	Hospice and Palliative Care -- Pain Screening	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.	Patients who are screened for the presence or absence of pain and its severity, if present, during the admission evaluation for hospice / initial encounter for palliative care.	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1634	University of North Carolina (UNC)
757	Hospice Quality Reporting	Hospice and Palliative Care -- Pain Assessment	Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.	Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.	Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.	Patients with length of stay < 1 day in palliative care or < 7 days in hospice, patients who were not screened for pain.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1637	University of North Carolina (UNC)
750	Hospice Quality Reporting	Hospice and Palliative Care -- Dyspnea Treatment	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Patients enrolled in hospice for 7 or more days OR patients receiving palliative care who report dyspnea when dyspnea screening is done on the admission evaluation / initial encounter.	Palliative care patients with length of stay < 1 day or hospice patients with length of stay < 7 days, patients who were not screened for dyspnea, and/or patients with a negative screening.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1638	University of North Carolina (UNC)
751	Hospice Quality Reporting	Hospice and Palliative Care -- Dyspnea Screening	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1639	University of North Carolina (UNC)
765	Hospice Quality Reporting	Hospice and Palliative Care – Treatment Preferences	Percentage of patients with chart documentation of preferences for treatments.	Patients whose medical record includes documentation of treatment preferences	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.	Patients with length of stay < 1 day in palliative care or < 7 days in hospice	Chronic and Elder Care	Palliative Care	Process	Endorsed	1641	University of North Carolina (UNC)
479	Hospital Acquired Condition Payment Reduction (ACA 3008)	Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	All documented patient falls with an injury level of minor (2) or greater.	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim), with a POA code of 'N' or 'U', and designated as a 2010 Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC): • Fracture 800–	Number of acute inpatient FFS discharges during time period.	• Non-FFS discharges (MCOPDSW=--1--) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.	Patient Safety	Complications	Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				829 (CC/MCC) • Dislocation ..... 830–839 (CC/MCC) • Intracranial injury ..... 850–854 (CC/MCC) • Crushing injury ..... 925–929 (CC/MCC) • Burn .....940–949 (CC/MCC) • Other injuries .....991–994 (CC/MCC)							
504	Hospital Acquired Condition Payment Reduction (ACA 3008)	Blood Incompatibility	Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible flood or blood products.	Numerator: Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': 999.6	Number of acute inpatient FFS discharges during time period.	• Non-FFS discharges (MCOPDSW=-1-) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of -X-) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.	Patient Safety	Complications	Outcome	Not Endorsed	N/A	CMS
506	Hospital Acquired Condition Payment Reduction (ACA 3008)	Air Embolism	Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 999.1	Number of acute inpatient FFS discharges during time period.	Hospital Inclusion/Exclusions: CMS is calculating and publicly reporting HAC Measures for hospitals that are paid under the IPPS only because these measures rely on Present on Admission (POA) coding, which is only required of IPPS hospitals. Non-IPPS hospitals are excluded from the measure calculation	Patient Safety	Complications	Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
508	Hospital Acquired Condition Payment Reduction (ACA 3008)	Pressure Ulcer Stages III & IV	None listed. See numerator and denominator description	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 707.23 • 707.24	Number of acute inpatient FFS discharges during time period.	-The following exclusions were applied: • Non-FFS discharges (MCOPDSW=--1--) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.-	Chronic and Elder Care	Pressure Ulcer	Outcome	Not Endorsed	N/A	CMS
1369	Hospital Acquired Condition Payment Reduction (ACA 3008)	Vascular Catheter-Associated Infections	None listed. See numerator and denominator description	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 999.31, 999.32, 999.33	Number of acute inpatient FFS discharges during time period.	• Non-FFS discharges (MCOPDSW=--1--) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.-	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CMS
507	Hospital Acquired Condition Payment Reduction (ACA 3008)	Foreign Object Retained After Surgery	None listed. See numerator and denominator description	Number of occurrences of the following diagnosis codes coded as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 998.4 • 998.7	Number of acute inpatient FFS discharges during time period.	• Non-FFS discharges (MCOPDSW=--1--) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.-	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1371	Hospital Acquired Condition Payment Reduction (ACA 3008)	Manifestations of Poor Glycemic Control	None listed. See numerator and denominator description	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 249.10–249.11 • 249.20–249.21 • 250.10–250.13 • 250.20–250.23 • 251.0	Number of acute inpatient FFS discharges during time period.	-• Non-FFS discharges (MCOPDSW=--1--) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.-	Patient Safety	Complications	Intermediate Outcome	Not Endorsed	N/A	CMS
1642	Hospital Acquired Condition Payment Reduction (ACA 3008)	Catheter-Associated Urinary Tract Infections (UTI)	None listed. See numerator and denominator description	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 996.64	Number of acute inpatient FFS discharges during time period.	• Non-FFS discharges (MCOPDSW=-1-) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of -X-) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CMS
1370	Hospital Acquired Condition Payment Reduction (ACA 3008)	Catheter Associated Urinary Tract Infection (CAUTI)	Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries]) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations (excluding Level I and Level II nurseries). Data from these locations are reported	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries)	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3."In and out" catheterizations	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	0138	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.									
566	Hospital Acquired Condition Payment Reduction (ACA 3008)	Central Line-Associated Blood Stream Infection (CLABSI)	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.	Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.	1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	0139	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1368	Hospital Acquired Condition Payment Reduction (ACA 3008)	PSI 04 Death Among Surgical Patients with Serious, Treatable Complications	This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization	All discharges with a disposition of "deceased" (DISP=20) among cases meeting the inclusion and exclusion rules for the denominator.	All surgical discharges age 18 years and older or MDC 14 (pregnancy, childbirth, and puerperium) defined by specific DRGs or MS-DRGs and an ICD-9-CM code for an operating room procedure, principal procedure within 2 days of admission OR admission type of elective (ATYPE=3) with potential complications of care listed in Death among Surgical definition (e.g., pneumonia, DVT/PE, sepsis, shock/cardiac arrest, or GI hemorrhage/acute ulcer).	Exclude cases: • age 90 years and older • transferred to an acute care facility (DISP = 2) • with missing discharge disposition (DISP=missing), gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing) or principal diagnosis (DX1=missing)	Mortality		Outcome	De-endorsed	0351	AHRQ
37	Hospital Acquired Condition Payment Reduction (ACA 3008)	PSI 15 Accidental puncture or laceration	This measure is used to assess the number of cases of technical difficulty (e.g., accidental cut, puncture, perforation, or laceration during procedure) per 1,000 discharges	Discharges among cases meeting the inclusion and exclusion rules for the denominator with ICD-9-CM code denoting accidental cut, puncture, perforation, or laceration during a procedure in any secondary diagnosis field.	All surgical and medical discharges age 18 years and older defined by specific DRGs or MS-DRGs.	Exclude cases: -with principal diagnosis denoting accidental cut, puncture, perforation, or laceration or secondary diagnosis present on admission -MDC 14 (pregnancy, childbirth, and puerperium) -with ICD-9-CM code for spine surgery -with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing) or principal diagnosis (DX1=missing)	Patient Safety	Complications	Outcome	Endorsed	0345	AHRQ
3032	Hospital Acquired Condition Payment Reduction (ACA 3008)	PSI 05 Foreign Body Left During Procedure	Count of discharges with foreign body left in during procedure in medical and surgical discharges among patients 18 years and older or MDC 14 (pregnancy, childbirth, and puerperium)	Discharges, 18 years and older or MDC 14 (pregnancy, childbirth, and puerperium), with ICD-9-CM codes for foreign body left in during procedure in any secondary diagnosis field of medical and surgical discharges defined by specific DRGs or MS-DRGs.	Not applicable	Not applicable	Patient Safety	Complications	Outcome	Endorsed	0363	AHRQ

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
499	Hospital Acquired Condition Payment Reduction (ACA 3008)	VTE-6: Incidence of Potentially-Preventable VTE	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date.	Patients who developed confirmed VTE during hospitalization.	Patients less than 18 years of age; Patients who have a length of stay greater than 120 days; Patients with Comfort Measures Only documented; Patients enrolled in clinical trials; Patients with ICD-9-CM Principal Diagnosis Code of VTE as defined in Appendix A, Table 7.03 or 7.04; Patients with VTE Present at Admission; Patients with reasons for not administering mechanical and pharmacologic prophylaxis; Patients without VTE confirmed by diagnostic testing	Cardiovascular	Venous Thromboembolism	Outcome	Endorsed	0376	CMS (The Joint Commission)
464	Hospital Acquired Condition Payment Reduction (ACA 3008)	PSI 12: Post Operative PE or DVT	This measure is used to assess the number of cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges with an operating room procedure	Discharges among cases meeting the inclusion and exclusion rules for the denominator with ICD-9-CM codes for deep vein thrombosis or pulmonary embolism in any secondary diagnosis field.	All surgical discharges age 18 and older defined by specific DRGs or MS-DRGs and an ICD-9-CM code for an operating room procedure.	Exclude cases: -with principal diagnosis of deep vein thrombosis or pulmonary embolism or secondary diagnosis present on admission -where a procedure for interruption of vena cava is the only operating room procedure -where a procedure for interruption of vena cava occurs before or on the same day as the first operating room procedure Note: If day of procedure is not available in the input data file, the rate may be slightly lower than if the information was available. -MDC 14 (pregnancy, childbirth, and puerperium) -with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing) or principal diagnosis (DX1=missing)	Patient Safety	Complications	Outcome	Endorsed	0450	AHRQ
38	Hospital Acquired Condition Payment Reduction (ACA 3008)	PSI 90 Complication/patient safety for selected indicators (Composite)	The composite measure is the weighted average of the scaled and reliability-adjusted ratios for the component indicators.	The composite measure is the weighted average of the component indicators using the selected weights and the scaled and reliability-adjusted indicators. Composite = [indicator1 RAR × weight1] + [indicator2 RAR × weight2] + . . . +	See numerator	None listed	Patient Safety	Complications	Outcome	Endorsed	0531	AHRQ

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				[indicatorN RAR × weightN] The confidence interval of the composite is based on the standard error of the composite, which is the square root of the variance. The variance is computed based on the signal variance covariance matrix and the reliability weights. The reliability-adjusted ratio (RAR) is computed as the weighted average of the risk-adjusted ratio and the reference population ratio, where the weights vary from 0 to 1, depending on the degree of reliability for the indicator and provider (or other unit of analysis). RAR = [risk-adjusted ratio × weight] + [reference population ratio × (1 – weight)]								
2703	Hospital Acquired Condition Payment Reduction (ACA 3008)	Specific Surgical Site Infection (SSI)	Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the	Deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients = 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies. SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). Case accrual will be guided by sampling algorithms as described below.	Using multivariable logistic regression models for colon surgeries and abdominal hysterectomies, the expected number of SSIs is obtained. These expected numbers are summed by facility and surgical procedure and used as the denominator of this measure	Persons under the age of 18, those having a procedure performed on an outpatient basis, those with ASA Class VI (6) are excluded. In the NHSN, patients without primary closure of the surgical incision are not considered eligible cases and are excluded- the NSQIP will match this practice for this measure, although this is not standard practice within the NSQIP.	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	0753	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			measure yields separate SIRs for each procedure.									
2755	Hospital Acquired Condition Payment Reduction (ACA 3008)	HAC-8 - Composite measure of seven hospital-acquired conditions	This composite aggregates the Z scores of 7 hospital-acquired measure rates into 3 equally weighted domains, as follows: Never Events Foreign Object Retained after Surgery Air Embolism Blood Incompatibility Accidents/Injuries Pressure Ulcer Falls and Trauma Poor Glycemic Control Infections Vascular Catheter-Associated Infection	Z scores are calculated from 7 individual HAC measure rates. Numerators for each of these 7 measures are defined as the number of Medicare inpatient FFS occurrences of the following diagnosis codes, appearing as a secondary diagnosis (in positions 2-9) and having a POA code of 'N' or 'U': Foreign object retained: 998.4 or 998.7 Air embolism: 999.1 Blood incompatibility: 999.60, 999.61, 999.62, 999.63, or 999.69 Stage III or IV pressure ulcer: 707.23 or 707.24 Falls/trauma: (Designated as complication or comorbidity) 800-829, 830-839, 850-854, 925-929, 940-949, 991-994 Vascular catheter-associated infection: 999.31 Poor glycemic control: 249.10-249.11, 249.20-249.21, 250.10-250.13, 250.20-250.23, or 251.10	Z scores are calculated from 7 individual HAC measure rates. For each component measure in the composite, the denominator is equal to the number of Medicare inpatient FFS discharges during the time period.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2756	Hospital Acquired Condition Payment Reduction (ACA 3008)	HAC-10 - Composite measure of nine hospital-acquired conditions	This composite aggregates the Z scores of 9 hospital-acquired measure rates into 3 equally weighted domains, as follows: Never Events Foreign Object Retained after Surgery Air Embolism Blood Incompatibility Accidents/Injuries Pressure Ulcer Falls and Trauma Poor Glycemic Control Deep Vein Thrombosis/Pulmonary Embolism Infections Vascular Catheter-Associated Infection Surgical Site Infection following: -CABG -Orthopedic Procedures -Bariatric Surgery	Z scores are calculated from 9 individual HAC measure rates. Numerators for each of the 9 measures are defined as the number of Medicare inpatient FFS occurrences of the following diagnosis codes, appearing as a secondary diagnosis (in positions 2-9) and having a POA code of 'N' or 'U': Foreign object retained: 998.4 or 998.7 Air embolism: 999.1 Blood incompatibility: 999.60, 999.61, 999.62, 999.63, or 999.69 Stage III or IV pressure ulcer: 707.23 or 707.24 Falls/trauma: (Designated as complication or comorbidity) 800-829, 830-839, 850-854, 925-929, 940-949, 991-994 Vascular catheter-associated infection: 999.31 Poor glycemic control: 249.10-249.11, 249.20-249.21, 250.10-250.13, 250.20-250.23, or 251.10 Surgical site infection: CABG-519.2; Ortho-996.7 or 998.59, or Bari-539.01, 539.81, or 998.59 Deep vein thrombosis/Pul embolism: 415.11 (MCC), 415.13 (MCC), 415.19 (MCC), or 453.40-453.42 (CC)	Z scores are calculated from 9 individual HAC measure rates. For the following 7 component measures, the denominator is equal to the number of Medicare inpatient FFS discharges during the time period: foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcer, vascular catheter-associated infection, falls and trauma, and poor glycemic control. For surgical site infection, the denominator is equal to the number of Medicare FFS discharges with the following procedure and diagnosis codes: CABG - Proc codes 36.10-39.19 Ortho - Proc codes 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85 Bari - Proc codes 44.38-44.39, or 44.95 AND diag code 278.01 For deep vein thrombosis and pulmonary embolism, the denominator is equal to the number of Medicare FFS discharges with the following procedure and diagnosis codes: 00.85-00.87, 81.51-81.52, or 81.54	For the surgical site infection component of the composite, Medicare FFS discharges without the following procedure and diagnosis codes are excluded: CABG - Proc codes 36.10-39.19 Ortho - Proc codes 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85 Bari - Proc codes 44.38-44.39, or 44.95 AND diag code 278.01 For the deep vein thrombosis and pulmonary embolism component of the composite, Medicare FFS discharges without the following procedure and diagnosis codes rae excluded: 00.85-00.87, 81.51-81.52, or 81.54	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
474	Hospital Acquired Condition Payment Reduction (ACA 3008)	Clostridium Difficile SIR Measure	Incidence rate of hospital-onset c. difficile. Report all healthcare-associated infections where C. difficile identified a positive toxin result are the associated pathogen. Refer to specific definitions (Chapter 17) for gastroenteritis (GI-GE) or gastrointestinal tract (GI-GIT) infections criteria. Cases of CDI (i.e., C. difficile pathogen identified with a positive toxin result) that are not present or incubating at the time of admission (i.e., meets criteria for a healthcare-associated infection) should be reported as gastroenteritis (GI-GE) or gastrointestinal tract (GI-GIT) infections, whichever is appropriate. Report the pathogen as C. difficile on the MDRO or CDI Infection Event form (CDC 57.126). If the patient develops both GI-GE and GI-GIT CDI, report only GI-GIT using the date of onset as that of GI-GE CDI. (This CDI HAI reporting corresponds to surveillance for healthcare-onset, healthcare facility-associated CDI in recently published recommendations3, which is considered the minimum surveillance for CDI.)	The total number of HAI CDI cases identified during the surveillance month.	The total number of patient days and admissions during the surveillance month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Candidate Standard	1717	CDC
582	Hospital Acquired Condition Payment Reduction (ACA 3008)	Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia	Incidence Rate of Hospital-Onset MRSA Based on Clinical Cultures	Report first clinical MRSA culture and all unique MRSA blood cultures (laboratory-identified events) per patient per month; no bedside assessment is needed nor complete antibiogram reported.	Report total facility-wide patient-days and admissions/encounters per month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Candidate Standard	1716	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3035	Hospital Acquired Condition Payment Reduction (ACA 3008)	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.	Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.	1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC
3036	Hospital Acquired Condition Payment Reduction (ACA 3008)	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries)	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3."In and out" catheterizations	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.									
3038	Hospital Acquired Condition Payment Reduction (ACA 3008)	Reliability Adjusted Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Report first clinical MRSA culture and all unique MRSA blood cultures (laboratory-identified events) per patient per month; no bedside assessment is needed nor complete antibiogram reported.	Report total facility-wide patient-days and admissions/encounters per month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3039	Hospital Acquired Condition Payment Reduction (ACA 3008)	Reliability Adjusted Clostridium Difficile SIR Measure	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	The total number of HAI CDI cases identified during the surveillance month.	The total number of patient days and admissions during the surveillance month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC
28	Hospital Inpatient Quality Reporting	READM-30-HF Hospital thirty-day all-cause risk standardized readmission rate (RSRR) following heart failure (HF) hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30 day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of HF.	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions within 30 days from the date of discharge from the index HF admission. If a patient has more than one admission (for any reason) within 30 days of the date of discharge of the index admission, only one was counted as a readmission.	The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from non-federal acute care hospitals or VA hospitals with a principal discharge diagnosis of HF.	Cohort exclusions (excluded admissions): - Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission. - Admissions for patients without at least 30 days post-discharge enrollment in FFS Medicare are excluded because the 30-day readmission outcome cannot be assessed in this group. This exclusion applies only to patients who have index admissions in non-VA hospitals. - Admissions for patients having a principal diagnosis of HF during the index hospitalization and subsequently transferred to another acute care facility are excluded because we are focusing on discharges to non-acute care settings.	Readmission		Outcome	Endorsed	0330	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						- Admissions for patients who are discharged against medical advice (AMA) are excluded because providers did not have the opportunity to deliver full care and prepare the patient for discharge.						
2307	Hospital Inpatient Quality Reporting	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver.	Documentation exists that the Home Management Plan of Care (HMPC) as a separate document, specific to the patient, was given to the patient/caregiver, prior to or upon discharge.	Pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care Elements(HMPC) document that addresses all of the following: Appointment for follow-up care; Environmental control and control of other triggers; Method and timing of rescue actions; Use of controllers; and Use of relievers.	Pediatric asthma inpatients discharged home, ICD-9-CM Principal Diagnosis Code of asthma (refer to Appendix A, Table 6.1). Pediatric asthma inpatient discharges age 2 through 17 years. Pediatric asthma inpatients discharged to home.	TBD	Health Services Administration	Patient Education	Process	De-endorsed	0338	The Joint Commission
2174	Hospital Inpatient Quality Reporting	Exclusive Breast Milk Feeding	Exclusive Breastfeeding (BF) for the first 6 months of neonatal life has long been the expressed goal of WHO, DHHS, APA, and ACOG. ACOG has recently reiterated its position (ACOG 2007). A recent Cochrane review substantiates the benefits (Kramer, 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Shealy, 2005; Taveras, 2004; Petrova, 2007; CDC-MMWR, 2007). Exclusive Breastfeeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. HP2010 and the CDC have also been active in promoting this measure. Holding prenatal and	Newborns that were fed breast milk only since birth	Single term liveborn newborns discharged from the hospital with ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for single liveborn newborn as defined in Appendix A, Table 11.20.1available at: http://manual.jointcommission.org.	TBD	Population Characteristics	Maternal & Child Health	Process	Endorsed	0480	The Joint Commission

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			intrapartum providers accountable is an important way to incent greater efforts during the critical prenatal and immediate postpartum periods where BF attitudes are solidified.									
845	Hospital Inpatient Quality Reporting	Severe Sepsis and Septic Shock: Management Bundle	This measure will focus on patients aged 18 years and older who present with symptoms of severe sepsis or septic shock. These patients will be eligible for the 3 hour (severe sepsis) and/or 6 hour (septic shock) early management bundle.	Number of patients who meet criteria for severe sepsis and septic shock and sucessfully receive the following early management bundle as indicated. WITHIN THREE HOURS OF SEVERE SEPSIS: 1) Measure lactate level 2) Obtain blood cultures prior to antibiotics 3) Administer broad spectrum antibiotics 4) Administer 30ml/kg crystalloid for hypotension or lactate >=4mmol/L WITHIN 6 HOURS OF INITIAL SYMPTOMS FOR SEPTIC SHOCK: 5) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure >=65mmHg) 6) In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate >=4 mmol/L (36 mg/dl):	Number of patients diagnosed or presenting with the symptoms of severe sepsis or septic shock.	Patients with advanced directives for comfort care or clinical conditions that preclude total measure completion should be excluded. Examples include but are not limited to mortality within the numerator time window (3 hrs for severe sepsis or 6 hrs for septic shock), patients who do not have the clinical evidence of an infection (severe sepsis or septic shock), patients for whom a central line is contraindicated, patients with coagulopathy, patients for whom central line placement was attempted but could not be inserted, or other medical, patient, or system reasons for exclusion.	Patient Safety		Composite	Endorsed	0500	Henry Ford Hospital

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				- Measure central venous pressure (CVP) - Measure central venous oxygen saturation (ScvO2) 7)Remeasure lactate								
29	Hospital Inpatient Quality Reporting	READM-30-AMI Hospital, thirty-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of AMI.	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from the index AMI admission. If a patient has more than one admission (for any reason) within 30 days of the date of discharge of the index admission, only one was counted as a readmission.	The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from non-federal acute care hospitals or VA hospitals with a principal discharge diagnosis of AMI.	Cohort exclusions (excluded admissions): Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission. Admissions for patients without at least 30 days post-discharge enrollment in FFS Medicare are excluded because the 30-day readmission outcome cannot be assessed in this group. This exclusion applies only to patients who have index admissions in non-VA hospitals. Admissions for patients having a principal diagnosis of AMI during the index hospitalization and subsequently transferred to another acute care facility are excluded because we are focusing on discharges to non-acute care settings. Admissions are excluded for patients who are discharged alive on the same day that they are admitted because these patients are unlikely to have had an AMI. Admissions for patients who are discharged against medical advice (AMA) are excluded because providers did not have the opportunity to deliver full care and prepare the patient for discharge.	Readmission		Outcome	Endorsed	0505	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
30	Hospital Inpatient Quality Reporting	READM: PNEUM: Hospital thirty-day all-cause risk-standardized readmission rate (RSRR) following pneumonia hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30 day readmission for patients discharged from the hospital with a principal discharge diagnosis of pneumonia (PN).	The outcome for this measure is 30 day all-cause readmission. We define all-cause readmission as an inpatient admission for any cause, with the exception of planned readmissions, within 30 days from the date of discharge from the index pneumonia admission. If a patient has one or more admissions (for any reason) within 30 days of the date of discharge of the index admission, only one was counted as a readmission.	The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from non-federal acute care hospitals or VA hospitals with a principal discharge diagnosis of pneumonia.	Cohort exclusions (excluded admissions): - Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission. - Admissions for patients without at least 30 days post-discharge enrollment in FFS Medicare are excluded because the 30-day readmission outcome cannot be assessed in this group. This exclusion applies only to patients who have index admissions in non-VA hospitals. - Admissions for patients having a principal diagnosis of pneumonia during the index hospitalization and subsequently transferred to another acute care facility are excluded because we are focusing on discharges to non-acute care settings. - Admissions for patients who are discharged against medical advice (AMA) are excluded because providers did not have the opportunity to deliver full care and prepare the patient for discharge.	Readmission		Outcome	Endorsed	0506	CMS
2179	Hospital Inpatient Quality Reporting	Healthy Term Newborn	Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.	The absence of conditions or procedures reflecting morbidity that happened during birth and nursery care to an otherwise normal infant.	The denominator is composed of singleton, term (>=37 weeks), inborn, live births in their birth admission. The denominator further has eliminated fetal conditions likely to be present before labor. Maternal and obstetrical conditions (e.g. hypertension, prior cesarean, malpresentation) are not excluded unless evidence of fetal effect prior to labor (e.g. IUGR/SGA).	TBD	Population Characteristics	Maternal & Child Health	Outcome	Endorsed	0716	California Maternal Quality Care Collaborative
2305	Hospital Inpatient Quality Reporting	EHDI-1a—Hearing screening prior to hospital discharge.	This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.	All live births during the measurement time period born at a facility and screened for hearing loss prior to discharge, or screened but still not discharged; Or not being screened due to medical reasons or medical exclusions.	All live births during the measurement time period born at a facility and, discharged without being screened, or screened prior to discharge, or screened but still not discharged.	TBD	Population Characteristics	Maternal & Child Health	Process	Endorsed	1354	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
521	Hospital Inpatient Quality Reporting	30-day Risk Standardized Readmission following Total Hip/Total Knee Arthroplasty	Hospital-specific, risk-standardized, all-cause, 30-day readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define the readmission outcome.	The target population for this measure includes admissions for patients at least 65 years of age undergoing primary THA and/or TKA procedures.	1. Patients with hip fractures 2. Patients undergoing revision procedures (with or without a concurrent THA/TKA) 3. Patients undergoing partial hip arthroplasty procedures (with or without a concurrent THA/TKA) 4. Patients undergoing resurfacing procedures (with or without a concurrent THA/TKA) 5. Patients without at least 30-days post-discharge enrolment in Medicare 6. Patients who are transferred in to the index hospital 7. Patients who were admitted for the index procedure and subsequently transferred to another acute care facility 8. Patients who leave against medical advice (AMA) 9. Patients with more than two THA/TKA procedures codes during the index hospitalization 10. Patients who die during the index admission Additional otherwise qualifying THA and/or TKA admissions that occurred within 30 days of discharge date of an earlier index admission are not considered as index admission. They are considered as potential readmissions. Any THA and/or TKA admission is either an index admission or a potential readmission, but not both.	Readmission		Outcome	Endorsed	1551	CMS
1639	Hospital Inpatient Quality Reporting	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) **THIS MEASURE IS PENDING A NEW NUMERATOR STATEMENT**	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty	**THIS MEASURE IS PENDING A NEW NUMERATOR STATEMENT**	This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.	We exclude from the measure all admissions for which full data are not available or for which 30-day readmission by itself cannot reasonably be considered a signal of quality of care. Exclusions: 1. Admissions for patients without 30 days of post-discharge data Rationale: This is necessary in order to	Readmission		Outcome	Endorsed	1789	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.			identify the outcome (readmission) in the dataset. 2. Admissions for patients lacking a complete enrollment history for the 12 months prior to admission Rationale: This is necessary to capture historical data for risk adjustment. 3. Admissions for patients discharged against medical advice (AMA) Rationale: Hospital had limited opportunity to implement high quality care. 4. Admissions for patients to a PPS-exempt cancer hospital Rationale: These hospitals care for a unique population of patients that is challenging to compare to other hospitals. 5. Admissions for patients with medical treatment of cancer Rationale: These admissions have a very different mortality and readmission profile than the rest of the Medicare population, and outcomes for these admissions do not correlate well with outcomes for other admissions. (Patients with cancer who are admitted for other diagnoses or for surgical treatment of their cancer remain in the measure). 6. Admissions for primary psychiatric disease Rationale: Patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers which are not comparable to acute care hospitals. 7. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices” Rationale: These admissions are not for acute care or to acute care hospitals. Additionally, in the all-payer testing, we excluded obstetric admissions because						

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						the measure was developed among patients aged 65 years or older (approximately 500,000).						
1637	Hospital Inpatient Quality Reporting	COPD 30-day Risk Standardized Readmission	The measure estimates a hospital-level risk-standardized readmission rate (RSRR), defined as readmission for any cause within 30 days after the date of discharge of the index admission, for patients 40 and older discharged from the hospital with either a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD.	The outcome for this measure is 30-day all-cause readmission. We define all-cause readmission as an inpatient admissions for any cause, with the exception of planned readmissions, within 30 days after the date of discharge from the index admission for patients 18 and older discharged from the hospital with either a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. If a patient has one or more admissions (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission.	This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 40 years or older. We have explicitly tested the measure in both age groups. The cohort includes admissions for patients discharged from the hospital with either a principal diagnosis of COPD (see codes below) OR a principal diagnosis of respiratory failure (see codes below) WITH a secondary discharge diagnosis of acute exacerbation of COPD (see codes below) and with a complete claims history for the 12 months prior to admission.	An index admission is any eligible admission to an acute care hospital assessed in the measure for the outcome (readmitted within 30 days of the date of discharge from the initial admission). The measure excludes admissions for patients: • with an in hospital death (because they are not eligible for readmission). • transferred to another acute care facility (We assign the outcome for the acute episode of care to the hospital that discharges the patient to the non-acute care setting because the discharging hospital initiates the discharge and the transition to the outpatient setting. Therefore, the last admission in the acute care setting for the episode of care is eligible to be an index admission in the measure. The prior admissions in the same acute episode are excluded from the measure.) • who were discharged alive and against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge). • without at least 30 days post-discharge claims data (because the 30-day readmission outcome cannot be assessed in this group). Additionally, admissions that occur within 30 days of the discharge date of an earlier index admission are not themselves	Readmission		Outcome	Under Review	1891	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						considered to be index admissions. Any COPD admission can only be an index admission or a readmission, but not both. Of note, a patient may satisfy multiple exclusion criteria.						
2757	Hospital Inpatient Quality Reporting	COPD 30-day Risk Standardized Mortality	The measure estimates a hospital-level risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients 40 and older discharged from the hospital with either a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD.	The outcome for this measure is 30-day all-cause mortality. We define mortality as death from any cause within 30 days from the date of admission for patients 40 and older discharged from the hospital with either a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD.	This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 40 years or older. We have explicitly tested the measure in both age groups. The cohort includes admissions for patients discharged from the hospital with either a principal diagnosis of COPD (see codes below) OR a principal diagnosis of respiratory failure (see codes below) WITH a secondary	An index admission is any eligible admission to an acute care hospital assessed in the measure for the outcome (died within 30 days after the index admission date). For all cohorts, the measure excludes admissions for patients: • transferred into the hospital from another acute care hospital (We assign the outcome for the acute episode of care to the first admitting hospital because the first hospital initiates patient management and is responsible for any decision to transfer the patient. Therefore, the first	Mortality		Outcome	Under Review	1893	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
					diagnosis of acute exacerbation of COPD (see codes below) and with a complete claims history for the 12 months prior to admission. If a patient has more than one COPD admission in a year, one hospitalization is randomly selected for inclusion in the measure.	admission in an acute episode of care is eligible to be an index admission in the measure. The second or subsequent admissions in the same acute episode are excluded from the measure). • with inconsistent or unknown mortality status or other unreliable data (e.g. date of death precedes admission date). • who were discharged alive and against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge); For Medicare FFS patients, the measure additionally excludes admissions for patients: • enrolled in the Medicare Hospice program any time in the 12 months prior to the index hospitalization including the first day of the index admission (since it is likely these patients are continuing to seek comfort measures only). Although this exclusion currently applies to Medicare FFS patients, it could be expanded to include all-payer data if an acceptable method for identifying hospice patients outside of Medicare becomes available. Of note, a patient may satisfy multiple exclusion criteria.						

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
524	Hospital Inpatient Quality Reporting	Stroke: 30-day all-cause risk-standardized mortality measures	The measure estimates a hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke. Mortality is defined as death from any cause within 30 days of the index admission date for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke.	The outcome for this measure is 30-day all-cause mortality. We define mortality as death from any cause within 30 days from the index admission date for patients discharged from the index hospital with a principal diagnosis of acute ischemic stroke.	The cohort includes admissions for patients age 65 years or older discharged from the hospital with a principal diagnosis of acute ischemic stroke (ICD-9-CM codes 433.x1, 434.x1, 436) and with a complete claims history for the 12 months prior to admission.	An index admission is the hospitalization considered for mortality outcome. The measure excludes admissions for patients: • transferred from another acute care hospital (because the death is attributed to the hospital where the patient was initially admitted); • with inconsistent or unknown mortality status or other unreliable data (e.g. date of death precedes admission date). • who were discharged alive and against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge); • enrolled in the Medicare Hospice program any time in the 12 months prior to the index hospitalization including the first day of the index admission (since it is likely these patients are continuing to seek comfort measures only).	Mortality		Outcome	Under Review	2026	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2758	Hospital Inpatient Quality Reporting	Stroke: 30-day all-cause readmission measure.	Hospital-specific, risk-standardized, all-cause 30-day readmission (defined as readmission for any cause within 30 days after the date of discharge of the index admission) for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke. The measure estimates a hospital-level risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke. We define this as readmission for any cause within 30 days from the date of discharge of the index stroke admission.	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge for patients 18 and older discharged from the hospital with a principal diagnosis of ischemic stroke. If a patient has one or more admissions (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission.	The cohort includes admissions for patients age 65 years or older discharged from the hospital with a principal diagnosis of ischemic stroke (ICD-9-CM codes 433.x1, 434.x1, 436) and with a complete claims history for the 12 months prior to admission.	An index admission is the hospitalization considered for the readmission outcome (readmitted within 30 days of the date of discharge from the initial admission). The measure excludes admissions for patients: • with an in hospital death (because they are not eligible for readmission). • transferred to another acute care facility (because the readmission is attributed to the hospital that discharges the patient to a non-acute setting). • discharged alive and against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge). • without at least 30 days post-discharge claims data (because the 30-day readmission outcome cannot be assessed in this group). In addition, if a patient has more than one admission within 30 days of discharge from the index admission, only one is counted as a readmission, as we are interested in a dichotomous yes/no readmission outcome, as opposed to the number of readmissions. No admissions within 30 days of discharge from an index admission are considered as additional index admissions, thus no hospitalization will be counted as both a readmission and an index admission. The next eligible index admission is 30 days after the discharge date of the previous index admission.	Readmission		Outcome	Under Review	2027	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1643	Hospital Inpatient Quality Reporting	Medicare Spending Per Beneficiary	The Medicare Spending per Beneficiary (MSPB) Measure evaluates hospitals' efficiency relative to the efficiency of the median hospital. Specifically, the MSPB Measure assesses the cost to Medicare of services performed by hospitals and other healthcare providers during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.	A hospital's average MSPB Amount, defined as the sum of standardized, risk-adjusted spending across all of a hospital's eligible episodes divided by the number of episodes for that hospital.	The median MSPB Amount across all hospitals.	Any episodes where at any time during the episode, the beneficiary is enrolled in a Medicare Advantage plan; the beneficiary becomes deceased; the beneficiary is covered by the Railroad Retirement Board; or Medicare is the secondary payer will be excluded from the MSPB calculation. Regarding beneficiaries whose primary insurance becomes Medicaid during an episode due to exhaustion of Medicare Part A benefits, Medicaid payments made for services rendered to these beneficiaries are excluded; however, all Medicare Part A payments made before benefits are exhausted and all Medicare Part B payments made during the episode are included. In addition, acute-to-acute transfers (where a transfer is defined based on the claim discharge code) will not be considered index admissions. In other words, these cases will not generate new MSPB episodes; neither the hospital which transfers a patient to another subsection (d) hospital, nor the receiving subsection (d) hospital will have an index admission attributed to them. Further, any episode in which the index admission inpatient claim has a $0 actual payment or a $0 standardized payment is excluded.	Health Services Administration	Cost	Efficiency	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2698	Hospital Inpatient Quality Reporting	AMI episode of care (inpatient hospitalization + 30 days post-discharge)	Hospital-specific, risk-standardized, 30-day episode of care payment for AMI. The measure includes all payments across care settings for the 30-days following an inpatient admission for AMI. The payments are either "stripped or standardized" to remove the effect of policy adjustments. The measure uses hierarchical modeling to estimate a hospital-level risk-standardized total payments for the 30-day window from admission.	The outcome for this measure is Medicare payments for an AMI episode of care. The payment timeframe is defined as admission for an index hospitalization through 30 days post-admission. We include payments for inpatient settings and up to 6 other post-discharge settings (Skilled Nursing Facility, Outpatient, Home Health Agency, Hospice, Carrier, and Durable Medical Equipment).	The target population for this measure includes episodes of care (as defined above) for patients who are 65 years of age or older with a principal discharge diagnosis of AMI (as defined by ICD-9 codes 410.xx, excluding 410.x2) during a qualifying index hospitalization.	1) Lack of continuous enrollment in Medicare FFS Parts A and B in the 12 months prior to index hospital stay. 2) Lack of continuous enrollment in Medicare FFS Parts A and B in the month following the index hospital stay (if alive). 3) Patients discharged alive on the day of admission who did not get transferred. 4) Transfers into the hospital (excluded from eligibility as an index admission), or transfers to federal hospitals. 5) Patients who are discharged against medical advice (AMA). 6) Occurred in Maryland hospitals and U.S. territories. 7)Episodes for Patients with 0 Payment	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS
3035	Hospital Inpatient Quality Reporting	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.	Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.	1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3036	Hospital Inpatient Quality Reporting	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries)	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3."In and out" catheterizations	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3038	Hospital Inpatient Quality Reporting	Reliability Adjusted Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Report first clinical MRSA culture and all unique MRSA blood cultures (laboratory-identified events) per patient per month; no bedside assessment is needed nor complete antibiogram reported.	Report total facility-wide patient-days and admissions/encounters per month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3039	Hospital Inpatient Quality Reporting	Reliability Adjusted Clostridium Difficile SIR Measure	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	The total number of HAI CDI cases identified during the surveillance month.	The total number of patient days and admissions during the surveillance month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1904	Hospital Outpatient Quality Reporting	Influenza Vaccination Coverage among Healthcare Personnel (HCP)	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.	HCP in the denominator population who, during the time from when the vaccine became available through March 31: (a) received an influenza vaccination administered at the healthcare facility or reported having received influenza vaccination elsewhere (computed separately); (b) were determined to have a medical contraindication for receiving the vaccination (computed separately); or (c) declined the vaccination (computed separately).	Number of persons who are working in the healthcare facility between October 1 and March 31 who meet the CDC definition of healthcare personnel (HCP)* - For each influenza season, influenza vaccination coverage among HCP should be measured at the overall facility level (e.g., hospital, nursing home). - Additional stratification is recommended: component facility, ward, unit, and specialty; occupational group (e.g., nurse, physician, student/trainee); and HCP who perform direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring).	None	Immunizations	Adult Immunization	Structure	TLE	0431	CDC
845	Hospital Outpatient Quality Reporting	Severe Sepsis and Septic Shock: Management Bundle	This measure will focus on patients aged 18 years and older who present with symptoms of severe sepsis or septic shock. These patients will be eligible for the 3 hour (severe sepsis) and/or 6 hour (septic shock) early management bundle.	Number of patients who meet criteria for severe sepsis and septic shock and successfully receive the following early management bundle as indicated. WITHIN THREE HOURS OF SEVERE SEPSIS: 1) Measure lactate level 2) Obtain blood cultures prior to antibiotics 3) Administer broad spectrum antibiotics 4) Administer 30ml/kg crystalloid for hypotension or lactate >=4mmol/L WITHIN 6 HOURS OF INITIAL SYMPTOMS FOR SEPTIC SHOCK: 5) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure	Number of patients diagnosed or presenting with the symptoms of severe sepsis or septic shock.	Patients with advanced directives for comfort care or clinical conditions that preclude total measure completion should be excluded. Examples include but are not limited to mortality within the numerator time window (3 hrs for severe sepsis or 6 hrs for septic shock), patients who do not have the clinical evidence of an infection (severe sepsis or septic shock), patients for whom a central line is contraindicated, patients with coagulopathy, patients for whom central line placement was attempted but could not be inserted, or other medical, patient, or system reasons for exclusion.	Patient Safety		Composite	Endorsed	0500	Henry Ford Hospital

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				>=65mmHg) 6) In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate >=4 mmol/L (36 mg/dl): - Measure central venous pressure (CVP) - Measure central venous oxygen saturation (ScvO2) 7)Remeasure lactate								
3003	Hospital Outpatient Quality Reporting	Complications within 30 Days following Cataract Surgery Requiring Additional Surgical Procedures	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of the specified list of surgical procedures in the 30 days following cataract surgery that would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power Intraocular Lens (IOL), 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	All patients aged 18 and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate	Patients with specific comorbid conditions impacting the surgical complication rate	Patient Safety	Complications	Outcome	TLE	0564	AMA-PCPI
2782	Hospital Outpatient Quality Reporting	Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients.	Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	All patients aged 50 years or older receiving screening colonoscopy without biopsy or polypectomy.	Documentation of medical reason(s) for not recommending at lease a 10 year follow-up interval (eg, above average risk patient, inadequate prep)	Cancer	Colorectal	Process	TLE	0658	AMA-PCPI
2783	Hospital Outpatient Quality Reporting	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use.	Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report.	Patients who had an interval of 3 or more years since their last colonoscopy.	All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy.	Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas) OR Documentation of a system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete).	Health Services Administration	Patient Care Management	Process	TLE	0659	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2781	Hospital Outpatient Quality Reporting	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older who had cataract surgery function achieved within 90 days following the cataract surgery.	Patients 18 years and older in sample who had improvement in visual function achieved within 90 days following cataract surgery, based on completing a pre-operative and post-operative visual function instrument.	All patients aged 18 years and older in sample who had cataract surgery.	None	Eyes/Vision		Outcome	Endorsed	1536	American Academy of Ophthalmology and the Hoskins Center for Quality Eye Care
2785	Hospital Outpatient Quality Reporting	Intra-procedure colonoscopy complication rate: percentage of patients who developed one or more intra-procedure complications.	This measure assesses the percentage of patients who developed one or more intra-procedure colonoscopy complications.	Number of patients from the denominator who developed one or more intra-procedure complications.	Patients undergoing colonoscopy procedure (CPT codes 45378-45385) at the ambulatory health care organization.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	AHRQ
28	Hospital Readmission Reduction Program	READM-30-HF Hospital thirty-day all-cause risk standardized readmission rate (RSRR) following heart failure (HF) hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30 day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of HF.	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions within 30 days from the date of discharge from the index HF admission. If a patient has more than one admission (for any reason) within 30 days of the date of discharge of the index admission, only one was counted as a readmission.	The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from non-federal acute care hospitals or VA hospitals with a principal discharge diagnosis of HF.	Cohort exclusions (excluded admissions): - Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission. - Admissions for patients without at least 30 days post-discharge enrollment in FFS Medicare are excluded because the 30-day readmission outcome cannot be assessed in this group. This exclusion applies only to patients who have index admissions in non-VA hospitals. - Admissions for patients having a principal diagnosis of HF during the index hospitalization and subsequently transferred to another acute care facility are excluded because we are focusing on discharges to non-acute care settings. - Admissions for patients who are discharged against medical advice (AMA) are excluded because providers did not have the opportunity to deliver full care and prepare the patient for discharge.	Readmission		Outcome	Endorsed	0330	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
29	Hospital Readmission Reduction Program	READM-30-AMI Hospital, thirty-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of AMI.	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from the index AMI admission. If a patient has more than one admission (for any reason) within 30 days of the date of discharge of the index admission, only one was counted as a readmission.	The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from non-federal acute care hospitals or VA hospitals with a principal discharge diagnosis of AMI.	Cohort exclusions (excluded admissions): Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission. Admissions for patients without at least 30 days post-discharge enrollment in FFS Medicare are excluded because the 30-day readmission outcome cannot be assessed in this group. This exclusion applies only to patients who have index admissions in non-VA hospitals. Admissions for patients having a principal diagnosis of AMI during the index hospitalization and subsequently transferred to another acute care facility are excluded because we are focusing on discharges to non-acute care settings. Admissions are excluded for patients who are discharged alive on the same day that they are admitted because these patients are unlikely to have had an AMI. Admissions for patients who are discharged against medical advice (AMA) are excluded because providers did not have the opportunity to deliver full care and prepare the patient for discharge.	Readmission		Outcome	Endorsed	0505	CMS
30	Hospital Readmission Reduction Program	READM: PNEUM: Hospital thirty-day all-cause risk-standardized readmission rate (RSRR) following pneumonia hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30 day readmission for patients discharged from the hospital with a principal discharge diagnosis of pneumonia (PN).	The outcome for this measure is 30 day all-cause readmission. We define all-cause readmission as an inpatient admission for any cause, with the exception of planned readmissions, within 30 days from the date of discharge from the index pneumonia admission. If a patient has one or more admissions (for any reason) within 30 days of the date of discharge of the index admission, only one was counted as a readmission.	The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from non-federal acute care hospitals or VA hospitals with a principal discharge diagnosis of pneumonia.	Cohort exclusions (excluded admissions): - Admissions for patients with an in-hospital death are excluded because they are not eligible for readmission. - Admissions for patients without at least 30 days post-discharge enrollment in FFS Medicare are excluded because the 30-day readmission outcome cannot be assessed in this group. This exclusion applies only to patients who have index admissions in non-VA hospitals. - Admissions for patients having a principal diagnosis of pneumonia during the index hospitalization and subsequently transferred to another acute care facility are excluded because we are	Readmission		Outcome	Endorsed	0506	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						focusing on discharges to non-acute care settings. - Admissions for patients who are discharged against medical advice (AMA) are excluded because providers did not have the opportunity to deliver full care and prepare the patient for discharge.						
2760	Hospital Readmission Reduction Program	30-day Risk Standardized Readmission following Total Hip/Total Knee Arthroplasty	Hospital-specific, risk-standardized, all-cause, 30-day readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define the readmission outcome.	The target population for this measure includes admissions for patients at least 65 years of age undergoing primary THA and/or TKA procedures.	1. Patients with hip fractures 2. Patients undergoing revision procedures (with or without a concurrent THA/TKA) 3. Patients undergoing partial hip arthroplasty procedures (with or without a concurrent THA/TKA) 4. Patients undergoing resurfacing procedures (with or without a concurrent THA/TKA) 5. Patients without at least 30-days post-discharge enrolment in Medicare 6. Patients who are transferred in to the index hospital 7. Patients who were admitted for the index procedure and subsequently transferred to another acute care facility 8. Patients who leave against medical advice (AMA) 9. Patients with more than two THA/TKA procedures codes during the index hospitalization 10. Patients who die during the index admission Additional otherwise qualifying THA and/or TKA admissions that occurred within 30 days of discharge date of an earlier index admission are not considered as index admission. They are considered as potential readmissions. Any THA and/or TKA admission is either an index admission or a potential readmission, but not both.	Readmission		Outcome	Endorsed	1551	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1637	Hospital Readmission Reduction Program	COPD 30-day Risk Standardized Readmission	The measure estimates a hospital-level risk-standardized readmission rate (RSRR), defined as readmission for any cause within 30 days after the date of discharge of the index admission, for patients 40 and older discharged from the hospital with either a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD.	The outcome for this measure is 30-day all-cause readmission. We define all-cause readmission as an inpatient admissions for any cause, with the exception of planned readmissions, within 30 days after the date of discharge from the index admission for patients 18 and older discharged from the hospital with either a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. If a patient has one or more admissions (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission.	This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 40 years or older. We have explicitly tested the measure in both age groups. The cohort includes admissions for patients discharged from the hospital with either a principal diagnosis of COPD (see codes below) OR a principal diagnosis of respiratory failure (see codes below) WITH a secondary discharge diagnosis of acute exacerbation of COPD (see codes below) and with a complete claims history for the 12 months prior to admission.	An index admission is any eligible admission to an acute care hospital assessed in the measure for the outcome (readmitted within 30 days of the date of discharge from the initial admission). The measure excludes admissions for patients: • with an in hospital death (because they are not eligible for readmission). • transferred to another acute care facility (We assign the outcome for the acute episode of care to the hospital that discharges the patient to the non-acute care setting because the discharging hospital initiates the discharge and the transition to the outpatient setting. Therefore, the last admission in the acute care setting for the episode of care is eligible to be an index admission in the measure. The prior admissions in the same acute episode are excluded from the measure.) • who were discharged alive and against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge). • without at least 30 days post-discharge claims data (because the 30-day readmission outcome cannot be assessed in this group). Additionally, admissions that occur within 30 days of the discharge date of an earlier index admission are not themselves considered to be index admissions. Any COPD admission can only be an index admission or a readmission, but not both. Of note, a patient may satisfy multiple exclusion criteria.	Readmission		Outcome	Under Review	1891	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2758	Hospital Readmission Reduction Program	Stroke: 30-day all-cause readmission measure.	Hospital-specific, risk-standardized, all-cause 30-day readmission (defined as readmission for any cause within 30 days after the date of discharge of the index admission) for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke. The measure estimates a hospital-level risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke. We define this as readmission for any cause within 30 days from the date of discharge of the index stroke admission.	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge for patients 18 and older discharged from the hospital with a principal diagnosis of ischemic stroke. If a patient has one or more admissions (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission.	The cohort includes admissions for patients age 65 years or older discharged from the hospital with a principal diagnosis of ischemic stroke (ICD-9-CM codes 433.x1, 434.x1, 436) and with a complete claims history for the 12 months prior to admission.	An index admission is the hospitalization considered for the readmission outcome (readmitted within 30 days of the date of discharge from the initial admission). The measure excludes admissions for patients: • with an in hospital death (because they are not eligible for readmission). • transferred to another acute care facility (because the readmission is attributed to the hospital that discharges the patient to a non-acute setting). • discharged alive and against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge). • without at least 30 days post-discharge claims data (because the 30-day readmission outcome cannot be assessed in this group). In addition, if a patient has more than one admission within 30 days of discharge from the index admission, only one is counted as a readmission, as we are interested in a dichotomous yes/no readmission outcome, as opposed to the number of readmissions. No admissions within 30 days of discharge from an index admission are considered as additional index admissions, thus no hospitalization will be counted as both a readmission and an index admission. The next eligible index admission is 30 days after the discharge date of the previous index admission.	Readmission		Outcome	Under Review	2027	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1370	Hospital Value-Based Purchasing	Catheter Associated Urinary Tract Infection (CAUTI)	Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries]) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations (excluding Level I and Level II nurseries). Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries)	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3.“In and out” catheterizations	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	0138	CDC
2149	Hospital Value-Based Purchasing	3-Item Care Transition Measure (CTM-3)	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan	The 15-item and the 3-item CTM share the same set of response patterns: Strongly Disagree; Disagree; Agree; Strongly Agree (there is also a response for Don't Know; Don't Remember; Not Applicable). Based on a subject's response, a score can be assigned to each item as follows: - Strongly Disagree = 1 - Disagree = 2 - Agree = 3 - Strongly Agree = 4 Next, the scores can be	None listed	None listed	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0228	University of Colorado Health Sciences Center

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				aggregated across either the 15 or 3 items, and then transformed to a scale ranging from 0 to 100. Thus the denominator is 100 and the numerator can range from 0 to 100. Time Window: Recommended within 30 days of event								
488	Hospital Value-Based Purchasing	Influenza Vaccination for Healthcare Personnel	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.	HCP in the denominator population who, during the time from when the vaccine became available through March 31: (a) received an influenza vaccination administered at the healthcare facility or reported having received influenza vaccination elsewhere (computed separately); (b) were determined to have a medical contraindication for receiving the vaccination (computed separately); or (c) declined the vaccination (computed separately).	Number of persons who are working in the healthcare facility between October 1 and March 31 who meet the CDC definition of healthcare personnel (HCP)* - For each influenza season, influenza vaccination coverage among HCP should be measured at the overall facility level (e.g., hospital, nursing home). - Additional stratification is recommended: component facility, ward, unit, and specialty; occupational group (e.g., nurse, physician, student/trainee); and HCP who perform direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring). *The term HCP refers to all paid and unpaid persons working in healthcare settings and might include (but is not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical,	None	Immunizations	Adult Immunization	Structure	TLE	0431	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
					dietary, housekeeping, maintenance, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP (MMWR 2006 vol. 55 RR-2).							
2182	Hospital Value-Based Purchasing	Elective Delivery Prior to 39 weeks	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.	Patients with elective deliveries (medical induction or cesarean section) while not in active labor or experiencing spontaneous rupture of membranes	Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Enrolled in clinical trials	Population Characteristics	Maternal & Child Health	Outcome	Endorsed	0469	The Joint Commission
455	Hospital Value-Based Purchasing	ED-1 Median Time from ED Arrival to ED Departure for Admitted ED Patients	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. ED-1a Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate ED-1b Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure ED-1c Median Time from ED Arrival to ED Departure for Admitted ED Patients – Observation Patients ED-1d Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	See numerator	Patients who are not an ED Patient	Health Services Administration	Access	Process	Endorsed	0495	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
477	Hospital Value-Based Purchasing	ED-2 Admit Decision Time to ED Departure Time for Admitted Patients	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. ED-2a Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate ED-2b Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure ED-2c Admit Decision Time to ED Departure Time for Admitted Patients – Psychiatric/Mental Health Patients	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.	See numerator	Patients who are not an ED Patient	Health Services Administration	Access	Structure	Endorsed	0497	CMS
2703	Hospital Value-Based Purchasing	Specific Surgical Site Infection (SSI)	Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs for each procedure.	Deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients = 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies. SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). Case accrual will be guided by sampling algorithms as described below.	Using multivariable logistic regression models for colon surgeries and abdominal hysterectomies, the expected number of SSIs is obtained. These expected numbers are summed by facility and surgical procedure and used as the denominator of this measure	Persons under the age of 18, those having a procedure performed on an outpatient basis, those with ASA Class VI (6) are excluded. In the NHSN, patients without primary closure of the surgical incision are not considered eligible cases and are excluded- the NSQIP will match this practice for this measure, although this is not standard practice within the NSQIP.	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	0753	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
523	Hospital Value-Based Purchasing	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	This measure estimates hospital risk-standardized complication rates (RSCRs) associated with primary elective THA and TKA in patients 65 years and older. The measure uses Medicare claims data to identify complications occurring from the date of index admission to 90 days post date of the index admission.	This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define the outcome (i.e. adverse events) following THA and/or TKA procedures. The composite complication is a binary outcome (yes for any complication(s); no for no complications). Therefore, if a patient experiences 1 or more complications, the outcome variable will get coded as a "yes." Complications are counted in the measure only if they occur during the index hospital admission or during a readmission. The complications captured in the numerator are identified during the index admission or associated with a readmission up to 90 days post date of index admission, depending on the complication. The follow-up period for complications from date of index admission is as follows: 1) Mechanical complications - 90 days 2) Wound infection/Periprosthetic joint infection (PJI) - 90 days 3) Surgical site bleeding - 30 days 4) Pulmonary embolism - 30 days 5) Death - 30 days 6) AMI - 7 days 7) Pneumonia - 7 days 8) Sepsis/septicemia/shock - 7days	The target population for this measure includes admissions for patients at least 65 years of age undergoing elective primary THA and/or TKA procedures.	1. Patients with hip fracture 2. Patients undergoing revision procedures (with or without a concurrent THA/TKA) 3. Patients undergoing partial hip arthroplasty procedures (with or without a concurrent THA/TKA) 4. Patients undergoing resurfacing procedures (with or without a concurrent THA/TKA) 5. Patients with a mechanical complication coded in the principal discharge diagnosis field of the index admission* 6. Patients who are transferred in to the index hospital 7. Patients who leave the hospital against medical advice (AMA) 8. Patients with more than two THA/TKA procedure codes during the index hospitalization 9. Patients with multiple admissions for THA/TKA in the 12 months studied; one hospitalization per patient was randomly selected for inclusion after applying the other exclusion criteria * Based on a medical record validation study of this measure, we also excluded patients with a mechanical complication coded in the principal discharge diagnosis field of the index admission because a complication coded in the principal field indicates it was present on admission. Furthermore, these patients represent more technically complex arthroplasty procedures, and may be at increased risk for complications, particularly mechanical complications.	Patient Safety	Complications	Outcome	Endorsed	1550	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
487	Hospital Value-Based Purchasing	IMM-1 Pneumonia Immunization	This prevention measure addresses acute care hospitalized inpatients 65 years of age and older (IMM-1b) AND inpatients aged between 6 and 64 years (IMM-1c) who are considered high risk and were screened for receipt of 23-valent pneumococcal polysaccharide vaccine (PPV23) and were vaccinated prior to discharge if indicated. The numerator captures two activities; screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to PPV23, patients who were offered and declined PPV23 and patients who received PPV23 anytime in the past are captured as numerator events.	Inpatient discharges who were screened for PPV23 status and received PPV23 prior to discharge, if indicated.	Inpatient discharges 65 years of age and older, and 6 through 64 years of age who have a high risk condition.	Patients less than 6 years of age; Patients who expire prior to hospital discharge; Patients who are pregnant; Patients with an organ transplant during the current hospitalization; Patients less than 19 with asthma and that have no other high risk conditions; Patients who have a Length of Stay greater than 120 days	Immunizations	Adult Immunization	Process	Endorsed	1653	CMS
486	Hospital Value-Based Purchasing	IMM-2 Flu Immunization	This prevention measure addresses acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine and patients who received the vaccine during the current year's influenza season but prior to the current hospitalization are captured as numerator events.	Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated	Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March.	Patients less than 6 months of age; Patients who expire prior to hospital discharge; Patients with an organ transplant during the current hospitalization; Patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but provider has not yet been received	Immunizations	Adult Immunization	Process	Endorsed	1659	CMS
1643	Hospital Value-Based Purchasing	Medicare Spending Per Beneficiary	The Medicare Spending per Beneficiary (MSPB) Measure evaluates hospitals' efficiency relative to the efficiency of the median hospital. Specifically, the MSPB Measure assesses the cost to Medicare of services performed by hospitals and other healthcare providers during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.	A hospital's average MSPB Amount, defined as the sum of standardized, risk-adjusted spending across all of a hospital's eligible episodes divided by the number of episodes for that hospital.	The median MSPB Amount across all hospitals.	Any episodes where at any time during the episode, the beneficiary is enrolled in a Medicare Advantage plan; the beneficiary becomes deceased; the beneficiary is covered by the Railroad Retirement Board; or Medicare is the secondary payer will be excluded from the MSPB calculation. Regarding beneficiaries whose primary insurance becomes Medicaid during an episode due	Health Services Administration	Cost	Efficiency	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						to exhaustion of Medicare Part A benefits, Medicaid payments made for services rendered to these beneficiaries are excluded; however, all Medicare Part A payments made before benefits are exhausted and all Medicare Part B payments made during the episode are included. In addition, acute-to-acute transfers (where a transfer is defined based on the claim discharge code) will not be considered index admissions. In other words, these cases will not generate new MSPB episodes; neither the hospital which transfers a patient to another subsection (d) hospital, nor the receiving subsection (d) hospital will have an index admission attributed to them. Further, any episode in which the index admission inpatient claim has a $0 actual payment or a $0 standardized payment is excluded.						
474	Hospital Value-Based Purchasing	Clostridium Difficile SIR Measure	Incidence rate of hospital-onset c. difficile. Report all healthcare-associated infections where C. difficile identified a positive toxin result are the associated pathogen. Refer to specific definitions (Chapter 17) for gastroenteritis (GI-GE) or gastrointestinal tract (GI-GIT) infections criteria. Cases of CDI (i.e., C. difficile pathogen identified with a positive toxin result) that are not present or incubating at the time of admission (i.e., meets criteria for a healthcare-associated infection) should be reported as gastroenteritis (GI-GE) or gastrointestinal tract (GI-GIT) infections, whichever is appropriate. Report the pathogen as C. difficile on the MDRO or CDI Infection Event form (CDC 57.126). If the patient develops both GI-GE and GI-GIT CDI, report only GI-GIT using the date of onset as that of GI-GE CDI. (This CDI	The total number of HAI CDI cases identified during the surveillance month.	The total number of patient days and admissions during the surveillance month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Candidate Standard	1717	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			HAI reporting corresponds to surveillance for healthcare-onset, healthcare facility-associated CDI in recently published recommendations3, which is considered the minimum surveillance for CDI.)									
582	Hospital Value-Based Purchasing	Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia	Incidence Rate of Hospital-Onset MRSA Based on Clinical Cultures	Report first clinical MRSA culture and all unique MRSA blood cultures (laboratory-identified events) per patient per month; no bedside assessment is needed nor complete antibiogram reported.	Report total facility-wide patient-days and admissions/encounters per month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Candidate Standard	1716	CDC
3035	Hospital Value-Based Purchasing	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.	Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.	1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC
3036	Hospital Value-Based Purchasing	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	nurseries)	same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	3."In and out" catheterizations						
3038	Hospital Value-Based Purchasing	Reliability Adjusted Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection	Report first clinical MRSA culture and all unique MRSA blood cultures (laboratory-identified events) per patient per month; no bedside assessment is needed nor complete antibiogram reported.	Report total facility-wide patient-days and admissions/encounters per month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			experience to the mean according to its patient case-mix and exposure volume.									
3039	Hospital Value-Based Purchasing	Reliability Adjusted Clostridium Difficile SIR Measure	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	The total number of HAI CDI cases identified during the surveillance month.	The total number of patient days and admissions during the surveillance month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2751	Inpatient Psychiatric Facility Quality Reporting	Follow-Up After Hospitalization for Mental Illness (7- and 30- day)	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1: The percentage of members who received follow-up within 30 days of discharge Rate 2: The percentage of members who received follow-up within 7 days of discharge.	Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred). Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for a mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify nonacute care. Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.	Mental Health Care & Substance-Related Care		Outcome	Endorsed	0576	NCQA
2750	Inpatient Psychiatric Facility Quality Reporting	Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services	28 item questionnaire completed by clients at discharge and/or at annual review. The ICS includes six domains of client perception: outcome of care, dignity, rights, participation in treatment, facility environment, empowerment	See Description	See Description	See Description	Mental Health Care & Substance-Related Care		Patient Perspective	Endorsed	0726	National Association of State Mental Health Program

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2753	Inpatient Psychiatric Facility Quality Reporting	SUB-1 Alcohol Use Screening	Hospitalized patients 18 years of age and older who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).	The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking	The number of hospitalized inpatients 18 years of age and older	The denominator has three exclusions: • Patients less than 18 years of age • Patients who are cognitively impaired • Patients who a have a duration of stay less than or equal to one day or greater than 120 days	Mental Health Care & Substance-Related Care		Process	Under Review	1661	The Joint Commission
2754	Inpatient Psychiatric Facility Quality Reporting	SUB-4 Alcohol and Drug Use: Assessing Status After Discharge	Hospitalized patients age 18 years and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1) Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).	The number of discharged patients that are contacted between 7 and 30 days after hospital discharge and follow-up information regarding alcohol or drug use status is collected	The number of discharged patients 18 years of age and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug use disorder during their hospital stay	The following are the exclusions from the denominator for this measure 1. Patients less than 18 years of age 2. Patients who are cognitively impaired 3. Patients who were not screened or refused to be screed for alcohol use 4. Patients who expired 5. Patients who have a length of stay less than or equal to one day or greater than 120 days 6. Patients who do not screen positive for unhealthy alcohol use 7. Patients discharged to another hospital 8. Patients who left against medical advice 9. Patients discharged to another health care facility 10. Patients discharged to home or other health care facility for hospice care 11. Patients who do not reside in the United States 12. Patients who do not have a phone or cannot provide any contact information 13. Patients discharged to a detention facility, jail, or prison 14. Patients who are readmitted within the follow-up time frame.	Mental Health Care & Substance-Related Care		Process	Under Review	1665	The Joint Commission

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2752	Inpatient Psychiatric Facility Quality Reporting	Follow-Up After Hospitalization for Schizophrenia (7- and 30- day)	The percentage of discharges for individuals 25 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1: The percentage of individuals who received follow-up within 30 days of discharge Rate 2: The percentage of individuals who received follow-up within 7 days of discharge	30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	Adults 25 – 64 years of age of December 31 of the measurement year Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis.	Schizophrenia readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a schizophrenia diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for a schizophrenia diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.	Mental Health Care & Substance-Related Care		Process	Candidate Standard	1937	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1657	Inpatient Rehabilitation Facility Quality Reporting	Staff immunization	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.	HCP in the denominator population who, during the time from when the vaccine became available through March 31: (a) received an influenza vaccination administered at the healthcare facility or reported having received influenza vaccination elsewhere (computed separately); (b) were determined to have a medical contraindication for receiving the vaccination (computed separately); or (c) declined the vaccination (computed separately).	Number of persons who are working in the healthcare facility between October 1 and March 31 who meet the CDC definition of healthcare personnel (HCP)* - For each influenza season, influenza vaccination coverage among HCP should be measured at the overall facility level (e.g., hospital, nursing home). - Additional stratification is recommended: component facility, ward, unit, and specialty; occupational group (e.g., nurse, physician, student/trainee); and HCP who perform direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring). *The term HCP refers to all paid and unpaid persons working in healthcare settings and might include (but is not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, maintenance, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP	None listed	Immunizations	Adult Immunization	Structure	TLE	0431	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1655	Inpatient Rehabilitation Facility Quality Reporting	Patient Immunization for Influenza	The measure reports the percentage of residents or patients who are assessed and appropriately given the influenza vaccine.	The numerator includes all residents or patients in the denominator sample who, during the numerator time window, meet one of three criteria: (1) received the influenza vaccine during the most recent vaccine season (either inside or outside the facility/hospital), (2) were offered and declined the vaccine, (3)were ineligible due to medical contraindications. Residents or patients who have already received the vaccine during the current influenza vaccine season do not need to be revaccinated. IRF-PAI: Patients are included in the numerator if they meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recent influenza vaccine season, either in the facility or outside the facility* (computed and reported separately); or (2) offered and declined the influenza vaccine* (computed and reported separately); or (3) ineligible due to contraindication(s)* (computed and reported separately). Included in the numerator are patients who meet the criteria on the target IRF-PAI admission assessment* or discharge assessment* during the numerator time window.	IRF-PAI: Patients are counted if they are aged 6 months or older and have an assessment meeting any of the following conditions: (1) the patient has an admission assessment with an entry date (item 12) during the denominator time window; or (2) the patient has a discharge assessment with a discharge date (Item 40) during the denominator time window.	Residents or patients are excluded from the denominator if they were not in the facility (MDS 3.0 item O0250C=1; LTCH CARE Data Set item O0250C=1; IRF-PAI item number not yet assigned), during the denominator time window. Nursing homes, IRFs and LTCHs with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size. All short-stay residents or patients under age 6 months will be excluded.	Immunizations	Adult Immunization	Process	Endorsed	0680	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1656	Inpatient Rehabilitation Facility Quality Reporting	Patient Immunization for Pneumonia	The measure reports the percentage of short stay nursing home residents or IRF or LTCH patients who were assessed and appropriately given the pneumococcal vaccine during the 12-month reporting period.	Patients aged 5 years and older are counted if they meet any of the following criteria on the most recent IRF-PAI assessment during the 12-month reporting period: (1) have an up-to-date pneumococcal vaccine status* ** or (2) were offered and declined the vaccine*; or (3) were ineligible due to medical contraindication(s)* (i.e., anaphylactic hypersensitivity to components of the vaccine; bone marrow transplant within the past 12 months; or receiving a course of chemotherapy within the past two weeks).	The pneumococcal vaccination sample includes patients aged 5 yeras and older who have (1) an IRF-PAI assessment with assessment reference date (item 13) during the 12-month target period or (2) a discharge assessment with discharge date (item 40) during the 12-month target period.	Residents or patients younger than 5 years old will be excluded from the denominator.	Immunizations	Adult Immunization	Process	Endorsed	0682	CMS
3035	Inpatient Rehabilitation Facility Quality Reporting	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.	Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.	1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1671	Inpatient Rehabilitation Facility Quality Reporting	Functional Change: Change in Motor Score	TBD	TBD - However, this measure is being developed through a joint project with ASPE and CMS. While a numerator and denomination statement was not available at the time that this spreadsheet was prepared, the measure developers do expect to have this information available by Fall 2012.	TBD	TBD	Chronic and Elder Care	Functional Status	Intermediate Outcome	Not Endorsed	N/A	CMS
2558	Inpatient Rehabilitation Facility Quality Reporting	Functional Outcome Measure (change in mobility)	Change in mobility score at discharge as compared to admission	TBD - However, this measure is being developed through a joint project with ASPE and CMS. While a numerator and denomination statement was not available at the time that this spreadsheet was prepared, the measure developers do expect to have this information available by Fall 2012.	TBD	TBD	Chronic and Elder Care	Functional Status	Intermediate Outcome	Not Endorsed	N/A	CMS
2559	Inpatient Rehabilitation Facility Quality Reporting	Functional Outcome Measure (change in self-care)	Change in mobility score at discharge as compared to admission	TBD - However, this measure is being developed through a joint project with ASPE and CMS. While a numerator and denomination statement was not available at the time that this spreadsheet was prepared, the measure developers do expect to have this information available by Fall 2012.	TBD	TBD	Chronic and Elder Care	Functional Status	Intermediate Outcome	Not Endorsed	N/A	CMS
1425	Inpatient Rehabilitation Facility Quality Reporting	All-Condition 30-day Risk-standardized All-Cause Readmission (IRF)	This measure is a risk-adjusted rate of hospital readmissions for patients discharged from an Inpatient Rehabilitation Facility (IRF) who were readmitted to a short-stay acute care hospital, or LTCH, within 30 days of an IRF discharge.	• Number of unplanned Acute or LTCH admission occurring within 30 days following an IRF discharge. A predicted risk-adjusted rate for the facility will be compared to the expected risk-adjusted rate for the same patients at an average facility.	• Patients who had been continuously enrolled in Part A FFS Medicare for the 12 months prior to the IRF Admission, and at least 1 month after IRF discharge, • AND had a short-term acute care stay within 30 days prior to an IRF stay, • AND who were discharged from the IRF to the community or a lower level of care, • AND who were followed for the lesser of 30 days post discharge from the IRF or till death.	TBD	Readmission		Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3036	Inpatient Rehabilitation Facility Quality Reporting	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries)	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3."In and out" catheterizations	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC
3039	Inpatient Rehabilitation Facility Quality Reporting	Reliability Adjusted Clostridium Difficile SIR Measure	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better	The total number of HAI CDI cases identified during the surveillance month.	The total number of patient days and admissions during the surveillance month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.									
3004	Long-term Care Hospital Quality Reporting	Medication Reconciliation	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented The medical record must indicate that the physician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of a inpatient facility discharge medication.	All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care	N/A	Patient Safety	Medication Management	Process	Endorsed	0097	NCQA
8	Long-term Care Hospital Quality Reporting	HF-1 Discharge instructions	Heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen	Heart failure patients with documentation that they or their caregivers were given written discharge instructions or other educational material addressing all of the following: 1. activity level 2. diet 3. discharge medications 4. follow-up appointment 5. weight monitoring 6. what to do if symptoms worsen	Heart failure patients discharged home	Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Patients enrolled in clinical trials Patients with Comfort Measures Only documented	Cardiovascular	Heart Failure	Process	De-endorsed	0136	CMS (The Joint Commission)

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1699	Long-term Care Hospital Quality Reporting	Patient Fall Rate	All documented falls, with or without injury, experienced by patients on an eligible unit in a calendar quarter	Total number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by hospital Unit during the month x 1000. Time window: month Fall definition: a patient fall is an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient, and occurs on an eligible reporting nursing unit. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Include assisted falls – when a staff member attempts to minimize the impact of the fall. Included populations: patient falls occurring while on an eligible reporting unit, assisted falls, and repeat falls	Patient days by hospital Unit during the calendar month. This includes inpatients, short stay patients, observation patients and same day surgery patients who receive care on eligible in-patient units for all or part of a day Adult critical care, step-down, medical, surgical, medical-surgical combined units Any age patient on an eligible reporting unit is included in the patient day count	• Other unit types (e.g., pediatric, psychiatric, obstetrical, rehab, etc)	Chronic and Elder Care	Falls	Outcome	Endorsed	0141	ANA
42	Long-term Care Hospital Quality Reporting	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey	27-items survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.	None listed	None listed	None listed	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0166	AHRQ

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2113	Long-term Care Hospital Quality Reporting	Care Transitions Measure - 3 (CTM-3)	Uni-dimensional self-reported survey that measure the quality of preparation for care transitions. In order to make the CTM-3 items more fully consistent and compatible with the original HCAHPS Survey items, we have made a few small modifications. Specifically, in the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28038), we proposed: (1) to slightly reword the first care transition item by adding the phrase, "During this hospital stay;" (2) to delete the "Don't Know/Don't Remember/Not Applicable" response option from each item; and (3) to add a new response option, "I was not given any medication when I left the hospital," to the third care transition item. These small modifications preserve the integrity and utility of the HCAHPS Survey as it is expanded to encompass a new dimension of patients' experience of hospital care. The developer of the CTM-3 has agreed to these modifications, which we believe are consistent with the NQF endorsement of the original 27-item HCAHPS Survey and the CTM-3.	The 15-item and the 3-item CTM share the same set of response patterns: Strongly Disagree; Disagree; Agree; Strongly Agree (there is also a response for Don't Know; Don't Remember; Not Applicable). Based on a subject's response, a score can be assigned to each item as follows: Strongly Disagree = 1 Disagree = 2 Agree = 3 Strongly Agree = 4 Next, the scores can be aggregated across either the 15 or 3 items, and then transformed to a scale ranging from 0 to 100. Thus the denominator is 100 and the numerator can range from 0 to 100. Time Window = recommended within 30 days of event	See Numerator	The CTM has application to all hospitalized adults. Testing has not included children, but the measure may have potential application to this population as well. Persons with cognitive impairment have been included in prior testing, provided they are able to identify a willing and able proxy. The CTM has been tested in English- and Spanish-speaking (using an available Spanish version of the CTM) populations.	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0228	University of Colorado Health Sciences Center
1695	Long-term Care Hospital Quality Reporting	Ventilator bundle	Percentage of intensive care unit patients on mechanical ventilation at time of survey for whom all five elements of the ventilator bundle are documented and in place. The ventilator bundle elements are: • Head of bed (HOB) elevation 30 degrees or greater; • Daily "sedation interruption" and daily assessment of readiness to extubate; • SUD (peptic ulcer disease) prophylaxis; • DVT prophylaxis • Oral care with Chlorehexidine	Number of intensive care unit patients on mechanical ventilation at time of survey for whom all five elements of the ventilator bundle are documented and in place. The ventilator bundle elements are: • Head of bed (HOB) elevation 30 degrees or greater; • Daily "sedation interruption" and daily assessment of readiness to extubate; • SUD (peptic ulcer disease) prophylaxis • DVT prophylaxis • Oral care with Chlorehexidine	Total number of intensive care unit patients on mechanical ventilation.	Patients less than 18 years of age at the date of ICU admission.	Patient Safety	Health Care-Associated Infections	Process	Endorsed	0302	IHI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3005	Long-term Care Hospital Quality Reporting	Patient Centered Goals of Care	Percentage of patients aged 65 years and older who have a care plan or decision maker documented in the medical record or documentation in the medical record that a care plan was discussed but the patient did not wish or was not able to name a decision maker or provide a care plan	Patients who have a care plan or decision maker documented in the medical record or documentation in the medical record that a care plan was discussed but patient did not wish or was not able to name a decision maker or provide a care plan	All patients aged 65 years and older	N/A	Health Services Administration	Patient Experience	Process	Endorsed	0326	NCQA
2107	Long-term Care Hospital Quality Reporting	VTE Prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.	Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given: 1. the day of or the day after hospital admission 2. the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission	All patients	Patients less than 18 years of age Patients who have a length of stay (LOS) < two days and > 120 days Patients with Comfort Measures Only documented Patients enrolled in clinical trials Patients who are direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU LOS = one day Patients with ICD-9-CM Principal Diagnosis Code of Mental Disorders or Stroke Patients with ICD-9-CM Principal or Other Diagnosis Codes of Obstetrics or VTE Patients with ICD-9-CM Principal Procedure Code of Surgical Care Improvement Project (SCIP) VTE selected surgeries	Cardiovascular	Venous Thromboembolism	Process	Endorsed	0371	The Joint Commission
498	Long-term Care Hospital Quality Reporting	VTE-5: VTE Discharge Instructions	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.	Patients with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all of the following: 1. compliance issues; 2. dietary advice; 3. follow-up monitoring; 4. potential for adverse drug reactions and interactions	Patients with confirmed VTE discharged on warfarin therapy	Patients less than 18 years of age; Patients who have a length of stay greater than 120 days; Patients enrolled in clinical trials; Patients without Warfarin Prescribed at Discharge; Patients without VTE confirmed by diagnostic testing	Cardiovascular	Venous Thromboembolism	Process	Endorsed	0375	CMS (The Joint Commission)

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
845	Long-term Care Hospital Quality Reporting	Severe Sepsis and Septic Shock: Management Bundle	This measure will focus on patients aged 18 years and older who present with symptoms of severe sepsis or septic shock. These patients will be eligible for the 3 hour (severe sepsis) and/or 6 hour (septic shock) early management bundle.	Number of patients who meet criteria for severe sepsis and septic shock and successfully receive the following early management bundle as indicated. WITHIN THREE HOURS OF SEVERE SEPSIS: 1) Measure lactate level 2) Obtain blood cultures prior to antibiotics 3) Administer broad spectrum antibiotics 4) Administer 30ml/kg crystalloid for hypotension or lactate >=4mmol/L WITHIN 6 HOURS OF INITIAL SYMPTOMS FOR SEPTIC SHOCK: 5) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure >=65mmHg) 6) In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate >=4 mmol/L (36 mg/dl): - Measure central venous pressure (CVP) - Measure central venous oxygen saturation (ScvO2) 7) Remeasure lactate	Number of patients diagnosed or presenting with the symptoms of severe sepsis or septic shock.	Patients with advanced directives for comfort care or clinical conditions that preclude total measure completion should be excluded. Examples include but are not limited to mortality within the numerator time window (3 hrs for severe sepsis or 6 hrs for septic shock), patients who do not have the clinical evidence of an infection (severe sepsis or septic shock), patients for whom a central line is contraindicated, patients with coagulopathy, patients for whom central line placement was attempted but could not be inserted, or other medical, patient, or system reasons for exclusion.	Patient Safety		Composite	Endorsed	0500	Henry Ford Hospital
2711	Long-term Care Hospital Quality Reporting	Medication Reconciliation Post-Discharge	Percentage of discharges from January 1 to December 1 of the measurement year for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Medication reconciliation on or within 30 days after discharge.	All patients 66 years and older as of December 31 of the measurement year.	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge	Patient Safety	Medication Management	Outcome	Endorsed	0554	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						from the facility to which the member was transferred						
2709	Long-term Care Hospital Quality Reporting	HBIPS-2 Hours of physical restraint use	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age groups: : Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years)	The number of hours that all psychiatric inpatients were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age groups: : Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Number of psychiatric inpatient hours overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Total leave days	Patient Safety		Outcome	Endorsed	0640	CMS (The Joint Commission)
2713	Long-term Care Hospital Quality Reporting	Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications to be TAKEN by patient: - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge. * Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed Medications NOT to be taken by patient: - Discontinued Medications taken by patient before the inpatient stay that should be	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.	- Patients who died - Patients who left against medical advice (AMA) or discontinued care	Patient Safety	Medication Management	Outcome	Endorsed	0646	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				discontinued or held after discharge, AND - Allergies and Adverse Reactions Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued.(1) Major procedures and tests performed during ED visit, AND(2) Principal diagnosis at discharge OR chief complaint, AND(3) Patient instructions, AND (4) Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2708	Long-term Care Hospital Quality Reporting	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge Post-Discharge/ Patient Self-Management • Current medication list, AND • Studies pending at discharge (eg, laboratory, radiological), AND • Patient instructions Care Plan • Patient preferences or care plan documented OR Documented reason for not providing patient preferences or care plan Contact Information/Plan for Follow-up Care • 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND • Contact information for obtaining results of studies pending at discharge, AND • Plan for follow-up care, AND • Primary physician, other health care professional, or site designated for follow-up care	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	- LTCH admissions for patients who die during the PAC stay - LTCH admissions for patients who are transferred to another LTCH upon discharge - LTCH admissions for patients who are not enrolled in FFS Medicare during the observation period - LTCH admissions for patients not continuously enrolled in FFS Medicare for the 12 months prior to the index admission - LTCH patients discharged against medical advice (AMA) - LTCH admissions for medical treatment of cancer	Health Services Administration	Patient Care Management	Outcome	Endorsed	0647	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2715	Long-term Care Hospital Quality Reporting	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	- Patients who died - Patients who left against medical advice (AMA) or discontinued care	Health Services Administration	Patient Care Management	Outcome	Endorsed	0648	AMA-PCPI
1700	Long-term Care Hospital Quality Reporting	Percent of Residents Experiencing One or More Falls with Major Injury	Percent of Residents Experiencing One or More Falls with Major Injury: This measure is based on data from all non-admission assessments which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of patients/residents who experienced one or more falls with major injury in the last year (12-month period). The measure is based on an item which indicates whether any falls that occurred were associated with major injury.	The numerator is based on the number of patient/residents who experienced one or more falls that resulted in major injury on any non-admission assessment in the last 12 months. Major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma.	The denominator is the total number of patient/residents in the nursing facility who were assessed during the selected time window and who did not meet the exclusion criteria.	Denominator exclusions: Patient/Residents with admission assessments from the current quarter are excluded. Also excluded are those for whom data from the relevant assessment data are missing.	Chronic and Elder Care	Falls	Outcome	TLE	0674	CMS
1697	Long-term Care Hospital Quality Reporting	Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	The measure reports the percentage of short stay nursing home residents or IRF or LTCH patients who were assessed and appropriately given the pneumococcal vaccine during the 12-month reporting period. This measure is based on data from Minimum Data Set (MDS) 3.0 assessments of nursing home residents, the Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI) for IRF patients, and the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set for long-term care hospital patients, using items that have been harmonized across the three assessment instruments. Short-stay nursing home residents are those residents who are discharged within the first 100 days of their nursing home stay.	The following numerator components will be computed and reported separately: (1) **up-to-date vaccine status; (2) ineligible to receive vaccine due to medical contraindications; or (3) offered and declined vaccine. For the LTCH Care Data Set: Patients aged 5 years and older are counted if they meet any of the following criteria on the most recent LTCH CARE Data Set assessment during the 12-month reporting period. The following numerator components will be computed and reported separately: 1. **Up-to-date vaccine status (O0300A=1) 2. Ineligible due to medical contraindications (O0300B=1) 3. Offered and declined vaccine (O0300B=2)	The denominator consists of all residents or patients aged 5 years and older in the pneumococcal vaccination sample (defined in Denominator Details section) with an assessment within the 12-month period. For the LTCH CARE Data Set: Patients aged 5 years and older in the pneumococcal vaccination sample with a LTCH CARE Data Set assessment (which may be an admission or discharge assessment) within the 12-month period.	Residents or patients younger than 5 years old will be excluded from the denominator. Facilities with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.	Immunizations	Adult Immunization	Process	Endorsed	0682	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2111	Long-term Care Hospital Quality Reporting	Functional Change: Change in Motor Score	TBD	TBD-However, this measure is being developed through a joint project with ASPE and CMS. While a numerator and denominator statement was not available at the time that this spreadsheet was prepared, the measure developers do expect to have this information available by Fall 2012.	TBD	TBD	Chronic and Elder Care	Functional Status	Intermediate Outcome	Not Endorsed	N/A	CMS
2561	Long-term Care Hospital Quality Reporting	Functional Outcome Measure (change in mobility)	Change in mobility score at discharge as compared to admission	TBD-However, this measure is being developed through a joint project with ASPE and CMS. While a numerator and denominator statement was not available at the time that this spreadsheet was prepared, the measure developers do expect to have this information available by Fall 2012.	TBD	TBD	Chronic and Elder Care	Functional Status	Intermediate Outcome	Not Endorsed	N/A	CMS
2562	Long-term Care Hospital Quality Reporting	Functional Outcome Measure (change in self-care)	Change in mobility score at discharge as compared to admission	TBD-However, this measure is being developed through a joint project with ASPE and CMS. While a numerator and denominator statement was not available at the time that this spreadsheet was prepared, the measure developers do expect to have this information available by Fall 2012.	TBD	TBD	Chronic and Elder Care	Functional Status	Intermediate Outcome	Not Endorsed	N/A	CMS
1643	Long-term Care Hospital Quality Reporting	Medicare Spending Per Beneficiary	The Medicare Spending per Beneficiary (MSPB) Measure evaluates hospitals' efficiency relative to the efficiency of the median hospital. Specifically, the MSPB Measure assesses the cost to Medicare of services performed by hospitals and other healthcare providers during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.	A hospital's average MSPB Amount, defined as the sum of standardized, risk-adjusted spending across all of a hospital's eligible episodes divided by the number of episodes for that hospital.	The median MSPB Amount across all hospitals.	Any episodes where at any time during the episode, the beneficiary is enrolled in a Medicare Advantage plan; the beneficiary becomes deceased; the beneficiary is covered by the Railroad Retirement Board; or Medicare is the secondary payer will be excluded from the MSPB calculation. Regarding beneficiaries whose primary insurance becomes Medicaid during an episode due to exhaustion of Medicare Part A benefits, Medicaid payments made for services rendered to these beneficiaries are excluded; however, all Medicare Part A payments made before benefits are	Health Services Administration	Cost	Efficiency	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						exhausted and all Medicare Part B payments made during the episode are included. In addition, acute-to-acute transfers (where a transfer is defined based on the claim discharge code) will not be considered index admissions. In other words, these cases will not generate new MSPB episodes; neither the hospital which transfers a patient to another subsection (d) hospital, nor the receiving subsection (d) hospital will have an index admission attributed to them. Further, any episode in which the index admission inpatient claim has a $0 actual payment or a $0 standardized payment is excluded.						
479	Long-term Care Hospital Quality Reporting	Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	All documented patient falls with an injury level of minor (2) or greater.	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim), with a POA code of 'N' or 'U', and designated as a 2010 Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC): • Fracture ..... 800–829 (CC/MCC) • Dislocation ..... 830–839 (CC/MCC) • Intracranial injury ..... 850–854 (CC/MCC) • Crushing injury ..... 925–929 (CC/MCC) • Burn .....940–949 (CC/MCC) • Other injuries .....991–994 (CC/MCC)	Number of acute inpatient FFS discharges during time period.	• Non-FFS discharges (MCOPDSW=--1--) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.	Patient Safety	Complications	Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1371	Long-term Care Hospital Quality Reporting	Manifestations of Poor Glycemic Control	None listed. See numerator and denominator description	Number of occurrences of the following diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim) with a POA code of 'N' or 'U': • 249.10–249.11 • 249.20–249.21 • 250.10–250.13 • 250.20–250.23 • 251.0	Number of acute inpatient FFS discharges during time period.	-• Non-FFS discharges (MCOPDSW=--1--) • Discharges in which a provider indicated it was exempt from POA coding rules (a terminal POA character of --X--) • Discharges with a missing or invalid POA indicator for any non-missing secondary diagnosis (diagnoses 2 to 9). • Discharges that failed internal consistency checks specific to the SAF data sets.-	Patient Safety	Complications	Outcome	Not Endorsed	N/A	CMS
582	Long-term Care Hospital Quality Reporting	Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia	Incidence Rate of Hospital-Onset MRSA Based on Clinical Cultures	Report first clinical MRSA culture and all unique MRSA blood cultures (laboratory-identified events) per patient per month; no bedside assessment is needed nor complete antibiogram reported.	Report total facility-wide patient-days and admissions/encounters per month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Candidate Standard	1716	CDC
2684	Long-term Care Hospital Quality Reporting	Restraint Rate per 1000 Patient Days	Include total number of days that patients were restrained during the reporting period. A restraint is anything that restricts or prohibits movement and includes mitts that are tied down, bed rails 4x4 rails are up in 4 bed rail system and 2x2 rails are up in a 2 bed rail system, medical, surgical, physical restraints.	Include Physical Restraints according to the CMS and NQF definition – "A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body". Excludes restraints that are only associated with medical. Dental, diagnostic or surgical procedures and are based on the standard practice for the procedure (sometimes referred to as treatment restraints); Seclusion; Restraints that are forensic or correctional restrictions used for security purposes unrelated to clinical care; devices used to meet the assessed needs of a patient who requires adaptive support or a medical protective device	Number of discharged LTCH patient days for the reporting period, with patient days calculated once per 24 hour period (usually at midnight). This includes total number of discharged LTCH patient days for the reporting period, with patient days calculated once per 24 hour period, usually at midnight.	Excludes patient days for the period for non-LTCH patients and LTCH patients who are not yet discharged.	Patient Safety		Process	Not Endorsed	N/A	National Association of Long Term Hospitals

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2707	Long-term Care Hospital Quality Reporting	30-Day All Cause Post Long-Term Care Hospital (LTCH) Discharge Hospital Readmission Measure	This measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for cases discharged from an Long Term Care Hosptial (LTCH) who were readmitted to a short-stay acute care hospital, within 30 days of a LTCH discharge	Number of cases with an unplanned Acute admission occurring within 30 days following an LTCH discharge.	• Patients who had been continuously enrolled in Part A FFS Medicare for the 12 months prior to the LTCH Admission, and at least 30 days after LTCH discharge, • AND had a short-term acute care stay within 30 days prior to an LTCH stay, • AND who were discharged from the LTCH to the community or a less intense level of care, • AND who were followed for 30 days post discharge from the LTCH or death if patient dies within 30 days.	TBD	Readmission		Outcome	Not Endorsed	N/A	CMS
3011	Long-term Care Hospital Quality Reporting	Clostridium Difficile SIR Measure	Incidence rate of hospital-onset c. difficile. Report all healthcare-associated infections where C. difficile identified a positive toxin result are the associated pathogen. Refer to specific definitions (Chapter 17) for gastroenteritis (GI-GE) or gastrointestinal tract (GI-GIT) infections criteria. Cases of CDI (i.e., C. difficile pathogen identified with a positive toxin result) that are not present or incubating at the time of admission (i.e., meets criteria for a healthcare-associated infection) should be reported as gastroenteritis (GI-GE) or gastrointestinal tract (GI-GIT) infections, whichever is appropriate. Report the pathogen as C. difficile on the MDRO or CDI Infection Event form (CDC 57.126). If the patient develops both GI-GE and GI-GIT CDI, report only GI-GIT using the date of onset as that of GI-GE CDI. (This CDI HAI reporting corresponds to surveillance for healthcare-onset, healthcare facility-associated CDI in recently published recommendations, which is considered the minimum surveillance for CDI.)	The total number of HAI CDI cases identified during the surveillance month.	The total number of patient days and admissions during the surveillance month.	None	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	1717	CDC

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3035	Long-term Care Hospital Quality Reporting	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.	Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.	1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC
3036	Long-term Care Hospital Quality Reporting	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries)	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3."In and out" catheterizations	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.									
3041	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Annual Wellness Assessment: Assessment of Health Risks (Draft)	Percentage of patients 65 years and older with an annual wellness visit (AWV) during the measurement period who received age- and sex-appropriate screenings: (General self-perceived health, Obesity, High blood pressure, Low HDL-C and high total cholesterol, Risky drinking, Tobacco use, Depression, Physical Inactivity, Falls, Colorectal cancer, Breast Cancer, & Osteoporosis)	Patients who received age- and sex-appropriate screenings	Patients 65 years and older with an AWV during the measurement period	Patients with a condition diagnosed prior to the AWV (for example, high blood pressure) will be excluded from screening for that condition	Environment & Public Health		Composite	Not Endorsed	N/A	CMS
3042	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Annual Wellness Assessment: Management of Health Risks (Draft)	Percentage of patients 65 years and older with an annual wellness visit (AWV) during the measurement period who *received management of identified risks and age-appropriate: (High blood pressure, Low HDL-C or high total cholesterol, Risky drinking, Tobacco use, Depression, Falls, Pneumonia vaccination status, Influenza vaccination status) *Received management could include preventive care & disease specific education, lab tests, disease specific screening tests, medical counseling advice.	Patients who received management of identified risks and age-appropriate immunizations	Patients 65 years and older with an AWV during the measurement period and at least one identified risk	None	Environment & Public Health		Composite	Not Endorsed	N/A	CMS
3040	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	Appropriate Monitoring of Patients Receiving PCA	Appropriate monitoring of patients receiving an opioid via IV patient controlled analgesia (PCA) device	Patient admissions during which the maximum period between documented respiratory rate, sedation score and pulse oximetry does not exceed 2.5 hours during the first 24 hours after initiation of the first IV PCA opioid administration , excluding any period when PCA is discontinued	All patient admissions with initiation of an opioid via an IV PCA device that is active for more than 2.5 continuous hours	Patients with an order for "comfort measures only" or "allow natural death"	Patient Safety	Medication Management	Process	Not Endorsed	N/A	CMS

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1110	Medicare Physician Quality Reporting System (PQRS)	Osteoporosis management in women >= 67 who had a fracture	Percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the date of fracture	Appropriate testing or treatment for osteoporosis after the fracture defined by any one of the following criteria: -A BMD test on the index episode start date or in the 180-day period after the index episode start date -A BMD test during the inpatient stay for the fracture (applies only to fractures requiring hospitalization) -A dispensed prescription to treat osteoporosis on the index episode start date or in the 180-day period after the index episode start date	Women 67 years and older as of December 31 of the measurement year who had a fracture between July 1 of the year prior to the measurement year through June 30 of the measurement year. If a patient has more than one fracture during the specified period, include only the first fracture identified. Do not use ambulance or durable medical equipment (DME) claim/encounter data to identify members who had a fracture.	Exclude patients who: - Had a BMD test or who received any osteoporosis treatment during the 365 days prior to the Index Episode Start Date. For patients with an inpatient stay, use the admission date to determine a negative diagnosis. - Had a fracture during the 60 days prior to the index episode start date.	Musculoskeletal	Osteoporosis	Process	Endorsed	0053	NCQA
1113	Medicare Physician Quality Reporting System (PQRS)	Diabetes: Hemoglobin A1c testing	Percentage of patients with diabetes ages 18-75 years receiving one or more A1c test(s) per year	One or more HbA1c tests performed during the measurement year.	Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through: Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. Diagnosis of Diabetes on the Problem List or at least two visits with diabetes listed as a diagnosis.	Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or the year prior to the measurement year.	Diabetes	HbA1c Management	Process	Endorsed	0057	NCQA

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2716	Medicare Physician Quality Reporting System (PQRS)	Lipid Profile for Beneficiaries less than or equal to 75 with Diabetes	Percentage of adult patients with diabetes aged 18-75 years receiving at least one lipid profile (or ALL component tests)	An LDL-C test performed during the measurement year.	Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).	Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year.	Diabetes	Cardiovascular	Process	Endorsed	0063	NCQA
1894	Medicare Physician Quality Reporting System (PQRS)	Vascular Composite: Optimal Vascular Care	Patients ages 18 to 75 with ischemic vascular disease (IVD) who meet all of the numerator targets of this composite measure: LDL less than 100, Blood Pressure less than 140/90, Tobacco-Free Status, and Daily Aspirin Use (unless contraindicated).	All members from the denominator who reach treatment targets* for all numerator components: - Low-Density Lipoprotein (LDL) Screening--Coronary artery disease (CAD) population who had an LDL during the measurement year or the year prior to the measurement year with a level less than 100 for the most recent screening - Tobacco Non-User--CAD population with documented non-smoking status - Blood Pressure Control--CAD population whose blood pressure is in control less than 140/90 during the measurement year - Aspirin Usage--CAD population eligible for aspirin use who were on aspirin therapy. *Numerator component target measure may be modified to reflect changing recommendations of treatment targets.	Members between 18 and 75 years of age as of December 31st of the reporting year, who were continually enrolled with not more than 1 month break in coverage and have a diagnosis of coronary artery disease (CAD)* *CAD diagnosis: 410.XX Acute Myocardial Infarction (AMI) 411.XX Post Myocardial Infarction Syndrome 412 Old AMI 413.XX Angina Pectoris 414.0X Coronary Atherosclerosis 414.10 Aneurysm of Heart Wall 414.8 Other Chronic Ischemic Heart Disease (IHD) 414.9 Chronic IHD	Numerator Exclusion: Members contraindicated to aspirin therapy are excluded from the -Aspirin Usage- component of the measure. Denominator Exclusions: Members can be excluded from the sample for the following reasons during the measurement year: member died, resident in nursing home, or hospice. Sampling error member does not have CAD.	Cardiovascular	Coronary Artery Disease/Ischemic Heart Disease	Intermediate Outcome	Endorsed	0076	Minnesota Community Measurement

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2232	Medicare Physician Quality Reporting System (PQRS)	Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents	Percentage of patients newly diagnosed with ADHD whose medical record contains documentation of DSM-IV-TR or DSM-PC criteria.	Number of medical records of newly diagnosed attention deficit hyperactivity disorder (ADHD) patients with documentation of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual for Primary Care (DSM-PC) criteria being addressed* *Documented is defined as any evidence in the medical record that DSM-IV or DSM-PC criteria were addressed. DSM-IV or DSM-PC criteria include evaluation for: - symptoms - onset - duration - pervasiveness - impairment Staff note: the supporting ICSI clinical practice guideline provides a list of symptoms and specifies that six or more of the symptoms must be present for at least 6 months to a degree that is maladaptive and inconsistent with developmental level in order to qualify as ADHD	Total number of medical records of newly diagnosed attention deficit hyperactivity disorder (ADHD) patients reviewed* *ADHD is defined as International Classification of Diseases, Ninth Revision (ICD-9) codes of 314.00 or 314.01. Newly diagnosed is defined as documented ADHD within the past 6 months and no documentation of ADHD codes in the previous 6 to 12 months.	None	Mental Health Care & Substance-Related Care		Outcome	Endorsed	0106	Institute for Clinical Systems Improvement
2233	Medicare Physician Quality Reporting System (PQRS)	Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents	Percentage of patients treated psychostimulant with medication for the diagnosis of ADHD whose medical record contains documentation of a follow-up visit at least twice a year.	Number of patients with ADHD on psycho-stimulant medication whose medical record contains documentation of a follow-up visit at least twice a year. *Documented is defined as any evidence in the medical record that a follow-up visit occurs in the past 12 months. A follow-up visit for ADHD includes documentation of the following twice a year: height, weight, a discussion of medication,	Number of patients with ADHD on psycho-stimulant medication whose medical records are reviewed. ADHD is defined as International Classification of Diseases, Ninth Revision (ICD-9) codes of 314.00 or 314.01. Diagnosed is defined as documented ADHD in the past 6 to 12 months. First-line medications include: methylphenidate (Ritalin), dextroamphetamine (Dexedrine),	None	Mental Health Care & Substance-Related Care		Process	Endorsed	0107	Institute for Clinical Systems Improvement

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				a discussion of school progress, and a care plan should be identified.	and atomoxetine (Strattera).							
2235	Medicare Physician Quality Reporting System (PQRS)	Bipolar Disorder: Monitoring change in level-of-functioning	Percentage of patients aged 18 years and older with an initial diagnosis or new episode/presentation of bipolar disorder.	Documentation of monitoring the patient's level-of-functioning in one of the following ways: - Patient self-report documented by clinician in record OR - Clinician documented review of patient-completed monitoring form/diary/tool OR - Documentation in patient chart of the use of ONE level-of-functioning monitoring tool, examples are as follows: o SOFAS: Social and Occupational Functioning Assessment Scale o GARF: Global Assessment of Relationship Functioning o GAF: Global Assessment of Functioning o WASA: Workload and Social Adjustment Assessment o PDS: Progressive Deterioration Scale (functional impairment; activities of daily living) o PHQ-9: Question 2 (How difficult has it been for you¦.) o SF 12 or SF 36 AND Timeframe for numerator chart documentation Documentation of assessment of level-of-functions at time of initial assessment and within 12 weeks of initiating treatment for bipolar disorder (Note: While the acute phase of treatment varies per individual, it is during this period that the clinician attempts to closely monitor the patient progress and has the	Patients 18 years of age or older with an initial or new episode of bipolar disorder AND Documentation of a diagnosis of bipolar disorder; to include at least one of the following: - Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms - Diagnosis or Impression or working diagnosis• documented in chart indicating bipolar disorder - Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis AND Documentation of treatment for bipolar disorder with pharmacotherapy; mood stabilizing agent and/or an antipsychotic agent. New diagnosis• or a new episode,• is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the out-patient care of a physician.	Patient has an active diagnosis of bipolar disorder or unipolar depression or any other patient reason the risk category assessment was not completed.	Mental Health Care & Substance-Related Care		Process	Endorsed	0112	Center for Quality Assessment and Improvement in Mental Health

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				opportunity to interact with the patient to assess level-of-functioning. This acute phase has been defined by the Project's content experts as having the possibility of lasting through the first 3 months of treatment/therapy; thus the 12 week period)								
2861	Medicare Physician Quality Reporting System (PQRS)	Pain brought under control within 48 hours	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.	Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment (after admission to hospice services).	Patients who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment (after admission to hospice services).	Inclusions: Patients are eligible if they: Report they are uncomfortable because of pain at the initial assessment (after admission to hospice services); Are able to communicate and understand the language of the person asking the question; Are able to self-report; and, Are at least 18 years of age or older	Chronic and Elder Care	Palliative Care	Outcome	Endorsed	0209	National Hospice and Palliative Care Organization
2086	Medicare Physician Quality Reporting System (PQRS)	Ambulatory Sensitive Conditions Admissions: Chronic obstructive pulmonary disease	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for COPD.	Population of Medicare FFS beneficiaries aged 18 years and older	Exclude cases: transferring from another institution (SID ASOURCE=2) MDC 14 (pregnancy, childbirth, and puerperium) MDC 15 (newborn and other neonates)	Respiratory	Chronic Obstructive Pulmonary Disease	Outcome	Endorsed	0275	AHRQ
2083	Medicare Physician Quality Reporting System (PQRS)	Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure	This measure is used to assess the number of admissions for congestive heart failure (CHF) per 100,000 population.	All non-maternal/non-neonatal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF.	Population in Metro Area or county, age 18 years and older.	Exclude cases: transferring from another institution (SID ASOURCE=2) MDC 14 (pregnancy, childbirth, and puerperium) MDC 15 (newborn and other neonates)	Cardiovascular	Heart Failure	Outcome	Endorsed	0277	AHRQ
2898	Medicare Physician Quality Reporting System (PQRS)	Low Back Pain: Shared Decision Making.	Percentage of patients with back pain with whom a physician or other clinician reviewed the range of treatment options, including alternatives to surgery prior to surgery. To demonstrate shared decision making, there must be documentation in the patient record of a discussion between the physician and the patient that includes all of the following. •Treatment choices, including alternatives to surgery; •Risks and benefits; •Evidence of effectiveness	The number of patients who had surgery, with documentation in the medical record that a clinician and the patient discussed treatment options prior to surgery, including alternatives to surgery, risks and benefits and evidence of effectiveness.	Patients who had surgery for back pain 18-80 years of age.	Did not include with submission	Health Services Administration	Patient Care Management	Process	Endorsed	0310	ACCF-AHA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2238	Medicare Physician Quality Reporting System (PQRS)	Lower Back Pain: Repeat Imaging Studies	Percentage of patients with back pain who received inappropriate imaging studies in the absence of red flags or progressive symptoms (overuse measure, lower performance is better)	The number of patients with inappropriate imaging studies (as defined below). Documentation requirements: - Include all imaging studies ordered or documented from the date of the initial visit to the end of the eligible episode. - The following types of imaging studies should be counted toward the numerator of this measure, unless otherwise specified below. --Plain x-ray --Bone scan --MRI --Myleography --Discography --CT scan - Determine if more than one imaging study has been ordered or if a report is present during the eligible episode. If the patient has been under the care of another physician, there should be documentation that the patient was asked about prior imaging studies and attempts made to get those studies/reports. --Patients with one imaging study or no documentation of assessing for prior studies count toward the numerator --Include imaging studies in the numerator and denominator if they have been ordered by the applicant or if there are imaging reports from another provider. - Do not include CT scan or MRI toward the numerator if the first imaging study is a plain x-ray. - If the patient is a surgical patient, the following rules apply.	Patients with more than one imaging study and patients with only one imaging study and no documentation in medical record of physician asking about prior imaging.	Patients with red flags or worsening/progressive signs.	Diagnostic Imaging		Process	Endorsed	0312	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				-- Do not count an imaging study (MRI, CT scan, myleography only) as a repeat in the numerator if it occurs in the 12 weeks prior to the surgical date -- If the surgical procedure was instrumented fusion or disc replacement, do not count plain, post-operative x-rays toward the numerator -- Do not count an imaging study toward the numerator that occurs post-operatively as a repeat if there is documentation of surgical complications - Exclude patients from the denominator with evidence or notation of any of the following in their medical record in the seven-day (one week) period preceding the second imaging study. -- Red flags (e.g., history of cancer, current infection, fracture or suspected fracture, cauda equina syndrome) -- Worsening/progressive signs (e.g., objective findings of progressive neurologic symptoms such as new sciatica; new or worsening numbness or weakness; or physical exam findings indicating new missing reflex or worsening weakness) Note: Failure to respond to treatment is not an indication of worsening symptoms.							
2960	Medicare Physician Quality Reporting System (PQRS)	Appropriate Imaging for Acute Back Pain	Percentage of patients with a diagnosis of back pain for whom the physician ordered imaging studies during the six weeks after pain onset, in the absence of red flags (overuse measure, lower performance is better).	The number of patients with an order for or report on an imaging study during the six weeks after pain onset	Patients with back pain lasting six weeks or less from 18-80 years of age	Did not include with submission	Diagnostic Imaging		Process	Endorsed	0315	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2445	Medicare Physician Quality Reporting System (PQRS)	American Society for Therapeutic Radiology and Oncology/American Society of Clinical Oncology/Physician Consortium for Performance Improvement: Oncology: Treatment Summary Communication – Radiation Oncology	Percentage of patients, Regardless of age, 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	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	All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy	Documentation of a patient reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient requests that report not be sent) and to the patient Denominator: Documentation of a system reason(s) for not communicating the treatment summary report to the physician(s) proving continuing care (eg, patient does not have any physician responsible for providing continuing care) and to the patient	Cancer		Process	TLE	0381	AMA-PCPI
2894	Medicare Physician Quality Reporting System (PQRS)	Influenza Vaccination Coverage Among Healthcare Personnel	Percentage of healthcare personnel (HCP) who receive the influenza vaccination	HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year: (a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or (b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination; or (c) declined influenza vaccination; or (d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories	Number of HCP who are working in the healthcare facility for at least 30 working days between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact		Immunizations	Adult Immunization	Structure	TLE	0431	CDC

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2256	Medicare Physician Quality Reporting System (PQRS)	Thorax CT: Use of Contrast Material	This measure calculates the percentage of thorax studies that are performed with and without contrast out of all thorax studies performed (those with contrast, those without contrast, and those with both).	Thorax CT -- Use of combined studies (with and without contrast) The number of thorax CT studies with and without contrast (combined studies). Sum of global and technical units associated with CPT codes: 71270 -- Thorax CT With and Without Contrast A technical unit can be identified by a modifier code of TC. A global unit can be identified by the absence of a TC or 26 modifier code. Thorax CT studies can be billed separately for the technical and professional components, or billed globally to include both the professional and technical components. Professional component claims with out number Technical component claims due to over-reads. To capture all outpatient and office volume, both office (typically paid under the MPFS) and facility claims (typically paid under the OPPS/APC methodology) should be considered. In the absence of a TC or 26 modifier code, outpatient facility claims should be considered technical components and included in utilization.	Thorax CT -- Use of combined studies (with and without contrast) The number of thorax CT studies performed (with contrast, without contrast or both with and without contrast). Sum of global and technical units for CPT codes : 71250 - Thorax Without Contrast 71260 -- Thorax CT With Contrast 71270 -- Thorax CT With and Without Contrast	None	Diagnostic Imaging		Efficiency	Endorsed	0513	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2257	Medicare Physician Quality Reporting System (PQRS)	Diabetic Foot Care and Patient/Caregiver Education Implemented During Short Term Episodes of Care	Percentage of short term home health episodes of care during which diabetic foot care and education were included in the physician-ordered plan of care and implemented for patients with diabetes.	Number of home health episodes where at end of episode, diabetic foot care and education specified in the care plan had been implemented. Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. Details: Number of patient episodes where at end of episode: - (M0100) Reason for Assessment equals 6 or 7 (transfer to inpatient) or 9(discharge) AND: - (M1095)Diabetic Foot Care Plan implement equals 1 (yes)	Number of home health episodes where diabetic foot care had been specified in the care plan and episode is not covered by denominator exclusions (Q6). Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly.	All episodes where -the patient is not diabetic OR the patient is a bilateral amputee (M1095 is N/A) OR -diabetic foot care was not included in the care plan (M1095 is N/A); OR - the episode did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home - OR -patients who receive a recertification (RFA 04) OASIS assessment between SOC/ROC (01/03) to Discharge OASIS.	Diabetes	Foot Care	Process	Endorsed	0519	CMS
728	Medicare Physician Quality Reporting System (PQRS)	Adherence to Chronic Medications	The measure addresses adherence to three types of chronic medications: statins, levothyroxine, and angiotensin converting enzyme inhibitors (ACEIs)/angiotensin receptor blockers (ARBs). The measure is divided into three submeasures: Measure A: The percentage of eligible individuals who had at least two prescriptions for statins and who have a Proportion of Days Covered (PDC) = 0.8 during the measurement period (12 consecutive months). Measure B: The percentage of eligible individuals who had at least two prescriptions for levothyroxine and who have a PDC = 0.8 during the measurement period (12 consecutive months). Measure C: The percentage of eligible individuals who had at least two prescriptions for ACEIs/ARBs and who have a PDC = 0.8 during the measurement period (12 consecutive months).	Numerator A: Individuals with at least two prescriptions for statins having a PDC of at least 0.8. Numerator B: Individuals with at least two prescriptions for levothyroxine having a PDC of at least 0.8. Numerator C: Individuals with at least two prescriptions for ACEIs/ARBs having a PDC of at least 0.8.	Denominator A: Individuals with at least two prescriptions for statins. Denominator B: Individuals with at least two prescriptions for levothyroxine. Denominator C: Individuals with at least two prescriptions for ACEIs/ARBs.	Not Applicable	Patient Safety	Medication Management	Process	Endorsed	0542	CMS
743	Medicare Physician Quality Reporting	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	The measure addresses adherence to three types of chronic medications; statins, angiotensin converting enzyme inhibitors (ACEIs)/angiotensin receptor blockers	Numerator A: Individuals in Denominator A with at least two prescriptions for statins with a PDC of at least 0.8 for statins.	Denominator A: Individuals 18 years or older with diabetes mellitus and at least two prescriptions for statins during the	Individuals with polycystic ovaries, gestational diabetes, or steroid-induced diabetes who do not have a face to face visit with a diagnosis of diabetes in any	Diabetes	Cardiovascular	Process	Endorsed	0545	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
	System (PQRS)		(ARBs) and oral hypoglycemic agents. The measure is divided into three submeasures: Measure a: The percentage of eligible individuals who had at least two prescriptions for statins and who have a Proportion of Days Covered (PDC) = 0.8 during the measurement period (12 consecutive months). Measure b: The percentage of eligible individuals who had at least two prescriptions for ACEIs/ARBs and who have a PDC = 0.8 during the measurement period (12 consecutive months). Measure c: The percentage of eligible individuals who had least two prescriptions for a single oral hypoglycemic agent or at least two prescriptions for multiple agents within an antidiabetic class and who have a PDC = 0.8 for at least 1 antidiabetic class during the measurement period (12 consecutive months).	Numerator B: Individuals in Denominator B with at least two prescriptions for ACEIs/ARBs with a PDC of at least 0.8 for ACEIs/ARBs. Numerator C: Individuals in Denominator C with at least two prescriptions for oral hypoglycemic agents, in any anti-diabetic class, with a PDC of at least 0.8 for at least one anti-diabetic class.	measurement year. Denominator B: Individuals 18 years or older with diabetes mellitus and at least two prescriptions for ACEIs/ARBs during the measurement year. Denominator C: Individuals 18 years or older with diabetes mellitus and at least two prescriptions for a single oral hypoglycemic agent or at least two prescriptions for multiple agents within an antidiabetic class.	setting during the measurement period.						
2964	Medicare Physician Quality Reporting System (PQRS)	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications to be TAKEN by patient: - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge * Prescribed dosage, instructions,	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care Time Window: Each time a patient is discharged from an inpatient facility	Patients who died Patients who left against medical advice (AMA) or discontinued care	Patient Safety	Medication Management	Outcome	Endorsed	0646	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				and intended duration must be included for each continued and new medication listed Medications NOT to be Taken by patient: - Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND - Allergies and Adverse Reactions Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued								
2962	Medicare Physician Quality Reporting System (PQRS)	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care • Reason for inpatient admission, AND • Major procedures and tests performed during inpatient stay and summary of results, AND • Principal diagnosis at discharge Post-Discharge/ Patient Self-Management • Current medication list, AND • Studies pending at discharge (e.g., laboratory, radiological), AND • Patient instructions Care Plan • Patient preferences or care plan documented OR Documented reason for not providing patient preferences or care plan Contact Information/Plan for	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.	Patients who died. Patients who left against medical advice (AMA) or discontinued care.	Health Services Administration	Patient Care Management	Outcome	Endorsed	0647	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				Follow-up Care • 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND • Contact information for obtaining results of studies pending at discharge, AND • Plan for follow-up care, AND • Primary physician, other health care professional, or site designated for follow-up care								
2961	Medicare Physician Quality Reporting System (PQRS)	Timely Transmission of Transition Record	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	Patients who died Patients who left against medical advice (AMA) or discontinued care	Health Services Administration	Patient Care Management	Outcome	Endorsed	0648	AMA-PCPI
2963	Medicare Physician Quality Reporting System (PQRS)	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND • List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended	All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care	Patients who died Patients who left against medical advice (AMA) or discontinued care Patients who declined receipt of transition record	Health Services Administration	Patient Care Management	Process	TLE	0649	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				duration) and instructions for each								
1017	Medicare Physician Quality Reporting System (PQRS)	American Academy of Otolaryngology-Head and Neck Surgery/Physician Consortium for Performance Improvement: Otitis Media with Effusion: Antihistamines or decongestants – Avoidance of inappropriate use	Percentage of patients aged 2 months through 12 years with a diagnosis of OME were not prescribed or recommended to receive either antihistamines or decongestants	Patients who were not prescribed or recommended to receive either antihistamines or decongestants	All patients aged 2 months through 12 years with a diagnosis of OME	Documentation of medical reason(s) for prescribing or recommending to receive either antihistamines or decongestants	Ears, Nose, and Throat		Process	TLE	0655	AMA-PCPI
1019	Medicare Physician Quality Reporting System (PQRS)	American Academy of Otolaryngology-Head and Neck Surgery/Physician Consortium for Performance Improvement: Otitis Media with Effusion:Systemic corticosteroids – Avoidance of inappropriate use	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic corticosteroids	Patients who were not prescribed systemic corticosteroids	All patients aged 2 months through 12 years with a diagnosis of OME	Documentation of medical reason(s) for prescribing systemic corticosteroids	Ears, Nose, and Throat		Process	TLE	0656	AMA-PCPI
2952	Medicare Physician Quality Reporting System (PQRS)	Ultrasound guidance for Internal Jugular central venous catheter placement.	Percent of adult patients aged 18 years and older with an Internal Jugular central venous catheter placed in the emergency department (ED) under ultrasound guidance	Number of adult patients aged 18 years and older who underwent ultrasound guided Internal Jugular central venous catheter insertion in the emergency department (ED).	Number of adult patients aged 18 years and older who underwent Internal Jugular central venous catheter insertion in the emergency department (ED).	Did not include with submission	Diagnostic Imaging		Process	TLE	0666	ACEP
2264	Medicare Physician Quality Reporting System (PQRS)	Depression Remission at Six Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score greater than 9 who demonstrate remission at six months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score of less than five.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Intermediate Outcome	Endorsed	0711	Minnesota Community Measurement

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2267	Medicare Physician Quality Reporting System (PQRS)	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Patient visits with an assessment for suicide risk	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder	None	Mental Health Care & Substance-Related Care	Suicide	Process	Endorsed	1365	AMA-PCPI
2931	Medicare Physician Quality Reporting System (PQRS)	Rate of Open Repair of Small or Moderate Non- ruptured Abdominal Aortic Aneurysms (AAA) who die while in hospital.	Percent of patients undergoing open repair of small or moderate sized non-ruptured abdominal aortic aneurysms who die while in hospital.	Death in-hospital following non-ruptured infrarenal AAA repair.	All open non-ruptured infrarenal abdominal aortic aneurysm repairs.		Mortality		Outcome	Endorsed	1523	Society for Vascular Surgery
1035	Medicare Physician Quality Reporting System (PQRS)	ACC/AHA/AMA-PCPI: Atrial Fibrillation and Atrial Flutter: Assessment of Thromboembolic Risk Factors (CHADS2)	Percentage of patients aged 18 years and older with a diagnosis of nonvalvular AF or atrial flutter with an assessment of all of the specified thromboembolic risk factors using the CHADS2 risk criteria has been documented	Patients with an assessment of all of the specified thromboembolic risk factors documented during the 12 month reporting period. Thromboembolic risk factors to be assessed include: prior stroke or TIA, age = 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function	All patients aged 18 years and older with a diagnosis of nonvalvular AF or atrial flutter	Documentation of medical reason(s) for not assessing risk factors using the CHADS2 risk criteria (eg, patients with transient or reversible causes of AF (eg, pneumonia or hyperthyroidism), patients with mitral stenosis or prosthetic heart valves, postoperative patients, patients who are pregnant, allergy to warfarin and all other oral anticoagulant drugs that are FDA approved for the prevention of thromboembolism, risk of bleeding, other medical reason)	Cardiovascular		Process	Endorsed	1524	ACC/AHA/AMA-PCPI
2929	Medicare Physician Quality Reporting System (PQRS)	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) who die while in hospital.	Percent of patients undergoing endovascular repair of small or moderate abdominal aortic aneurysms (AAA) who die while in the hospital.	In-hospital death following endovascular AAA repair.	All infrarenal non-ruptured endovascular AAA repairs.		Mortality		Outcome	Endorsed	1534	Society for Vascular Surgery
2933	Medicare Physician Quality Reporting System (PQRS)	Rate of postoperative stroke or death in Asymptomatic Patients undergoing Carotid Endarterectomy (CEA).	Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital.	Patients who experience stroke or death during their hospitalization.	Asymptomatic patients over age 18.		Patient Safety	Complications	Outcome	Endorsed	1540	Society for Vascular Surgery

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2932	Medicare Physician Quality Reporting System (PQRS)	Rate of postoperative stroke or death in Asymptomatic Patients undergoing Carotid Artery Stenting (CAS).	Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital.	Patients who experience stroke or death during their hospitalization.	Asymptomatic patients undergoing CAS.		Patient Safety	Complications	Outcome	Endorsed	1543	Society for Vascular Surgery
2917	Medicare Physician Quality Reporting System (PQRS)	Patients Treated with an Opioid who are given a bowel regimen	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed	Vulnerable adults who are given a new prescription for an opioid	None	Pain		Process	Endorsed	1617	RAND
2883	Medicare Physician Quality Reporting System (PQRS)	Hospitalized Patients who Die an Expected Death with an ICD that has been deactivated	Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated	Patients from the denominator who have their ICDs deactivated prior to death or have documentation of why this was not done	Patients who die an expected death who have an ICD in place	None	Mortality		Process	Endorsed	1625	RAND
2501	Medicare Physician Quality Reporting System (PQRS)	Patients Admitted to ICU who Have Care Preferences Documented	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Patients in the denominator who had their care preferences documented within 48 hours of ICU admission or have documentation of why this was not done	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission	None	Health Services Administration	Patient Care Management	Process	Endorsed	1626	RAND
2874	Medicare Physician Quality Reporting System (PQRS)	Hospice and Palliative Care: Pain Screening	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter	Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for hospital-based palliative care. Screening may be completed using verbal, numeric, visual analog, rating scales designed for use the non-verbal patients, or other standardized tools.	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1634	University of North Carolina (UNC)

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2873	Medicare Physician Quality Reporting System (PQRS)	Hospice and Palliative Care: Pain Assessment	This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.	Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.	Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.	Patients with length of stay < 1 day in palliative care or < 7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1637	University of North Carolina (UNC)
2872	Medicare Physician Quality Reporting System (PQRS)	Hospice and Palliative Care: Dyspnea Treatment	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Patients enrolled in hospice for 7 or more days OR patients receiving palliative care who report dyspnea when dyspnea screening is done on the admission evaluation / initial encounter.	Palliative care patients with length of stay < 1 day or hospice patients with length of stay < 7 days, patients who were not screened for dyspnea, and/or patients with a negative screening.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1638	University of North Carolina (UNC)
2871	Medicare Physician Quality Reporting System (PQRS)	Hospice and Palliative Care: Dyspnea Screening	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.	Chronic and Elder Care	Palliative Care	Process	Endorsed	1639	University of North Carolina (UNC)
2877	Medicare Physician Quality Reporting System (PQRS)	Hospice and Palliative Care: Treatment Preferences	Percentage of patients with chart documentation of preferences for treatments.	Patients whose medical record includes documentation of treatment preferences	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.	Patients with length of stay < 1 day in palliative care or < 7 days in hospice	Chronic and Elder Care	Palliative Care	Process	Endorsed	1641	University of North Carolina (UNC)
2844	Medicare Physician Quality Reporting System (PQRS)	CAHPS Surgical Care Survey: Surgeon administered the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey (S-CAHPS) in a systematic sample of eligible patients AND documented review of their Semi-Annual S-CAHPS Summary Report	This is a measure of surgeon participation in the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey (S-CAHPS). Adherence to this measure requires: (1) administration of the S-CAHPS patient survey in sample of eligible patients that is of at least minimally adequate sample size as defined by S-CAHPS methodology; (2) documentation that a surgeon's specific SCAHPS Semi-Annual Summary Report was reviewed. This measure is an all-or-nothing participation measure and is scored as "YES, surgeon successfully participated in S-CAHPS during the reporting period," or "NO, surgeon did not successfully participate in S-CAHPS during the	Fulfillment of this measure requires that a surgeon have successfully participated in S-CAHPS during the reporting period. Successful participation in S-CAHPS requires: 1. Administration of S-CAHPS survey in a sample of eligible adult patients (age 18 and over) having had a major surgery as defined by CPT codes (See CPT Codes Appendix). Surgery performed had to be scheduled and not an emergency procedure since emergency procedures are unlikely to have visits with the surgeon before the surgery. AND 2. Documentation that a surgeon reviewed his/her surgeon-specific	This measure is reported as a participation measure.	None Provided (NQF lists the following) • Surgical patients whose procedure was greater than 6 months or less than 3 months prior to the start of the survey. • Surgical patients younger than 18 years old. • Surgical patients who are institutionalized (put in the care of a specialized institution) or deceased. • Surgery performed had to be scheduled and not an emergency procedure since emergency procedures are unlikely to have visits with the surgeon before the surgery. • Multiple surgery patients within the same household can be included in the sampling frame. However, once one patient in the household is sampled, any	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	1741	American College of Surgeons

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			reporting period."	Semi-Annual S-CAHPS Summary Report during the reporting period.		other patients in the same household would be excluded from being sampled in order to minimize survey burden to the household						
2881	Medicare Physician Quality Reporting System (PQRS)	Hospital Wide All Cause Unplanned Readmissions.	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.	Note: This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we use this field to define the measure outcome.)	The outcome for this measure is unplanned all-cause 30-day readmission. We defined a readmission as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.	Did not include with submission	Readmission		Outcome	Endorsed	1789	CMS
2866	Medicare Physician Quality Reporting System (PQRS)	External Beam Radiotherapy for Bone Metastases	This measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme as defined by the guideline	All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn.	All patients with bone metastases and no previous radiation to the same anatomic site who receive EBRT	1) Previous radiation treatment to the same anatomic site (Medical Record) 2) Patients with femoral axis cortical involvement greater than 3 cm in length(Imaging Studies) 3) Patients who have undergone a surgical stabilization procedure (Operative Report) 4) Patients with spinal cord compression, cauda equina compression or radicular pain (Diagnosis/Problem list)	Cancer		Process	Endorsed	1822	American Society for Radiation Oncology (ASTRO)
2804	Medicare Physician Quality Reporting System (PQRS)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia.	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months)	Individuals with schizophrenia or schizoaffective disorder who filled at least two prescriptions for any antipsychotic medication and have a Proportion of Days Covered (PDC) for antipsychotic medications of at least 0.8.	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder with at least two claims for any antipsychotic medication during the measurement period (12 consecutive months).	Did not include with submission	Patient Safety	Medication Management	Process	Endorsed	1879	CMS
3045	Medicare Physician Quality Reporting System (PQRS)	Medical visit frequency	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period.	Patients who died at any time during the 24-month measurement period.	Communicable Diseases	HIV/AIDS	Process	Under Review	2079	HRSA

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				the subsequent 6-month period. (Measurement period is a consecutive 24-month period of time.)								
3044	Medicare Physician Quality Reporting System (PQRS)	Gap in medical visits	Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year (Measurement year is a consecutive 12-month period of time).	Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year. (The measurement year can be any consecutive 12-month period.)	Patients who died at any time during the measurement year.	Communicable Diseases	HIV/AIDS	Process	Under Review	2080	HRSA
3043	Medicare Physician Quality Reporting System (PQRS)	HIV viral load suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year	None	Communicable Diseases	HIV/AIDS	Outcome	Under Review	2082	HRSA
3046	Medicare Physician Quality Reporting System (PQRS)	Prescription of HIV Antiretroviral Therapy	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year.	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year	None	Communicable Diseases	HIV/AIDS	Process	Under Review	2083	HRSA
2463	Medicare Physician Quality Reporting System (PQRS)	Concordance Assessment Following Image- Guided Breast Biopsy	Percent of breast patients who have concordance assessment performed following an image– guided breast biopsy	The number of patients age 18 and older who have documentation of concordance assessment following image guided breast biopsy	The number of patients age 18 and older who undergo an image guided breast biopsy	Patients undergoing image-guided open surgical biopsy or lumpectomy The following are excluded from imaged guided percutaneous biopsy: 19101 Open/incisional biopsy 19120 Open/excisional biopsy 19125 Open excisional biopsy identified by radiologic marker 19301 Partial mastectomy Partial mastectomy with radiologic marker 19302 Partial mastectomy with axillary dissection Partial mastectomy with sentinel node procedure Skin punch biopsy of breast skin and breast skin shave biopsy	Cancer	Breast	Process	Not Endorsed	N/A	American Society of Breast Surgeons

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2534	Medicare Physician Quality Reporting System (PQRS)	Specimen orientation for Partial mastectomy or Excisional breast biopsy	Breast cancer and many excisional biopsy specimen are commonly divided into six sides: superficial (or anterior), deep (or posterior), superior (or cranial), inferior (caudal), lateral and medial. Orienting stitches, clips or ink are commonly used techniques by the operating surgeon to allow accurate pathological orientation and margin assessment. Proper breast specimen orientation is of paramount importance to minimize unnecessary surgery and tissue loss if reexcisional surgery for positive margins is necessary.	Number of patients age 18 and older undergoing a therapeutic breast surgical procedure considered an initial partial mastectomy or "lumpectomy" for a diagnosed cancer or an excisional biopsy for a lesion that that is not clearly benign based on previous biopsy or clinical and radiographic criteria with surgical specimens properly oriented for pathologic analysis such that six margins can be identified.	Number of patients age 18 and older undergoing a therapeutic breast surgical procedure considered an initial partial mastectomy or "lumpectomy" for a diagnosis of cancer or an excisional biopsy for a lesion that that is not clearly benign based on previous biopsy or clinical and radiographic criteria a (excludes total mastectomy).	19110 Nipple exploration with or without excision Total/Simple/Complete Mastectomy Subcutaneous mastectomy Mastectomy with sentinel lymph node Modified radical mastectomy Radical mastectomy Excision skin lesion of breast Breast Nipple excision Excision of fibroadenoma, lipoma, psuedoangiomatous stromal hyperplasia, gynecomastia, and other breast lesions that are felt by surgeon to have very low chance of malignancy based on pre-operative history, clinical breast examination, and breast imaging, with or without prior minimally invasive biopsy	Cancer	Breast	Process	Not Endorsed	N/A	American Society of Breast Surgeons
2536	Medicare Physician Quality Reporting System (PQRS)	Surgeon assessment for hereditary cause of breast cancer	Percent of newly diagnosed invasive and ductal carcinoma in situ (DCIS) breast cancer patients (Stage 0 - Stage 4) seen by surgeon that undergo risk assessment for a hereditary cause of breast cancer. Patients with Lobular Carcinoma in situ (LCIS) are excluded from this Quality Measure.	Number of newly diagnosed invasive and DCIS breast cancer patients (Stage 0 - Stage 4) seen by surgeon that undergo risk assessment for a hereditary cause of breast cancer. Exclude LCIS patients.	Number of newly diagnosed invasive and DCIS breast cancer patients (Stage 0 -Stage 4) seen by surgeon. Exclude LCIS patients.	Non-epithelial breast cancer Lobular carcinoma in situ (LCIS)	Cancer	Breast	Process	Not Endorsed	N/A	American Society of Breast Surgeons
2899	Medicare Physician Quality Reporting System (PQRS)	Lung cancer reporting (biopsy/cytology specimens)	Pathology reports based on biopsy and/or cytology specimens with a diagnosis of non small cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report	Biopsy and cytology specimen reports with a diagnosis of non small cell lung cancer classified into specific histologic type (squamous cell carcinoma, adenocarcinoma) OR classified as NSCLC-NOS with an explanation included in the pathology report.	Biopsy and cytology specimen reports with a diagnosis of non small cell lung cancer	Reports on • Metastatic disease to lung • Benign tumors • Malignant tumors other than carcinomas • Inadequate surgical specimens Based on surgically resected specimens (e.g. biopsy for lymph nodes associated with resection) • On small cell lung cancer • On large cell neuroendocrine cancer	Cancer	Respiratory Tract	Process	Not Endorsed	N/A	College of American Pathologists
2900	Medicare Physician Quality Reporting System (PQRS)	Lung cancer reporting (resection specimens)	Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non small cell lung cancer, histologic type	Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non small cell lung cancer, histologic type (squamous cell carcinoma,	Pathology reports for resection specimens for primary lung carcinoma	Reports on • Metastatic disease to lung • Benign tumors • Malignant tumors other than carcinomas • Inadequate surgical specimens	Cancer	Respiratory Tract	Process	Not Endorsed	N/A	College of American Pathologists

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				adenocarcinoma and NOT NSCLC-NOS)								
2905	Medicare Physician Quality Reporting System (PQRS)	Melanoma reporting	This is a measure based on whether melanoma pathology reports for excision of primary malignant cutaneous melanomas include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate.	Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate	All melanoma pathology reports for primary malignant cutaneous melanoma	Reports with/for: • Inadequate sample (e.g. poorly fixed, too small) • Metastatic melanoma • Non-cutaneous melanoma • Melanoma in situ/Tis • Benign melanocytic lesions • Fragmented/curettage specimens	Cancer	Skin	Process	Not Endorsed	N/A	College of American Pathologists
2489	Medicare Physician Quality Reporting System (PQRS)	New Cancer Patient–Intervention Urgency	The demonstrated urgency in which new cancer patients are scheduled with an oncologist. This measurable sense of urgency for this initial visit establishes the foundation for commitment and service to the patient and their family. The date/time of the new cancer patient appointment minus the date/time the phone call was received to schedule the appointment for the new cancer patient appointment	Total sum of each occurrence of time in calendar days in takes for an oncologist to see a new cancer patient. New cancer patient appointment date and time minus the appointment booked date and time for the same appointment	Number of patients with new or consult CPT codes of 99242 through 99245 or 99201 through 99205 and with principal diagnosis codes of 140.00 through 239.99.	TBD	Cancer		Process	Not Endorsed	N/A	Community Oncology Alliance
2481	Medicare Physician Quality Reporting System (PQRS)	LDL poor control	Percentage of patients 18 - 75 years of age who had most recent LDL level under poor control (greater than or equal to 130 mg/dl).	The number of the eligible patients from the Chart Review who: 1) had most recent LDL result during the 12-month abstraction period or one month prior to the abstraction period greater than or equal to 130 mg/dl, with date and value documented OR 2) did NOT have test done during the 12-month abstraction period or one month prior to the abstraction period OR 3) did NOT have a result documented.	The number of the eligible patients from the Chart Review.	None	Cardiovascular	Cholesterol Screening & Management	Intermediate Outcome	Not Endorsed	N/A	American Board of Internal Medicine

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2482	Medicare Physician Quality Reporting System (PQRS)	LDL Superior Control	Percentage of patients 18 - 75 years of age who had most recent LDL level under superior control (less than 100 mg/dl)	The number of the eligible patients from the Chart Review who had most recent LDL result during the 12-month abstraction period or one month prior to the abstraction period less than 100 mg/dl, with date and value documented.	The number of the eligible patients from the Chart Review.	None	Cardiovascular	Cholesterol Screening & Management	Intermediate Outcome	Not Endorsed	N/A	American Board of Internal Medicine
2510	Medicare Physician Quality Reporting System (PQRS)	Physician Consortium for Performance Improvement: [DRAFT]: Preventive Care and Screening: Lipid Screening	Percentage of male patients aged 35 through 80 years and percentage of female patients aged 45 through 80 years who received a fasting or nonfasting total cholesterol (TC) level and high density lipoprotein cholesterol (HDL-C) level with results documented during the two-year measurement period	Patients who received a current* fasting or nonfasting total cholesterol (TC) level and high-density lipoprotein cholesterol (HDL-C) level with results documented	All male patients aged 35 through 80 years and all female patients aged 45 through 80 years who were seen at least twice for any visits or who had at least one preventive care visit during the two-year measurement period	Documentation of medical reason(s) for not receiving at least one fasting or non-fasting total cholesterol (TC) test and high-density lipoprotein cholesterol (HDL-C) test at least once in the past five years (eg, female patient not at increased risk for coronary heart disease, limited life expectancy, other medical reasons) Documentation of patient reason(s) for not receiving at least one fasting or non-fasting total cholesterol (TC) test and high-density lipoprotein cholesterol (HDL-C) test at least once in the past five years (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving at least one fasting or non-fasting total cholesterol (TC) test and high-density lipoprotein cholesterol (HDL-C) test at least once in the past five years (eg, financial reasons, other system reasons)	Cardiovascular	Cholesterol Screening & Management	Process	Not Endorsed	N/A	AMA-PCPI
2435	Medicare Physician Quality Reporting System (PQRS)	American Board of Internal Medicine: Hypertension Composite	Consists of 11 Measures: 1. Aspirin or Other Anti-Platelet or Anti-Coagulant Therapy (PQRS # 295): Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who were prescribed aspirin or other anticoagulant/antiplatelet therapy 2. Complete Lipid Profile (PQRS #296): Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who received a complete lipid profile within	Numerator statement is not applicable for this type of composite measure. Please see the individual measures' numerator specification. 1. Aspirin or Other Anti-Platelet or Anti-Coagulant therapy: Patients who were prescribed aspirin or other anticoagulant/antiplatelet therapy 2. Complete Lipid Profile: Patients	The inclusion criteria for the individual component measures are: Patients aged 18 through 90 years with a diagnosis of hypertension. The management decisions regarding hypertension are made primarily by this practice. Patients have been in the practice for at least one year AND the patients have been seen within the past 12 months.	Patients who have a diagnosis of stage 5 chronic kidney disease (GFR of < 15ml/min per 1.72 m2 or end-stage kidney disease), or patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate, or Patients unable to complete a patient survey, even with assistance.	Cardiovascular	Hypertension	Composite	Not Endorsed	N/A	American Board of Internal Medicine

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			24 months 3. Urine Protein Test (PQRS #297): Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who either have chronic kidney disease diagnosis documented or had a urine protein test done within 36 months 4. Annual Serum Creatinine Test (PQRS #298): Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had a serum creatinine test done within 12 months 5. Diabetes Documentation or Screen Test (PQRS #299): Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had a diabetes screening test within 36 months 6. Smoking Status and Cessation Advice and Treatment (Not currently in PQRS): TBD 7. Counseling for Diet and Physical Activity (PQRS #302): Counseling for Diet and Physical Activity (PQRS #302) 8. Blood Pressure Control (PQRS #300): Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had most recent blood pressure level under control (at goal) 9. LDL Control (PQRS #301); Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had most recent LDL cholesterol level under control (at goal) 10. Overall Hypertension Care Satisfaction (1 survey question) (Not currently in PQRS): TBD 11. Patient Self-care Support (4 survey questions combined) (Not currently in PQRS): TBD	who received at least one lipid profile (including total cholesterol, HDL-C, triglycerides and calculated LDL-C) within 24 months 3. Urine Protein Test: Patients who either have chronic kidney disease diagnosis documented OR had a urine protein test done within 36 months 4. Annual Serum Creatinine Test: Patients who had most recent serum creatinine test done within 12 months 5. Diabetes Documentation or Screen Test: Patients who had a diabetes screening test done within 36 months 6. Smoking Status and Cessation Advice and Treatment: The number of the eligible patients from the Chart Review with documentation of smoking status for non-smokers OR date of cessation counseling or treatment during the 12- month abstraction period or one month prior to the abstraction period if the patient is a smoker. 7. Counseling for Diet and Physical Activity: Patients who received dietary and physical activity counseling at least once within 12 months 8. Blood Pressure Control: Patients who had most recent blood pressure under control 9. LDL Control: Patients are considered to have most recent LDL-C level under control if any of the following are documented: • < 100 mg/dL for those with coronary heart disease, OR stroke	The composite measure does not have its specific denominator specification.							

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				or transient ischemic attack, OR peripheral artery disease, OR diabetes • < 130 mg/dL for those without conditions listed above, but with one or more additional risk factors for CHD (Low HDL (< 40 mg/dL) or on HDL-raising medication, risk age (men <= 45, women <= 55), family history of premature CHD, smoking); HDL cholesterol <= 60 acts as a negative risk factor • < 160 mg/dL for those without conditions listed above, and without additional risk factors for CHD (Low HDL (< 40 mg/dL) or on HDL-raising medication, risk age (men <= 45, women <= 55), family history of premature CHD, smoking); HDL cholesterol <= 60 acts as a negative risk factor; Numerator Options: Most recent LDL-C under control, results documented and reviewed (G8890) 10. Overall Hypertension Satisfaction: Number of patients in the sample who rated overall hypertension care “excellent” or “very good” 11. Patient Self-Support: umber of “excellent” or “very good” responses to seven questions regarding patient self-care support ”							
2845	Medicare Physician Quality Reporting System (PQRS)	Cardiovascular Disease Risk Factor Assessment for Psoriasis Patients	Percentage of psoriasis patients who have been informed that they may be at increased risk for cardiovascular disease and cardiovascular risk factors and that they should undergo appropriate medical assessment.	Patients counseled that they may be at increased risk for cardiovascular disease and for having cardiovascular risk factors, to seek appropriate cardiovascular risk assessment with their primary care provider, and the patient’s	All patients with a diagnosis of psoriasis who are 20 years of age or older.	The patient does not have a primary care physician	Cardiovascular		Process	Not Endorsed	N/A	American Academy of Dermatology

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				primary care practitioner was notified by the reporting clinician that an appropriate cardiovascular assessment should be performed.								
2889	Medicare Physician Quality Reporting System (PQRS)	HRS-2 Failure to Achieve Adequate Heart Rate Control for Patients with Atrial Fibrillation (AF).	Proportion of adult patients with AF with a resting heart rate (HR) of >110 beats per minute (bpm) at three successive encounters over a maximum of one month during the reporting period.	Patients from the denominator with a resting HR of >110 bpm at three successive encounters over a maximum of one month during the reporting period	All patients aged 18 years and older with a diagnosis of AF	Exclude patients with any of the following diagnoses/conditions: 1. Contraindication(s) to negative chronotropic drugs. 2. Untreated hyperthyroidism or euthyroidism achieved <3 months prior to the beginning of the reporting period. 3. Patients with severe anemia 4. Patients with high fever/infection 5. Patient preference for other or no treatment.	Cardiovascular		Intermediate Outcome	Not Endorsed	N/A	HRS
2930	Medicare Physician Quality Reporting System (PQRS)	Rate of Major Complications (Discharged to Home by Post- Operative Day #2) Carotid Artery Stenting (CAS) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2	Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post- operative day #2.	Patients discharged to home no later than post- operative day 2 following CAS.	CAS performed on asymptomatic patients.		Cardiovascular		Outcome	Not Endorsed	N/A	Society for Vascular Surgery
2152	Medicare Physician Quality Reporting System (PQRS)	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t PA) Considered (Paired Measure)	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke who arrive at the hospital within 4.5 Hour of time last known well who were considered for t-PA administration	Patients who were considered for t-PA administration	All patients aged 18 years and older with a diagnosis of ischemic stroke who arrive at the hospital within 4.5 hours of time last known well	None	Cerebrovascular	Stroke	Process	Not Endorsed	N/A	AMA-PCPI/NCQA
2431	Medicare Physician Quality Reporting System (PQRS)	American Association of Nurse Anesthetists/Certified Registered Nurse Anesthetists/National Committee for Quality Assurance/Physician Consortium for Performance	Percentage of patients aged 18 years and older with a diagnosis of transient ischemic attack (TIA) or ischemic stroke for whom cross sectional imaging of the brain and imaging of the cervical cerebral vasculature, which at a minimum includes imaging of the carotid artery, was performed within 24 hours of admission for an inpatient stay OR within 72 hours of	Patients for whom cross sectional imaging of the brain* and imaging of the cervical cerebral vasculature, which at a minimum includes imaging of the carotid artery, was performed** within 24 hours of admission for an inpatient stay OR within 72hours of suspected TIA or ischemic stroke for an outpatient	All patients aged 18 years and older with a diagnosis of TIA or ischemic stroke	All patients that expired during inpatient stay are excluded. Documentation of medical reason(s) for not performing cross sectional imaging of the brain and imaging of the cervical cerebral vasculature within 24 hours of admission for an inpatient stay OR within 72 hours for an outpatient visit (eg, other	Cerebrovascular	Stroke	Process	Not Endorsed	N/A	AMA-PCPI/NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
		Improvement: [DRAFT]: Stroke and Stroke Rehabilitation: Imaging for Transient Ischemic Attack or Ischemic Stroke	suspected TIA or ischemic stroke for an outpatient visit	visit		medical reason(s)). Documentation of patient reason(s) for not performing cross sectional imaging of the brain and imaging of the cervical cerebral vasculature within 24 hours of admission for an inpatient stay OR within 72 hours for an outpatient visit (eg, patient left against medical advice/patient declined, other patient reason(s)). Documentation of system reason(s) for not performing cross sectional imaging of the brain and imaging of the cervical cerebral vasculature within 24 hours of admission for an inpatient stay OR within 72 hours for an outpatient visit (eg, other system reason(s)).						
2432	Medicare Physician Quality Reporting System (PQRS)	American Association of Nurse Anesthetists/Certified Registered Nurse Anesthetists/National Committee for Quality Assurance/Physician Consortium for Performance Improvement: [DRAFT]: Stroke and Stroke Rehabilitation: Lipid Management	Percentage of patients aged 18 years and older with diagnosis of ischemic stroke who have a most recent LDL-C of greater than or equal to 100 mg/dL, OR LDL-C not measured, OR who were on a lipid-lowering medication prior to hospital arrival who were prescribed statin therapy at hospital discharge	Patients who were prescribed statin therapy at hospital discharge	All patients aged 18 years and older with a diagnosis of ischemic stroke who have a most recent LDL-C of greater than or equal to 100 mg/dL, OR LDL-C not measured, OR who were on a lipid-lowering medication prior to hospital arrival	All patients that expired during inpatient stay are excluded. Documentation of medical reason(s) for not prescribing statin therapy at discharge (eg, patient has acute or chronic liver disease, patient is taking a contraindicated medication, , other medical reason(s)). Documentation of patient reason(s) for not prescribing statin therapy at discharge (eg, patient left against medical advice, patient declined, other patient reason(s)).	Cerebrovascular	Stroke	Intermediate Outcome	Not Endorsed	N/A	AMA-PCPI/NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2433	Medicare Physician Quality Reporting System (PQRS)	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Administered Initiated (Paired Measure)	Percentage of all patients aged 18 years and older with a diagnosis of ischemic stroke who present within two hours of time last known well and who are eligible for t- PA, for whom t-PA was initiated within three hours of time last known well	Patients for whom t-PA was initiated within three hours of time last known well	All patients aged 18 years and older with a diagnosis of ischemic stroke who present within two hours of time last known well and who are eligible for t-PA	Documentation of medical reason(s) for not initiating Tissue Plasminogen Activator (t-PA) within three hours of time last known well (eg, contraindications*, other medical reason(s)) Documentation of patient reason(s) for not initiating Tissue Plasminogen Activator (t-PA) within three hours of time last known well (eg, patient declined, other patient reason(s)) Contraindications* • CT findings of intracranial hemorrhage, subarachnoid hemorrhage, or major infarct signs • History of intracranial hemorrhage, brain aneurysm, vascular malformation, or brain tumor • Internal bleeding (less than 22 days) • IV or IA t-PA given at a transferring hospital • No IV access • Platelets less than 100,000, PTT greater than 40 sec after heparin use • PT greater than 15 or INR greater than 1.7, or unknown bleeding diathesis • Recent intracranial or spinal surgery, head trauma, or stroke (less than 3 months) • Recent surgery/trauma (less than 15 days) • Seizure with postictal residual neurological impairments • Suspicion of subarachnoid hemorrhage • Systolic blood pressure greater than 185 or diastolic blood pressure greater than 110 mm hg. • Unable to determine eligibility Warnings/Conditions that might lead to increased risk of bleeding or unfavorable outcomes*: • Acute pericarditis • Advanced age	Cerebrovascular	Stroke	Process	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						• Diabetic hemorrhagic retinopathy or other ophthalmic bleeding • Glucose less than 50 or greater than 400 mg/dl • Hemostatic defects including those secondary to severe renal or hepatic disease • Left heart thrombus • Life expectancy less than 1 year or severe co-morbid illness • Patient currently receiving oral anticoagulants (e.g. Warfarin sodium, Coumadin) • Pregnancy • Rapid improvement • Septic thrombophlebitis or occluded AV cannula at seriously infected site • Stroke severity – Too mild • Stroke severity – Too severe (e.g., NIHSS greater than 22) • Subacute bacterial endocarditis *Lists harmonized with The Joint Commission measure.						
2519	Medicare Physician Quality Reporting System (PQRS)	Querying about Falls for Patients with DSP	Percentage of patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy who were queried about falls within the past 12 months and the response was documented in the medical record at least annually.	Patients who were queried about falls within the past 12 months and the response was documented in the medical record.	All patients 18 years and older with a diagnosis of distal symmetric polyneuropathy.	EXCEPTION: Documentation of medical reason for not querying the patient about falls within the past 12 months and documenting the response in the medical record (eg patient is non-ambulatory, patient unable to communicate) Documentation of patient reason for not querying the patient about falls within the past 12 months and documenting the response in the medical record (eg patient refuses to communicate)	Chronic and Elder Care	Falls	Process	Not Endorsed	N/A	American Academy of Neurology

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2520	Medicare Physician Quality Reporting System (PQRS)	Querying about Pain and Pain Interference with Function	Percentage of patient visits for patients age 18 years and older with diagnosis of distal symmetric polyneuropathy who were queried about pain and pain interference with function and the querying was documented in the medical record for all visits during the measurement period.	Patient visits with the patients queried about pain and pain interference with function (eg Graded Chronic Pain Scale) and the responses at all visits documented in the medical record.	All visits for patients aged 18 years and older with a diagnosis of distal symmetric polyneuropathy.	EXCEPTION: Documentation of medical reason for not querying the patient about pain and pain interference with function and the responses at all visits documented in the medical record. (eg patient unable to respond) Documentation of patient reason for not querying the patient about pain and pain interference with function and the responses at all visits documented in the medical record. (eg patient declines to respond to questions)	Chronic and Elder Care	Functional Status	Process	Not Endorsed	N/A	American Academy of Neurology
2471	Medicare Physician Quality Reporting System (PQRS)	Documentation of support surface or offloading status for patients with serious pressure ulcers	Percentage of total visits among patients aged 18 years and older with a diagnosis of a Stage III or IV pressure ulcer in whom the status of offloading or support surface was documented within the 12-month reporting period.	Patients with Stage III/IV pressure ulcers who were prescribed adequate support surfaces within the 12 month reporting period.	All patients aged 18 years and older with a diagnosis of stage III/IV pressure ulcer on the body	None	Chronic and Elder Care	Pressure Ulcer	Process	Not Endorsed	N/A	Alliance of Wound Care Stakeholders
2283	Medicare Physician Quality Reporting System (PQRS)	ASPS/AMA-PCPI/NCQA: Chronic Wound Care: Patient education regarding long term compression therapy	Percentage of patients aged 18 years and older with a diagnosis of venous ulcer who received education regarding the need for long term compression therapy including interval replacement of compression stockings within the 12-month reporting period.	Patients who received education regarding the need for long term compression therapy including interval replacement of compression stockings within the 12 month reporting period	All patients aged 18 years and older with a diagnosis of venous ulcer	Number of patients with valid medical, patient or system exclusions (where applicable; will differ by measure)	Chronic and Elder Care		Process	Not Endorsed	N/A	AMA-PCPI/NCQA
2285	Medicare Physician Quality Reporting System (PQRS)	ASPS/AMA-PCPI/NCQA: Chronic Wound Care: Patient Education regarding diabetic foot care	Percentage of patients aged 18 years and older with a diagnosis of diabetes and foot ulcer who received education regarding appropriate foot care AND daily inspection of the feet within the 12 month reporting period.	Patients who received education regarding appropriate foot care* AND daily inspection of the feet within the 12 month reporting period Definition - Appropriate foot care may include "self inspection and surveillance, monitoring foot temperatures, appropriate daily foot hygiene, use of proper footwear, good diabetes control, and prompt recognition and professional treatment of newly discovered lesions."	All patients aged 18 years and older with a diagnosis of diabetes and foot ulcer	None	Chronic and Elder Care		Process	Not Endorsed	N/A	AMA-PCPI/NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2437	Medicare Physician Quality Reporting System (PQRS)	American Board of Medical Specialties/American Board of Allergy and Immunology/American Academy of Dermatology/America n Association of Immunologists/Physici an Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Reevaluation of Treatment	Percentage of patients aged 25 years or younger with atopic dermatitis with 2 or more visits within a six-month period without improvement of disease for whom evaluation or treatment was modified	Number of patients for whom evaluation or treatment was modified at the most recent visit with or including: - Referral to specialist - Assessment or management of food allergy - Assessment and/or treatment of staph infection - Increased topical therapy or discussion of strategies for improving compliance with topical regimen - Prescription for calcineurin inhibitors - Ordering or discussion of phototherapy - Ordering or discussion of other systemic treatments (eg, methotrexate,azathioprine, cyclosporin)	Total number of patients aged 25 years or younger with atopic dermatitis with 2 or more visits within a six-month period without improvement of disease	Documentation of medical reason(s) for not modifying the evaluation or treatment for patients with atopic dermatitis (eg, patients have mild, well-controlled atopic disease	Chronic and Elder Care		Process	Not Endorsed	N/A	AMA-PCPI
2438	Medicare Physician Quality Reporting System (PQRS)	American Board of Medical Specialties/American Board of Allergy and Immunology/American Academy of Dermatology/America n Association of Immunologists/Physici an Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Topical Steroid Preparations	Percentage of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis who were prescribed topical steroid preparations with midrange potency (Groups III, IV and V)	Number of patients who were prescribed* topical steroid preparations with mid-range potency (Groups III, IV and V)	Total number of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis	Documentation of the medical reason(s) for not prescribing a mid-range topical steroid preparations (eg, patients who have well-controlled atopic dermatitis on a low potency topical steroid, patients who were prescribed a high potency topical preparation, patients who have herpes simplex virus infection).	Chronic and Elder Care		Process	Not Endorsed	N/A	AMA-PCPI

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2439	Medicare Physician Quality Reporting System (PQRS)	American Board of Medical Specialties/American Board of Allergy and Immunology/American Academy of Dermatology/American Association of Immunologists/Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Disease Assessment	Percentage of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis who were assessed for currents symptoms of disease activity based on three or more of the following manifestations: degree of inflammation, extent of skin involvement, sleep disturbances, itching, recent unscheduled visits over the last six months, or alterations in quality of life	Number of patients who were assessed for current symptoms of disease activity based on three or more of the following manifestations: - degree of inflammation - extent of skin involvement - degree of sleep disturbances - degree of itching recent unscheduled visits* within the last six months or - alterations in quality of life	Total number of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis	None	Chronic and Elder Care		Process	Not Endorsed	N/A	AMA-PCPI
2440	Medicare Physician Quality Reporting System (PQRS)	American Board of Medical Specialties/American Board of Allergy and Immunology/American Academy of Dermatology/American Association of Immunologists/Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Moisture Care	Percentage of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis for which daily hydration (eg, bath or shower) immediately followed by application of a moisturizing product was recommended	Number of patients for which daily hydration (eg, bath or shower) immediately followed by application of a moisturizing product was recommended	Total number of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis	None	Chronic and Elder Care		Process	Not Endorsed	N/A	AMA-PCPI
2472	Medicare Physician Quality Reporting System (PQRS)	Documentation of venous compression at each visit for patients with venous stasis ulcers	Percentage of total visits among patients aged 18 years and older with a diagnosis of venous ulcer in whom the status of compression was documented at each visit within the 12-month reporting period.	Patients with venous stasis ulcers prescribed adequate compression therapy at each visit during the 12 month reporting period	All visits for patients aged 18 years and older with a diagnosis of venous stasis ulcer	None	Chronic and Elder Care		Process	Not Endorsed	N/A	Alliance of Wound Care Stakeholders
2513	Medicare Physician Quality Reporting System (PQRS)	Podiatry Exam	Percentage of patients 18 - 75 years of age who had a foot exam performed over the reporting period.	The number of the eligible patients from the Chart Review excluding those with amputation of both legs or feet who had a complete foot examination (visual, sensory and pulses exam) during the 12-month	The number of the eligible patients from the Chart Review who did not have amputation of both legs or feet.	Exclude patients with amputation of both legs or feet.	Chronic and Elder Care		Process	Not Endorsed	N/A	American Board of Internal Medicine

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				abstraction period or one month prior to the abstraction period with date of the exam documented.								
2544	Medicare Physician Quality Reporting System (PQRS)	Vascular testing of patients with leg ulcers	Percentage of patients aged 18 years and older with a diagnosis of a leg ulcer(s) in whom vascular screening was performed within the 12-month reporting period.	Patients with leg ulcers who underwent vascular testing during the 12 month reporting period	All patients aged 18 years and older with a diagnosis of a leg ulcer(s)	None	Chronic and Elder Care		Process	Not Endorsed	N/A	Alliance of Wound Care Stakeholders
2807	Medicare Physician Quality Reporting System (PQRS)	ALS Communication Support Referral	Percentage of patients diagnosed with amyotrophic lateral sclerosis who are dysarthric who were offered a referral at least once annually to a speech language pathologist for an augmentative/alternative communication evaluation.	Patients who were offered a referral at least once annually to a speech language pathologist for an augmentative/alternative communication evaluation.	All patients with a diagnosis of amyotrophic lateral sclerosis who are dysarthric.	Documentation of a medical reason for not offering a referral to a speech language pathologist for an augmentative/alternative communication evaluation (eg patient is already using an augmentative communication device).	Chronic and Elder Care		Process	Not Endorsed	N/A	American Academy of Neurology
2810	Medicare Physician Quality Reporting System (PQRS)	ALS Noninvasive Ventilation Treatment for Respiratory Insufficiency Discussed	Percentage of patients diagnosed with ALS and respiratory insufficiency with whom the clinician discussed at least once annually treatment options for noninvasive respiratory support (eg noninvasive ventilation (NIV), assisted cough).	Patients with whom the clinician discussed at least once annually treatment options for noninvasive respiratory support (eg noninvasive ventilation (NIV), assisted cough).	All patients with a diagnosis of amyotrophic lateral sclerosis and respiratory insufficiency.	* Documentation of a medical reason for not discussing treatment options for noninvasive respiratory support (eg patient is in a coma; patient has severe cognitive impairment and cannot communicate; patient is already on appropriate respiratory support) * Documentation of patient reason for not discussing treatment options for noninvasive respiratory support (eg patient declines to discuss treatment options)	Chronic and Elder Care		Process	Not Endorsed	N/A	American Academy of Neurology
2811	Medicare Physician Quality Reporting System (PQRS)	ALS Nutritional Support Offered	Percentage of patients diagnosed with ALS and dysphagia, weight loss, or impaired nutrition who were offered at least once annually dietary or enteral nutrition support via PEG or RIG*.	Patients who were offered at least once annually dietary or enteral nutrition support via PEG or RIG*.	All patients with a diagnosis of amyotrophic lateral sclerosis and dysphagia, weight loss or impaired nutrition.	Documentation of a medical reason for not offering dietary or enteral nutritional support (eg patient already on PEG/RIG; patient cannot tolerate the procedure)	Chronic and Elder Care		Process	Not Endorsed	N/A	American Academy of Neurology

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2812	Medicare Physician Quality Reporting System (PQRS)	ALS Respiratory Insufficiency Querying and Referral for Pulmonary Function Testing	Percentage of patients with a diagnosis of amyotrophic lateral sclerosis who were queried about symptoms of respiratory insufficiency (awake or associated with sleep) and referred for pulmonary function testing (eg vital capacity (VC), maximum inspiratory pressure (MIP), sniff nasal pressure (SNP), or peak cough expiratory flow (PCEF)), at least every three months.	Patients who were who were queried about symptoms of respiratory insufficiency (awake or associated with sleep) and referred for pulmonary function testing (eg vital capacity (VC), maximum inspiratory pressure (MIP), sniff nasal pressure (SNP), or peak cough expiratory flow (PCEF)), at least every three months.	All patients with a diagnosis of amyotrophic lateral sclerosis.	* Documentation of medical reason for not querying about symptoms of respiratory and referring for pulmonary function testing or peak cough expiratory flow (eg patient with severe cognitive impairment who cannot answer any queries) * Documentation of patient reason for not querying about symptoms of respiratory and referring for pulmonary function testing or peak cough expiratory flow (eg patient declines to be referred for pulmonary function testing)	Chronic and Elder Care		Process	Not Endorsed	N/A	American Academy of Neurology
2813	Medicare Physician Quality Reporting System (PQRS)	ALS Screening for Dysphagia, Weight Loss or Impaired Nutrition	Percentage of patients diagnosed with ALS who were screened at least every 3 months for dysphagia, weight loss or impaired nutrition* and the result(s) of the screening(s) was documented in the medical record.	Patients who were screened at least every 3 months for dysphagia, weight loss or impaired nutrition* and the result(s) of the screening(s) was documented in the medical record.	All patients with a diagnosis of amyotrophic lateral sclerosis.	* Documentation of a patient reason for not screening for dysphagia, weight loss or impaired nutrition and documenting the result(s) of the screening(s) in the medical record (eg patient declines screening) * Documentation of a system reason for not screening for dysphagia, weight loss or impaired nutrition and documenting the result(s) of the screening(s) in the medical record (eg equipment not available to complete the screenings; no insurance)	Chronic and Elder Care		Process	Not Endorsed	N/A	American Academy of Neurology
2814	Medicare Physician Quality Reporting System (PQRS)	ALS Symptomatic Therapy Treatment Offered	Percentage of visits for patients with a diagnosis of ALS with patient offered treatment* for pseudobulbar affect, sialorrhea, and ALS related symptoms**.	Patient visits with patient offered treatment* for pseudobulbar affect, sialorrhea, or ALS related symptoms**, if present.	All visits for patients with a diagnosis of amyotrophic lateral sclerosis.	No exclusions appropriate for this measure	Chronic and Elder Care		Process	Not Endorsed	N/A	American Academy of Neurology
2951	Medicare Physician Quality Reporting System (PQRS)	Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier	This measure evaluates whether providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.	Patients who have a documented negative annual TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (i.e. chest x-ray, CT).	All patients with a diagnosis of psoriasis and/or psoriatic arthritis who are on a biologic immune response modifier.	Did not include with submission	Communicable Diseases	Tuberculosis	Process	Not Endorsed	N/A	American Academy of Dermatology

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2474	Medicare Physician Quality Reporting System (PQRS)	Education of patient about the role of good glucose control in slowing progression of diabetic retinopathy	Percentage of patients aged 18 years and older with diabetic retinopathy and received education about the role of good glucose control in slowing progression of diabetic retinopathy	Patients with diabetic retinopathy who received education about the role of good glucose control in slowing progression of diabetic retinopathy	All patients aged 18 years and older who have diabetic retinopathy	None	Diabetes	Eye Care	Process	Not Endorsed	N/A	American Academy of Ophthalmology and the Hoskins Center for Quality Eye Care
2470	Medicare Physician Quality Reporting System (PQRS)	Documentation of offloading status for patients with diabetic foot ulcers	Percentage of total visits among patients aged 18 years and older with a diagnosis of diabetic foot ulcer in whom the status of offloading or pressure relief was documented within the 12-month reporting period.	Patients with diabetic foot ulcers prescribed adequate offloading therapy at each visit during the 12 month reporting period	All patients aged 18 years and older with a diagnosis of diabetic foot ulcer	None	Diabetes	Foot Care	Process	Not Endorsed	N/A	Alliance of Wound Care Stakeholders
2434	Medicare Physician Quality Reporting System (PQRS)	American Board of Internal Medicine: Diabetes Composite	Consists of 10 Measures: Measure 1. Hemoglobin A1C (HbA1c) Poor Control: Percentage of patients 18 - 75 years of age who had most recent HbA1c level in poor control (greater than 9.0%). Measure 2. Hemoglobin A1C (HbA1c): Percentage of patients 18 - 75 years of age who had most recent HbA1c level under control (at goal). Measure 3. Blood Pressure Poor Control:Percentage of patients 18 - 75 years of age who had most recent blood pressure in poor control (greater than or equal to 140/90 mm Hg). Measure 4. Blood Pressure Superior Control:Percentage of patients 18 - 75 years of age who had most recent blood pressure under superior control (less than 130/80 mm Hg). Measure 5. LDL Poor Control: Percentage of patients 18 - 75 years of age who had most recent LDL level under poor control (greater than or equal to 130 mg/dl). Measure 6. LDL Superior Control:	Measure 1. The number of the eligible patients from the Chart Review who: 1) had most recent HbA1c results during the 12-month abstraction period or one month prior to the abstraction period greater than 9.0% with date and value of the test documented OR 2) did NOT have test done during the 12-month abstraction period or one month prior to the abstraction period OR 3) did NOT have a result documented. Measure 2. The number of the eligible patients from the Chart Review whose most recentHbA1c result during the 12-month abstraction period or one month prior to the abstraction period was: 1) less than 8.0% for patients who were aged 65 and over, OR had	The number of the eligible patients from the Chart Review.	Measure 8. Exclude patients with amputation of both legs or feet. Measure 9. Exclude patients with diagnosis of end-stage renal disease (ESRD).	Diabetes		Process	Not Endorsed	N/A	American Board of Internal Medicine

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			Percentage of patients 18 - 75 years of age who had most recent LDL level under superior control (less than 100 mg/dl Measure 7. Ophthalmologic exam: Percentage of patients 18 - 75 years of age who had an eye screening exam for diabetic retinal disease over the reporting period. Measure 8: Podiatry Exam: Percentage of patients 18 - 75 years of age who had a foot exam performed over the reporting period. Measure 9.Nephropathy Assessment for Eligible Patients: Percentage of patients 18 - 75 years of age who had a screening for nephropathy or medical attention for nephropathy (ACE/ARB therapy) documented over the reporting period. Measure 10. Smoking Status and Cessation Advice and Treatment: Percentage of patients 18 - 75 years of age who had documentation of smoking status and if patient is a smoker, received cessation counseling or treatment over the reporting period.	clinical cardiovascular disease (including coronary heart disease, cerebrovascular disease, and peripheral artery disease), OR had end-stage renal disease, OR had significant loss of vision or blindness 2) less than 7.0% for other patients with date and value of the test documented. Measure 3. The number of the eligible patients from the Chart Review who: 1) had most recent systolic blood pressure greater than or equal to 140 mm Hg or diastolic blood pressure greater than or equal to 90 mm Hg during the 12-month abstraction period or one month prior to the abstraction period, with date and value of the measurement documented OR 2) did NOT have blood pressure measurement done during the 12-month abstraction period or one month prior to the abstraction period OR 3) did NOT have a result of the most recent blood pressure measurement documented. Measure 4. The number of the eligible patients from the Chart Review who had most recent blood pressure result during the 12-month abstraction period or one month prior to the abstraction period less than 130/80 mm Hg, with date and value of the measurement documented. Measure 5. The number of the								

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				eligible patients from the Chart Review who: 1) had most recent LDL result during the 12-month abstraction period or one month prior to the abstraction period greater than or equal to 130 mg/dl, with date and value documented OR 2) did NOT have test done during the 12-month abstraction period or one month prior to the abstraction period OR 3) did NOT have a result documented. Measure 6. The number of the eligible patients from the Chart Review who had most recent LDL result during the 12-month abstraction period or one month prior to the abstraction period less than 100 mg/dl, with date and value documented. Measure 7. The number of the eligible patients from the Chart Review who had a dilated eye examination with date of the examination documented during: 1) the 12-month abstraction period or one month prior to the abstraction period, OR 2) the 24-month abstraction period or one month prior to the abstraction period if the patient did not have retinopathy. Measure 8. The number of the eligible patients from the Chart Review excluding those with amputation of both legs or feet who							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				had a complete foot examination (visual, sensory and pulses exam) during the 12-month abstraction period or one month prior to the abstraction period with date of the exam documented. Measure 9. The number of the eligible patients from the Chart Review excluding those who had documented diagnosis of end-stage renal disease (ESRD) who had: 1) positive result of urine dipstick test for protein regardless of the test date OR 2) normal microalbuminuria test during the 12-month abstraction period or one month prior to the abstraction period OR 3) a microalbuminuria assessment and result is Micro or Macroalbuminuria, regardless of the date of the test OR 4) under ACE/ARB therapy. Measure 10. The number of the eligible patients from the Chart Review with documentation of smoking status for non-smokers OR date of cessation counseling or treatment during the 12- month abstraction period or one month prior to the abstraction period if the patient is a smoker.							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1383	Medicare Physician Quality Reporting System (PQRS)	Magnetic Resonance Imaging/Computed Tomography Scan (MRI/CT Scan) Results	All patients with a diagnosis of epilepsy seen for an initial evaluation who had the results of at least one MRI or CT scan reviewed or requested or, if a MRI or CT scan was not obtained previously, then a MRI or CT scan ordered (MRI Preferred).	Patients who had the results of at least one MRI or CT scan reviewed or requested or, if a MRI or CT scan was not obtained previously, then a MRI or CT scan ordered (MRI Preferred).	All patients with a diagnosis of epilepsy seen for an initial evaluation.	* Documentation of medical reason for not reviewing or requesting MRI or CT scan results or, if a MRI or CT scan was not obtained previously, for not ordering a MRI or CT scan (e.g. diagnosis of an idiopathic epilepsy syndrome). * Documentation of patient reason for not reviewing or requesting MRI or CT scan results or, if a MRI or CT scan was not obtained previously, for not ordering MRI or CT a scan (e.g. patient refusal). * Documentation of system reason for not reviewing or requesting MRI or CT scan results or, if a MRI or CT scan was not obtained previously, for not ordering a MRI or CT scan (e.g. no insurance; patient unable to pay for either scan).	Diagnostic Imaging		Process	Not Endorsed	N/A	American Academy of Neurology
1886	Medicare Physician Quality Reporting System (PQRS)	Equipment Evaluation for Pediatric CT Imaging Protocols	Percentage of pediatric CT imaging studies for patients aged 17 years and younger performed with equipment that has complied with a CT equipment evaluation protocol at least once within the 12 month period prior to the exam	Number of pediatric CT imaging studies performed with equipment that has complied with a CT equipment evaluation protocol at least once within a 12 month period prior to the exam	Total number of pediatric CT imaging studies for patients aged 17 years and younger	Documentation of medical reason(s) for not performing studies with equipment that has complied with a CT equipment evaluation protocol (eg, CT studies performed for radiation treatment planning or image-guided radiation treatment delivery)	Diagnostic Imaging		Structure	Not Endorsed	N/A	AMA-PCPI
1887	Medicare Physician Quality Reporting System (PQRS)	American Board of Radiology/American Board of Medical Specialties/American College of Radiology/Physician Consortium for Performance Improvement: [DRAFT] Radiation Dose Optimization: Utilization of Pediatric CT Imaging Protocols	Percentage of pediatric CT imaging studies for patients aged 17 years and younger performed with individualized equipment evaluation protocols that comply with a widely used guideline	Number of pediatric CT imaging studies performed with individualized equipment evaluation protocols that comply with a widely used guideline	Total number of pediatric CT imaging studies for patients aged 17 years and younger	Documentation of medical reason(s) for not performing CT studies with individualized equipment evaluation protocols (eg, CT studies performed for radiation treatment planning or image-guided radiation treatment delivery)	Diagnostic Imaging		Structure	Not Endorsed	N/A	AMA-PCPI

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2417	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI:Adult Sinusitis: Appropriate Diagnostic Testing for Chronic Sinusitis (underuse)	Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had either a CT scan or nasal endoscopy of the paranasal sinuses ordered at the time of diagnosis or received within 90 days of initial diagnosis of chronic sinusitis.	Patients who had either a CT scan or nasal endoscopy of the paranasal sinuses ordered at the time of diagnosis or received with 90 days of initial diagnosis	Patients aged 18 years and older with a diagnosis of chronic sinusitis	Documentation of system reason(s) for not having a CT scan or nasal endoscopy ordered at the time of diagnosis or received within 90 days of initial diagnosis of chronic Sinusitis (eg, CT not available, MRI received instead, patient had previously received a CT scan or nasal endoscopy, other system reasons).	Diagnostic Imaging		Process	Not Endorsed	N/A	AMA-PCPI
2418	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI:Adult Sinusitis: Computerized Tomography for Acute Sinusitis (overuse)	Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	Patients who had computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis	Patients aged 18 years and older with a diagnosis of acute sinusitis	Documentation of medical reason(s) for patient having computerized tomography ordered at the time of diagnosis or received within 28 days after date of diagnosis (eg, persons with sinusitis symptoms lasting at least 7 to 10 days, antibiotic resistance, immunocompromised, recurrent sinusitis, acute frontal sinusitis, acute sphenoid sinusitis, periorbital cellulitis, other medical reasons).	Diagnostic Imaging		Process	Not Endorsed	N/A	AMA-PCPI
2419	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI:Adult Sinusitis: More than 1 Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered at the time of diagnosis or received within a 90 day period after date of diagnosis	Patients who received more than one CT scan of the paranasal sinuses ordered at the time of diagnosis or received within 90 days after date of diagnosis	Patients aged 18 years and older with a diagnosis of chronic sinusitis	Documentation of medical reason(s) for having more than one CT scan ordered within 90 days of diagnosis (eg, patients with complications, second CT obtained prior to surgery, other medical reasons).	Diagnostic Imaging		Process	Not Endorsed	N/A	AMA-PCPI
2421	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI:Adult Sinusitis: Plain Film Radiography for Acute Sinusitis (overuse)	Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who had a plain film radiography of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	Patients who had a plain film radiography of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	Patients aged 18 years and older with a diagnosis of acute sinusitis	None	Diagnostic Imaging		Process	Not Endorsed	N/A	AMA-PCPI

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2444	Medicare Physician Quality Reporting System (PQRS)	American Board of Radiology/American Board of Medical Specialties/American College of Radiology/Physician Consortium for Performance Improvement: [DRAFT] Radiation Dose Optimization: Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules According to Recommended Guidelines	Percentage of final reports for CT imaging studies of the thorax for patients aged 18 years and older with documented follow-up recommendations for incidental pulmonary nodules (eg, follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size AND patient risk factors	Number of final reports with documented follow-up recommendations* for incidental pulmonary nodules (eg, follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size AND patient risk factors	Total number of final reports for CT imaging studies of the thorax for patients aged 18 years and older	Documentation of medical reason(s) for not recording follow-up recommendations according to recommended guidelines for incidentally detected pulmonary nodules (eg, patients with known malignant disease, patients with unexplained fever, CT studies performed for radiation treatment planning or image-guided radiation treatment delivery)	Diagnostic Imaging		Process	Not Endorsed	N/A	AMA-PCPI
2535	Medicare Physician Quality Reporting System (PQRS)	Static Ultrasound in elective internal jugular vein cannulation	Percentage of patients aged 18 years and older who have static ultrasound imaging used in elective situations for pre-puncture identification of anatomy and vessel localization when the internal jugular vein is selected for cannulation.	Patients who have documentation that static ultrasound imaging is used in elective situations for pre-puncture identification of anatomy and vessel localization when the internal jugular vein is selected for cannulation.	All patients aged 18 years and older who are having an elective internal jugular vein cannulation for central venous access by an anesthesiologist.	Emergent indications for establishment of central venous cannulation (eg. Shock, acute hemorrhage, venous air embolism, intraoperative loss of venous access).	Diagnostic Imaging		Process	Not Endorsed	N/A	American Society of Anesthesiologists
2863	Medicare Physician Quality Reporting System (PQRS)	Electroencephalogram (EEG) Results Reviewed, Requested, or Test Ordered	All patients with a diagnosis of epilepsy seen for an initial evaluation who had the results of at least one electroencephalogram (EEG) reviewed or requested, or if EEG was not performed previously, then an EEG ordered.	All patients with a diagnosis of epilepsy seen for an initial evaluation who had the results of at least one electroencephalogram (EEG) reviewed or requested, or if EEG was not performed previously, then an EEG ordered.	All patients with a diagnosis of epilepsy seen for an initial evaluation.	Denominator Exclusions: * Documentation of medical reason for not reviewing or requesting electroencephalogram (EEG) results or, if an EEG was not performed previously, for not ordering an EEG (e.g. patient has a serious skin condition that prevents EEG electrode adhesion). * Documentation of patient reason for not reviewing or requesting electroencephalogram (EEG) results or, if an EEG was not performed previously, for not ordering an EEG (e.g. patient refuses to cooperate). * Documentation of system reason for not reviewing or requesting electroencephalogram (EEG) results or, if	Diagnostic Imaging		Process	Not Endorsed	N/A	American Academy of Neurology

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						an EEG was not performed previously, for not ordering an EEG (e.g. no insurance; patient cannot pay).						
1018	Medicare Physician Quality Reporting System (PQRS)	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials	Patients who were not prescribed systemic antimicrobials	All patients aged 2 months through 12 years with a diagnosis of OME	Documentation of medical reason(s) for prescribing systemic antimicrobials	Ears, Nose, and Throat		Process	Endorsed	0657	AAO-HNS/PCPI
2414	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI: Adult Sinusitis: Accurate Diagnosis: Distinguishing Viral Vs. Bacterial Sinusitis at Initial Visit	Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis, whose symptoms were assessed (history and physical exam) AND symptoms were classified as either viral sinusitis or acute bacterial sinusitis at the time of diagnosis.	Patients whose symptoms were assessed (history and physical exam) AND symptoms were classified as either viral sinusitis or acute bacterial sinusitis at the time of diagnosis	Patients aged 18 years and older with a diagnosis of acute sinusitis	None	Ears, Nose, and Throat		Process	Not Endorsed	N/A	AMA-PCPI
2793	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI: Adult Sinusitis: Premature Changing of Initial Antibiotic for Acute Bacterial Sinusitis (Overuse)	Percentage of patients, aged 18 years and older, with a diagnosis of acute bacterial sinusitis, on an initial antibiotic, whose antibiotic prescriptions were changed before 5 days of use	Patients who were prescribed a second antibiotic within 5 days of the first antibiotic prescription for acute bacterial sinusitis	All patients aged 18 years and older with a diagnosis of acute bacterial sinusitis who were prescribed an initial antibiotic.	None	Ears, Nose, and Throat		Process	Not Endorsed	N/A	AMA-PCPI
2512	Medicare Physician Quality Reporting System (PQRS)	Physician Consortium for Performance Improvement: Preventive Care and Screening: Obesity Screening	Percentage of patients aged 18 years and older for whom body mass index (BMI) is documented at least once during the two year measurement period	Patients for whom body mass index (BMI) is documented	All patients aged 18years and older who were seen at least twice for any visits or who had at least one preventive care visit during the two-year measurement period	Documentation of medical reason(s) for not documenting body mass index (BMI) (eg, patient is non-ambulatory) Documentation of patient reason(s) for not documenting body mass index (BMI) (eg, patient declined) Documentation of system reason(s) for not documenting body mass index (BMI) (eg, equipment not available)	Environment & Public Health	Obesity	Process	Not Endorsed	N/A	AMA-PCPI
2292	Medicare Physician Quality Reporting System (PQRS)	Glaucoma Screening in Older Adults	Percentage of patients 65 years and older, without a prior diagnosis of glaucoma or glaucoma suspect, who received a glaucoma eye exam by an eye-care professional for early identification of glaucomatous conditions.	Patients who received one or more eye exams for glaucoma by an eye care professional (i.e., ophthalmologist or optometrist) during the measurement year or year prior to the measurement year	Patients aged 67 years and older	Denominator exclusion: Patients with a prior diagnosis of glaucoma or glaucoma suspect	Eyes/Vision		Process	Not Endorsed	N/A	NCQA

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2473	Medicare Physician Quality Reporting System (PQRS)	Education of patient about symptoms of choroidal Neovascularization necessitating early return for examination	Percentage of patients aged 50 years and older with age related macular degeneration and received education about symptoms of choroidal neovascularization necessitating early return for examination	Patients with age-related macular degeneration and received education about symptoms of choroidal neovascularization	All patients aged 50 years and older who have age-related macular degeneration	None	Eyes/Vision		Process	Not Endorsed	N/A	American Academy of Ophthalmology and the Hoskins Center for Quality Eye Care
2490	Medicare Physician Quality Reporting System (PQRS)	Ophthalmologic exam	Percentage of patients 18 - 75 years of age who had an eye screening exam for diabetic retinal disease over the reporting period.	The number of the eligible patients from the Chart Review who had a dilated eye examination with date of the examination documented during: 1) the 12-month abstraction period or one month prior to the abstraction period, OR 2) the 24-month abstraction period or one month prior to the abstraction period if the patient did not have retinopathy.	The number of the eligible patients from the Chart Review.	None	Eyes/Vision		Process	Not Endorsed	N/A	American Board of Internal Medicine
2452	Medicare Physician Quality Reporting System (PQRS)	Biopsy for Barrett's esophagus (PCPI and NCQA measure to be updated by AGA)	Percentage of patients aged 18 years and older with a diagnosis of GERD or heartburn whose endoscopy report indicates a suspicion of Barrett's esophagus who had a forceps esophageal biopsy performed	Patients who had a forceps esophageal biopsy performed	All patients aged 18 years and older with a diagnosis of GERD or heartburn whose endoscopy report indicates a suspicion of Barrett's esophagus	TBD	Gastrointestinal		Process	Not Endorsed	N/A	AMA-PCPI/(American Gastroenterological Association)
2461	Medicare Physician Quality Reporting System (PQRS)	Chronic Medication Therapy - Assessment of GERD Symptoms (PCPI measure to be updated by AGA)	Percentage of patients aged 18 years and older with the diagnosis of GERD who have been prescribed continuous proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) therapy who received an assessment of their GERD symptoms within 12 months	Patients who had an assessment of their GERD symptoms within 12 months of initiation of therapy	All patients aged 18 years and older patients with a diagnosis of GERD who have been prescribed continuous proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) therapy	No additional information provided by Measure Developer.	Gastrointestinal		Process	Not Endorsed	N/A	AMA-PCPI/(American Gastroenterological Association)

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2477	Medicare Physician Quality Reporting System (PQRS)	GERD: Assessment for Alarm Symptoms (PCPINCQA measure to be updated by AGA)	Percentage of patients aged 18 years and older with diagnosis of GERD, seen for an initial evaluation, who were assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding	Patients who were assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding	All patients aged 18 years and older with the diagnosis of GERD, seen for an initial evaluation	Documentation of medical reason(s) for not assessing for alarm symptoms	Gastrointestinal		Process	Not Endorsed	N/A	AMA-PCPI/NCQA
2478	Medicare Physician Quality Reporting System (PQRS)	GERD: Barium swallow – inappropriate use (PCPI measure to be updated by AGA)	Percentage of patients aged 18 years and older seen for an initial evaluation of GERD who did not have a Barium swallow test ordered	Patients who did not have Barium swallow test ordered	All patients aged 18 years and older seen for an initial evaluation of GERD	Documentation of medical reason(s) for ordering a Barium swallow test	Gastrointestinal		Process	Not Endorsed	N/A	AMA-PCPI/(American Gastroenterological Association)
2479	Medicare Physician Quality Reporting System (PQRS)	GERD: Upper endoscopy for patients with alarm symptoms (PCPINCQA measure to be updated by AGA)	Percentage of patients aged 18 years and older seen for an initial evaluation of GERD with at least one alarm symptom who were either referred for upper endoscopy or had an upper endoscopy performed	Patients who were either referred for an upper endoscopy or had an upper endoscopy performed	All patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with documentation of at least one alarm symptom (involuntary weight loss, dysphagia, or GI bleeding)	Documentation of medical reason(s) for not referring for or not performing an upper endoscopy Documentation of patient reason(s) for not referring for or not performing an upper endoscopy Documentation of system reason(s) for not referring for or not performing an upper endoscopy	Gastrointestinal		Process	Not Endorsed	N/A	AMA-PCPI/NCQA
2860	Medicare Physician Quality Reporting System (PQRS)	Colonoscopy Quality Composite e Measure	Percentage of patients age 18 years and older for whom a screening or surveillance colonoscopy is performed will have each of the following: 1.Assessment of adequacy of bowel preparation 2.Photo documentation of completeness of colonoscopy examination including cecal intubation or ileocolonic (No Suggestions)	1: Patients with documentation of assessment t of bowel preparation 2: Patients with photodocumentation of completeness of colonoscopy including cecal intubation or ileocolonic anastomosis	Patients age 18 years and older for whom a screening or surveillance colonoscopy was performed. (See attached draft Colonoscopy Quality Composite Measure for detailed specifications)	Did not include with submission	Gastrointestinal		Composite	Not Endorsed	N/A	American College of Gastroenterology, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy

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2938	Medicare Physician Quality Reporting System (PQRS)	Screening Colonoscopy Adenoma Detection Rate Measure	The percentage of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy.	Number of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy.	Patients age 50 years or older undergoing a screening colonoscopy (See attached draft Screening Colonoscopy Adenoma Detection Rate Measure for detailed specifications).		Gastrointestinal		Outcome	Not Endorsed	N/A	American College of Gastroenterology, the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy
1880	Medicare Physician Quality Reporting System (PQRS)	Patient Self-care Support	Percent of “excellent” or “very good” responses to seven questions regarding patient self-care support.	Number of “excellent” or “very good” responses to seven questions regarding patient self-care support ”- How is this practice at: 1) showing understanding of what it is like to live with diabetes? 2) encouraging you to ask questions and answering them clearly? 3) making sure you Number of “excellent” or “very good” responses to seven questions regarding patient self-care support ”- How is this practice at: 1) showing understanding of what it is like to live with diabetes? 2) encouraging you to ask questions and answering them clearly? 3) making sure you understand your recommended eating plan? 4) making sure you have the information you need to take your medications properly? 5) giving you information about side effects of your medications? 6) making sure you have the information you need to take care	Number of all responses (excluding “not applicable” or skipped responses) to seven questions regarding patient self-care support	1. Patients are unable to complete a patient survey, even with assistance OR 2. Patients have a terminal illness, or treatment of their diabetes is not clinically relevant OR 3.missing and “not applicable” responses	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	American Board of Internal Medicine

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				of your feet? 7) making sure you check your blood sugar at home?								
2448	Medicare Physician Quality Reporting System (PQRS)	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report	All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep)	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	AMA-PCPI
2514	Medicare Physician Quality Reporting System (PQRS)	Post-Anesthetic Transfer of Care Measure: Use of Checklist for Direct Transfer of Care from Procedure Room to Intensive Care Unit.	Whether a patient who received an anesthesia service and was directly admitted to a critical care unit had documentation or use of a checklist for the transfer of care from the responsible anesthesia practitioner to the responsible critical care unit practitioner.	Patients with documented use of a checklist for the transfer of care from the responsible anesthesia practitioner to the responsible critical care unit practitioner	All patients who receive an anesthesia service and are transferred directly from the anesthetizing location to a critical care unit. Denominator Criteria (Eligible Cases): Patients of all ages AND Who received an anesthesia service (00100-01969) AND Who are transferred directly from anesthetizing location to a critical care unit (CPT II Code0581F – Patient transferred directly from the anesthetizing location to a critical care unit.) Note: Patients that are not transferred directly from anesthetizing location to a critical care unit (CPT II Code 0582F – Patient not transferred directly from the anesthetizing location to a critical care unit) are not in the denominator.	None	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	American Society of Anesthesiologists
2809	Medicare Physician Quality Reporting System (PQRS)	ALS Multidisciplinary Care Plan Developed or Updated	Percentage of patients diagnosed with ALS for whom a multi-disciplinary care plan* was developed, if not done previously, and the plan was updated at least once annually.	Patients for whom a multi-disciplinary care plan* was developed, if not done previously, and the plan was updated at least once annually.	All patients with a diagnosis of amyotrophic lateral sclerosis.	Documentation of a system reason for not developing and updating annually a multi-disciplinary care plan (eg patient has no insurance to cover a multidisciplinary plan)	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	American Academy of Neurology

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2892	Medicare Physician Quality Reporting System (PQRS)	HRS-4 In-person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED).	Proportion of adult patients with a new CIED with an in-person evaluation within 2 to 12 weeks following implantation.	The number of patients from the denominator with an in-person evaluation within 2-12 weeks following implantation. For the purposes of this measure, an "in-person evaluation" is defined as an in-person interrogation device evaluation either with or without iterative adjustment, as clinically indicated. The in-person evaluation can be provided by any trained physician or Clinically Employed Allied Professional (CEAP) in a designated CIED follow-up clinic, medical institution, or physician office.	All patients aged 18 years and older with implantation of a new CIED during the reporting period. CIEDs encompassed for this measure are the following devices: • Pacemakers (PMs) • Implantable cardioverter-defibrillators (ICDs) • Cardiac resynchronization devices (CRTs)	Exclude patients with any of the following diagnoses/conditions: 1. Patients with Implantable Loop Recorders or Implantable Cardiovascular Monitors. 2. Patients with pulse generator exchange only. 3. Patients with prior CIED implantation. 4. Patient preference for other or no treatment.	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	HRS
2907	Medicare Physician Quality Reporting System (PQRS)	Neurosurgery: Initial Visit (Similar to PQRS Measure 148)	The percentage of patients aged 18 through 80 years with a diagnosis of a neurosurgical procedure or pathology who had function assessed during the initial visit to the clinician for the episode of the condition .	Patients who had four of the following components assessed at the initial visit to the clinician for an episode of a neurosurgical procedure: functional status, patient history (including notation of presence or absence of warning signs), assessment of prior treatment and response, and employment status	Total patient sample from ages 18-80.	Did not include with submission	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	AANS/CNS
2908	Medicare Physician Quality Reporting System (PQRS)	Neurosurgery: Shared Decision Making	Percentage of patients with neurosurgical procedure with whom a physician or other clinician reviewed the range of treatment options, including alternatives to surgery prior to surgery. To demonstrate shared decision making, there must be documentation in the patient record of a discussion between the physician and the patient that includes all of the following. •Treatment choices, including alternatives to surgery; •Risks and benefits; •Evidence of effectiveness	The number of patients who had surgery, with documentation in the medical record that a clinician and the patient discussed treatment options prior to surgery, including alternatives to surgery, risks and benefits and evidence of effectiveness.	Patients who had neurosurgery between 18-80 years of age.	Did not include with submission	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	AANS/CNS

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2927	Medicare Physician Quality Reporting System (PQRS)	Querying about Parkinson's Disease Medication-Related Motor Complications	All visits for patients with a diagnosis of Parkinson's disease where patients (or caregiver(s), as appropriate) were queried about Parkinson's disease medication-related motor complications (e.g., wearing off, dyskinesia, or off-time).	Patient visits with patient (or caregiver(s), as appropriate) queried about Parkinson's disease medication-related motor complications (e.g., wearing off, dyskinesia, or off-time).	All visits for patients with a diagnosis of Parkinson's disease.	Documentation of medical reason for not querying patient (or caregiver) about Parkinson's disease medication-related motor complications (e.g., patient is not on a Parkinson's disease medication; patient is unable to respond and no informant is available)	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	American Academy of Neurology
2928	Medicare Physician Quality Reporting System (PQRS)	Querying about Symptoms of Autonomic Dysfunction	All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were queried about symptoms of autonomic dysfunction (e.g., orthostatic hypotension, constipation, urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, or persistent erectile failure) at least annually.	Patients (or caregiver(s), as appropriate) who were queried about symptoms of autonomic dysfunction (e.g., orthostatic hypotension, constipation, urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, or persistent erectile failure) at least annually.	All patients with a diagnosis of Parkinson's disease.	Documentation of medical reason for not querying patient (or caregiver) about symptoms of autonomic dysfunction at least annually (e.g., patient is unable to respond and no informant is available)	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	American Academy of Neurology
2944	Medicare Physician Quality Reporting System (PQRS)	Surgical Therapy Referral Consideration for Intractable Epilepsy	All patients with a diagnosis of intractable epilepsy who were considered for referral for a neurological evaluation of appropriateness for surgical therapy and the consideration was documented in the medical record within the past 3 years.	Patients who were considered for referral for a neurological evaluation of appropriateness for surgical therapy and the consideration was documented in the medical record within the past 3 years.	Patients who were considered for referral for a neurological evaluation of appropriateness for surgical therapy and the consideration was documented in the medical record within the past 3 years.	No exclusions appropriate for this measure	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	American Academy of Neurology
1384	Medicare Physician Quality Reporting System (PQRS)	Querying and Counseling about Anti-Epileptic Drug (AED) Side-Effects	All visits for patients with a diagnosis of epilepsy who were queried and counseled about Anti-Epileptic Drug (AED) side-effects and the querying and counseling was documented in the medical record.	Patient visits with patient queried and counseled about Anti-Epileptic Drug (AED) side-effects and the querying and counseling was documented in the medical record.	All visits for patients with a diagnosis of epilepsy.	Denominator Exclusions: * Documentation of medical reason for not querying and counseling patient about AED side effects (e.g. patient is NOT receiving an AED; patient is unable to communicate and no informant is available)	Health Services Administration	Patient Education	Process	Not Endorsed	N/A	AMA PCPI AAN
1386	Medicare Physician Quality Reporting System (PQRS)	Counseling about Epilepsy Specific Safety Issues	All patients with a diagnosis of epilepsy (or their caregiver(s)) who were counseled about context-specific safety issues, appropriate to the patient's age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (e.g. injury prevention, burns, appropriate driving restrictions or bathing) at least once a year.	All patients with a diagnosis of epilepsy (or their caregiver(s)) who were counseled about context-specific safety issues, appropriate to the patient's age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (e.g. injury prevention, burns, appropriate driving restrictions or bathing) at least once a year.	All patients with a diagnosis of epilepsy.	Documentation of system reason for not counseling the patient about context-specific safety issues (i.e. caregiver is not available for the patient who is unable to comprehend counseling about safety issues)	Health Services Administration	Patient Education	Process	Not Endorsed	N/A	AMA PCPI AAN

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1812	Medicare Physician Quality Reporting System (PQRS)	Parkinson's Disease Related Safety Issues Counseling	All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were counseled about context-specific safety issues appropriate to the patient's stage of disease (e.g., injury prevention, medication management, or driving) at least annually.	Patients (or caregiver(s), as appropriate) who were counseled about context-specific safety issues appropriate to the patient's stage of disease (e.g., injury prevention, medication management, or driving) at least annually.	All patients with a diagnosis of Parkinson's disease.	Documentation of medical reason for not counseling the patient (or caregiver) about context-specific safety issues appropriate to the patient's stage of disease (e.g., patient is unable to respond and no informant is available)	Health Services Administration	Patient Education	Process	Not Endorsed	N/A	AMA PCPI AAN
1879	Medicare Physician Quality Reporting System (PQRS)	Overall Hypertension Care Satisfaction	Patients in the sample who rated their overall hypertension care as "excellent" or "very good".	Number of patients in the sample who rated overall hypertension care "excellent" or "very good"	Number of patients in the sample excluding those who did not rate overall hypertension care.	1.Patients with kidney failure (GFR < 15 or dialysis) OR 2.Patients unable to complete a patient survey, even with assistance OR 3.Patients have a terminal illness, or treatment of their hypertension is not clinically relevant.	Health Services Administration	Patient Experience	Patient Perspective	Not Endorsed	N/A	American Board of Internal Medicine
2497	Medicare Physician Quality Reporting System (PQRS)	Patient satisfaction with overall diabetes care	Patients in the sample who rated overall diabetes care "excellent" or "very good".	Number of patients in the sample who rated overall diabetes care "excellent" or "very good"	Number of patients in the sample excluding those who did not rate overall diabetes care	1. Patients are unable to complete a patient survey, even with assistance OR 2. Patients have a terminal illness, or treatment of their diabetes is not clinically relevant OR 3. Patients who did not rate overall diabetes care.	Health Services Administration	Patient Experience	Outcome	Not Endorsed	N/A	American Board of Internal Medicine
2498	Medicare Physician Quality Reporting System (PQRS)	Patient satisfaction with physician care provided for age related macular degeneration	Percentage of patients aged 50 years and older with age related macular degeneration and were satisfied with their care	Patients with age-related macular degeneration and were satisfied with their care	All patients aged 50 years and older who have age-related macular degeneration	Patient reason for not performing the patient satisfaction questionnaire	Health Services Administration	Patient Experience	Outcome	Not Endorsed	N/A	American Academy of Ophthalmology and the Hoskins Center for Quality Eye Care
2499	Medicare Physician Quality Reporting System (PQRS)	Patient satisfaction with physician care provided for diabetic retinopathy	Percentage of patients aged 18 years and older with diabetic retinopathy and who were satisfied with their care	Patients with diabetic retinopathy and were satisfied with their care	All patients aged 18 years and older who have diabetic retinopathy	Patient reason for not performing the patient satisfaction questionnaire	Health Services Administration	Patient Experience	Outcome	Not Endorsed	N/A	American Academy of Ophthalmology and the Hoskins Center for Quality Eye Care

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2531	Medicare Physician Quality Reporting System (PQRS)	Screening for Unhealthy Alcohol Use	Percentage of patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy who were screened with validated screening instrument for unhealthy alcohol use when seen for an initial evaluation for distal symmetric polyneuropathy.	Patients who were screened with a validated screening instrument for unhealthy alcohol use* when seen for an initial evaluation for distal symmetric polyneuropathy.	All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy.	* Documentation of a medical reason for not screening the patient with a validated screening instrument for unhealthy alcohol use (eg patient diagnosed with alcoholism) * Documentation of a patient reason for not screening the patient with a validated screening instrument for unhealthy alcohol use (eg patient declines to answer questions/complete the screening)	Mental Health Care & Substance-Related Care	Alcohol Use	Process	Not Endorsed	N/A	American Academy of Neurology
2806	Medicare Physician Quality Reporting System (PQRS)	ALS Cognitive Impairment and Behavioral Impairment Screening	Percentage of patients diagnosed with ALS who are screened at least once annually for cognitive impairment (eg frontotemporal dementia screening or ALS Cognitive Behavioral Screen (CBS)) and behavioral impairment (eg ALS CBS).	Patients who are screened at least once annually for cognitive impairment (eg frontotemporal dementia screening or ALS Cognitive Behavioral Screen (CBS)) and behavioral impairment (eg ALS CBS).	All patients with a diagnosis of amyotrophic lateral sclerosis.	* Documentation of a medical reason for not screening the patient for cognitive and behavioral impairment (eg patient currently diagnosed with severe cognitive impairment) * Documentation of a patient reason for not screening the patient for cognitive and behavioral impairment (eg patient declines to be screened for cognitive or behavioral impairment) * Documentation of a system reason for not screening the patient for cognitive and behavioral impairment (eg no insurance to cover screening cost)	Mental Health Care & Substance-Related Care	Cognitive Disorders	Process	Not Endorsed	N/A	American Academy of Neurology
2504	Medicare Physician Quality Reporting System (PQRS)	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Follow Up Assessment of Depression Care	Percentage of patients aged 18 years and older with a diagnosis of MDD with documentation of the patient's response to treatment three times in the first 90 days following diagnosis, and, if patient has not improved, documentation of treatment plan review or alteration	Patients with documentation of the patient's response to treatment three times in the first 90 days following diagnosis, and, if patient has not improved, documentation of treatment plan review or alteration	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)	None	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Process	Not Endorsed	N/A	AMA-PCPI
2505	Medicare Physician Quality Reporting System (PQRS)	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Continuation of Antidepressant Medications	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) who were continued on antidepressant medication for a minimum of 16 weeks following initial status change to remission	Patients who were continued on antidepressant medication for a minimum of 16 weeks following initial status change to remission	Antidepressant medication for a minimum of 16 weeks following initial status change to remission All patients aged 18 years and older with a diagnosis of major depressive disorder(MDD) who were started on antidepressant medication	Documentation of medical reason(s) for not continuing the antidepressant therapy for the required timeframe (eg, other medical reasons) Documentation of patient reason(s) for not continuing the antidepressant therapy for the required timeframe (eg, other patient reasons)	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Process	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2506	Medicare Physician Quality Reporting System (PQRS)	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Patient Education	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) who received patient education two times per year, including at diagnosis, regarding, at a minimum: -the symptoms and treatment of major depressive disorder, including somatic symptoms, potential side effects, suicidal thoughts and behaviors, and the importance of treatment adherence; -its effects on functioning (including relationships, work, etc.); -the effect of healthy behaviors on depression, such as exercise, good sleep hygiene, good nutrition, and decreased use of tobacco, alcohol, and other potentially deleterious substances	Patients who received patient education two times per year, including at diagnosis, regarding, at a minimum: -the symptoms and treatment of major depressive disorder, including somatic symptoms, potential side effects, suicidal thoughts and behaviors, and the importance of treatment adherence; -its effects on functioning (including relationships, work, etc.); -the effect of healthy behaviors on depression, such as exercise, good sleep hygiene, good nutrition, and decreased use of tobacco, alcohol, and other potentially deleterious substances	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)	Documentation of patient reason(s) for not receiving patient education (eg, patient unable or unwilling to receive patient education, other patient reasons)	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Process	Not Endorsed	N/A	AMA-PCPI
2507	Medicare Physician Quality Reporting System (PQRS)	Adult Major Depressive Disorder: Screening for Depression	Percentage of patients aged 18 years and older who were screened for depression annually using a validated depression screening tool (such as the PHQ-2) and, for those who screen positive for depression, a follow-up plan is documented	Patients who were screened for depression with a validated depression screening tool (such as the PHQ-2) and, for those who screen positive for depression, a follow-up plan is documented	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the one year measurement period	None	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Process	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2508	Medicare Physician Quality Reporting System (PQRS)	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Treatment for Depression	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) who have a depression severity classification and who receive, at a minimum, treatment appropriate to their depression severity classification at the most recent visit during the measurement period	Patients who have a depression severity classification and who receive, at a minimum, treatment appropriate to their depression severity classification* at the most recent visit	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)	Documentation of medical reason(s) for not receiving treatment appropriate to MDD severity classification (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving treatment appropriate to MDD severity classification (eg, patient declined, patient preference**, other patient reasons) **Documented patient preference could include (but is not limited to) preference information related to prior treatment response, family history of treatment response, treatment administration method, treatment side effects, or other personal concerns (financial, functional, etc.). Documentation of system reason(s) for not receiving treatment appropriate to MDD severity classification (eg, treatment not covered by insurance, other system reasons)	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Process	Not Endorsed	N/A	AMA-PCPI
2511	Medicare Physician Quality Reporting System (PQRS)	Adult Major Depressive Disorder: Coordination of Care of Patients with Comorbid Conditions-Timely Follow Up	Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a diagnosed comorbid condition being treated by another physician with communication to the other physician treating the comorbid condition	Medical records of patients with communication to another physician treating the comorbid condition	All medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a diagnosed comorbid condition being treated by another physician	None	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Process	Not Endorsed	N/A	AMA/ASPN
2532	Medicare Physician Quality Reporting System (PQRS)	Smoking Status and Cessation Advice and Treatment	Percentage of patients 18 - 75 years of age who had documentation of smoking status and if patient is a smoker, received cessation counseling or treatment over the reporting period.	The number of the eligible patients from the Chart Review with documentation of smoking status for non-smokers OR date of cessation counseling or treatment during the 12- month abstraction period or one month prior to the abstraction period if the patient is a smoker.	The number of the eligible patients from the Chart Review.	None	Mental Health Care & Substance-Related Care	Tobacco Use	Process	Not Endorsed	N/A	American Board of Internal Medicine

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2822	Medicare Physician Quality Reporting System (PQRS)	AV Fistula 2: Post-operative death within 30 days of procedure (2 of 5 Measures Group: AV Fistula)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a death occurring within 30 days following surgery, regardless of cause, in or out of the hospital.	Any death occurring within 30 days following surgery, regardless of cause, in or out of the hospital.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Mortality		Outcome	Not Endorsed	N/A	American College of Surgeons
2852	Medicare Physician Quality Reporting System (PQRS)	Colectomy 3: Post-operative death within 30 days of procedure (3 of 6: Measures Group Colectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a death occurring within 30 days following surgery, regardless of cause, in or out of the hospital.	Any death occurring within 30 days following surgery, regardless of cause, in or out of the hospital.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Mortality		Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2958	Medicare Physician Quality Reporting System (PQRS)	Ventral Hernia 2: Post-operative death within 30 days of procedure (2 of 5 : Measures Group Ventral Hernia)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a death occurring within 30 days following surgery, regardless of cause, in or out of the hospital.	Any death occurring within 30 days following surgery, regardless of cause, in or out of the hospital.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Mortality		Outcome	Not Endorsed	N/A	American College of Surgeons
2820	Medicare Physician Quality Reporting System (PQRS)	Assessment of Patient History, Physical Examination and Radiographic Evidence of Arthritis	Percentage of patients undergoing a total knee replacement who had a history and physical completed within one year prior to the procedure that included all of the following: onset and duration of symptoms, location and severity of pain, activity limitations, gait, knee range of motion, presence or absence of deformity of the knee, stability of the knee, neurologic status, vascular status, skin, height, and weight; AND had radiographic evidence of arthritis within one year prior to the procedure	Patients who had a history and physical completed within one year prior to the procedure that included all of the following: onset and duration of symptoms, location and severity of pain, activity limitations, gait, knee range of motion, presence or absence of deformity of the knee, stability of the knee, neurologic status, vascular status, skin, height, and weight; AND had radiographic evidence of arthritis within one year prior to the procedure	All patients undergoing a total knee replacement	Documentation of medical reason(s) for no radiographic evidence for arthritis (e.g., patients with osteonecrosis or bone tumor, MRI studies showing full thickness cartilage loss) Append modifier to CPT Category II code: XXXXF-1P	Musculoskeletal	Arthritis	Process	Not Endorsed	N/A	American Association of Hip and Knee Surgeons
2154	Medicare Physician Quality Reporting System (PQRS)	Osteoporosis: Current Level of Alcohol Use and Advice on Potentially Hazardous Drinking Prevention	Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older whose current level of alcohol use was documented and for those engaging in potentially hazardous drinking who received counseling within 12 months	Patients whose current level of alcohol use was documented and for those engaging in potentially hazardous drinking who received counseling within 12 months	Patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older	Patients who have a terminal illness or for whom treatment of their osteoporosis is not clinically relevant should be excluded.	Musculoskeletal	Osteoporosis	Process	Not Endorsed	N/A	American Board of Internal Medicine

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2700	Medicare Physician Quality Reporting System (PQRS)	Osteoporosis Composite	• Status of Participation in Weight-Bearing Exercise and Weight-bearing Exercise Advice: Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older whose status regarding participation in weight-bearing exercise was documented and for those not participating regularly who received advice within 12 months to participate in weight-bearing exercise • Current Level of Alcohol Use and Advice on Potentially Hazardous Drinking Prevention: Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older whose current level of alcohol use was documented and for those engaging in potentially hazardous drinking who received counseling within 12 months • Screen for Falls Risk Evaluation and Complete Falls Risk Assessment and Plan of Care: Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older who had a screen for falls risk evaluation within the past 12 months and for those reported as having a history of two or more falls, or fall-related injury who had a complete risk assessment for falls and a falls plan of care within the past 12 months • Dual-Emission X-ray Absorptiometry (DXA) Scan: Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older who had a DXA	•Measure # 1: Osteoporosis: Status of Participation in Weight-bearing Exercise and Weight-bearing Exercise Advice: Patients whose status regarding participation in weight-bearing exercise was documented and for those not participating regularly who received advice within 12 months to participate in weight-bearing exercise •Measure # 2: Osteoporosis: Current Level of Alcohol Use and Advice on Potentially Hazardous Drinking Prevention: Patients whose current level of alcohol use was documented and for those engaging in potentially hazardous drinking who received counseling within 12 months •Measure # 3: Osteoporosis: Screen for Falls Risk Evaluation and Complete Falls Risk Assessment and Plan of Care: Patients who had a screen for falls risk evaluation within 12 months and for those reported as having a history of two or more falls, or fall-related injury who had a complete risk assessment for falls and a falls plan of care within the past 12 months •Measure # 4: Osteoporosis: DXA Scan: Patients who had a DXA scan and result documented. •Measure # 5: Osteoporosis: 5. Calcium Intake Assessment and Counseling: Patients who had calcium intake assessment and	Patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older.	Measure # 1: Osteoporosis: Status of Participation in Weight-bearing Exercise and Weight-bearing Exercise Advice Patients who have a terminal illness or for whom treatment of their osteoporosis is not clinically relevant should be excluded. Measure # 2: Osteoporosis: Current Level of Alcohol Use and Advice on Potentially Hazardous Drinking Prevention Patients who have a terminal illness or for whom treatment of their osteoporosis is not clinically relevant should be excluded. Measure # 3: Osteoporosis: Screen for Falls Risk Evaluation and Complete Falls Risk Assessment and Plan of Care Patients who have a terminal illness or for whom treatment of their osteoporosis is not clinically relevant should be excluded. Measure # 4: Osteoporosis: DXA Scan Patients who have a terminal illness, for whom treatment of their osteoporosis is not clinically relevant, who are already on therapy and for whom imaging would not be likely to add benefit, who have documented refusal, or for whom DXA scan could not be done due to healthcare system delivery reason should be excluded. Measure # 5: Osteoporosis: 5. Calcium Intake Assessment and Counseling Patients who have a terminal illness, for whom treatment of their osteoporosis is not clinically relevant, or who have normal DXA scan result (i.e. T-score of -1.0 or greater) should be excluded. Measure # 6: Osteoporosis: Vitamin D Intake Assessment and Counseling Patients who have a terminal illness, for whom treatment of their osteoporosis is not clinically relevant, or who have normal DXA scan result (i.e. T-score of -1.0 or greater) should be excluded.	Musculoskeletal	Osteoporosis	Composite	Not Endorsed	N/A	American Board of Internal Medicine

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			scan and result documented • Calcium Intake Assessment and Counseling: Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older who had calcium intake assessment and counseling at least once within 12 months • Vitamin D Intake Assessment and Counseling: Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older who had vitamin D intake assessment and counseling at least once within 12 months • Pharmacologic Therapy: Percentage of patients aged 18 and older with a diagnosis of osteoporosis, osteopenia, or prior low impact fracture; women age 65 and older; or men age 70 and older who were prescribed pharmacologic therapy approved by the Food and Drug Administration	counseling at least once within 12 months. •Measure # 6: Osteoporosis: Vitamin D Intake Assessment and Counseling: Patients who had vitamin D intake assessment and counseling at least once within 12 months •Measure # 7: Osteoporosis: Pharmacologic Therapy: Patients who were prescribed pharmacologic therapy.		Measure # 7: Osteoporosis: Pharmacologic Therapy Patients who have a terminal illness or for whom treatment of their osteoporosis is not clinically relevant, who do not have a diagnosis of osteoporosis or osteopenia, or have a diagnosis of osteopenia and a 10-year probability of a hip fracture < 3% and a 10-year probability of a major osteoporosis-related fracture < 20%, or who are allergic, intolerant, or have a contraindication to pharmacologic therapy should be excluded					
2939	Medicare Physician Quality Reporting System (PQRS)	Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	Percentage of patients undergoing a total knee replacement with documented shared decision-making with discussion of conservative (non-surgical) therapy (e.g. NSAIDs, analgesics, exercise, injections) prior to the procedure	Patients with documented shared decision-making with discussion of conservative (non-surgical) therapy (e.g. NSAIDs, analgesics, exercise, injections) prior to the procedure	All patients undergoing a total knee replacement		Musculoskeletal		Process	Not Endorsed	N/A	American Association of Hip and Knee Surgeons
2789	Medicare Physician Quality Reporting System (PQRS)	Ventral Hernia 5: Surgical site infection (SSI) (1 of 5 : Measures Group Ventral Hernia)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a surgical site infection.	The number of patients aged =65 years who underwent the procedure during the reporting period and experienced: • Any grade of Surgical Site Infection (SSI) o Definition: Includes all of the following: Superficial Incisional SSI: Superficial incisional SSI is an	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged =65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class,	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative.	emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.						

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				• An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician. Organ/Space SSI: Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following: • Purulent drainage from a drain that is placed through a stab wound into the organ/space. • Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space. • An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of an organ/space SSI by a surgeon or attending physician.							
2791	Medicare Physician Quality Reporting System (PQRS)	Appendectomy 4: Surgical site infection (SSI) (4 of 4: Measures Group Appendectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a Surgical Site Infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced an grade of Surgical Site Infection (SSI) including any of the following: Superficial Incisional SSI:	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness,	measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician. Organ/Space SSI: Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following: • Purulent drainage from a drain that is placed through a stab wound into the organ/space. • Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space. • An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of an organ/space SSI by a surgeon or attending physician.								

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2792	Medicare Physician Quality Reporting System (PQRS)	AV Fistula 1: Iatrogenic injury to adjacent organ/structure(1 of 5 Measures Group: AV Fistula)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged =65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2817	Medicare Physician Quality Reporting System (PQRS)	Appendectomy 1: Iatrogenic injury to adjacent organ/structure (1 of 4: Measures Group Appendectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged =65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2818	Medicare Physician Quality Reporting System (PQRS)	Appendectomy 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Appendectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2823	Medicare Physician Quality Reporting System (PQRS)	AV Fistula 3: Unplanned reoperation within the 30 day postoperative period (3 of 5 Measures Group: AV Fistula)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >= 65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2825	Medicare Physician Quality Reporting System (PQRS)	AV Fistula 5: Surgical site infection (SSI) (5 of 5 Measures Group: AV Fistula)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a surgical site infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced any grade of Surgical Site Infection (SSI) Includes any of the following: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician.							
2826	Medicare Physician Quality Reporting System (PQRS)	Bariatric Lap Band Procedure 2: Unplanned reoperation within the 30 day postoperative period (2 of 3 Measures Group: Bariatric lap Band Procedure)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2828	Medicare Physician Quality Reporting System (PQRS)	Bariatric Lap Band Procedure 1: Iatrogenic injury to adjacent organ/structure (1 of 3 Measures Group: Bariatric lap Band Procedure)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., stomach, esophagus, liver, spleen, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., stomach, esophagus, liver, spleen, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2829	Medicare Physician Quality Reporting System (PQRS)	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 1: Anastomotic Leak Intervention (1 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through an anastomosis. The presence of an infection/abscess thought to be related to an anastomosis, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered an anastomotic leak.	Intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through an anastomosis. The presence of an infection/abscess thought to be related to an anastomosis, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered an anastomotic leak.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2830	Medicare Physician Quality Reporting System (PQRS)	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 2: Iatrogenic injury to adjacent organ/structure (2 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., stomach, esophagus, liver, spleen, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., stomach, esophagus, liver, spleen, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2831	Medicare Physician Quality Reporting System (PQRS)	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 3: Unplanned reoperation within the 30 day postoperative period (3 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2833	Medicare Physician Quality Reporting	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 5: Surgical site infection	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced any grade	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
	System (PQRS)	(SSI) (5 of 6 Measures Group:Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	who had a Surgical Site Infection.	of Surgical Site Infection (SSI) o Definition: Includes all of the following: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened	>=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician. Organ/Space SSI: Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following: • Purulent drainage from a drain that is placed through a stab wound into the organ/space. • Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space. • An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of an organ/space SSI by a surgeon or attending physician.							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2834	Medicare Physician Quality Reporting System (PQRS)	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 6: Bleeding Requiring Transfusion (3 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who required any transfusion (including autologous) of packed red blood cells or whole blood given from the time the patient leaves the operating room up to and including 72 hours postoperatively. If the patient receives shed blood, autologous blood, cell saver blood or pleurovac postoperatively, this is counted if greater than four units.	Any transfusion (including autologous) of packed red blood cells or whole blood given from the time the patient leaves the operating room up to and including 72 hours postoperatively. If the patient receives shed blood, autologous blood, cell saver blood or pleurovac postoperatively, this is counted if greater than four units.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2835	Medicare Physician Quality Reporting System (PQRS)	Bariatric Sleeve Gastrectomy 1: Leak Intervention (1 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through a staple line. The presence of an infection/abscess thought to be related to a staple line, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered a leak.	Intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through a staple line. The presence of an infection/abscess thought to be related to a staple line, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered a leak.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2836	Medicare Physician Quality Reporting System (PQRS)	Bariatric Sleeve Gastrectomy 2: Iatrogenic injury to adjacent organ/structure (2 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., stomach, esophagus, liver, spleen, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., stomach, esophagus, liver, spleen, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2837	Medicare Physician Quality Reporting System (PQRS)	Bariatric Sleeve Gastrectomy 3: Unplanned reoperation within the 30 day postoperative period (3of 6 Measures Group: Bariatric Sleeve Gastrectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at ay hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2839	Medicare Physician Quality Reporting	Bariatric Sleeve Gastrectomy 5: Surgical site infection (SSI) (5 of 6 Measures	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older	The number of patients aged =65 years who underwent the procedure during the reporting period and experienced any grade	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
	System (PQRS)	Group: Bariatric Sleeve Gastrectomy)	who had a surgical site infection.	of Surgical Site Infection (SSI) Includes all of the following: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has	>=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician. Organ/Space SSI: Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following: • Purulent drainage from a drain that is placed through a stab wound into the organ/space. • Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space. • An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of an organ/space SSI by a surgeon or attending physician.							
2840	Medicare Physician Quality	Bariatric Sleeve Gastrectomy 6: Bleeding Requiring	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting)	Any transfusion (including autologous) of packed red blood cells or whole blood given from the	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
	Reporting System (PQRS)	Transfusion (6 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	Percentage of patients age 65 and older who had an any transfusion (including autologous) of packed red blood cells or whole blood given from the time the patient leaves the operating room up to and including 72 hours postoperatively. If the patient receives shed blood, autologous blood, cell saver blood or pleurovac postoperatively, this is counted if greater than four units.	time the patient leaves the operating room up to and including 72 hours postoperatively. If the patient receives shed blood, autologous blood, cell saver blood or pleurovac postoperatively, this is counted if greater than four units.	to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							
2846	Medicare Physician Quality Reporting System (PQRS)	Cholecystectomy 1: Iatrogenic injury to adjacent organ/structure (1 of 4: Measures Group Cholecystectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2847	Medicare Physician Quality Reporting System (PQRS)	Cholecystectomy 2: Unplanned reoperation within the 30 day postoperative period (2of 4: Measures Group Cholecystectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation,	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.		functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							
2849	Medicare Physician Quality Reporting System (PQRS)	Cholecystectomy 4: Surgical site infection (SSI) (4 of 4: Measures Group Cholecystectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a Surgical Site Infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced any grade of Surgical Site Infection (SSI) including any of the following: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician. Organ/Space SSI: Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following: • Purulent drainage from a drain that is placed through a stab wound into the organ/space. • Organisms isolated from an aseptically obtained culture of fluid								

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				or tissue in the organ/space. • An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of an organ/space SSI by a surgeon or attending physician.								
2850	Medicare Physician Quality Reporting System (PQRS)	Colectomy 1: Anastomotic Leak Intervention (1 of 6: Measures Group Colectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through an anastomosis. The presence of an infection/abscess thought to be related to an anastomosis, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered an anastomotic leak	Intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through an anastomosis. The presence of an infection/abscess thought to be related to an anastomosis, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered an anastomotic leak	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2851	Medicare Physician Quality Reporting System (PQRS)	Colectomy 2: Iatrogenic injury to adjacent organ/structure (2 of 6: Measures Group Colectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., small bowel, stomach, spleen, liver, duodenum, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., small bowel, stomach, spleen, liver, duodenum, vasculature, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			injury, damage, disruption, or defect.									
2853	Medicare Physician Quality Reporting System (PQRS)	Colectomy 4: Unplanned reoperation within the 30 day postoperative period (4 of 6: Measures Group Colectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2855	Medicare Physician Quality Reporting System (PQRS)	Colectomy 6: Surgical site infection (SSI) (6 of 6: Measures Group Colectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a Surgical Site Infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and any grade of Surgical Site Infection (SSI) o Definition: Includes all of the following: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician. Organ/Space SSI: Organ/Space SSI is an infection that occurs							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following: • Purulent drainage from a drain that is placed through a stab wound into the organ/space. • Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space. • An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of an organ/space SSI by a surgeon or attending physician.							
2856	Medicare Physician Quality Reporting System (PQRS)	Colonoscopy 1: Iatrogenic injury to adjacent organ/structure (1 of 4: Measures Group Colonoscopy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, and defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2857	Medicare Physician Quality Reporting System (PQRS)	Colonoscopy 2: Cecal Intubation Rate (2 of 4: Measures Group Colonoscopy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had passage of the colonoscope to the ileocecal valve and visualization of the entire cecum. This should be documented by naming or photography of the identified cecal landmarks (appendiceal orifice and ileocecal valve) or intubation of the terminal ileum.	Passage of the colonoscope to the ileocecal valve and visualization of the entire cecum. This should be documented by naming or photography of the identified cecal landmarks (appendiceal orifice and ileocecal valve) or intubation of the terminal ileum.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2864	Medicare Physician Quality Reporting System (PQRS)	Esophagogastroduodenoscopy (EGD) 1: Iatrogenic injury to adjacent organ/structure (1 of 2: Measures Group Esophagogastroduodenoscopy [EGD])	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., colon, small bowel, ureter, blood vessel, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2865	Medicare Physician Quality Reporting System (PQRS)	Esophagogastroduodenoscopy (EGD) 2: Unplanned intubation (2 of 2: Measures Group Esophagogastroduodenoscopy [EGD])	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who required placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia,	Patient required placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis within 30 days of the procedure. In patients who were intubated for	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			hypercarbia, or respiratory acidosis within 30 days of the procedure. In patients who were intubated for their procedure, unplanned intubation occurs after they have been extubated after their procedure. In patients who were not intubated during their procedure, intubation at any time after their procedure is considered unplanned.	their procedure, unplanned intubation occurs after they have been extubated after their procedure. In patients who were not intubated during their procedure, intubation at any time after their procedure is considered unplanned.	variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							
2867	Medicare Physician Quality Reporting System (PQRS)	Hemorrhoidectomy 1: Bleeding requiring transfusion (1 of 4: Measures Group Hemorrhoidectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any transfusion (including autologous) of packed red blood cells or whole blood given from the time the patient leaves the operating room up to and including 72 hours postoperatively. If the patient receives shed blood, autologous blood, cell saver blood or pleurovac postoperatively, this is counted if greater than four units.	Any transfusion (including autologous) of packed red blood cells or whole blood given from the time the patient leaves the operating room up to and including 72 hours postoperatively. If the patient receives shed blood, autologous blood, cell saver blood or pleurovac postoperatively, this is counted if greater than four units.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2868	Medicare Physician Quality Reporting System (PQRS)	Hemorrhoidectomy 2: Iatrogenic injury to adjacent organ/structure (2of 4: Measures Group Hemorrhoidectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2869	Medicare Physician Quality Reporting System (PQRS)	Hemorrhoidectomy 3: Unplanned reoperation within the 30 day postoperative period (3 of 4: Measures Group Hemorrhoidectomy)	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2886	Medicare Physician Quality Reporting System (PQRS)	HRS-1 Complications of Catheter Ablation Treatment for Atrial Fibrillation (AF).	Rates of procedural complications following catheter ablation treatment for paroxysmal, persistent or long-standing persistent AF in adult patients.	Number of patients from the denominator with one or more of the following complications within 30 or 90 days (depending on the complication) following catheter ablation for AF Complications measured for 30 days following procedure: • Death* • Left atrial-esophageal fistula • Sepsis Complications measured for 90 days following procedure: • Symptomatic severe (i.e., >70% diameter narrowing) pulmonary vein stenosis or occlusion • Phrenic nerve paralysis persisting more than 30 days* • Cardiac arrest • Myocardial infarction and balloon angioplasty and/or stent placement • Complete heart block requiring permanent pacemaker • Cardiac tamponade and	All patients aged 18 years and older who have catheter ablation for the treatment of paroxysmal, persistent, and long-standing persistent AF within the reporting period. The denominator population is captured using the following ICD-9 and CPT codes: • AF AND • SVT ablation WITH • Transseptal puncture	Wolf Parkinson White Syndrome Patients with pacemakers Patients with Implantable Cardioverter-Defibrillators (ICDs)	Patient Safety	Complications	Outcome	Not Endorsed	N/A	HRS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				pericardiocentesis • Pneumothorax requiring chest tube • Hemothorax requiring chest tube • Mitral valve injury requiring surgical repair during index hospitalization • Vascular injury requiring surgical repair and blood transfusion during index hospitalization • Pulmonary embolus • Deep venous thrombosis • Systemic arterial embolus requiring bypass, thromboaspiration, embolectomy, and/or angioplasty • Bleed requiring blood transfusion or surgical intervention • Hematoma requiring blood transfusion or evacuation • Retroperitoneal bleed requiring blood transfusion or surgical intervention • Cerebrovascular accident							
2888	Medicare Physician Quality Reporting System (PQRS)	HRS-12: Cardiac Tamponade Following Atrial Fibrillation Ablation.	3-year rolling average cardiac tamponade rate following atrial fibrillation ablation.	The number of patients from the denominator with cardiac tamponade occurring within 30 days following atrial fibrillation ablation	All patients aged 18 years and older with atrial fibrillation ablation performed during the reporting period	Did not include with submission	Patient Safety	Complications	Outcome	Not Endorsed	N/A	HRS
2890	Medicare Physician Quality Reporting System (PQRS)	HRS-3 Implantable Cardioverter-Defibrillator (ICD) Complications Rate.	Physician-specific risk-standardized rates of procedural complications following the implantation of an ICD.	Number of patients from the denominator with one or more of the following complications or mortality within 30 or 90 days (depending on the complication) following ICD implantation Complications measured for 30 days: 1. Death 2. Pneumothorax or hemothorax plus a chest tube 3. Hematoma plus a blood	1. Non-Medicare FFS patients. 2. Claims that are not the first in the same claim bundle. 3. Patient stays that lack 90 days of Medicare FFS enrollment post-discharge. 4. Patients with prior ICD implantation.		Patient Safety	Complications	Outcome	Not Endorsed	N/A	HRS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				transfusion or evacuation 4. Cardiac tamponade or pericardiocentesis Complications measured for 90 days: 5. Mechanical complications requiring a system revision 6. Device related infection Additional ICD implantation								
2893	Medicare Physician Quality Reporting System (PQRS)	HRS-9: Infection within 180 days of CIED Implantation, Replacement, or Revision.	Infection rates following CIED device implantation, replacement, or revision (3-year rolling average).	The number of patients from the denominator admitted with an infection requiring device removal or surgical revision within 180 days following CIED implantation, replacement, or revision	All Medicare fee-for-service (FFS) beneficiaries with implantation, replacement, or revision of a CIED during the reporting period CIEDs encompassed for this measure are the following devices: • Pacemaker devices (single or dual chamber) • Implantable cardioverter-de?brillators (ICDs, single or dual chamber) • Cardiac resynchronization devices (pacemaker or ICD) Implantable loop recorders (ILRs)	Did not include with submission	Patient Safety	Complications	Outcome	Not Endorsed	N/A	HRS
2895	Medicare Physician Quality Reporting System (PQRS)	Inguinal Hernia 1: Iatrogenic injury to adjacent organ/structure (1 of 3) Measures Group Inguinal Hernia	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2896	Medicare Physician Quality Reporting System (PQRS)	Inguinal Hernia 2: Unplanned reoperation within the 30 day postoperative period (2 of 3) Measures Group Inguinal Hernia	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2901	Medicare Physician Quality Reporting System (PQRS)	Mastectomy +/- Lymphadenectomy or SLNB 1: Iatrogenic injury to adjacent organ/structure (1 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2902	Medicare Physician Quality Reporting System (PQRS)	Mastectomy +/- Lymphadenectomy or SLNB 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2904	Medicare Physician Quality Reporting System (PQRS)	Mastectomy +/- Lymphadenectomy or SLNB 4: Surgical site infection (SSI) (4 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a surgical site infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				• Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician.							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2910	Medicare Physician Quality Reporting System (PQRS)	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 1: Iatrogenic injury to adjacent organ/structure(1 of 4: Measures Group Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2911	Medicare Physician Quality Reporting System (PQRS)	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2913	Medicare Physician Quality Reporting System (PQRS)	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 4: Surgical site infection (SSI) (4 of 4: Measures Group Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a surgical site infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician.								
2916	Medicare Physician Quality Reporting System (PQRS)	Patient-centered Surgical Risk Assessment and Communication: the percent of patients who underwent non-emergency major surgery who received preoperative risk assessment for procedure-specific postoperative complications using a data-based, patient-specific risk calculator, and who also received a personal discussion of risks with the surgeon.	Percentage of patients who underwent a non-emergency major surgery who had their risks of postoperative complications assessed by their surgical team prior to surgery using a data-based, patient-specific risk calculator and who received personal discussion of those risks. A higher value for this measure corresponds to higher quality.	Documentation of risk assessment with a risk calculator based on clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family.	Adult patients (age 18 and over) having had non-emergency major surgery	Did not include with submission	Patient Safety	Complications	Process	Not Endorsed	N/A	American College of Surgeons
2919	Medicare Physician Quality Reporting System (PQRS)	Percutaneous Central Line Placement 1: Iatrogenic injury to adjacent organ/structure (1 of 3: Measures Group Percutaneous Central Line Placement)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture,	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.						
2920	Medicare Physician Quality Reporting System (PQRS)	Percutaneous Central Line Placement 2: Central line-associated bloodstream infection (CLABSI) (2 of 3: Measures Group Percutaneous Central Line Placement)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who developed a central line associated blood stream infections are laboratory-confirmed bloodstream infections that are central line associated as (CLABSI as defined by the CDC)	Central line associated blood stream infections are laboratory-confirmed bloodstream infections that are central line associated. See CDC definition of CLABSI at http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2921	Medicare Physician Quality Reporting System (PQRS)	Percutaneous Central Line Placement 3: Failure to complete procedure (unable to obtain access) (3 of 3: Measures Group Percutaneous Central Line Placement)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a procedure that was not completed secondary to inability to gain vascular access	Procedure was not completed secondary to inability to gain vascular access.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2940	Medicare Physician Quality Reporting System (PQRS)	Skin / Soft Tissue Lesion Excision 1: Iatrogenic injury to adjacent organ/structure (1 of 4: Measures Group Skin / Soft Tissue Lesion Excision)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2941	Medicare Physician Quality Reporting System (PQRS)	Skin / Soft Tissue Lesion Excision 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Skin / Soft Tissue Lesion Excision)	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2943	Medicare Physician Quality Reporting System (PQRS)	Skin / Soft Tissue Lesion Excision 4: Surgical site infection (SSI) / wound dehiscence (4 of 4: Measures Group Skin / Soft Tissue Lesion Excision)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a surgical site infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. • Diagnosis of a deep incision SSI by a surgeon or attending physician. • Diagnosis of an organ/space SSI by a surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.		Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician. Wound dehiscence (or disruption): Separation of the layers of a surgical wound, which may be partial or complete, with disruption of the fascia if involved.							
2945	Medicare Physician Quality Reporting System (PQRS)	Thyroidectomy 1: Recurrent laryngeal nerve injury (1 of 5: Measures Group Thyroidectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an injury documented in the operative note, postoperative note, or progress note. Mechanisms of injury to the recurrent laryngeal nerve include complete or partial transection, traction, contusion, crush, burn, misplaced ligature, and compromised blood supply. The consequence of a recurrent laryngeal nerve is true vocal cord paresis or paralysis. Symptoms primarily include hoarseness that remains at 30-days.	Injury documented in the operative note, postoperative note, or progress note. Mechanisms of injury to the recurrent laryngeal nerve include complete or partial transection, traction, contusion, crush, burn, misplaced ligature, and compromised blood supply. The consequence of a recurrent laryngeal nerve is true vocal cord paresis or paralysis. Symptoms primarily include hoarseness that remains at 30-days.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2946	Medicare Physician Quality Reporting System (PQRS)	Thyroidectomy 2: Neck hematoma / bleeding (2 of 5: Measures Group Thyroidectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had postoperative bleeding at neck site or the development of a hematoma requiring increased length of stay, readmission, or intervention. Prolonged length of stay would be assigned if there is documentation that the patient is being observed for a hematoma.	Postoperative bleeding at neck site or the development of a hematoma requiring increased length of stay, readmission, or intervention. Prolonged length of stay would be assigned if there is documentation that the patient is being observed for a hematoma.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2947	Medicare Physician Quality Reporting System (PQRS)	Thyroidectomy 3: Iatrogenic injury to adjacent organ/structure (3 of 5: Measures Group Thyroidectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2948	Medicare Physician Quality Reporting System (PQRS)	Thyroidectomy 4: Unplanned reoperation within the 30 day postoperative period (4 of 5: Measures Group Thyroidectomy)	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2954	Medicare Physician Quality Reporting System (PQRS)	Varicose Veins 1: Iatrogenic injury to adjacent organ/structure (1 of 3 : Measures Group Varicose Veins)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2955	Medicare Physician Quality Reporting System (PQRS)	Varicose Veins 2: Venous thromboembolism (VTE) (2 of 3 : Measures Group Varicose Veins)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an venous thromboembolism (VTE) includes deep vein thrombosis (DVT), thrombophlebitis, and pulmonary embolism (PE). DVT and/or thrombophlebitis is identification of a new blood clot or thrombus within the venous	Venous thromboembolism (VTE) includes deep vein thrombosis (DVT), thrombophlebitis, and pulmonary embolism (PE). DVT and/or thrombophlebitis is identification of a new blood clot or thrombus within the venous system, which may be coupled with inflammation within 30 days of the operation. This diagnosis is	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class,	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			system, which may be coupled with inflammation within 30 days of the operation. This diagnosis is confirmed by a duplex, venogram, or CT scan. PE is lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system within 30 days of the operation. PE documented if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive CT spiral exam, pulmonary arteriogram or CT angiogram. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.	confirmed by a duplex, venogram, or CT scan. PE is lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system within 30 days of the operation. PE documented if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive CT spiral exam, pulmonary arteriogram or CT angiogram. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.	emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.						
2956	Medicare Physician Quality Reporting System (PQRS)	Varicose veins 3: Surgical site infection (SSI) (3 of 3 : Measures Group Varicose Veins)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had a surgical site infection.	The number of patients aged >=65 years who underwent the procedure during the reporting period and experienced: • Any grade of Surgical Site Infection (SSI). Definition: Includes all of the following: Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: • Purulent drainage, with or without laboratory confirmation, from the superficial incision. • Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. • At least one of the following signs or symptoms of infection: pain or	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. • Diagnosis of superficial incisional SSI by the surgeon or attending physician. Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following: • Purulent drainage from the deep incision but not from the organ/space component of the surgical site. • A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative. • An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination. • Diagnosis of a deep incision SSI by a surgeon or attending physician.							

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2957	Medicare Physician Quality Reporting System (PQRS)	Ventral Hernia 1: Iatrogenic injury to adjacent organ/structure (1 of 5 : Measures Group Ventral Hernia)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had an iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	Iatrogenic injury documented in the operative note, postoperative note, or progress note. Iatrogenic injury is an unplanned laceration, puncture, transection or cautery injury to an adjacent structure (e.g., sphincters, vasculature, nerve, other) that occurs during the index procedure, whether recognized at the time of surgery or post-operatively. Synonyms for the injury could include: hole, wound, perforation, tear, injury, laceration, cautery injury, damage, disruption, or defect.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons
2959	Medicare Physician Quality Reporting System (PQRS)	Ventral Hernia 3: Unplanned reoperation within the 30 day postoperative period (3 of 5 : Measures Group Ventral Hernia)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital). Note: This definition is not meant to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies which return for re-excisions; insertion of port-a-cath for chemotherapy.	Any unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure. The return to the OR may occur at any hospital or surgical facility (i.e. your hospital or at an outside hospital).	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Patient Safety	Complications	Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2987	Medicare Physician Quality Reporting System (PQRS)	Acute Composite: Acute Composite (1 of 3): Bacterial pneumonia Acute Composite (2of 3): UTI Acute Composite (3 of 3): Dehydration	Consists of the following 3 individual measures: -Bacterial pneumonia -UTI - Dehydration	Consists of the following 3 individual measures: Bacterial Pneumonia: The number of admissions for bacterial pneumonia per 100,000 population. UTI: The number of discharges for urinary tract infection per 100,000 population Age 18 Years and Older in a one year time period Dehydration: The number of admissions for dehydration per 100,000 population.	Population in Metro Area or county, age 18 years and older	Acute Composite 1 of 3 - Exclude cases: •transferring from another institution (SID ASOURCE=2) •MDC 14 (pregnancy, childbirth, and puerperium) •MDC 15 (newborn and other neonates) •With diagnosis code for sickle cell anemia or HB-S disease Acute Composite 2 of 3 - Not applicable Acute Composite 3 of 3 - Exclude cases: •transferring from another institution (SID ASOURCE=2) •MDC 14 (pregnancy, childbirth, and puerperium) •MDC 15 (newborn and other neonates)	Patient Safety	Complications	Outcome	Not Endorsed	N/A	AHRQ
2991	Medicare Physician Quality Reporting System (PQRS)	Chronic Composite (See 2 individual measures AND 1 composite measure consisting of 4 additional individual measures below [Total of 7 measures] to define Chronic Composite)	Chronic Composite (1 of 7): Ambulatory Sensitive Conditions Admissions: Chronic obstructive pulmonary disease - This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. Chronic Composite (2 of 7): Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure - This measure is used to assess the number of admissions for congestive heart failure (CHF) per 100,000 population. Chronic Composite (3 of 7): Diabetes composite (Consist of 4 individual measures in this subset) -Uncontrolled diabetes: The number of discharges for uncontrolled diabetes per 100,000 population Age 18 Years and Older in a one year time period. -Short Term Diabetes complications: The number of discharges for diabetes short-term complications per 100,000 Age 18 Years and Older population in a one year period. -Long term diabetes complications: The	Chronic Composite (1 of 7): All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for COPD. Chronic Composite (2 of 7): All non-maternal/non-neonatal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF. Chronic Composite (3 of 7): Diabetes Composite: -Uncontrolled Diabetes: All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication. -All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, coma) -Long term diabetes complications: All discharges age 18 years and older with ICD-9-CM principal diagnosis code for diabetes long-term complications (renal, eye, neurological,	Population age 18 years and older in Metro Area or county	Acute Composite 1 and 2 : Exclude cases: transferring from another institution (SID ASOURCE=2) MDC 14 (pregnancy, childbirth, and puerperium) MDC 15 (newborn and other neonates) Acute Composite 3, 4, 5, 6, 7 - Not applicable	Patient Safety	Complications	Outcome	Not Endorsed	N/A	AHRQ

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			number of discharges for long-term diabetes complications per 100,000 population Age 18 Years and in a one year time period.-Lower extremity amputation for diabetes: The number of discharges for lower-extremity amputation among patients with diabetes per 100,000 population age 18 Years in a one year time period. Chronic Composite (4 of 7): Diabetes composite (Consist of 4 individual measures in this subset) Uncontrolled diabetes - The number of discharges for uncontrolled diabetes per 100,000 population Age 18 Years and Older in a one year time period. Chronic Composite (5 of 7): Diabetes composite (Consist of 4 individual measures in this subset): Short Term Diabetes complications - The number of discharges for diabetes short-term complications per 100,000 Age 18 Years and Older population in a one year period. Chronic Composite (6 of 7): Diabetes composite (Consist of 4 individual measures in this subset.): Long Term Diabetes complications - The number of discharges for long-term diabetes complications per 100,000 population Age 18 Years and in a one year time period. Chronic Composite (7 of 7): Diabetes composite (Consist of 4 individual measures in this subset. This is 3d): Lower extremity amputation for diabetes - The number of discharges for lower-extremity amputation among patients with diabetes per 100,000 population Age 18 Years in a one year time period.	circulatory, or complications not otherwise specified). -Lower extremity amputation for diabetes: All discharges of age 18 years and older with a ICD-9-CM procedure code for lower-extremity amputation and diagnosis code of diabetes in any field. Chronic Compostie (4 of 7): Uncontrolled Diabetes: All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication. Chronic Composite (5 of 7): Short Term Diabetes complications: All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, coma) Chronic Composite (6 of 7): Long term diabetes complications: All discharges age 18 years and older with ICD-9-CM principal diagnosis code for diabetes long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified). Chronic Composite (7 of 7): Lower extremity amputation for diabetes: All discharges of age 18 years and older with a ICD-9-CM procedure code for lower-extremity amputation and diagnosis code of diabetes in any field.							

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2211	Medicare Physician Quality Reporting System (PQRS)	Adverse Drug Event (ADE) Prevention: Outpatient therapeutic drug monitoring	Percentage of patients 18 years of age and older receiving outpatient chronic medication therapy who had the appropriate therapeutic drug monitoring during the measurement year.	Patients who received the appropriate therapeutic drug monitoring during the measurement year	Patients 18 years of age and older receiving outpatient chronic medication therapy that requires routine therapeutic drug monitoring	None	Patient Safety	Medication Management	Process	Not Endorsed	N/A	CMS
2415	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI:Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 7 days of diagnosis.	Patients prescribed any antibiotic within 7 days of diagnosis	Patients aged 18 years and older with a diagnosis of acute sinusitis	None	Patient Safety	Medication Management	Process	Not Endorsed	N/A	AMA-PCPI
2416	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI:Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Acute Bacterial Sinusitis (Appropriate Use)	Percentage of patients, aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, without clavulante, as a first line antibiotic at the time of diagnosis.	Patients who were prescribed amoxicillin, without clavulante, as a first line antibiotic at the time of diagnosis	Patients aged 18 years and older with a diagnosis of acute bacterial sinusitis	Documentation of medical reason(s) for not prescribing amoxicillin with or without clavulanate as a first line antibiotic (eg, patients with the following modifying factors: cystic fibrosis, immotile cilia disorders, ciliary dyskinesia, immune deficiency, prior history of sinus surgery within the past 12 months, and anatomic abnormalities, such as deviated nasal septum, resistant organisms, allergy to medication, recurrent sinusitis or chronic sinusitis other medical reasons).	Patient Safety	Medication Management	Process	Not Endorsed	N/A	AMA-PCPI
2420	Medicare Physician Quality Reporting System (PQRS)	American Academy of Otolaryngology-Head and Neck Surgery/Physician Consortium for Performance Improvement: Premature Changing of Initial Antibiotic for Acute Bacterial Sinusitis	Percentage of patients, aged 18 years and older, with a diagnosis of acute bacterial sinusitis, on an initial antibiotic, whose antibiotic prescriptions were changed before 5 days of use.	Number of patients for which daily hydration (eg, bath or shower) immediately followed by application of a moisturizing product was recommended	Total number of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis	Documentation of medical reason(s) for defining treatment failure and antibiotic prescription was changed (eg, worsening symptoms, allergy, intolerance, adverse event, other medical reasons).	Patient Safety	Medication Management	Process	Not Endorsed	N/A	AMA-PCPI
2422	Medicare Physician Quality Reporting System (PQRS)	AAO- HNS/AMA-PCPI:Adult Sinusitis: Watchful Waiting for Acute Bacterial Sinusitis: Initial Observation Without Antibiotics for Patients	Percentage of patients, aged 18 years and older, with a diagnosis of acute bacterial sinusitis who have mild illness, who were initially managed by observation without the use of antibiotics for up to 7 days after date of diagnosis.	Patients who were initially managed by observation without the use of antibiotics for up to 7 days after diagnosis	Patients aged 18 years and older with a diagnosis of acute bacterial sinusitis who have mild illness	Documentation of medical reason(s) for not initially managed by observation without the use of antibiotics within 7 days of diagnosis or within 10 days onset of symptoms. (eg, other bacterial infection, immune deficiency, other medical reasons).	Patient Safety	Medication Management	Process	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
		With Mild Illness (Appropriate Use)										
2441	Medicare Physician Quality Reporting System (PQRS)	American Board of Medical Specialties/American Board of Allergy and Immunology/American Academy of Dermatology/American Association of Immunologists/Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Overuse: Role of Antihistamine	Percentage of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis, who did not have a diagnosis of allergic rhinitis or urticaria, who were prescribed oral nonsedating antihistamines	Number of patients who were prescribed* oral nonsedating antihistamines	Total number of patients aged 25 years or younger seen at one or more visits within a 12-month period with a diagnosis of atopic dermatitis, who did not have a diagnosis of allergic rhinitis or urticaria	Documentation of the medical reason(s) for prescribing oral antihistamines (eg, patient or parent reports significant daytime pruritus that is controlled with nonsedating antihistamine)	Patient Safety	Medication Management	Process	Not Endorsed	N/A	AMA-PCPI
2485	Medicare Physician Quality Reporting System (PQRS)	Medication Management for People With Asthma	The percentage of patients 5–64 years of age during the measurement period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period	Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period	All patients aged 5 through 64 years with a diagnosis of persistent asthma and at least one medical encounter during the one-year measurement period	Patients diagnosed with Emphysema, COPD, Cystic Fibrosis, and Acute Respiratory Failure.	Patient Safety	Medication Management	Process	Not Endorsed	N/A	AMA-PCPI/NCQA
2538	Medicare Physician Quality Reporting System (PQRS)	The Endocrine Society DRAFT Baseline Gonadotropin (LH or FSH) Measurement	Percentage of male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy, who have a baseline gonadotropin (LH or FSH) measurement performed within six months prior to initiating testosterone therapy	Patients who have a baseline gonadotropin (LH or FSH) measurement performed within six months prior to initiating testosterone therapy	All male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy	Documentation of medical reason(s) for not performing a baseline gonadotropin (LH or FSH) measurement within six months prior to initiating testosterone therapy (e.g. karyotype diagnosis of Klinefelter's syndrome, prior history of total hypophysectomy, history of bilateral orchiectomy or anatomically confirmed congenital absence of testes.)	Patient Safety	Medication Management	Process	Not Endorsed	N/A	The Endocrine Society (as part of the AMA-PCPI)
2539	Medicare Physician Quality Reporting System (PQRS)	The Endocrine Society DRAFT Follow-up Hematocrit or Hemoglobin Test	Percentage of male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy, who have a follow-up hematocrit or hemoglobin test performed within two to six months after initiation of testosterone therapy	Patients who have a follow-up hematocrit or hemoglobin test performed within two to six months after initiation of testosterone therapy	All male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy	Documentation of patient reason(s) for not performing a hematocrit or hemoglobin test within two to six months after initiation of testosterone therapy (e.g. patient refusal)	Patient Safety	Medication Management	Process	Not Endorsed	N/A	The Endocrine Society (as part of the AMA-PCPI)

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2540	Medicare Physician Quality Reporting System (PQRS)	The Endocrine Society DRAFT Follow-up Testosterone Measurement	Percentage of male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy, who have a follow-up total testosterone performed within six months after initiation of testosterone therapy	Patients who have a follow-up testosterone measurement performed within six months after initiation of testosterone therapy	All male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy	Documentation of patient reason(s) for not performing follow-up testosterone measurement within six months after initiation of testosterone therapy (e.g. patient refusal)	Patient Safety	Medication Management	Process	Not Endorsed	N/A	The Endocrine Society (as part of the AMA-PCPI)
2541	Medicare Physician Quality Reporting System (PQRS)	The Endocrine Society DRAFT Testosterone Measurement	Percentage of male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy, who have a testosterone measurement performed within six months prior to initiating testosterone therapy	Patients who have a testosterone measurement performed within six months prior to initiating testosterone therapy	All male patients aged 18 years and older with androgen deficiency who are receiving testosterone therapy	Documentation of medical reason(s) for not performing a testosterone measurement within six months prior to initiating testosterone therapy (e.g. bilateral orchiectomy, congenital absence of testes, Kallmann syndrome, documented longstanding hypogonadotropic hypogonadism, and history of hypophysectomy with longstanding hypogonadism)	Patient Safety	Medication Management	Process	Not Endorsed	N/A	The Endocrine Society (as part of the AMA-PCPI)
2862	Medicare Physician Quality Reporting System (PQRS)	Disease Modifying Pharmacotherapy for ALS Discussed	Percentage of patients with a diagnosis of amyotrophic lateral sclerosis with whom the clinician discussed disease-modifying pharmacotherapy (riluzole) to slow ALS disease progression at least once annually.	Patients with whom the clinician discussed disease-modifying pharmacotherapy (riluzole) to slow ALS disease progression at least once annually.	All patients with a diagnosis of amyotrophic lateral sclerosis.	No exclusions applicable for this measure	Patient Safety	Medication Management	Process	Not Endorsed	N/A	American Academy of Neurology
2456	Medicare Physician Quality Reporting System (PQRS)	Bone Marrow and FNADirect Specimen Acquisition**	This is a measure based on whether the qualified healthcare professional followed and documented a fine needle aspiration (FNA) timeout procedure to verify correct patient correct site correct procedure.	Patients for whom there is documentation of the proper timeout procedure to verify correct patient/ correct site/ correct procedure	All patients who had fine needle aspiration (FNA) or bone marrow aspiration and/or biopsy.	None	Patient Safety		Process	Not Endorsed	N/A	College of American Pathologists
2794	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Behavioral Health Risk Assessment	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening	Patients who received the following behavioral health screening risk assessments at the first prenatal visit: - Depression screening Patients who were screened for depression at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care	None	Population Characteristics	Maternal & Child Health	Process	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				depression screening tool (eg, PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)) - Alcohol use screening Patients who were screened for any alcohol use at the first visit - Tobacco use screening Patients who were screened for tobacco use* at the first visit - Drug use (illicit and prescription, over the counter) screening Patients who were screened for any drug use at the first visit - Intimate partner violence screening- Patients who were screened for intimate partner violence/abuse at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Intimate partner violence screening may include a self-reported validated depression screening tool (eg, Hurt, Insult, Threaten, and Scream (HITS), Woman Abuse Screening Tool (WAST), Partner Violence Screen (PVS), Abuse Assessment Screen (AAS)) To satisfactorily meet the numerator – ALL screening components must be performed								

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2795	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: BMI Assessment and Recommended Weight Gain	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who had a BMI value recorded and were counseled on recommended weight gain during pregnancy at first prenatal care visit	Patients who had a BMI value recorded and were counseled on recommended weight gain during pregnancy at first prenatal care visit	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care	None	Population Characteristics	Maternal & Child Health	Process	Not Endorsed	N/A	AMA-PCPI
2796	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Care Coordination: Prenatal Record Present at Time of Delivery	Percentage of patients, regardless of age, who gave birth at 36 weeks gestation or beyond during a 12-month period whose prenatal record*, or equivalent medical record, was present at the facility at the time of delivery (may include faxing or emailing copy to labor and delivery)	Patients whose prenatal record, or equivalent medical record, were present at the facility at time of delivery (may include faxing or emailing copy to labor and delivery) *Components of the prenatal record to be present at delivery are: gestational age; results of: screening for neural tube defects; Screening for Gestational Diabetes; Screening for Asymptomatic Bacteriuria; Hepatitis B specific antigen screening; HIV screening; Group B streptococcus screening (GBS)	All patients, regardless of age, who gave birth at 36 weeks gestation or beyond during a 12-month period	Exception: System reason for prenatal record not being present at time of delivery (eg, patient delivered at a different facility than planned, other system reason)	Population Characteristics	Maternal & Child Health	Structure	Not Endorsed	N/A	AMA-PCPI
2798	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Elective Delivery or Early Induction Without Medical Indication at >=37 and < 39 weeks (overuse)	Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at =37 and < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication	Patients who had elective deliveries or early inductions	All patients, regardless of age, who gave birth during a 12-month period delivering a live singleton at >=37 and < 39 weeks of gestation completed without medical indication for induction* *Following are examples of maternal or fetal conditions that may be medical indications for induction of labor: - Hemorrhage and Placental Complications, Hypertension, Preeclampsia and Eclampsia, Rupture of Membranes-Premature, Prolonged, Maternal Conditions Complicating Pregnancy/Delivery. Fetal Conditions Complicating Pregnancy/Delivery, Malposition and Malpresentation of Fetus, Late Pregnancy, Prior Uterine Surgery OR Patient in clinical trial	Patients with an active diagnosis of late pregnancy, fetal or maternal conditions complicating pregnancy or delivery, hypertension, preeclampsia, eclampsia, hemorrhage and placental complications, malposition and malpresentation of fetus, premature or prolonged rupture of membranes, prior uterine surgery, or clinical trial status	Population Characteristics	Maternal & Child Health	Outcome	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2799	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Episiotomy (overuse)	Percentage of patients, regardless of age, who gave birth vaginally (without shoulder dystocia), during a 12-month period who underwent an episiotomy	Patients who underwent an episiotomy	All patients, regardless of age, who gave birth vaginally (without shoulder dystocia), during a 12-month period	Patients who had an active diagnosis of shoulder dystocia during the measurement period	Population Characteristics	Maternal & Child Health	Outcome	Not Endorsed	N/A	AMA-PCPI
2800	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Establishment of Gestational Age	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who had gestational age of the fetus estimated by ultrasound at or prior to 20 weeks (20 weeks initially estimated by date of LMP)	Patients who had gestational age of the fetus estimated by ultrasound at or prior to 20 weeks (20 weeks initially estimated by date of LMP)	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care	None	Population Characteristics	Maternal & Child Health	Process	Not Endorsed	N/A	AMA-PCPI
2801	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Post-Partum Follow-Up and Care Coordination	Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post- partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post- partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning	Patients receiving the following at a post-partum visit: Breast feeding evaluation and education, including patient- reported breast feeding, Post-partum depression screening, Post-partum glucose screening for gestational diabetes patients. Family and contraceptive planning, Breast Feeding Evaluation and Education: Patients who were evaluated for breast feeding before or at 8 weeks post-partum. Post-Partum Depression Screening: Patients who were screened for post- partum depression before or at 8 weeks post-partum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self- reported validated depression screening tool (eg, PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression	All patients, regardless of age, who gave birth during a 12-month period seen for post-partum care visit before or at 8 weeks of giving birth	None	Population Characteristics	Maternal & Child Health	Process	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
				Scale (EPDS)) Post-Partum Glucose Screening for Gestational Diabetes: Patients who were diagnosed with gestational diabetes during pregnancy who were screened with a glucose screen before or at 8 weeks post-partum. Family and Contraceptive Planning; Patients who were provided family and contraceptive planning and education (including contraception, if necessary) before or at 8 weeks post- partum *To satisfactorily meet the numerator ALL components must be performed							
2802	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Prenatal Care Screening	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received the following screening tests within the specified time frames: screening for neural tube defects; screening for Gestational Diabetes; screening for Asymptomatic Bacteriuria; Hepatitis B specific antigen screening; HIV screening; Group B streptococcus screening (GBS)	Patients who received the following screening tests during the prenatal period within the specified time frames: - Screening for neural tube defects: - Screening using Maternal Serum alpha-fetoprotein Screen (MSAFP) between weeks 15- 20 weeks gestation OR by ultrasound after 16 weeks gestation - Screening for Gestational Diabetes before or at 28 weeks - Screening for Asymptomatic Bacteriuria before or at 16 weeks gestation - Hepatitis B specific antigen screening at first visit - HIV screening at first visit - Group B streptococcus screening (GBS) at 35 to 37 weeks *To satisfactorily meet the numerator – ALL components must be performed	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care	Patients who have an active diagnosis of diabetes (2b), hepatitis B (2d), HIV (2e), or AIDS (2e); or a positive screening for group b streptococcus (2f); or a previous diagnosis of group b streptococcus infection (2f) or GBS infection of infant (2f)	Population Characteristics	Maternal & Child Health	Process	Not Endorsed	N/A	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2803	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Spontaneous Labor and Birth	Percentage of patients, regardless of age, who gave birth vaginally or by cesarean during a 12-month period to a live singleton in vertex presentation between 37and 41 weeks of gestation who have not had a prior cesarean section, whose labor started spontaneously, without the use of induced labor, using no forceps and no vacuum assistance and who gave birth vaginally	Patients whose labor started spontaneously without the use of induced labor, using no forceps and no vacuum assistance and who gave birth vaginally Definition of induction: Labor induction is the use of medications or other methods to bring on (induce) labor (ACOG)	All patients, regardless of age, who gave birth vaginally or by cesarean during a 12-month period to a live singleton in vertex presentation between 37 to 41 weeks of gestation who have not had a prior cesarean section	Patients who had previously given birth via cesarean section	Population Characteristics	Maternal & Child Health	Outcome	Not Endorsed	N/A	AMA-PCPI
1170	Medicare Physician Quality Reporting System (PQRS)	ACO 8 (CMS): Risk-Standardized, All Condition Readmission	Risk-adjusted percentage of Accountable Care Organization (ACO) assigned beneficiaries who were hospitalized who were readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	Risk-adjusted readmissions at a non-Federal, short-stay, acute-care or critical access hospital, within 30 days of discharge from the index admission included in the denominator, and excluding planned readmissions.	All hospitalizations not related to medical treatment of cancer, primary psychiatric disease, or rehabilitation care, fitting of prostheses, and adjustment devices for ACO assigned beneficiaries at non-Federal, short-stay acute-care or critical access hospitals, where the beneficiary was age 65 or older, was continuously enrolled in fee-for-service Medicare Part A for at least one month after discharge, was not discharged to another acute care hospital, was not discharged against medical advice, and was alive upon discharge and for 30 days post-discharge.	None listed	Readmission		Outcome	Not Endorsed	N/A	CMS
2580	Medicare Physician Quality Reporting System (PQRS)	All Cause Readmissions	The rate of readmissions within 30 days of discharge from an acute care hospital per 1000 discharges among eligible beneficiaries assigned.	The number of hospital readmissions to an acute care hospital within 30 days of an acute care hospital discharge. Numerator Inclusions: Beneficiaries must be assigned to the group.Any readmission occurring within 30 days of an index hospital discharge counts as a readmission, even if the patient expires, or is transferred later in his/her stay. Zero-day stays are included	Number of hospital discharges from the assigned beneficiaries who were discharged alive Denominator Inclusions: -Acute care hospital discharges from the assigned beneficiaries who were discharged alive. Medicare Part A claims from the assigned group.	None	Readmission		Outcome	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2790	Medicare Physician Quality Reporting System (PQRS)	Ventral Hernia 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 5 : Measures Group Ventral Hernia)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who a readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged =65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2819	Medicare Physician Quality Reporting System (PQRS)	Appendectomy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Appendectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2824	Medicare Physician Quality Reporting System (PQRS)	AV Fistula 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 5 Measures Group: AV Fistula)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class,	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
					emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							
2827	Medicare Physician Quality Reporting System (PQRS)	Bariatric Lap Band Procedure 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 3 Measures Group: Bariatric lap Band Procedure)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2832	Medicare Physician Quality Reporting System (PQRS)	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2838	Medicare Physician Quality Reporting System (PQRS)	Bariatric Sleeve Gastrectomy 4: Unplanned hospital readmission within 30 days of principal procedure (4of 6 Measures Group: Bariatric Sleeve Gastrectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2848	Medicare Physician Quality Reporting System (PQRS)	Cholecystectomy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Cholecystectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2854	Medicare Physician Quality Reporting System (PQRS)	Colectomy 5: Unplanned hospital readmission within 30 days of principal procedure (5 of 6: Measures Group Colectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class,	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
					emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							
2858	Medicare Physician Quality Reporting System (PQRS)	Colonoscopy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Colonoscopy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital), for any reason, within 30 days of the principal surgical procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2870	Medicare Physician Quality Reporting System (PQRS)	Hemorrhoidectomy 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 4: Measures Group Hemorrhoidectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.		Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2897	Medicare Physician Quality Reporting System (PQRS)	Inguinal Hernia 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 3) Measures Group Inguinal Hernia	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2903	Medicare Physician Quality Reporting System (PQRS)	Mastectomy +/- Lymphadenectomy or SLNB 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2912	Medicare Physician Quality Reporting System (PQRS)	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Partial Mastectomy or Breast	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class,	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
		Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)			emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.							
2942	Medicare Physician Quality Reporting System (PQRS)	Skin / Soft Tissue Lesion Excision 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Skin / Soft Tissue Lesion Excision)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.		Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons
2949	Medicare Physician Quality Reporting System (PQRS)	Thyroidectomy 5: Unplanned hospital readmission within 30 days of principal procedure (5 of 5: Measures Group Thyroidectomy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	Any readmission (to the same or another hospital) for any reason, within 30 days of the principal procedure. The readmission has to be classified as an "inpatient" stay by the readmitting hospital, or reported by the patient/family as such.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Readmission		Outcome	Not Endorsed	N/A	American College of Surgeons

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2523	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Percentage of patients aged 18 years and older with a diagnosis of CKD (Stages 1-5, not receiving RRT) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period	Patients who were prescribed ACE inhibitor or ARB therapy within a 12-month period	All patients aged 18 years and older with a diagnosis of CKD (Stages 1-5, not receiving RRT) and proteinuria	Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, pregnancy, history of angioedema to ACEI, other allergy to ACEI and ARB, hyperkalemia or history of hyperkalemia while on ACEI or ARB therapy, acute kidney injury due to ACEI or ARB therapy, other medical reasons) Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, patient declined, other patient reasons)	Renal & Genitourinary	Chronic Kidney Disease	Process	Not Endorsed	N/A	AMA-PCPI
2525	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement: Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis access is a catheter at the time maintenance hemodialysis is initiated	Percentage of patients aged 18 years and older with a diagnosis of ESRD who initiate maintenance hemodialysis during the measurement period, whose mode of vascular access is via a catheter at the time maintenance hemodialysis is initiated	Patients whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated	All patients aged 18 years and older with a diagnosis of ESRD who initiate maintenance hemodialysis during the measurement period	Documentation of medical reason(s) for patient's mode of vascular access being a catheter (eg, patient has a maturing AVF/AVG, time-limited trial of hemodialysis, patients undergoing palliative dialysis, other medical reasons) Documentation of patient reason(s) for patient's mode of vascular access being a catheter (eg, patient declined AVF/AVG, other patient reasons) Documentation of system reason(s) for patient's mode of vascular access being a catheter (eg, patient followed by reporting nephrologist for fewer than 90 days, other system reasons)	Renal & Genitourinary	Chronic Kidney Disease	Process	Not Endorsed	N/A	AMA-PCPI
2527	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement: Adult Kidney Disease: Referral to Nephrologist	Percentage of patients aged 18 years and older with a diagnosis of CKD (not receiving RRT) with an eGFR less than 30 and proteinuria who are referred to a nephrologist and have documentation that an appointment was made for a nephrology consultation within a 12- month period	Patients who are referred to a nephrologist AND have documentation that an appointment was made for a nephrology consultation within a 12-month period	All patients aged 18 years and older with a diagnosis of CKD* (not receiving RRT) with an eGFR < 30 and proteinuria	Documentation of system reason(s) for patient not being referred to a nephrologist (eg, patient already received a nephrology consultation, other system reasons)	Renal & Genitourinary	Chronic Kidney Disease	Process	Not Endorsed	N/A	AMA-PCPI

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2522	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement : Adult Kidney Disease: Catheter Use for greater than or equal to 90 Days	Percentage of patients aged 18 years and older with a diagnosis of ESRD receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter	Patients whose mode of vascular access is a catheter	All patients aged 18 years and older with a diagnosis of ESRD receiving maintenance hemodialysis for = 90 days	Documentation of medical reason(s) for patient's mode of vascular access being a catheter (eg, patient is undergoing palliative dialysis with a catheter, patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant, other medical reasons) Documentation of patient reason(s) for patient's mode of vascular access being a catheter (eg, patient declined AVF/AVG, other patient reasons)	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	AMA-PCPI
2524	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement: Adult Kidney Disease: Arteriovenous Fistula Rate	Percentage of calendar months within a 12 month period during which patients aged 18 years and older with a diagnosis of ESRD and receiving maintenance hemodialysis are using an autogenous arteriovenous (AV) fistula with two needles	Calendar months during which patients are using an autogenous arteriovenous (AV) fistula with two needles	All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are receiving hemodialysis or peritoneal dialysis	Documentation of medical reason(s) for not having an autogenous arteriovenous (AV) fistula with two needles (eg, patient has a functioning AV graft, patient is undergoing palliative dialysis with a catheter, patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant, other medical reasons) Documentation of patient reason(s) for not having an autogenous arteriovenous (AV) fistula with two needles (eg, patient declined fistula placement, other patient reasons)	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	AMA-PCPI
2526	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement: Adult Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level <10g/dL	Percentage of calendar months within a 12-month period during which patients aged 18 years and older with a diagnosis of ESRD who are receiving hemodialysis or peritoneal dialysis have a Hemoglobin level less than 10 g/dL	Calendar months during which patients have a Hemoglobin level < 10 g/dL	All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are receiving hemodialysis or peritoneal dialysis	Documentation of medical reason(s) for patient having a Hemoglobin level <10 (eg, patients who have non-renal etiologies of anemia [eg, sickle cell anemia or other hemoglobinopathies, multiple myeloma, primary bone marrow disease, anemia related to chemotherapy for diagnosis of malignancy], other medical reasons)	Renal & Genitourinary	End-Stage Renal Disease	Intermediate Outcome	Not Endorsed	N/A	AMA-PCPI

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2528	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement: Adult Kidney Disease: Transplant Referral	Percentage of patients aged 18 years and older with a diagnosis of ESRD on hemodialysis or peritoneal dialysis for 90 days or longer who are referred to a transplant center for kidney transplant evaluation within a 12-month period	Patients who are referred to a transplant center for kidney transplant evaluation within a 12-month period	All patients aged 18years and older with a diagnosis of ESRD on hemodialysis or peritoneal dialysis for 90 days or longer	Documentation of medical reason(s) for not referring for kidney transplant evaluation (eg, patient undergoing palliative dialysis, patient already approved by a qualified transplant program and scheduled to receive a living donor kidney transplant, other medical reasons) Documentation of patient reason(s) for not referring for kidney transplant evaluation (eg, patient declined, other patient reasons) Documentation of system reason(s) for not referring for kidney transplant evaluation (eg, lack of insurance coverage, nearest facility too far away, other system reasons)	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	AMA-PCPI
2530	Medicare Physician Quality Reporting System (PQRS)	Renal Physician's Association/American Society of Pediatric Nephrology/Physician Consortium for Performance Improvement: Adult Kidney Disease: Adequacy of Volume Management	Percentage of calendar months within a 12 month period during which patients aged 18 years and older with a diagnosis of ESRD undergoing maintenance hemodialysis in an outpatient dialysis facility have an assessment of the adequacy of volume management from a nephrologist	Calendar months during which patients have an assessment of the adequacy of volume management from a nephrologist	All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are undergoing maintenance hemodialysis in an outpatient dialysis facility	None	Renal & Genitourinary	End-Stage Renal Disease	Process	Not Endorsed	N/A	AMA-PCPI
2909	Medicare Physician Quality Reporting System (PQRS)	Objective characterization of pelvic organ prolapse prior to surgery	Percentage of female patients with a characterization of the degree of prolapse in each vaginal compartment, using a validated, objective measurement system (e.g.POP-Q or Baden/Walker) within 12 months of surgery for pelvic organ prolapse.	The number of female patients whose pelvic organ prolapse was documented using a validated, objective measurement tool (i.e. POP-Q or Baden/Walker Halfway System) performed within the 12 months prior to surgery for pelvic organ prolapse.	All patients undergoing pelvic organ prolapse (POP) surgery.	Did not include with submission	Renal & Genitourinary	Gynecology	Process	Not Endorsed	N/A	American Urogynecologic Society (AUGS)

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2922	Medicare Physician Quality Reporting System (PQRS)	Performing vaginal apical suspension (uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy to address uterovaginal prolapse	Percentage of female patients undergoing hysterectomy for the indication of uterovaginal prolapse in which a concomitant vaginal apical suspension (i.e.uterosacral, iliococygeus, sacrospinous or sacral colpopexy)is performed.	The number of female patients who have a concomitant vaginal apical suspension (i.e.uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy for uterovaginal prolapse.	Hysterectomy, performed for the indication of uterovaginal prolapse.	Did not include with submission	Renal & Genitourinary	Gynecology	Process	Not Endorsed	N/A	American Urogynecologic Society (AUGS)
2953	Medicare Physician Quality Reporting System (PQRS)	Use of cystoscopy concurrent with prolapse repair surgery	Percentage of patients that undergo concurrent cystoscopy at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury.	Numerator is the number of female patients where a concurrent intraoperative cystoscopy was performed at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury.	Denominator is the number of female patients undergoing any prolapse repair surgery for correction of anterior and/or apical vaginal prolapse.	Did not include with submission	Renal & Genitourinary	Gynecology	Process	Not Endorsed	N/A	American Urogynecologic Society (AUGS)
2467	Medicare Physician Quality Reporting System (PQRS)	Diabetes/Pre-Diabetes Screening for Patients with DSP	Percentage of patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy who had screening tests for diabetes (eg fasting blood sugar test, a hemoglobin A1C, or a 2 hour Glucose Tolerance Test) reviewed, requested or ordered when seen for an initial evaluation for distal symmetric polyneuropathy.	Patients who had screening tests for diabetes (eg, fasting blood sugar test, hemoglobin A1C, or a 2 hour Glucose Tolerance Test) reviewed, requested, or ordered when seen for an initial evaluation for distal symmetric polyneuropathy.	All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy.	Documentation of a medical reason for not reviewing, requesting or ordering diabetes screening tests (eg patient has a diagnosis of diabetes, patient has a known medical condition to cause neuropathy, patient had previous diabetes screening) * Documentation of a patient reason for not reviewing, requesting or ordering diabetes screening tests (eg patient declines to undergo testing) * Documentation of a system reason for not reviewing, requesting or ordering diabetes screening tests (eg patient does not have insurance to pay for testing)	Renal & Genitourinary		Process	Not Endorsed	N/A	American Academy of Neurology
2468	Medicare Physician Quality Reporting System (PQRS)	Distal Symmetric Polyneuropathy (DSP) Diagnosis Criteria: DSP Signs and Symptoms	Percentage of patients aged 18 years and older with a diagnosis of distal symmetric polyneuropathy who had their neuropathic symptoms and signs reviewed and documented at the initial evaluation for distal symmetric polyneuropathy.	Patients who had their neuropathic symptoms and signs* reviewed and documented at the initial evaluation for distal symmetric polyneuropathy.	All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy.	Documentation of a medical reason for not reviewing and documenting neuropathic symptoms and signs (eg, patient has profound mental retardation, patient has a language disturbance, or patient is cognitively impaired)	Renal & Genitourinary		Process	Not Endorsed	N/A	American Academy of Neurology

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2469	Medicare Physician Quality Reporting System (PQRS)	Distal Symmetric Polyneuropathy (DSP) Diagnosis Criteria-Electrodiagnostic Study	Percentage of patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy who had electrodiagnostic studies (EDX) conducted, documented and reviewed within 6 months of initial evaluation for distal symmetric polyneuropathy.	Patients who had electrodiagnostic (EDX) studies conducted, documented, and reviewed within 6 months of initial evaluation for distal symmetric polyneuropathy.	All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy.	Documentation of a medical reason for not conducting, documenting and reviewing EDX studies (eg patient has a skin conditions which contraindicates EDX) * Documentation of a patient reason for not conducting, documenting and reviewing EDX studies (eg patient declines to undergo testing) * Documentation of a system reason for not conducting, documenting and reviewing EDX studies (eg patient does not have insurance to pay for the testing)	Renal & Genitourinary		Process	Not Endorsed	N/A	American Academy of Neurology
2488	Medicare Physician Quality Reporting System (PQRS)	Nephropathy Assessment for Eligible Patients	Percentage of patients 18 - 75 years of age who had a screening for nephropathy or medical attention for nephropathy (ACE/ARB therapy) documented over the reporting period.	The number of the eligible patients from the Chart Review excluding those who had documented diagnosis of end-stage renal disease (ESRD) who had: 1) positive result of urine dipstick test for protein regardless of the test date OR 2) normal microalbuminuria test during the 12-month abstraction period or one month prior to the abstraction period OR 3) a microalbuminuria assessment and result is Micro or Macroalbuminuria, regardless of the date of the test OR 4) under ACE/ARB therapy.	The number of the eligible patients from the Chart Review who did not have documented diagnosis of end-stage renal disease (ESRD).	Exclude patients with diagnosis of end-stage renal disease (ESRD).	Renal & Genitourinary		Process	Not Endorsed	N/A	American Board of Internal Medicine
1030	Medicare Physician Quality Reporting System (PQRS)	Assessment of Asthma Risk - Emergency Department Inpatient Setting	Percentage of patients aged 5 through 64 years with an emergency department visit or an inpatient admission for an asthma exacerbation who were evaluated for asthma risk	Patients who were evaluated during an emergency department visit or inpatient admission about the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months (asthma risk)	All patients aged 5 through 64 years with an emergency department OR inpatient admission for asthma during the one-year measurement period	None	Respiratory	Asthma	Process	Not Endorsed	N/A	AMA-PCPI

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1031	Medicare Physician Quality Reporting System (PQRS)	Asthma Discharge Plan – Emergency Department Inpatient Setting	Percentage of patients aged 5 through 64 years with an emergency department visit or inpatient admission for an asthma exacerbation who are discharged from the emergency department OR inpatient setting with an asthma discharge plan	Patients discharged from the emergency department OR inpatient setting with an asthma discharge plan* *The asthma discharge plan must include: 1. Instructions regarding inhaled corticosteroid use (if inhaled corticosteroids not prescribed, note should document reason prescription not given) AND 2. Information regarding discharge medications and how to use them (e.g., instruction on inhaler technique) AND 3. Referral for a follow-up appointment AND 4. Instructions for recognizing and managing relapse of exacerbation or recurrence of airflow obstruction.	All patients age 5 through 64 years with an emergency department visit or inpatient admission for an asthma exacerbation during the one-year measurement period	None	Respiratory	Asthma	Process	Not Endorsed	N/A	AMA-PCPI
2484	Medicare Physician Quality Reporting System (PQRS)	Management of Asthma Controller and Reliever Medications —Ambulatory Care Setting	Percentage of patients aged 5 to 64 years identified as having persistent asthma whose asthma medication ratio was greater than or equal to 0.5. Three rates are reported for this measure: Patients whose controller medication was inhaled corticosteroids (ICS), Patients whose controller medication was an alternative long term control medications (non-ICS), Total ratio of all prescriptions for controller medications over prescriptions for controller medications plus prescriptions for short acting reliever medications	Patients with an asthma medication ratio greater than or equal to 0.5	All patients aged 5 through 64 years with a diagnosis of persistent asthma and at least one medical encounter during the one-year measurement period	Patients diagnosed with Emphysema, COPD, Cystic Fibrosis, and Acute Respiratory Failure. OR Patients with no asthma controller medications dispensed during the measurement period	Respiratory	Asthma	Intermediate Outcome	Not Endorsed	N/A	AMA-PCPI/NCQA

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2486	Medicare Physician Quality Reporting System (PQRS)	National Committee for Quality Assurance/Physician Consortium for Performance Improvement: [DRAFT] Asthma: Assessment of Asthma Risk - Emergency Department Inpatient Setting	Percentage of patients aged 5 through 50 years with an emergency department visit or an inpatient admission for an asthma exacerbation who were evaluated for asthma risk.	Patients who were evaluated for asthma risk during an emergency department visit or inpatient admission	All patients aged 5 through 50 years with an emergency department OR inpatient admission for asthma during the one-year measurement period	None	Respiratory	Asthma	Process	Not Endorsed	N/A	AMA-PCPI/NCQA
2487	Medicare Physician Quality Reporting System (PQRS)	National Committee for Quality Assurance/Physician Consortium for Performance Improvement: [DRAFT] Asthma: Asthma Discharge Plan – Emergency Department Inpatient Setting	Percentage of patients aged 5 through 50 years with an emergency department visit or inpatient admission for an asthma exacerbation who are discharged from the emergency department OR inpatient setting with an asthma discharge plan	Patients discharged from the emergency department OR inpatient setting with an asthma discharge plan	All patients age 5 through 50 years with an emergency department visit or inpatient admission for an asthma exacerbation during the one-year measurement period	None	Respiratory	Asthma	Process	Not Endorsed	N/A	AMA-PCPI/NCQA
2491	Medicare Physician Quality Reporting System (PQRS)	Optimal Asthma Care	Composite measure of the percentage of pediatric and adult patients who have asthma. Optimal care is defined as: Asthma is well controlled, Patient is not at increased risk of exacerbations, Patient has a current written asthma action management plan	Percentage of asthma patients ages 5-50 in the measurement period who meet ALL of the following targets: a) Asthma well-controlled (take the most recent asthma control tool available): • Patient has an Asthma Control Test (ACT) score of 20 or above (taken from most recent Asthma Control Test on file) – only applicable for patients 12 and older ---OR--- • Patient has a Childhood Asthma Control Test (C-ACT) score of 20 or above (taken from most recent C-ACT on file) – only applicable for patients 11 and younger ---OR---	Established patients meeting the following criteria: • Date of birth on or between MM/DD/YYYY-MM/DD/YYYY (ages 5-50 during the measurement period). • Patient has been seen at least two times for asthma (face-to-face with a provider) in the past two years AND patient has had at least one office visit during the measurement.	Exclusions: Death, hospice and permanent nursing home resident and the following conditions: COPD Emphysema Cystic fibrosis Acute respiratory failure	Respiratory	Asthma	Composite	Not Endorsed	N/A	Minnesota Community Measurement

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				• Patient has an Asthma Control Questionnaire (ACQ) score of 0.75 or lower (taken from most recent ACQ on file) – only applicable for patients 17 and older ---OR--- • Patient has an Asthma Therapy Assessment Questionnaire (ATAQ) score of 0 (taken from most recent ATAQ) – only applicable for children and adolescents b) Patient not at elevated risk of exacerbation: • Patient reports values for all of the following questions (at date of most recent asthma visit): o Number of emergency department visits not resulting in a hospitalization due to asthma in last 12 months ---AND--- o Number of inpatient hospitalizations requiring an overnight stay due to asthma in last 12 months o The total number of emergency department visits and hospitalizations due to asthma must be less than 2							
2503	Medicare Physician Quality Reporting System (PQRS)	Pharmacologic Therapy for Persistent Asthma —Ambulatory Care Setting	Percentage of patients aged 5 through 64 years with a diagnosis of persistent asthma and at least one medical encounter for asthma during the measurement year who were prescribed long-term control medication. Three rates are reported for this measure: Patients prescribed inhaled corticosteroids (ICS) as their long term control medication. Patients prescribed other alternative long term control medications (non-ICS).	Patients who were prescribed long-term control medication* *Long-term control medication includes: 1. Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy) OR Patients prescribed alternative long-term control medications	All patients aged 5 through 64 years with a diagnosis of persistent asthma and at least one medical encounter during the one-year measurement period	Patients diagnosed with Emphysema, COPD, Cystic Fibrosis, and Acute Respiratory Failure.	Respiratory	Asthma	Process	Not Endorsed	N/A	AMA-PCPI/NCQA

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2821	Medicare Physician Quality Reporting System (PQRS)	Asthma: spirometry evaluation	Percentage of asthma patients aged 5 years and older with a documented spirometry result in the medical record within the last 24 months	Patients who have a documented spirometry result in their medical record	All patients aged 5 years and older who have a documented diagnosis of asthma and who have been seen in the reporting physician's office within twenty four months	Did not include with submission	Respiratory	Asthma	Process	Not Endorsed	N/A	American Academy of Allergy, Asthma & Immunology
2502	Medicare Physician Quality Reporting System (PQRS)	Peri-operative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy (CEA)	Percentage of patients aged 18 years and older undergoing carotid endarterectomy who are taking antiplatelet agent (aspirin or clopidogrel) within 48 hours prior to surgery and are prescribed this medication at discharge	Patients undergoing elective CEA who received aspirin and/or clopidogrel within 48 hours prior to the initiation of surgery AND are prescribed this medication at discharge	All patients aged 18 years and older undergoing elective CEA	TBD	Surgery	Cardiovascular	Process	Not Endorsed	N/A	Society for Vascular Surgery
2515	Medicare Physician Quality Reporting System (PQRS)	Preoperative Use of Aspirin for Patients with Drug-Eluting Coronary Artery Stents	Percentage of patients aged 18 years and older who are having an anesthetic in which the patient has a pre-existing drug-eluting coronary stent and either continue therapy or document the reason continuation of therapy was associated with greater risk than benefit.	Patients who have documentation that they received aspirin within 24 hours of the anesthesia start time or documentation that the risks of preoperative aspirin therapy are greater than withholding aspirin. NUMERATOR NOTE: Exclusion – Documentation of medical (eg, risks of preoperative aspirin therapy are greater than the risks of withholding aspirin) or patient (patient not compliant in taking aspirin within the past 24 hours) reasons for not prescribing aspirin within 24 hours of the anesthesia start time or patient receives anesthesia services where there is an absence of an incision.	All patients aged 18 years and older who are having an anesthetic for a surgical procedure in which the patient has a pre-existing drug-eluting coronary stent.	Contraindication or allergy to aspirin	Surgery	Cardiovascular	Process	Not Endorsed	N/A	American Society of Anesthesiologists
2934	Medicare Physician Quality Reporting System (PQRS)	Rate of Stratification by Aneurysm Size of Patients Undergoing Abdominal Aortic Aneurysm Repair.	Percent of patients undergoing open or endovascular non-ruptured, infrarenal AAA repair who are stratified by aneurysm size.	Please see measure specifications.	Patients undergoing open or endovascular non-ruptured, infrarenal AAA repair		Surgery	Cardiovascular	Outcome	Not Endorsed	N/A	Society for Vascular Surgery
2935	Medicare Physician Quality Reporting System (PQRS)	Rate of Stratification by Symptom Status of Patients Undergoing Carotid Intervention.	Percent patients undergoing carotid endarterectomy (CEA) or carotid artery stenting (CAS) who are stratified by preoperative symptom status.	Patients classified as asymptomatic , symptomatic or other symptomatic.	Patients undergoing carotid endarterectomy or carotid artery stenting.		Surgery	Cardiovascular	Outcome	Not Endorsed	N/A	Society for Vascular Surgery

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2859	Medicare Physician Quality Reporting System (PQRS)	Colonoscopy 4: Examination time during endoscope withdrawal, when no biopsies or polypectomies are performed (4 of 4: Measures Group Colonoscopy)	(None provided by developer. Assumed description for specification provided. Requested Registry Reporting) Percentage of patients age 65 and older who had withdrawal time (time between when the cecum is reached and the time at which the endoscope is withdrawn from the anus) ? 6 min, in colonoscopies with normal results performed in patients with intact colons.	Withdrawal time (time between when the cecum is reached and the time at which the endoscope is withdrawn from the anus) ? 6 min, in colonoscopies with normal results performed in patients with intact colons.	This measure will be reported as a risk-adjusted, provider-specific odds ratio. This measure applies to the population of patients aged >=65 years during the reporting period who underwent the procedure. *This is a risk adjusted measure Case-mix adjustment is performed using the following variables: age, ASA class, emergent/urgent operation, functional status, wound class, preoperative sepsis, dyspnea, ascites, and surgical approach in a random intercept, fixed slope, hierarchical model.	None	Surgery	Gastrointestinal	Outcome	Not Endorsed	N/A	American College of Surgeons
2797	Medicare Physician Quality Reporting System (PQRS)	ACOG/NCQA/ AMA-PCPI: Maternity Care: Cesarean Delivery for Nulliparous (NTSV) Women (appropriate use)	Percentage of nulliparous patients, regardless of age, who gave birth during a 12-month period to a live singleton in vertex presentation at or beyond 37 weeks of gestation who had a cesarean delivery	Patients who had a cesarean delivery	All nulliparous patients, regardless of age, who gave birth during a 12-month period to a live singleton in vertex presentation at or beyond 37 weeks of gestation.	Patients who were participating in a clinical trial during the measurement period	Surgery	Obstetrical	Outcome	Not Endorsed	N/A	AMA-PCPI
2483	Medicare Physician Quality Reporting System (PQRS)	Maintenance of Intraoperative Normothermia	Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom at least one body temperature equal to or greater than 35.5 degrees Centigrade (or 95.9 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.	Patients for whom at least one body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was 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, except patients undergoing cardiopulmonary bypass. (Cardiopulmonary bypass patients are filtered out with the CPT anesthesia codes defining the eligible population.)	None	Surgery	Perioperative care	Outcome	Not Endorsed	N/A	American Society of Anesthesiologists
2517	Medicare Physician Quality Reporting System (PQRS)	Prevention of Post-Operative Nausea and Vomiting – Multimodal therapy (pediatric)	Percentage of patients aged 18 years and younger who are having a general anesthetic in which an inhalational anesthetic agent is used, and who are at high or very high risk for PONV, who receive prophylactic antiemetic agents.	Patients, aged 18 years and younger who are having a general anesthetic in which an inhalational anesthetic is used, and who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive at least two prophylactic pharmacologic	All patients aged 18 years and younger who are having a general anesthetic in which an inhalational anesthetic agent is used, and who have three or more risk factors for PONV.	Documentation of medical reason(s) for not administering pharmacologic prophylaxis	Surgery	Perioperative care	Outcome	Not Endorsed	N/A	American Society of Anesthesiologists

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				antiemetic agents of different classes (e.g. 5-HT3 antagonists, droperidol, dexamethasone, scopolamine, and phenothiazides) preoperatively and intraoperatively for the prevention of nausea and vomiting. There are four risk factors defined for this measure: (1) female gender, (2) history of PONV or a history of motion sickness, (3) non-smoker, and (4) intended administration of opioids for post operative analgesia. This includes use of opioids given intraoperatively and whose effects extend into the PACU or post-operative period, or opioids given in the PACU, or opioids given or intended to be given after discharge from the PACU.								
2518	Medicare Physician Quality Reporting System (PQRS)	Prevention of Post-Operative Nausea and Vomiting -Multimodal therapy (adults)	Patients aged 18 years and older who receive an inhalational general anesthesia service, and have three or more risk factors for post-operative nausea and vomiting (PONV), and receive at least two prophylactic pharmacological anti-emetic agents.	Patients who received a current* fasting or nonfasting total cholesterol (TC) level and high-density lipoprotein cholesterol (HDL-C) level with results documented	All male patients aged 35 through 80 years and all female patients aged 45 through 80 years who were seen at least twice for any visits or who had at least one preventive care visit during the two-year measurement period	Documentation of medical reason(s) for not receiving at least one fasting or non-fasting total cholesterol (TC) test and high-density lipoprotein cholesterol (HDL-C) test at least once in the past five years (eg, female patient not at increased risk for coronary heart disease, limited life expectancy, other medical reasons) Documentation of patient reason(s) for not receiving at least one fasting or non-fasting total cholesterol (TC) test and high-density lipoprotein cholesterol (HDL-C) test at least once in the past five years (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving at least one fasting or non-fasting total cholesterol (TC) test and high-density lipoprotein cholesterol (HDL-C) test at least once in the past five years (eg, financial reasons, other system reasons)	Surgery	Perioperative care	Process	Not Endorsed	N/A	American Society of Anesthesiologists

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2579	Medicare Physician Quality Reporting System (PQRS)	30 Day Post-discharge visit	The rate of provider visits within 30 days of discharge from an acute care hospital per 1000 discharges among eligible beneficiaries assigned.	Includes all cases in the denominator that have seen a physician within 30 days of discharge or prior to readmission (if the readmission occurs within 30 days. Numerator Inclusions: Includes all cases in the denominator that have seen a physician within 30 days of discharge or prior to readmission (if readmission occurs within 30 days).	Includes all discharges from an acute care hospital during the measurement period from Medicare FFS beneficiaries assigned to a group. Denominator Inclusions: Discharges from an acute care hospital during the measurement period from Medicare FFS beneficiaries 18 years and older assigned to a group from the beginning of the measurement period.	Claims for dates of service for institutional post acute care in the 30 day window following discharge including: Skilled Nursing Facility Hospice Critical Access Hospital Long-term Hospital Rehabilitation Hospital Psychiatric Hospital Claims for dates of discharge from an acute care hospital on or within 30-days of the end of the measurement period.	Health Services Administration	Patient Care Management	Process	Not Endorsed	N/A	CMS
1163	Physician Compare/Physician Feedback/ Value-Based Modifier	ACO 1 (NQF #0005): Getting Timely Care, Appointments, and Information	Q6. Got urgent care appointment as soon as you needed Q8. Got appointment for check-up or routine care as soon as you needed Q10. Called provider's office during regular hours and got answer to medical questions same day Q12. Called provider's office after hours and got answer to medical questions as soon as you needed Q15. Saw provider within 15 minutes of appointment time Q56. Ease of getting care, tests, or treatment you thought you needed	None Listed	None listed	None listed	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0005	AHRQ
1164	Physician Compare/Physician Feedback/ Value-Based Modifier	ACO 2 (NQF #0005): How Well Your Doctors Communicate	Q16. Provider explained things in a way that was easy to understand Q17. Provider listened carefully to you Q19. Provider gave you easy to understand instructions about health problem or concern Q20. Provider knew the importan information about your medical history Q22. Provider showed respect for what you had to say Q23. Provider spent enough time with you	None listed	None listed	None listed	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0005	AHRQ

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1165	Physician Compare/Physician Feedback/ Value-Based Modifier	ACO 5 (NQF #0005): Health Promotion and Education	Q51. Care team talked with you about specific things you could do to prevent illness Q52. Care team talked with you about healthy diet and healthy eating habits. Q53. Care team talked with you about your exercise or physical activity Q54. Care team talked with you about specific goals for your health Q55. Care team asked if there are things that make it hard for you to take care of your health Q58. Care team talked with you about all your prescription medicines Q60. Care team asked if you had a period of feeling sad, empty or depressed Q61. Care team talked with you about things that worry you or cause you stress Q62. Care team talked with you about a personal problem, family problem, alchohol abuse, drug use, mental or emotional illness				Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0005	AHRQ
1166	Physician Compare/Physician Feedback/ Value-Based Modifier	Clinician/Group CAHPS: Helpful, Courteous, Respectful Office Staff	Q44. Clerks and receptionist at this provider's office were helpful Q45. Clerks and receptionists at this provider's office treated you with courtesy				Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0005	AHRQ
1168	Physician Compare/Physician Feedback/ Value-Based Modifier	ACO 6 (NQF #0005): Shared Decision Making	Q27. Provider talked about the reasons you might want to take a prescription medicine Q28. Provider talked about the reasons you might not want to take a prescription medicine Q29. When talking about starting or stopping a prescription medicine, provider asked you what was best for you Q36. Provider talked about the reasons you might want to have surgery or procedure Q37. Provider talked about the reasons	None listed	None listed	None listed	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0005	AHRQ

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			you might not want to have surgery or procedure Q39. Provider talked about including family or friends in making health decisions Q40. Provider talked about how much of your personal health information you wanted to share with family or friends Q41. Provider respected your wishes about sharing personal health information Q42. You brought a family member or friend with you to talk with this provider Q42. You brought a family member or friend with you to talk with this provider									
1171	Physician Compare/Physician Feedback/ Value-Based Modifier	ACO 3 (NQF #0005): Patient Rating of Doctor	Q43. 0 to 10 Rating of Provider				Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0005	AHRQ
2118	Physician Compare/Physician Feedback/ Value-Based Modifier	ACO 4 (NQF #0005): Access to Specialist	Q48. Ease of making appointments with specialists Q49. Specialist you saw most often knew the important information about your medical history Q50. Number of specialists seen	None listed	None listed	None listed	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0005	AHRQ
1861	Physician Compare/Physician Feedback/ Value-Based Modifier	236 GPRO-HTN 2 Hypertension: Blood Pressure Control	Percentage of patients aged 18 through 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90 mmHg)	Patients with most recent systolic blood pressure measurement < 140 mmHg and a diastolic blood pressure < 90 mmHg	All patients with HTN = or > 18 years of age. • Documentation of medical reason(s) for not recording a blood pressure measurement (diagnosis for ESRD and pregnancy are the only acceptable exclusions)	Exclude from the eligible population all patients with evidence of end-stage renal disease (ESRD) (including dialysis or renal transplant), all patients who are pregnant, and all patients who had an admission to a nonacute inpatient setting on or prior to December 31 of the measurement year.	Cardiovascular	Hypertension	Intermediate Outcome	Endorsed	0018	NCQA
183	Physician Compare/Physician Feedback/ Value-Based Modifier	114 Preventive Care and Screening: Inquiry Regarding Tobacco Use	Percentage of patients aged 18 years or older who were queried about tobacco use one or more times within 24 months	Patients who were queried about tobacco use one or more times within 24 months	All patients aged 18 years and older	None listed	Mental Health Care & Substance-Related Care	Tobacco Use	Process	Endorsed	0028	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
181	Physician Compare/Physician Feedback/ Value-Based Modifier	112 GPRO Prev-5 Preventive Care and Screening: Screening Mammography	Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months	Patients who had a mammogram at least once within 24 months	All female patients aged 40 through 69 years	Exclude women who had a bilateral mastectomy and for whom administrative data does not indicate that a mammogram was performed. Look for evidence of bilateral mastectomy as far back as possible in the patient's history, through either administrative data or medical record review (exclusionary evidence in the medical record must include a note indicating a bilateral mastectomy.) If there is evidence of two separate mastectomies, this patient may be excluded from the measure. The bilateral mastectomy must have occurred by December 31st of the measurement year.	Cancer	Breast	Process	De-endorsed	0031	NCQA
182	Physician Compare/Physician Feedback/ Value-Based Modifier	113 GPRO Prev-6 Preventive Care and Screening: Colorectal Cancer Screening	Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening	Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period	All patients aged 50 through 75 years	Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by December 31 of the measurement year. Use the following codes or descriptions of the codes to identify allowable exclusions: Malignant neoplasm of colon and other specified sites of colon and large intestine ICD-9-CM codes (153.X, 154.0, 154.1, 197.5, V10.05) Total colectomy CPT codes (44150-44153, 44155-44156, 44210-44212) ICD-9-CM codes (45.8)	Cancer	Colorectal	Process	Endorsed	0034	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
179	Physician Compare/Physician Feedback/ Value-Based Modifier	110 GPRO Prev-7 Preventive Care and Screening: Influenza	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 of the one-year measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization	Patients who have received an influenza immunization OR who reported previous receipt of influenza immunization Definition: Previous Receipt – May include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1	All patients aged 6 months and older seen for a visit between October 1 and March 31	None	Immunizations	Adult Immunization	Process	Endorsed	0041	AMA-PCPI
180	Physician Compare/Physician Feedback/ Value-Based Modifier	111 GPRO Prev-8 Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine	Patients who have ever received a pneumococcal vaccination	All patients 65 years and older	None	Immunizations	Adult Immunization	Process	Endorsed	0043	NCQA
1803	Physician Compare/Physician Feedback/ Value-Based Modifier	Arthritis: Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	Percentage of patients 18 years or older diagnosed with rheumatoid arthritis who had at least one ambulatory prescription dispensed for a DMARD during the measurement year	Patients who had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug (DMARD) during the measurement year. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	All patients, ages 18 years and older as of December 31 of the measurement year, with a diagnosis of rheumatoid arthritis (RA). Two face-to-face physician encounters with a rheumatoid arthritis diagnosis with different dates of service in an ambulatory or nonacute inpatient setting between January 1 and November 30 of the measurement year are required to confirm a rheumatoid arthritis diagnosis.	Exclude the following patients from the denominator: - Patients who have been diagnosed with human immunodeficiency virus - Women who are identified as being pregnant.	Musculoskeletal	Rheumatoid Arthritis	Process	Endorsed	0054	NCQA
101	Physician Compare/Physician Feedback/ Value-Based Modifier	001 GPRO DM-2 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%	Patients with most recent hemoglobin A1c level > 9.0%	Patients aged 18 through 75 years with the diagnosis of diabetes	Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list who did not have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year.	Diabetes	HbA1c Management	Intermediate Outcome	Endorsed	0059	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
187	Physician Compare/Physician Feedback/ Value-Based Modifier	118 GPRO CAD-7 Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy	Patients who were prescribed ACE inhibitor or ARB therapy; Definition: Prescribed – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the measurement period OR patient already taking ACE inhibitor or ARB therapy as documented in current medication list.	There are two reporting criteria for this measure: (REPORTING CRITERIA 1): All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a current or prior LVEF < 40%, (REPORTING CRITERIA 2): All patients aged 18 years and older with a diagnosis of CAD who also have a diagnosis of diabetes	Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, allergy, intolerant, pregnancy, renal failure due to ACE inhibitor, diseases of the aortic or mitral valve, other medical reasons) Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, patient declined, other patient reasons) Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, lack of drug availability, other reasons attributable to the health care system)	Cardiovascular	Coronary Artery Disease/Ischemic Heart Disease	Process	Endorsed	0066	AMA-PCPI/ACCF/AHA
303	Physician Compare/Physician Feedback/ Value-Based Modifier	204 GPRO IVD-2 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-thrombotic	Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic	Patients who are using aspirin or another antithrombotic therapy	Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)	None	Cardiovascular	Coronary Artery Disease/Ischemic Heart Disease	Process	Endorsed	0068	NCQA
1135	Physician Compare/Physician Feedback/ Value-Based Modifier	Acute Myocardial Infarction (AMI): Persistence of Beta-Blocker Treatment After a Heart Attack	The percentage of patients age 18 years and older during the measurement year who were hospitalized and discharged alive July 1 of the year prior to the measurement year through June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.	A 180-day course of treatment with beta-blockers post discharge. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Patients 18 years and older as of December 31 of the measurement year discharged alive from an acute inpatient setting with an AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year.	Exclude patients who are identified as having a contraindication to beta-blocker therapy or previous adverse reaction to beta-blocker therapy. Also exclude from the denominator hospitalizations in which the patient was transferred directly to a nonacute care facility for any diagnosis.	Cardiovascular	Acute Myocardial Infarction	Process	Endorsed	0071	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
296	Physician Compare/Physician Feedback/ Value-Based Modifier	197 GPRO CAD-2 Coronary Artery Disease (CAD): Lipid Control	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result <= 100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin	Patients who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result <= 100 mg/dL AND have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin Definitions: Documented plan of care: Includes the prescription of a statin and may also include: documentation of discussion of lifestyle modifications (diet, exercise) or scheduled re-assessment of LDL-C Prescribed: May include prescription given to the patient for a statin at one or more visits within the measurement period OR patient already taking a statin as documented in current medication list Instructions: The first numerator option can be reported for patients who have a documented LDL-C < 100 mg/dL at any time during the measurement period (if more than one result, report most current)	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period	Documentation of medical reason(s) for not prescribing a statin (eg, allergy, intolerance to statin medication(s), other medical reasons) Documentation of patient reason(s) for not prescribing a statin (eg, patient declined, other patient reasons) Documentation of system reason(s) for not prescribing a statin (eg, financial reasons, other system reasons)	Cardiovascular	Coronary Artery Disease/Ischemic Heart Disease	Process	Endorsed	0074	AMA-PCPI/ACCF/AHA
1891	Physician Compare/Physician Feedback/ Value-Based Modifier	241 GRPO IVD-1 Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control	Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level was in control (less than 100 mg/dL)	Patients who received at least one lipid profile (or ALL component tests) with most recent LDL-C < 100 mg/dL	Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)	Exclude patient self-report or self-monitoring, LDL to HDL ratio and findings reported on progress notes or other non-laboratory documentation.	Cardiovascular	Coronary Artery Disease/Ischemic Heart Disease	Intermediate Outcome	Endorsed	0075	NCQA
107	Physician Compare/Physician Feedback/ Value-Based	008 GPRO HF-6 Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the	Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge Definition:	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%	Documentation of medical reason(s) for not prescribing beta-blocker therapy Documentation of patient reason(s) for not prescribing beta-blocker therapy Documentation of system reason(s) for not prescribing beta-blocker therapy	Cardiovascular	Heart Failure	Process	Endorsed	0083	AMA-PCPI/ACCF/AHA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
	Modifier		outpatient setting or at each hospital discharge	Prescribed – May include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list. Beta-blocker therapy – should include bisoprolol, carvedilol, or sustained release metoprolol succinate.								
132	Physician Compare/Physician Feedback/ Value-Based Modifier	046 GPRO Care-1 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented	Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented Definition: Medical Record – Must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.	All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care	None	Patient Safety	Medication Management	Process	Endorsed	0097	AMA-PCPI/NCQA
1895	Physician Compare/Physician Feedback/ Value-Based Modifier	318 GPRO Care-2 Falls: Screening for Falls Risk	Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months	Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	All patients aged 65 years and older	Documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory) Exclude patients for whom patient was not an eligible candidate for fall risk screening by reason of medical exclusion.	Chronic and Elder Care	Falls	Process	TLE	0101	AMA-PCPI/NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
234	Physician Compare/Physician Feedback/ Value-Based Modifier	134 Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented	All patients aged 12 years and older	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.	Mental Health Care & Substance-Related Care	Depression & Mood Disorders	Process	Endorsed	0418	CMS
231	Physician Compare/Physician Feedback/ Value-Based Modifier	128 GPRO Prev-9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal Normal Parameters: Age 65 years and older BMI <= 23 and < 30; Age 18 – 64 years BMI <= 18.5 and < 25	Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters Definitions: BMI – Body mass index (BMI), expressed as weight/height (BMI; kg/m2), is commonly used to classify overweight (BMI 25.0-29.9), obesity (BMI greater than or equal to 30.0) and extreme obesity (BMI greater than or equal to 40) among adults (CDC). BMI is calculated either as weight in pounds divided by height in inches	All patients aged 18 years and older	Patients can be considered not eligible in the following situations: There is documentation in the medical record that the patient is over or under weight and is being managed by another provider If the patient has a terminal illness If the patient refuses BMI measurement If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate 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.	Environment & Public Health	Obesity	Process	TLE	0421	CMS

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				squared multiplied by 703, or as weight in kilograms divided by height in meters squared. Elderly BMI – Most experts suggest use of a higher BMI threshold for underweight elderly individuals, compared to what is used for the general population. International Dietetics and Nutrition Terminology defines underweight in persons > 65 years of age as a BMI of < 23. This BMI value is one indicator of malnutrition when forming a nutrition diagnosis for the elderly population. A BMI of < 23 classifies an older adult (older than age 65) as underweight and may require nutrition intervention. Calculated BMI – Requires that both the height and weight are actually measured by an eligible professional or by their staff. Self-reported values cannot be used. Follow-Up Plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education, referral (such as, a registered dietician, nutritionist, occupational therapy, primary care physician, exercise physiologist, mental health professional, surgeon, etc.), prescription/administration of medications/dietary supplements, exercise counseling, nutrition counseling, etc.								

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1144	Physician Compare/Physician Feedback/ Value-Based Modifier	INR for Beneficiaries Taking Warfarin and Interacting Anti-Infective Medications	Percentage of episodes with an INR test performed 3 to 7 days after a newly-started interacting anti-infective medication for patients of patients 18 years or older receiving warfarin	Number of episodes in the denominator with an INR test performed 3 to 7 days after the start date of an anti-infective medication We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Number of episodes with a newly started interacting anti-infective medication with an overlapping days' supply of warfarin.	Individuals with a diagnosis of cancer Optional Exclusion: Individuals who are monitoring INR at home	Patient Safety	Medication Management	Process	Endorsed	0556	CMS
1145	Physician Compare/Physician Feedback/ Value-Based Modifier	Appropriate Work-Up Prior to Endometrial Ablation Procedure	Percentage of female patients who had an endometrial ablation procedure during the measurement year and who received endometrial sampling or hysteroscopy with biopsy during the previous year	Women who received endometrial sampling or hysteroscopy with biopsy during the year prior to the index date (inclusive of the index date). We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Continuously enrolled women who had an endometrial ablation procedure during the measurement year.	Women who had an endometrial ablation procedure during the year prior to the index date (exclusive of the index date).	Renal & Genitourinary		Process	Endorsed	0567	Health Benchmarks, Inc
1146	Physician Compare/Physician Feedback/ Value-Based Modifier	Appropriate Follow Up for Patients With HIV	Percentage of patients diagnosed with HIV who received a CD4 count and an HIV RNA level laboratory test in the 180 days (6 months) following diagnosis	Members who received at least one CD4 count and two HIV RNA level laboratory during the measurement year. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Continuously enrolled members with a diagnosis of HIV-1 or HIV-2 during the year prior to the measurement and the measurement year.	Members who were in hospice care or had a hospice referral during the measurement year.	Communicable Diseases	HIV/AIDS	Process	Endorsed	0568	Health Benchmarks, Inc
1149	Physician Compare/Physician Feedback/ Value-Based Modifier	Deep Vein Thrombosis Anticoagulation at least 3 Months	This measure identifies patients with deep vein thrombosis (DVT) on anticoagulation for at least 3 months after the diagnosis	Patients in the denominator who had at least 3 months of anticoagulation after acute deep vein thrombosis (DVT) We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Patients diagnosed with acute DVT more than 3 months prior to the end of the measurement year, who do not have contraindications to warfarin therapy (contraindications include: evidence of eye surgery, GI bleed, aortic dissection, cerebral aneurysm, pericarditis, bacterial endocarditis, pregnancy, bleeding diatheses, or head	Does not have contraindications to warfarin, which includes evidence of eye surgery, GI bleed, aortic dissection, cerebral aneurysm, pericarditis, bacterial endocarditis, pregnancy, bleeding diatheses, or head trauma anytime during the two years prior to the end of the measurement year through 90 days following onset of DVT	Cardiovascular	Venous Thromboembolism	Process	Endorsed	0581	Resolution Health, Inc

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
					trauma)							
1151	Physician Compare/Physician Feedback/ Value-Based Modifier	Hepatitis C: Viral Load Test	Percentage of patients 18 years or older with Hepatitis C (HCV) who began HCV antiviral therapy during the measurement year and had HCV Viral Load testing prior to initiation of antiviral therapy	Patients in the denominator who had an HCV Viral Load test prior to the initiation of antiviral therapy We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	HCV patients who started HCV antiviral therapy during the measurement year	None	Communicable Diseases	Hepatitis C	Process	Endorsed	0584	Resolution Health, Inc
1152	Physician Compare/Physician Feedback/ Value-Based Modifier	Pulmonary Embolism Anticoagulation at least 3 Months	This measure identifies patients with pulmonary embolism (PE) on anticoagulation for at least 3 months after the diagnosis.	Patients in the denominator who had at least 3 months of anticoagulation after acute pulmonary embolism We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Patients diagnosed with a PE during the first 9 months of the measurement year, who do not have contraindications to warfarin therapy (contraindications include: evidence of eye surgery, GI bleed, aortic dissection, cerebral aneurysm, pericarditis, bacterial endocarditis, pregnancy, bleeding diatheses, or head trauma during or 1 year prior to the measurement year)	Does not have contraindications to warfarin, which includes evidence of eye surgery, GI bleed, aortic dissection, cerebral aneurysm, pericarditis, bacterial endocarditis, pregnancy, bleeding diatheses, or head trauma anytime during the two years prior to the end of the measurement year through 90 days following onset of PE	Cardiovascular	Venous Thromboembolism	Process	Endorsed	0593	Resolution Health, Inc
1154	Physician Compare/Physician Feedback/ Value-Based Modifier	Steroid Use - Osteoporosis Screening	Percentage of patients 18 years or older on chronic steroids for at least 180 days in the past 9 months and who had a bone density evaluation or osteoporosis treatment	Medicare beneficiaries who had a bone density evaluation or osteoporosis treatment between 1/1/10 and 12/31/10. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Medicare beneficiaries 18 years or older as of 12/31/10, with continuous Medicare Parts A, B, and D coverage between 1/1/09 and 12/31/10, who were on chronic steroids for at least 180 days between 4/1/10 and 12/31/10.	Exclusions: Medicare beneficiaries with two or more diagnoses of corticoadrenal insufficiency between 1/1/09 and 12/31/10, and pregnant beneficiaries.	Musculoskeletal	Osteoporosis	Process	Endorsed	0614	ActiveHealth Management

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
1155	Physician Compare/Physician Feedback/ Value-Based Modifier	Breast Cancer - Cancer Surveillance	Percentage of female patients with breast cancer who had breast cancer surveillance in the past 12 months	Female patients with a history of breast cancer who had breast cancer surveillance (e.g., mammogram, MRI) Time Window: 12 months We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Female patients with a history of breast cancer Time Window: Anytime in the past	Bilateral mastectomy in the past, bilateral breast implants, biopsy/excision of breast lesion General exclusions: Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; Patients who have been in a skilled nursing facility in the last 3 months	Cancer	Breast	Process	Endorsed	0623	ActiveHealth Management
2875	Physician Compare/Physician Feedback/ Value-Based Modifier	Prostate Cancer-Cancer Surveillance	Percentage of males with definitively treated localized prostate cancer that have had at least one prostate-specific antigen (PSA) level monitoring in the past 12 months	Male Medicare beneficiaries who had at least one PSA level monitoring between 1/1/11 and 12/31/11. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Male Medicare beneficiaries diagnosed with localized prostate cancer and received treatment with a curative intent between 1/1/10 and 12/31/10, and who had continuous Medicare Parts A and B coverage between 1/1/11 and 12/31/11.	Exclusions: Male Medicare beneficiaries who received prostate cancer treatment between 1/1/11 and 12/31/11.	Health Services Administration	Patient Experience	Patient Perspective	De-endorsed	0625	AHRQ
2492	Physician Compare/Physician Feedback/ Value-Based Modifier	Diabetes Composite: Optimal Diabetes Care	Patients ages 18 to 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c less than 8.0, LDL less than 100, Blood Pressure less than 140/90, Tobacco non-user and for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.	Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes.	Patients with diabetes who have two or more visits with diabetes codes in the last two years and at least one visit in the last 12 months.	Exclusions: Death, hospice, permanent nursing home resident, and diabetes mellitus complicating pregnancy,	Diabetes		Composite	Endorsed	0729	Minnesota Community Measurement

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1892	Physician Compare/Physician Feedback/ Value-Based Modifier	317 GPRO Prev-11 Preventive Care and Screening: Blood Pressure Measurement	Percentage of patients aged 18 and older who are screened for high blood pressure	Patients who were screened for high blood pressure Recommended screening intervals: • Screening every 2 years for patient with blood pressure < 120/80 mm Hg • Screening every year with systolic blood pressure of 120-139 mm Hg or diastolic blood pressure of 80-90 mm Hg • Patients with one elevated reading of systolic blood pressure <= 140 mm Hg or diastolic blood pressure > 90 mm Hg should be screened every year NOTE: Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure. VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s): SYSTOLIC BLOOD PRESSURE WITH Documentation of Systolic BP AND DIASTOLIC BLOOD PRESSURE WITH Documentation of Diastolic BP	All patients aged 18 and older without known hypertension;	Patients who were diagnosed with hypertension at any time in the patient's history or whose 2 most recent systolic blood pressure <= 140 mm Hg or diastolic blood pressure > 90 mm Hg. NOTE: Due to variability in individual blood pressure measurements, it is recommended that hypertension be diagnosed before or during a qualifying visit only after 2 or more elevated readings are obtained on at least 2 visits (at least one day apart) over a period of one day to four weeks apart.	Cardiovascular	Hypertension	Process	Not Endorsed	N/A	CMS

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2762	Physician Compare/Physician Feedback/ Value-Based Modifier	Clinician/Group CAHPS: Care Coordination	Q21. Provider had medical records during your visits Q25. Provider's office followed up to give you results of test or x-ray Q64. You needed help from your care team to manage care, tests, or treatment from different providers Q65. You got help from your care team to manage care, tests, or treatment from different providers Q66. Satisfaction with help from your care team to manage care, tests, or treatment from different providers	See Description	See Description	TBD	Health Services Administration	Patient Experience	Patient Perspective	Not Endorsed	N/A	AHRQ
2763	Physician Compare/Physician Feedback/ Value-Based Modifier	Clinician/Group CAHPS: Between Visit Communication	Q13. Got reminders from provider's office between visits Q14. Got reminder from provider's office to make an appointment for tests or treatment	See Description	See Description	TBD	Health Services Administration	Patient Experience	Patient Perspective	Not Endorsed	N/A	AHRQ
2764	Physician Compare/Physician Feedback/ Value-Based Modifier	Clinician/Group CAHPS: Educating Patients about Medication Adherences	Q31. Provider gave you easy to understand instructions about how to take prescriptions medicines Q33. Provider gave you information in writing about how to take prescription medicines that was easy to understand Q34. Provider suggested ways to help you remember to take your medicines	See Description	See Description		Health Services Administration	Patient Experience	Patient Perspective	Not Endorsed	N/A	AHRQ
2765	Physician Compare/Physician Feedback/ Value-Based Modifier	Clinician/Group CAHPS: Stewardship of Patient Resources	Q59. Care team talked with you about cost of your prescription medicines	See Description	See Description	TBD	Health Services Administration	Patient Experience	Patient Perspective	Not Endorsed	N/A	AHRQ
2876	Physician Compare/Physician Feedback/ Value-Based	Episode Grouper: Acute Myocardial Infarction (AMI)	Inpatient admission with AMI diagnosis	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
	Modifier			physicians as identified by a single Tax Identification Number (TIN).								
2878	Physician Compare/Physician Feedback/ Value-Based Modifier	Episode Grouper: Pneumonia	A. Inpatient admission with pneumonia diagnosis B. 2 E&M visits with pneumonia dx at least one day apart; if hospitalization occurs in episode window, the episode begins with the 2 E&M visits	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS
2879	Physician Compare/Physician Feedback/ Value-Based Modifier	Episode Grouper: Coronary Artery Bypass Graft (CABG)	A hospitalization that contains a CABG procedure	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS
2880	Physician Compare/Physician Feedback/ Value-Based Modifier	Episode Grouper: Percutaneous Coronary Intervention (PCI)	A hospitalization that contains a PCI procedure in principal position	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS
2882	Physician Compare/Physician Feedback/ Value-Based Modifier	Episode Grouper: Coronary Artery Disease	An episode which starts with either physician visits or acute exacerbation (hospitalization) A. Physician visit: 2 E&M services spaced at least 30 days apart (but no more than 365 days apart) with dx. B. Acute exacerbations / Inpatient initiating events: 1. CABG, PCI , AMI episodes 2. CAD hospitalization (with dx)	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2884	Physician Compare/Physician Feedback/ Value-Based Modifier	Episode Grouper: Congestive Heart Failure (CHF)	Episode begins with either physician visits or acute exacerbation (hospitalization) A. 2 E&M services spaced at least 30 days apart (but no more than 365 days apart) with dx. B. Acute exacerbations / Inpatient initiating events: 1. CHF hospitalization (with dx)	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS
2885	Physician Compare/Physician Feedback/ Value-Based Modifier	Episode Grouper: Chronic Obstructive Pulmonary disease (COPD)	Episode begins with either physician visits or acute exacerbation (hospitalization) A. 2 E&M services spaced at least 30 days apart (but no more than 365 days apart) with dx	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS
2887	Physician Compare/Physician Feedback/ Value-Based Modifier	Episode Grouper: Asthma	Epidose begins with either physician visits or acute exacerbation (hospitalization) A. 2 E&M services spaced at least 30 days apart (but no more than 365 days apart) with dx. B. Acute exacerbations / Inpatient initiating events: 1. Asthma hospitalization (with dx)	Not available at this time. Measure still under development. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	Not available at this time. Measure still under development.	Exclusions: Part D	Health Services Administration	Cost	Cost/Resource Use	Not Endorsed	N/A	CMS
1160	Physician Compare/Physician Feedback/ Value-Based Modifier	Potentially Harmful Drug-Disease Interactions in the Elderly	Percentage of patients 65 years or older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication, concurrent with or after the diagnosis Report each of three rates separately and as a total rate: Rate 1: A history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents Rate 2: Dementia and a prescription for tricyclic antidepressants or anticholinergic agents Rate 3: Chronic renal failure (CRF) and a prescription for non-aspirin NSAIDs or Cox-2 Selective NSAIDs	Rate 1: Drug-Disease Interactions—History of Falls and Tricyclic Antidepressants, Antipsychotics or Sleep Agents - Dispensed an ambulatory prescription for a tricyclic antidepressant or an antipsychotic or sleep agent on or between the IESD and December 31 of the measurement year Rate Drug-Disease Interactions—Dementia and Tricyclic Antidepressants or Anticholinergic Agents - Dispensed an ambulatory prescription for a tricyclic antidepressant, or anticholinergic agent on or between the IESD and December 31 of the measurement	Medicare beneficiaries who were a) 67 years or older as of the measurement year, b) No more than one gap in enrollment of up to 45 days during each year of continuous enrollment c) Enrolled as of December 31 of the measurement year, d)Members with at least one disease, condition or procedure in the measurement year or the year prior to the measurement year. Refer to Additional Eligible Population Criteria for each rate: Rate 1: An accidental fall or hip fracture on or between January 1 of the year prior to the measurement year and December	Rate 1: Exclude members with a diagnosis of psychosis on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Rate 2 Exclusions: None. Rate 3 Exclusions: None.	Patient Safety	Medication Management	Process	Not Endorsed	N/A	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			Total rate: The sum of the three numerators divided by the sum of the three denominators	year. Rate 3: Drug-Disease Interactions—CRF and Nonaspirin NSAIDs or Cox-2 Selective NSAIDs - Dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID on or between the IESD and December 31 of the measurement year. We note these measures will be assessed for Medicare beneficiaries assigned to a group of physicians as identified by a single Tax Identification Number (TIN).	1 of the measurement year. Rate 2: Had a diagnosis of dementia or a dispensed dementia medication on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Rate 2 Exclusions: None Rate 3: Had a diagnosis of CRF on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Rate 3 Exclusions: None						
2751	Physician Compare/Physician Feedback/ Value-Based Modifier	Follow-Up After Hospitalization for Mental Illness (7- and 30- day)	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1: The percentage of members who received follow-up within 30 days of discharge Rate 2: The percentage of members who received follow-up within 7 days of discharge.	Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred). Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.	Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for a mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify nonacute care. Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables MPT-A and MPT-B. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.	Mental Health Care & Substance-Related Care		Outcome	Endorsed	0576	NCQA

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
42	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey	27-items survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.	None Listed	None Listed	None Listed	Health Services Administration	Patient Experience	Patient Perspective	Endorsed	0166	AHRQ
27	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Pre/Post Surgery	Surgery patients who received appropriate Venous Thromboembolism (VTE) prophylaxis within 24 hours prior to Anesthesia Start Time to 24 hours after Anesthesia End Time.	Surgery patients who received appropriate Venous Thromboembolism (VTE) prophylaxis within 24 hours prior to Anesthesia Start Time to 24 hours after Anesthesia End Time.	All selected surgery patients	Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Burn patients Patients enrolled in clinical trials Patients who are on oral anticoagulation therapy prior to admission Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients whose total surgery time is less than or equal to 60 minutes Patients who stay less than two nights Patients who expire perioperatively Patients with reasons for not administering both mechanical and pharmacological prophylaxis Patients who did not receive VTE Prophylaxis	Surgery	Perioperative care	Process	Endorsed	0218	CMS (The Joint Commission)

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
18	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP Cardiovascular-2 Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period. The perioperative period for the SCIP Cardiac measure is defined as the day prior to surgery through postoperative day two (POD 2) with day of surgery being day zero. If the postoperative length of stay is = 2 days, the measure evaluates the administration of more than one dose of a beta-blocker: the day prior to or the day of surgery and on postoperative day one (POD 1) or postoperative day two (POD 2) unless reasons for not administering the medication were documented. If the postoperative length of stay is < 2 days, the measure will evaluate the administration of the beta-blocker on the day prior to or the day of surgery only, unless reasons for not administering the medication were documented.	Surgery patients on beta-blocker therapy prior to arrival who receive a beta-blocker during the perioperative period	All surgery patients on beta-blocker therapy prior to arrival.	Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Patients enrolled in clinical trials Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients who expired during the perioperative period Pregnant patients taking a beta-blocker prior to arrival Patients with a documented Reason for Not Administering Beta-Blocker-Perioperative Patients with Ventricular Assist Devices or Heart Transplantation	Surgery	Perioperative care	Process	Endorsed	0284	CMS (The Joint Commission)
22	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP-Inf-04 Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	Cardiac surgery patients with controlled 6 A.M. blood glucose (less than or equal to 200 mg/dL) on postoperative day one (POD 1) and postoperative day two (POD 2) with Anesthesia End Date being postoperative day zero (POD 0).	Surgery patients with controlled 6 A.M. blood glucose (less than or equal to?200 mg/dL) on POD 1 and POD 2.	Cardiac surgery patients with no evidence of prior infection.	Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Patients who had a principal diagnosis suggestive of preoperative infectious diseases Burn and transplant patients Patients enrolled in clinical trials Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interest Patients who expired perioperatively Patients whose post-operative length of stay is less than or equal to 2 days	Surgery	Perioperative care	Intermediate Outcome	Endorsed	0300	CMS (The Joint Commission)

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2745	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Multiple Myeloma – Treatment with Bisphosphonates	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	Patients who were prescribed or received intravenous bisphosphonate therapy within the 12 month reporting period.	All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission	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) Documentation of patient reason(s) for not prescribing bisphosphonates	Cancer	Hematologic	Process	TLE	0380	AMA-PCPI
2746	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Oncology: Radiation Dose Limits to Normal Tissues	Percentage of patients with a diagnosis of cancer receiving 3D conformal radiation therapy with documentation in medical record that normal tissue dose constraints were established within five treatment days for a minimum of one tissue	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	All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy	None	Cancer		Process	TLE	0382	AMA-PCPI
1626	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Oncology: Plan of care for pain-medical oncology and radiation oncology	Oncology: 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	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.	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain	None	Cancer		Process	TLE	0383	CMS
2747	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy in which pain intensity is quantified	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	All visits for patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	None	Cancer		Process	TLE	0384	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
2748	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Prostate Cancer: Avoidance of Overuse Measure – Isotope Bone Scan for Staging Low-Risk Patients	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 a bone scan performed at any time since diagnosis of prostate cancer	Patients who did not have an isotope bone scan performed 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 risk2 High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinical stage T2c or greater; and not qualifying for very high risk2 Note: Only patients with prostate cancer with low risk of recurrence will be counted in the denominator of this measure	Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician) Denominator Exclusion: Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons)	Cancer	Prostate	Process	TLE	0389	AMA-PCPI
2749	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients	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)	Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)	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 risk2 High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinical stage T3a or greater; and not qualifying for very high risk2 Note: Only patients with prostate cancer with high risk of recurrence will be counted in the denominator	Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy (GnRH agonist or antagonist) Denominator Exclusion: Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (GnRH agonist or antagonist)	Cancer	Prostate	Process	TLE	0390	AMA-PCPI

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
					of this measure							
25	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP-Inf-10 Surgery Patients Preoperative Temperature Management	Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8° Fahrenheit/36° Celsius recorded within the 30 minutes immediately prior to or the 15 minutes immediately after Anesthesia End Time.	Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8° Fahrenheit/36° Celsius recorded within the 30 minutes immediately prior to or the fifteen minutes immediately after Anesthesia End Time.	All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration	Patients who have a Length of Stay greater than 120 days Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients whose length of anesthesia was less than 60 minutes Patients who did not have general or neuraxial anesthesia Patients with physician/APN/PA documentation of Intentional Hypothermia for the procedure performed	Surgery	Perioperative care	Process	Endorsed	0452	CMS (The Joint Commission)
24	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP-Inf-09 Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery Being Day Zero	Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	Number of surgical patients whose urinary catheter is removed on POD 1 or POD 2 with day of surgery being day zero.	All selected surgical patients with a catheter in place postoperatively.	Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Patients enrolled in clinical trials Patients who had a urological, gynecological or perineal procedure performed Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients who expired perioperatively Patients whose length of stay was less than two days postoperatively Patients who did not have a catheter in place postoperatively Patients who had physician/APN/PA documentation of a reason for not removing the urinary catheter postoperatively Patients who had a urinary diversion or a urethral catheter or were being intermittently catheterized prior to hospital arrival	Surgery	Perioperative care	Process	Endorsed	0453	CMS (The Joint Commission)

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
19	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP-Inf-01 Prophylactic antibiotic received within 1 hour prior to surgical incision	Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.	Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin)	All selected surgical patients with no evidence of prior infection.	Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Patients who had a hysterectomy and a caesarean section performed during this hospitalization Patients who had a principal diagnosis suggestive of preoperative infectious diseases Patients enrolled in clinical trials Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interest Patients who had other procedures requiring general or spinal anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stay Patients who were receiving antibiotics more than 24 hours prior to surgery Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics)	Surgery	Perioperative care	Process	Endorsed	0527	CMS (The Joint Commission)
20	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP-Inf-02 Prophylactic antibiotic selection for surgical patients	Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	All selected surgical patients with no evidence of prior infection.	Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Patients who had a principal diagnosis suggestive of preoperative infectious diseases Patients enrolled in clinical trials Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients with physician/advanced practice nurse/physician assistant	Surgery	Perioperative care	Process	Endorsed	0528	CMS (The Joint Commission)

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						(physician/APN/PA) documented infection prior to surgical procedure of interest Patients who expired perioperatively Patients who had other procedures requiring general or spinal anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stay Patients who were receiving antibiotics more than 24 hours prior to surgery (except colon surgery patients taking oral prophylactic antibiotics) Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics) Patients who did not receive any antibiotics before or during surgery, or within 24 hours after Anesthesia End Time (i.e., patient did not receive prophylactic antibiotics) Patients who did not receive any antibiotics during this hospitalization						
21	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	SCIP-Inf-03 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time.	Number of surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time (48 hours for CABG or Other Cardiac Surgery).	All selected surgical patients with no evidence of prior infection	Patients less than 18 years of age Patients who have a Length of Stay greater than 120 days Patients who had a principal diagnosis suggestive of preoperative infectious diseases Patients enrolled in clinical trials Patients whose ICD-9-CM principal procedure occurred prior to the date of admission Patients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interest Patients who expired perioperatively Patients who had other procedures requiring general or spinal anesthesia that	Surgery	Perioperative care	Process	Endorsed	0529	CMS (The Joint Commission)

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
						occurred within three days (four days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stay Patients who were receiving antibiotics more than 24 hours prior to surgery (except colon surgery patients taking oral prophylactic antibiotics) Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics) Patients who did not receive any antibiotics during this hospitalization. Patients who received urinary antiseptics only Patients with Reasons to Extend Antibiotics.						
2703	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Specific Surgical Site Infection (SSI)	Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs for each	Deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients = 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies. SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). Case accrual will be guided by sampling algorithms as described below.	Using multivariable logistic regression models for colon surgeries and abdominal hysterectomies, the expected number of SSIs is obtained. These expected numbers are summed by facility and surgical procedure and used as the denominator of this measure	Persons under the age of 18, those having a procedure performed on an outpatient basis, those with ASA Class VI (6) are excluded. In the NHSN, patients without primary closure of the surgical incision are not considered eligible cases and are excluded- the NSQIP will match this practice for this measure, although this is not standard practice within the NSQIP.	Patient Safety	Health Care-Associated Infections	Outcome	Endorsed	0753	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			procedure.									
1643	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Medicare Spending Per Beneficiary	The Medicare Spending per Beneficiary (MSPB) Measure evaluates hospitals' efficiency relative to the efficiency of the median hospital. Specifically, the MSPB Measure assesses the cost to Medicare of services performed by hospitals and other healthcare providers during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.	A hospital's average MSPB Amount, defined as the sum of standardized, risk-adjusted spending across all of a hospital's eligible episodes divided by the number of episodes for that hospital.	The median MSPB Amount across all hospitals.	Any episodes where at any time during the episode, the beneficiary is enrolled in a Medicare Advantage plan; the beneficiary becomes deceased; the beneficiary is covered by the Railroad Retirement Board; or Medicare is the secondary payer will be excluded from the MSPB calculation. Regarding beneficiaries whose primary insurance becomes Medicaid during an episode due to exhaustion of Medicare Part A benefits, Medicaid payments made for services rendered to these beneficiaries are excluded; however, all Medicare Part A payments made before benefits are exhausted and all Medicare Part B payments made during the episode are included. In addition, acute-to-acute transfers (where a transfer is defined based on the claim discharge code) will not be considered index admissions. In other words, these cases will not generate new MSPB episodes; neither the hospital which transfers a patient to another subsection (d) hospital, nor the receiving subsection (d) hospital will have an index admission attributed to them. Further, any episode in which the index admission inpatient claim has a $0 actual payment or a $0 standardized payment is excluded.	Health Services Administration	Cost	Efficiency	Not Endorsed	N/A	CMS

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
3035	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.	Total number of expected CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.	1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines 2. Peripheral intravenous lines are excluded from this measure	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC
3036	Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	The reliability-adjusted standardized infection ratio (SIR) is an outcome measure that summarizes the healthcare-associated infection experience by type of infection (e.g., central-line associated bloodstream infection, surgical site infection) for individual hospitals. The reliability-adjusted measure enables more meaningful statistical differentiation between hospitals by accounting for differences in patient case-mix, exposure volume (e.g. central line-days, surgical procedure volume), and unmeasured factors that are not reflected in the unadjusted SIR and that cause variation between hospitals. Accounting for these sources of variability enables better	Total number of observed healthcare-associated CAUTI among inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries)	Total number of expected CAUTIs, which is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure	Non-indwelling catheters by NHSN definitions: 1.Suprapubic catheters 2.Condom catheters 3."In and out" catheterizations	Patient Safety	Health Care-Associated Infections	Outcome	Not Endorsed	N/A	CDC

Measure ID	CMS Program	Measure Title	Description	Numerator	Denominator	Exclusions	Condition	Sub-Condition	Measure Type	NQF Endorsed Status	NQF ID	Measure Steward
			measure discrimination between hospitals and leads to more reliable performance rankings. Methodologically, the reliability-adjusted SIR takes fuller advantage of the data reported by hospitals and is produced by weighting each hospital's infection experience to the mean according to its patient case-mix and exposure volume.									